



## Invited Review

# The changing face of the English National Health Service: new providers, markets and morality

Lucy Frith\*

Department of Health Service Research, The University of Liverpool, Block B, The Waterhouse Building, Brownlow Street, Liverpool, L69 3GL, UK.

\*Correspondence address. Department of Health Service Research, The University of Liverpool, Block B, The Waterhouse Building, Brownlow Street, Liverpool, L69 3GL, UK. E-mail: frith@liverpool.ac.uk

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## Abstract

**Introduction:** One significant change in the English National Health Service (NHS) has been the introduction of market mechanisms. This review will explore the following questions: should we have markets in healthcare? What is the underlying philosophy of introducing more market mechanisms into the NHS? What are the effects of this and does it change the NHS beyond anything Bevan might have imagined in 1948?

**Sources of data:** The review will use empirical studies, philosophical literature, bioethics discussion, policy and NHS documents.

**Areas of agreement:** The NHS is facing unprecedented challenges at the beginning of the 21st century, with funding levels not meeting the increase in demand.

**Areas of controversy:** The extent and appropriate role for market mechanisms in the NHS is hotly debated. It will be argued that we are moving towards a more market-based NHS and the possible effects of this will be discussed.

**Growing points:** Rarely are the policy changes in the NHS evidence based in any meaningful way and they are often driven by ideological considerations rather than clear evidence. There needs to be a greater reliance on evidence of what works and a continuing commitment to healthcare as a societal good.

**Areas timely for developing research:** There needs to be a discussion of what the NHS should be—a funder and provider, a funder or a partial

funder? How the balance of power between regulators, different types of provider, commissioners and ultimately patients will play out in this changing environment are also areas for future study.

**Key words:** National Health Service (NHS), health policy, markets, morality, healthcare

## Introduction

The National Health Service (NHS) has changed in many ways since 1948; one significant change has been the introduction of market mechanisms. This review will explore: should we have markets in healthcare? What is the underlying philosophy of introducing market mechanisms into the NHS? Has there been an increase in market mechanisms in the NHS? What are the effects of recent policies and do they change the NHS beyond anything Bevan might have imagined in 1948? This review will focus on one aspect of the introduction of market mechanisms into the NHS, the use of non-NHS providers. It will be argued that rarely are the policy changes in the NHS evidence based in any meaningful way,<sup>1</sup> and they are often driven by ideological considerations rather than clear evidence of what models of organization are most effective.

## Background

### Markets in healthcare

Since the Thatcher government, there has been an ideological shift in perceptions of the government's role in welfare provision and a gradual cross-party acceptance that market mechanisms are an appropriate way of delivering public services. This has led to an increasing role for private financing and provision.<sup>2</sup> Underlying this position are assumptions about the appropriate role the state should play in financing and providing welfare services. I shall first consider the arguments surrounding markets in healthcare in general and then consider how these arguments apply to recent policy developments in the English NHS.

As Sen<sup>3</sup> notes there are two strategies for justifying or critiquing markets: rights and liberty, and the consequences of markets. Markets have traditionally

been justified on the grounds that they promote the basic right to private property. This is a negative right to be free from interference and state provision of services, and the tax systems needed to fund such services, prevent individuals exercising their liberty to dispose of their property as they see fit. This is an underlying tenet of much conservative thinking on the welfare state. The NHS is akin to having a Soviet style planned economy,<sup>4</sup> and basic rights and freedoms are best promoted by private enterprise—a state-owned bureaucratic NHS prevents individuals from exercising their basic freedoms. This is problematic as restricting freedoms is *prima facie* harmful, in that freedom is a good in itself (cf. John Stuart Mill) and the consequences are also harmful, creating a hierarchical, static healthcare system, that is designed for the needs of the organization not the patient. Recently, this idea has motivated the choice agenda that seeks to encourage a, 'consumerist market-based choice model which defines healthcare users as individualistic actors striving to maximise their preferences.'<sup>5</sup>

The consequences of having markets in healthcare, however, have been argued to be problematic for three main reasons. First, there is a justice-based argument. A purely private market in healthcare would not provide sufficient coverage for all of society, leaving those without sufficient financial means unable to access healthcare,<sup>6</sup> and this is viewed as morally wrong. Daniels<sup>7</sup> advances an argument of this type, appealing to concepts of social justice to demonstrate that we have a moral obligation to provide healthcare to all. Healthcare and health promoting activities are 'special' because they have a positive impact on opportunity. He argues that as ill health reduces the range of opportunities open to us and healthcare promotes and protects our opportunity range, if we have an obligation to protect opportunity range, we also have obligations to

promote and protect health. Heath<sup>8</sup> argues that this is an egalitarian justification for the welfare state, that a purely market economy can lead to an unequal distribution of wealth and extreme poverty for some members of society. Hence, the state needs to step in to redistribute wealth. He argues that this model can be challenged because, simply put, if the state was mainly concerned about equality, it could redistribute wealth via taxation without becoming involved in financing and/or provision of healthcare.

