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ANALYSIS

Health systems should be publicly funded and publicly provided

A market in healthcare increases the likelihood of inequity and exploitation, with suboptimal care for both rich and poor, say **Neena Modi and colleagues**

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In a publicly funded health system such as the NHS, does it matter whether care is provided publicly or privately? Here we discuss evidence relevant to this question. Definitions of what we mean by "public" and "private" are found in box 1.

Box 1: Definitions

Publicly funded—paid for out of the public purse

Publicly provided—delivered by a public sector workforce, in facilities that are managed and owned by public sector organisations

Privately funded—paid for directly through out-of-pocket payments, indirectly through insurance, or by charity

Privately provided—services that are managed and owned, or a workforce that is employed by, a for-profit organisation, not-for-profit social enterprise or charity; or a self employed workforce

Market mechanisms

At the heart of the question of who should provide health services is their commodification, through the application of market mechanisms, so that healthcare is regarded as a product to be bought and sold. Arguments about markets as a means of delivering healthcare were set out as long ago as 1963 by the Nobel laureate Kenneth Arrow.[1] In his landmark paper Arrow said that the medical care market had failed because healthcare is not a simple product, like a box of screws, but is complex and subject to major information asymmetries as the healthcare professional will usually know more than the patient. This opens up the possibility of exploitation on many levels, with potential for adverse consequences, including iatrogenesis, as described by Ivan Illich[2] in relation to excessive or inappropriate use and as set out by Julian Tudor Hart in his "inverse care law" relating to underuse: "The availability of good medical care tends to vary inversely with the need for it in the population served."[3] When quoted, the qualification that the law "operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced"[4] is often omitted.

Patients and the public are vulnerable to offers of profitable, direct to consumer health services that may be unnecessary, unhelpful, or even harmful by raising anxieties that provoke more investigation and greater expenditure.[5,6] Margaret McCartney describes a "patient paradox" in which she finds it increasingly difficult to get necessary NHS care for her patients, while they are simultaneously exposed to advertisements to purchase whole body scans, personal genome screening, and other unwarranted "health checks."[7] Another effect of direct to consumer health services is the rise in multiple births conceived as a consequence of poorly regulated private artificial reproductive treatments purchased abroad by UK citizens. A proportion of these result in the birth of extremely preterm babies who require prolonged, expensive, and often ultimately futile NHS care.[8]

The consequences of a marketised system are that both rich and poor people are made more vulnerable; the former to over investigation, unnecessary intervention, higher costs, and dubious treatments and the latter to lack of necessary care.[9] The NHS lowered the likelihood of this divergent provision by creating a public sector workforce committed to a publicly funded system in which care is not only delivered according to need (rather than the ability of the patient to pay) but, importantly, without immediate benefit to the healthcare worker or their employer.

Effectiveness and efficiency

Arrow's work informed that of another Nobel laureate, Oliver Williamson, who drew attention to transaction costs and to the scope for opportunistic behaviour, especially when purchasing a product that is difficult to define precisely. These are both conditions that apply to marketised healthcare.[10] World Bank staff have developed these ideas, saying that, when the product is simple, the process clearly defined, and the outcomes easily measured, there may be a case for purchasing privately.[11] But they failed to consider the complex relations between different components of healthcare provision; for example, purchasing radiology or pathology services from a private provider, often based in a different location that may be abroad, separates staff who report results from those who deliver care. The lack of clinical context and discussion can lower the quality of interpretation of almost all diagnostic tests; discussions between radiologist and referring clinician have been reported to change

diagnosis and treatment in 50-60% of cases.[12] Fragmentation of care between providers also diminishes training opportunities.

A related argument is that private services are more efficient, but the available evidence challenges this view. A systematic review of hospital performance in the European Union found that "most evidence suggests that public hospitals are at least as efficient as or are more efficient than private hospitals."[13] Insurance based systems provide little incentive to limit tests and investigations but ample motive to recommend more, necessitating initiatives such as Choosing Wisely, which originated in the United States.[14]

Employment market dynamics

Employment conditions also feature in the public versus private debate. But this complex factor differs across the variety of roles in a health service. For some senior doctors, the opportunity to work independently in the private sector carries professional advantages, such as increased autonomy, higher income, and the time to provide a more personal and responsive service. These latter characteristics are likely to appeal to patients seeking rapid access to an experienced doctor. Notably, however, the NHS has a majority medical workforce proud to work in the public sector and eschewing opportunities for private practice.

