'Accident & Emergency' Why is the NHS in England being privatised?

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The decade that 'ends the NHS'

Privatisation of England's NHS

- England's NHS: founded in 1947, taxpayer funded and nationalised.
- 2010s accelerate a long (linear?) history of marketisation and privatisation;
  - Private provision of NHS treatments trebles;
  - But huge regional variation in levels of privatisation.

What model of privatisation?

Contracting-out and Delegation

- Outsourcing via markets;
  - Contracting-out processes (Burchardt, 1997)
  - Managed-markets in place (Gingrich, 2011);
- Privatisation through 'delegation' strategy (Savas, 1990);

"Our NHS too has always benefited from a mixed economy of providers... new providers, more choice and competition raises standards"
- David Cameron, UK Prime Minister, 2011

So what?

Why do we care about privatisation?

- The advocates of contracting-out and delegation argue it improves quality of care by assuming:
  - 1) Commissioners actively decide who provides NHS services (or 'accidents');
  - 2) Commissioners prioritise the best quality provider (or 'emergencies');
- But, evidence that NHS privatisation in England negatively impacts outcomes (Goodair, 2022);
- So... why outsource? and do those assumptions hold true?

- RQ: What do commissioners of NHS service perceive to be the main reasons for outsourcing?;

- Data:
  - 20 interviews with individuals working at three different commissioning bodies;
  - Asked a) why outsource? and b) what explains regional differences?;
- Methods:
  - Thematic analysis.
  - Inductive under a priori categories of 1) why outsource? and 2) why does it vary regionally?

Findings: The private sector is 'a release valve'

Success of NHS providers in meeting demand

"Participant E: So to produce capacity quickly, to get to 18 week waiting time targets. That was the inception of the independent sector, but that still holds true."

So what...

- Release valves can be turned off
- Agency with the commissioner
- Primacy with the public providers

'Build another lane on the M25 and people will drive on it'

Patient choice, locations and predatory providers

> *"Participant F: Some of these companies do a lot of marketing. So we've had leaflets sent to just about every household, and some of them are linked as well to primary care services to have a direct link through... We had quite a lot of anecdotal feedback from people that had been through those services that said, 'I didn't even know I had a cataract', but they had it operated on."*

So what...

- Regulatory framework allows 'non-contractual activity'
- Combined with strict patient choice laws - 'pork-barrel market' (Gingrich, 2011)
- Results in 'direct to consumer advertising' see USA...

> *"If you're an independent sector provider, you can go and look to a venture capitalist company for your start-up monies you can buy or build a property and you can be up and running very, very quickly. Whereas in the NHS, it's a bit of a slow burn."*

So what...

- Austerity has limited the intended mechanism for quality... competition
- 'Displacement' (Savas, 1989)
- Interacts with meeting demand theme.

‘No money = can’t outsource’ vs ‘no money = forced to outsource’

An austerity paradox?

”Participant A: if you’re a financially challenged CCG, which [redacted CCG name] has been for a long time. We’ve used procurement to try and secure the best value and potentially make savings”

”Participant E: We had so much money that we couldn’t spend it all... And we could commission as much independent sector capacity”

So what...

- Large variation in NHS regions funding levels
- Results in different forms of privatisation
- I have tried so hard to quantify this and failed so far...

Interpretation

Discussion and policy implications

- My main research agenda: is privatisation good for quality of care, if not, how is it bad?
- Policy implications: Getting towards a picture of 'probably bad' practices within NHS privatisation: austerity/ provider abuse;
- Theoretical implications: Challenges some characterisations of NHS privatisation as managed markets/ contracted-out/ delegation (Gingrich, Burchardt, Savas);
- A new theory of controlled/uncontrolled outsourcing.