Second, there is a view that healthcare and the professions who provide it should not, primarily, be motivated by financial considerations. These arguments are based on the view that healthcare itself is a moral practice—the goals of medicine are to promote well-being and human flourishing. Concepts of medical professionalism build on this, that there are specific moral responsibilities and obligations required of doctors *qua* their membership of the profession of medicine, based on furthering the goals of medicine.<sup>9</sup> Callahan and Wasunna<sup>10</sup> argue that a market ideology that privileges individual choice as the greatest good cannot ensure that the key values underpinning good healthcare are not lost. Relman, a former editor of the *New England Journal of Medicine*, has written extensively on the dangers of the commercialization of healthcare, he argues such trends, ‘will inevitably undermine the ethical foundations of medical practice and dissolve the moral precepts that have historically defined the medical profession.’<sup>11</sup> These kinds of concerns motivate authors such as Waltzer<sup>12</sup> to argue that medicine should be a ‘blocked exchange’, goods that should not be brought or sold. This objection to markets in healthcare draws on a long tradition found in ancient Greek thought and Judeo-Christianity that the profit motive corrupts and that the pursuit of money distracts us from higher goals.<sup>13</sup> There are objections to this position: while it is problematic to treat the provision of healthcare only as a means of generating profit, it does not follow that other motivations cannot be upheld alongside it. Although, as authors have noted, profit motives have the tendency to ‘crowd out’ other values, they do not *have* to crowd them out, and regulation and oversight can provide

suitable breaks on ‘lucrepathic’ behaviour.<sup>13</sup> As Radin<sup>14</sup> advances, medicine can be seen as something that, rather than being a blocked exchange, could operate in the commercial arena, but within certain constraints.

Finally, there are economic reasons why healthcare is special and makes the introduction of markets in healthcare problematic. In economic theory, markets are simply mechanisms of transferring information (on price, quality, availability, etc.) and markets fail when there are problems with the free flow of information, or consumers cannot react in a way that sends back signals to suppliers. Arrow<sup>15</sup> in his famous 1963 article outlined reasons why the healthcare market is ‘a special case in economic analysis’. Healthcare markets are characterized by the vulnerability of most healthcare patients; the necessity for professional excellence; asymmetries of information (consumer ignorance); demand is not price led and demand is not necessarily negotiated by those who consume the product (i.e. professionals or commissioning groups purchase healthcare rather than individual patients). Donaldson<sup>6</sup> sums up the reasons why there are elements of healthcare that restrict markets operating optimally: failure of health insurance (if unregulated would exploit consumers); the caring externality (it is important to provide care for all or at least most of society) and consumer ignorance (healthcare is professionally mediated). These elements mean that the risk of market failure is high and therefore, for economic and efficiency reasons, the state needs to step in. Heath argues that this most persuasive reason for a welfare state, what he calls the ‘public-economics’ model. The role of the state is to resolve collective action problems and the welfare state, ‘emerges in those areas where liberal markets fail to produce optimal outcomes.’<sup>8</sup> Other justifications of the welfare state, the justice/egalitarian model and the goals of medicine argument (that Heath considers under the rubric of a communitarian model of welfare provision), do not stand up to scrutiny. Heath argues that the “normative logic” of these [welfare] systems is one of efficiency. The way that public healthcare systems are *paid for* is redistributive ... but this is a property of the tax system, not

the healthcare system.<sup>8</sup> Therefore, the explanation, which gives the best account of the rise of the welfare state and has most normative force, is the ‘public-economics model’—the state can provide and finance healthcare more efficiently than if it were left to the market.

The arguments that healthcare is a ‘special’ kind of commodity both morally and economically implies that there needs to be some form of state intervention to ensure that market forces operate in the best interests of society and produce a more efficient system. The key debate is how far the state needs to intervene to regulate this market—or in the case of the NHS—how far the state can be rolled back before commercial interests take precedence over the interests of those using and working in the NHS.

### Health policy in England

Having considered the idea of markets in healthcare in principle, I shall now turn to recent policy developments in England that have introduced market mechanisms into the NHS. The biggest, most fundamental changes in the NHS have occurred in the last 30 years, a time where state provision of welfare and goods was questioned and a neo-liberal philosophy of rolling back the state gained greater ascendancy.<sup>16</sup> Many diverse policy and social trends have led to these reforms that cannot be fully considered in this review.<sup>17</sup> However, there are some central claims that underpin the justifications for this move away from the post-war consensus on the welfare state that have been articulated by both recent Labour and Conservative governments.<sup>17,18</sup> The main claim was based on a view, set out in the Griffiths Report,<sup>19</sup> that the NHS was a hierarchical monopoly with little accountability, was poor at containing costs and did not provide good quality care to patients. This was a view set out by both conservative thinkers Letwin and Redmon<sup>4</sup> and later Le Grand,<sup>20</sup> who advised Tony Blair on new Labour’s health policies. The solution to this was broadly that the NHS should learn from the private sector and ‘market forces’ and the relationships created by these could begin to solve these problems. This is based on a classical economics view that

markets function efficiently and the state cannot attempt to emulate this.<sup>6</sup> Specifically, it was thought that the private sector was better managed. The lack of individual managerial accountability was highlighted as a problem for the NHS and changes, under the rubric of New Public Management were introduced, with a greater focus on performance management (such as pay awards, individual accountability, targets and league tables). Second, it was argued that market forces would encourage leaner more efficient service provision and the introduction of quasi-markets and later the provider/commissioning split, were all attempts to improve organizational performance by using the mechanisms of competition. Competition and patient choice would improve the quality of healthcare and stimulate innovation by ensuring that the best providers were chosen by commissioners and patients and such incentives would ensure innovatory practice.<sup>21</sup>

The culmination of this philosophy of the market as the ideal regulator was the passage of the Health and Social Care Act in 2012. The Act changed how healthcare is commissioned (bought). It established clinical commissioning groups (CCGs) (overseen by NHS England)—who have responsibility for commissioning services for their local populations replacing Primary Care Trusts and Strategic Health Authorities. The ‘any qualified provider’ initiative,<sup>22</sup> enabled patients to choose from a range of providers from different sectors: commercial, third sector and the NHS. This built on previous initiatives to encourage non-NHS organizations to bid for services previously offered by the NHS. Section 75 of the 2012 Act has been described as the ‘engine of privatisation’<sup>23</sup> as it ensures that NHS contracts are opened up to the market. The regulations state that CCGs must put all services out to tender unless they can prove the service could only be provided by one particular provider. As one commentator notes: ‘This reform represents the completion of the roll-out of competition throughout NHS-funded provision.’<sup>24</sup> The Act also extended the role of Monitor, from overseeing foundation trusts, to acting as the oversight body to manage this new competitive environment. Monitor was merged with the NHS Trust

Development Authority in 2015 to become NHS Improvement.

Although the state still pays for the bulk of health-related expenditure, there has been an increasing use of private sector finance in the form of Public Finance Initiatives (PFI) such as the Local Improvement Finance Trust that was introduced in 2000 to improve primary care facilities. It has been argued that these co-financing arrangements are the most profound change in the NHS as it represents a move towards more private financing of healthcare.<sup>25</sup> The Department of Health (DH) has also divested in certain areas, for example, it sold an 80% share in Plasma Resources UK to Bain Capital a private equity firm, for £200 million in 2013.<sup>26</sup>

### Market mechanisms in the NHS

Having considered recent developments in healthcare policy in England, I now want to delineate exactly what form of market mechanisms have been introduced into the NHS. The term ‘market’, when used in a healthcare context, is often ambiguous and can cover numerous different mechanisms and organizational forms.<sup>2</sup> ‘There is no single, simple concept of market that can be adopted for use in a health system. Rather market style mechanisms include a number of specific instruments such as consumer sovereignty (patient choice), negotiated contracts and open bidding.’<sup>27</sup> Markets can vary depending on the mechanisms used to foster competition and choice, who pays for healthcare, how doctors are reimbursed for their services and how the sector is regulated. Powell advances a mixed economy of welfare perspective that takes a three dimensional approach to consider different aspects of healthcare to assess how far and in what way market mechanisms have penetrated: who owns the resource; who finances it; and how it is regulated.<sup>25</sup> A further way of analysing markets in healthcare is to consider how markets affect and alter power relationships—for example, the countervailing powers framework focuses attention on the degrees of power key stakeholders have and how different market forms alter and remould these relationships.<sup>28</sup> These

frameworks will be used to assess the effects of the introduction of market mechanisms in the NHS.