Limitations

Methodological and theoretical considerations

- Interviews conducted as I published a paper showing relationship with more deaths + involved in disseminating and advocacy
  (my own position on this has changed since starting a PhD - from 'probably immoral' to 'potentially dangerous')
- Temporal and geographic contexts important (covid, reform, 3 locations, no patients/ providers involved)
- Single-author coding, findings circulated to participants but likely no time to publish data properly

Conclusions and questions

Conclusions:

- England's NHS is being privatised;
- Privatisation involves a range of processes and strategies - some accidental, some emergencies.
- Sets up a research agenda quantifying how privatisation impacts health outcomes;

Questions for you:

- Is anything I said exciting? (honestly!)
- Are my 'theoretical contributions' meaningful?
- Are there other questions this data can help answer or poses? (Particularly something answerable with mixed methods...)

Appendix

Table 1 – Varieties of privatisation in England's NHS

Organising Theme	Basic Theme	'Managed' or 'Uncontrolled' outsourcing?	'Accidental' or 'Emergency' privatisation at the commissioner level?
Success of NHS providers in meeting demand	Longer waiting times increase use of private sector.	Managed – the metaphor of 'a release valve' suggests it can be turned on or off – the decision is with commissioners.	'Emergency' – often prioritises quantity of provision, rather than quality. Enforced by limited NHS capacity.
	Varying population demographics would alter need for, and uptake of, private sector.	Could be either – managed when commissioners responding to population need, uncontrolled when outsourcing is driven by 'aspiration' of middle-classes.	Could be 'accidental' for commissioners but this theme often identified power in the hands of the patients.
	Quality metrics and user feedback may lead to use of competitive procurement process.	Managed – often using procurement procedures responding actively to data – the decision is with commissioners.	Neither – prioritises quality and locates power with the commissioners.
Private provider locations and the choice agenda	Privatisation driven by locations of private hospitals.	Uncontrolled – suggests the decision is with the 'market' of providers.	'Accidental' – commissioners do not have the power to control the healthcare market.
	New Labour reforms created the situ of private hospitals through ISTC contracts.	Uncontrolled – suggests the decision is with the central government and cannot be changed by commissioners.	'Accidental' at the site of commissioners but the key site of power was central government in this theme.
	Rural commissioners have limited access to private provision.	Uncontrolled – suggests the decision is with the 'market' of providers.	'Accidental' – commissioners do not have the power to control the healthcare market.
	'The Choice Agenda' and predatory providers empower private providers.	Uncontrolled – the decision is with individual providers who bypass commissioners entirely.	'Accidental' – No power with the commissioner to dictate the provision. It was suggested this could be an 'emergency' at the patient level through direct-to-consumer advertising.
NHS capital	Absence of NHS provision, often for siloed services.	Uncontrolled – commissioners had no choice if there was no available NHS provision.	'Accidental' – power lies with 'the market' of provision.
	Workforce availability limited NHS expansion.	Uncontrolled – suggested their decision-making power was constrained due to workforce limitations.	'Accidental' – power lies with central workforce policies.
Commissioning Leadership and Politics	Leader's appetite for alternatives.	Managed – individuals within the commissioning body used the commissioner's decision-making powers to influence outsourcing.	Neither – always with the aim of improving quality of care and locates power with the commissioners.
	Outsourcing to challenge NHS provider cultures.	Managed – commission decision-making power used to purposefully outsource services.	"Emergency" – not clear that the cultures being challenged were primarily about health service quality.
Consequences of Financing and Austerity	Stringent budgets induce outsourcing	Managed – sometimes uncontrolled if pressured into outsourcing by central administration - but mostly actively 'searching for efficiencies'.	Emergency – prioritises finances.
	Stringent budgets constrain outsourcing	Managed – decisions made about which services to cut or constrain.	Emergency – prioritises finances.
	Prices of comparable services don't generalise by sector of provision	Managed – discussed as part of competitive procurement process.	Emergency – prioritises finances.

'Someone being brave and innovative'

'Leadership appetite' and personal relationships

> *"Participant N: [redacted CCG leader] did threaten the hospital with quite a lot of procurement at the very start of [redacted pronoun] tenure, I think that was pushed to shake the hospital up a bit. And to some extent that you can play a bit of tactics, and you can play politics with people, as a leader to try and, well I guess, manipulate essentially..."*

So what...

- Different 'philosophies of healthcare' from within NHS
- Privatisation requires some 'entrepreneurs'
- Different kind of 'privatisation' - to the individuals inside?