In the UK, while keeping the central idea of healthcare free at the point of delivery and, largely, paid for by the state, the main market mechanism that has been introduced is a degree of competition into the supply side of the chain between providers. This has been done in two ways: providers compete for contracts; and providers compete for patients who can choose where to be treated. In this review, I will concentrate on the first element of increasing competition and choice—providers competing for contracts—putting to one side the issues surrounding the use patient choice to drive competition, as this merits a discussion in its own right.<sup>5</sup> This form of competition will result in new relationships being created between providers and commissioners and new regulatory mechanisms (i.e. Monitor and now NHS Improvement) to oversee these ways of operating.

### Areas of agreement

#### Challenges for the NHS

There is general agreement that the NHS is facing unprecedented challenges at the beginning of the 21st century. Many of these are challenges that face all health services: increasing demand for healthcare arising from technological developments; demographic changes; rising expectations and the increase in chronic diseases that require long-term coordinated care.<sup>29</sup> In terms of public spending, the UK has entered a period of austerity. Under the Coalition government (2010–15) spending increased by 0.8% but growth in demand was 3–4% resulting in a shortfall in funding. ‘The coalition government met its commitment to increase NHS funding in real terms over the course of the parliament, this was less than the growth required to meet demand. Combined with significant cuts in social care services (12% in real terms), sustained financial constraints have meant that services have come under growing pressure and increasing numbers of NHS providers are in deficit.’ In winter 2015, 88% of hospital Trusts were forecasting deficits,<sup>30</sup> and ‘NHS

providers and commissioners ended 2015/16 with a deficit of £1.85 billion—the largest aggregate deficit in NHS history.<sup>31</sup> It has been estimated that by 2020/21, there will be a gap of £30 billion between patient need and NHS resources.<sup>32</sup> The key question is how to respond to these financial and system pressures: increase public funding through taxation or introduce market mechanisms to shift fiscal responsibility from the government and, hopefully, increase efficiency and cut costs.

## Areas of controversy

### Moving towards markets in the NHS

Whether the NHS is being dismantled and irretrievably changed or whether it is business as usual is a matter of heated debate. There are two issues to consider here: whether the NHS is being subject to more market forces; and second, if so, what are the implications of this? In assessing these changes, it must be noted that drawing firm conclusions is hampered by the lack of comprehensive information. As the Care Quality Commission (CQC) notes, there is a lack of data on the independent sector<sup>33</sup> and the DH does not keep central information on the number or value of contracts held between the NHS and non-NHS providers. In response to a Parliamentary question, the under-secretary for health said, ‘The information requested on contract awards is not held centrally. It is therefore not possible to provide an estimate centrally on the number and value of contracts that will be awarded to different types of provider.’<sup>34</sup> Furthermore, with commercial confidentiality, the full value of contracts is often not published.

According to government figures, there are 13 042 non-NHS organizations currently providing healthcare in UK.<sup>35</sup> In 2006/07 the NHS spent £5.6 billion (in 2011/12 prices) on care provided by non-NHS providers; by 2011/12 this had increased to £8.7 billion.<sup>36</sup> More recent figures from the Nuffield suggest that although the increase in spending on non-NHS providers has been slow it has nevertheless increased by 5% between 2012/13 and 2013/14<sup>37</sup> and private community health

provision has increased from 11% of expenditure in 2010/11 to 18% in 2012/13, whereas spending on acute care by non-NHS providers has fallen.<sup>38</sup> The *BMJ* conducted an investigation and found that a third of contracts between April 2013 and August 2014 had gone to the private sector.<sup>39</sup> Drawing on data from the DH accounts, a quarter of NHS UK’s budget and 16% of CCGs budget has gone on private providers.<sup>40</sup> Some NHS trusts subcontract out services that they have been commissioned by their CCG to provide (i.e. referring patients to private hospitals for treatment to avoid financial penalties of not treating within designated time limits), however, full data on this are scarce.<sup>40</sup>

Powell and Miller<sup>25</sup> argue that the ‘doomsday’ scenario of NHS provision receding has not materialized; however, the direction of healthcare policy under the Labour, Coalition and Conservative governments has been to encourage non-NHS providers and the 2012 Act has only accelerated these trends. The current government promotes the use of non-public sector providers<sup>16</sup> and Cameron, in setting out his vision for public services said that reform is needed, ‘whether be it breaking state monopolies, bringing in new providers, or allowing new ways of doing things.’<sup>41</sup> This alludes to several of the themes in market thinking outlined above: that state monopolies restrict choice and that different providers will be more innovative and efficient. The CQC has announced in July 2015 that it will try and recruit inspectors from the private sector, ‘as it is conscious of a “risk of political bias” towards independent providers.’<sup>42</sup> Therefore, I would argue that there will be increasing numbers of non-NHS providers entering the ‘market’ and the long-term effects on the NHS as a public body need to be monitored.

### Debates over markets in the NHS

#### Is this really a challenge to the NHS?

The NHS has always been a complex organization. Although it started out, nominally, as publically owned, Bevan was forced to begin by making concessions to get agreement from organizations such as the BMA: doctors were allowed to maintain their



private practice, general practitioners (GP) were contracted rather than employees and private beds remained in NHS hospitals. Outside contractors have always played a role in the NHS, ophthalmic and pharmacy services have been provided by independent contractors almost since the inception of the NHS. So while the NHS has never been the completely publically owned, centrally managed organization that Bevan had in mind, it has been guided by a set of core principles that underpin what the NHS is: comprehensive treatment, within available resources; universal access, based on need; and services delivered free at the point of delivery.<sup>43</sup>

So have these reforms compromised these principles? It has been argued that the core principles of Bevan's health service have largely been enshrined in the NHS Constitution. In a debate over the extent of the changes introduced by the 2012 Act, Klein<sup>44</sup> argued that 'The NHS in England is being neither privatized nor destroyed; the rights and entitlements of citizens, as enshrined in the NHS Constitution are not at risk.... the essential, defining characteristics of the NHS are not under threat.' The NHS Constitution arose out of Lord Darzi's review of the NHS in 2008, that recommended, 'the NHS should make explicit its values and commitments to patients.'<sup>45</sup> One of the key principles is 'Access to NHS services is based on clinical need, not an individual's ability to pay. NHS services are free of charge, except in limited circumstances sanctioned by Parliament.'<sup>46</sup> So arguably the reforms do not challenge this core aspect of NHS delivery.

In opposition to this view, Hunter<sup>16</sup> has argued, 'Free at the point of delivery is not the only principle invoked.... Bevan's principles were also about the way things are delivered.... This is a critical point because many of those who ostensibly support the NHS view it principally as a funding mechanism rather than as the deliverer of care services which, they believe, could just as well (or better) be undertaken by a range of for-profit and not-for-profit bodies as well as public ones.'<sup>43</sup> Therefore, the increase in non-NHS providers can be argued to challenge the original conception of the NHS—that healthcare was state funded and state provided.

Furthermore, in several places, the NHS Constitution states that 'The NHS belongs to the people.' But a system increasingly characterized by delivery from outside providers, PFI and disinvestment by DH shifts the ownership of the NHS away from the state and arguably, from Bevan's core principles. In principle, there is nothing wrong with the separating the two aspects of state involvement in healthcare: paying for healthcare and providing healthcare. In most other systems, the state is just a payer rather than provider. However, in the UK, this provision element is key in seeing the welfare state as a collective enterprise in which labour is 'devalored'—surplus value is not extracted from the workers and the system as they are in commercial exchanges.<sup>47</sup> Hence, the situation in the UK currently is that the state does 'own' the bulk of our healthcare system. Selling these to private companies involves a transferral of assets out of the state system—a 'privatization of the commons'<sup>48</sup>—with no guarantees that they will remain available, free at the point of delivery, to NHS users.

### Implications of the increased use of non-NHS providers

Contracting with the private sector—one concern is the ability of public bodies to adequately manage contracts with the private sector. There have been several well-documented failures of government contracting of private providers, for example, Serco's misreporting of out of hours GP services in Cornwall, which overstated how services were performing.<sup>49</sup> Serco has also been accused of clinical failings and overcharging NHS hospitals for pathology services provided by Viapath a pathology company it set up in conjunction with Guys and St Thomas.<sup>50</sup> A further example is Hinchingbrooke hospital in Cambridgeshire that was taken over by Circle Healthcare (a private company) in 2011, who pulled out of the contract in 2015, after it became clear that they had initially submitted an unrealistic bid to win the contract. An investigation into contracting private providers by the Public Accounts Committee concluded: 'Government is clearly failing to manage performance across the

board, and to achieve the best for citizens out of the contracts into which they have entered. Government needs a far more professional and skilled approach to managing contracts and contractors, and contractors need to demonstrate the high standards of ethics expected in the conduct of public business, and be more transparent about their performance and costs.<sup>51</sup>

As consumers of healthcare CCGs have to ensure that they are purchasing the ‘best’ service: the contracts they enter into are not exploitative and they manage those contracts properly—making sure the service is delivered as specified and meets quality standards. Questions have been raised about the ability of CCGs to ensure that the contracts they enter into are in the public interest. Monitor<sup>52</sup> conducted a study on ‘local contracting’, commissioning of services that do not have a set national price, and found the following issues: commissioners lack good information about providers; some commissioners do not have good contracting skills; transaction costs maybe high (it is estimated that CCGs cost around £1.35 billion to run<sup>53</sup>); commissioners are dependent on providers, so providers (due to a lack of competition, either actual or perceived) had little incentive to perform at the highest levels; and contract enforcement is difficult, as commissioners are reluctant to impose financial penalties.<sup>52</sup> Hence, in some cases, the contracting process did not improve provider’s performance and there was a power imbalance, with CCGs unable to negotiate or enforce contracts properly. These can be seen as examples of the limitations of the operation of markets in healthcare: lack of adequate information, power imbalances and high transaction costs. Whether, as CCGs bed in and develop more expertise, these problems can be overcome remains to be seen.

Limits on competition and integrated care—it is not clear what limits will be placed on competition as an end in itself and how the regulators will oversee this area. As the BMA note: ‘Despite Government assurances, many, including the BMA, felt the Regulations were unclear as to when commissioners would be able to legitimately restrict competition.’<sup>54</sup>... ‘to prioritise integration over

competition and choice without leaving themselves open to challenge from Monitor... [And this is] potentially damaging to the comprehensiveness and integration of services.’<sup>55</sup> This lack of clarity in the regulations and the government’s commitment to a competitively run health service mean that it will be hard to restrict competition even on grounds of ensuring integration, cooperation and continuity of good quality care.

Implications for standards of care—it is hard to find good data to make comparisons between the performance of different sectors of healthcare in UK. A Kings Fund report<sup>56</sup> on Labour’s health reforms that introduced new providers found little evidence for the quality of care being substantially different in NHS, private, foundation trusts and third sector organizations and in places non-NHS care was rated more highly. However, they considered the effects of these new providers on the local health economy and argued: ‘In the current context of substantial cuts in public spending and little or no increase in NHS budgets, any growth in the market share of one organisation is more likely to be at the expense of another organisation. This may result in some existing NHS organisations becoming financially unstable, and difficulties in ensuring seamless care for patients across organisational boundaries.’<sup>56</sup>

There is some evidence from the UK to suggest that the more market driven environment is already influencing healthcare delivery. A recent study on the views of nursing staff that had relocated to Independent Sector Treatment Centres (which are private providers of routine and low risk care) from the NHS found that, ‘clinicians described new ways of working as extending managerial or corporate control over clinical practice.’<sup>57</sup> This illustrated, ‘a production or factory-like model of healthcare.... The priority given to productivity was seen by many staff and managers as driven by the need to make the ISTC commercially viable.’<sup>58</sup> Some respondents expressed concerns that productivity took precedence over quality of care. One manager said, ‘This is a business at the end of the day, we have got to make it work financially.’<sup>58</sup> How much the ethical obligations of professionals



are altered or compromised in a commercial environment is a subject for further study. However, concepts of professionalism that operate within these private providers are changing<sup>59</sup>: with efficiency and performance indicators taking centre stage and the long-term effects on patient care uncertain. Light argues that marketization of medicine is the biggest threat to professional knowledge and practice and that healthcare professionals, ‘need to be rescued from market forces and from pursuing their own interests.’<sup>28</sup> This shows some support for the contention that something is lost if medicine becomes subject to the same kinds of commercial ethos and pressures as more market orientated services.

## Conclusions and areas for developing research

There has, undoubtedly, been an increase in ‘market’ thinking in healthcare policy and while the form this takes may differ,<sup>60</sup> the ideological basis, rolling back the state, greater consumer choice and efficiency drives, are common to attempts to make the state, ‘an overseer and purchaser of services rather than their provider.’<sup>60</sup> So, have these recent policy moves fulfilled their aims? If we apply the discussion of the arguments for and against markets in healthcare to this question—the answer is far from conclusive.

First, the underlying commitment, particularly on the part of conservative governments, to view the welfare state as impeding individuals’ freedom can be questioned. A counterargument can be made that state funding and providing healthcare through the NHS do the opposite and promotes individual freedoms—the NHS is more an enabler of rights than a restriction—by providing free healthcare at the point of delivery regardless of ability to pay. Furthermore, the NHS does not prevent individuals from taking out health insurance and/or receiving care privately—it does not interfere with an individual’s negative right to dispose of their property as they feel fit—although we all have to pay taxes that contribute to the NHS. However, at this level of argument, it is

about conceptions of the good life and basic world views—how one weighs negative versus positive freedoms—that cannot be solved by appeals to evidence alone.

The consequences of markets in healthcare, however, are where evidence can be brought to bear on the discussion. In regard to markets not providing adequate coverage, the justice argument, it is probably too early to see the implications of recent policy changes in the NHS. Healthcare is still free at the point of delivery; however, this is gradually being questioned. Professional bodies are voting on whether patients should be charged for GP visits and increasingly out of pocket charges are on the agenda<sup>61</sup>—all of which could have implications for access to healthcare for poorer members of society. International comparison suggests that health systems that are heavily market driven, such as the USA, have less coverage; 33 million not insured and an estimated 31 million of those who were insured were underinsured.<sup>62</sup>

The third argument that medicine is special and should not be commercialized is hard to prove one way or the other. As noted above there does seem to be some, limited, evidence that commercial pressures can impede professionalism, but there are ways of curbing this (such as robust professional ethics) and the evidence is not conclusive. Hence, firm conclusions cannot be drawn on how this will play out in UK—although evidence from other countries suggests that a heavily commercialized sector does not always put patients’ needs first.<sup>59</sup> Finally, the ‘public-economics’ theory of the welfare state does appear to provide a justification for the NHS, both as a funder and provider. The costs of introducing competition into the NHS are hard to pin down, for the reasons outlined above, but the recurrent annual cost of competition has been estimated, conservatively, to be £4.5 billion.<sup>63</sup> Both in the UK and internationally, there is little evidence that market mechanisms will reduce or contain costs<sup>21</sup> and good evidence that they will in fact increase them. International comparison suggests that health systems that are heavily market driven, such as the USA, spend more on healthcare and have poorer outcomes.<sup>62</sup> Therefore, market mechanisms do

not straight forwardly reduce costs or improve efficiency.

How far market mechanisms have permeated the NHS can be considered in terms of Powell's<sup>2</sup> mixed economy of welfare lens: ownership still lies largely with the NHS—but there is increasing provision by non-NHS providers and areas of activity are being transferred to the private sector; financing is again still largely by the state, but PFI and franchising agreements are moving this away from the state; in terms of regulation, arguably this has increased, with NHS England and NHS Improvement seeking greater control of providers and commissioners<sup>64</sup> which could be used to keep in check the negative effects of market mechanisms in the NHS,<sup>25</sup> although, as Hunter notes,<sup>16</sup> regulation is often ineffective and cannot be relied upon to keep the system in check. There have been recent policy developments such as the Five Year Forward View<sup>32</sup> that puts the emphasis on cooperation rather than competition. Hence, how the balance of power between regulators, different types of provider, commissioners and ultimately patients will play out in this changing environment is an area for future study.

Other areas that could benefit from more sustained analysis and research are: what are patient's views of new providers—do they care who provides their care? How can commissioning processes be improved so that contracts benefit patients and are in the public interest? What should the NHS be—a funder and provider, a funder or a partial funder? At root much of this discussion is driven by ideological commitments: a more free-market approach to welfare provision, underpinned by a conception of negative rights, or a belief that certain goods should be provided by the state and 'social rights' should be safeguarded (the post-war consensus begun by Atlee and ended by Thatcher). A greater reliance on evidence of what works and a commitment to healthcare as a societal good should frame the policy agenda so that healthcare in England remains globally respected and can continue to improve and develop in the 21st century.

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