The dynamics of the employment market may have destabilising consequences for the public sector. In a labour intensive sector such as healthcare, the scope for substantial efficiency gains is limited. So, to achieve "efficiencies" private employers contracted to provide NHS services often bear down on terms and conditions, especially of non-medical staff.[15 16] At scale, differential contractual arrangements may result in cuts to overall staffing, employment of less skilled workers, and poorer, inconsistent conditions in the NHS. These circumstances pose major risks to workforce morale and patient wellbeing. Where cleaning services have been contracted out, for example, staff numbers are lower and hospital infections more common[17]; contracted out services have also been known to engage in "gaming" to misrepresent their performance.[18] When morale suffers, staff vote with their feet and leave, as shown by the 100 000 vacant full time posts across the NHS at the start of 2018[19] and by the rate of junior doctors choosing to move into specialist training being only 43% in 2017.[20] The sustainability of high quality, publicly provided healthcare may therefore depend in large part on the ability of the NHS to attract, harness, and retain those with highly marketable skills and expertise.[21]

Reducing public sector burden

Many commentators have argued that purchasing from private providers will reduce the strain on NHS services, but experience from other countries does not support this. Even when the healthcare procedure is clearly definable (such as a hip operation) and has an easily measured outcome (such as survival), the creation of a parallel private sector to provide services reduces the number of staff available to work in the public sector and their training opportunities. Public health systems, such as those in Chile[22] and Brazil,[23] are chronically short of staff and getting progressively more limited in what they can provide as a result of a parallel private sector, a situation that is now emerging in the UK.[24] High throughput NHS operating lists may offer advantages over outsourcing to the private sector—surgery would be delivered according to need, assessed using consistent criteria, provide supervised training opportunities, and carry negligible transaction costs. Instead, in the UK today, the emerging situation is that the public sector deals with complex cases, chronic conditions, and complications, and invests in staff training, while the private sector cherry-picks the simple and straightforward and rarely provides training. Private maternity providers, for example, charge large sums for overseeing normal deliveries in healthy women but transfer births of very preterm or sick babies that require complex intensive care to the NHS.[25] The Care Quality Commission has noted the reliance of the private sector on the NHS as a concern[26] and the destabilising effect on NHS general practice of online private consultation services that accept only healthy patients.[27]

Size, power, and influence

The relative size, power, and influence of providers is a further consideration. Those for and against markets tend to conflate all private providers, whether small social enterprises and charities or global corporations. Yet they are entirely different. The former tend to occupy specialist niches for universal benefit. The latter are positioned to exert tremendous power and take a dominant position in a system that allows them to set the rules in their favour.[28] Independent sector treatment centres (ISTCs) are private *sector* providers contracted to treat NHS patients. ISTC contracts were designated "commercially confidential," thereby keeping them outside the Freedom of Information Act. One study of a Scottish ISTC indicated that large payments were being made for patients who were not actually treated.[29] ISTCs have also been shown to engage in "up-coding," where patients are categorised as having more severe conditions than they actually have, in order to charge higher payments.[30]

The involvement of large private provider corporations in the NHS, many of which are household names, has other implications for the public purse, including costly and protracted litigation. Several private providers have challenged, or threatened to challenge, the NHS when not awarded contracts and have received substantial sums of public monies in recompense.[31 32]

Quality of care

Quality, efficiency, and effectiveness are important for any health system. A recent overview of systematic reviews concluded that, in general, outcomes are worse in private-for-profit hospitals than in not-for-profit and public hospitals.[33] In the UK, some ISTCs achieved better outcomes than NHS facilities for elective surgery, but the differences were marginal even though they had healthier, more affluent patients.[34] Moreover, outcomes were not adjusted for key influences such as BMI.[35] ISTCs also provide poorer training environments,[36] reduce communication across institutional boundaries,[37] and, in an example where surgery was transferred from a NHS hospital to a nearby ISTC, reduce overall activity.[38]

Private providers can also exempt themselves from certain evaluations; for example, no private provider of neonatal services in the UK is evaluated through national audit.[39] The Centre for Health and the Public Interest (a non-party think tank) identified several systemic patient safety risks specific to the private hospital sector such as inadequate medical cover and poor ability to deal with patients with serious complications.[40]

The NHS is facing major challenges from the growing fragmentation of patient care pathways across the multiple care providers that have emerged after the 2012 Health and Social Care Act. Knowing where responsibility and accountability lie in a fragmented system is difficult. The addition of private

providers, the incentives and values of which are not necessarily aligned with public care providers, risks worsening this situation.

Collateral effects

The wider economy is affected by a nation's health system choices. The 2012 Health and Social Care Act removed the duty of the secretary of state for health to "provide" a comprehensive service; this was a shift in the primary responsibility of government from population health to population (universal) health coverage. Additionally, when profit is the primary goal, efforts to tackle the wider determinants of health are likely to be disadvantaged. Current efforts to curb the power of the junk food industries are a case in point. Although a government "obesity strategy" has been published, it has been widely criticised for being weak and overly accommodating of industry perspectives, while obesity related conditions impose annual costs of over £6bn on the NHS and around £27bn on the wider economy.[41]

We must again differentiate between small and large private providers. Small providers support local economies and are likely to pay their taxes. Some large provider corporations pay virtually no UK taxes.[42] All for-profit private providers must produce a return on capital to their investors. Those driven by short term gain have an incentive to strip assets; those with a longer term perspective may engage in predatory pricing to capture the market share and drive out the public sector competitor. The consequences can be seen in the failure of several for-profit organisations (such as Serco) to fulfil their contractual obligations after taking over services previously delivered by the NHS,[43 44] inflicting further damage on the public purse.

Size also matters for charities and non-profit social enterprises. Some of the largest pay extremely high salaries to their executives, thus reducing funds available for frontline care. The top three highest paid charity executives in the UK in 2014 were in the independent health sector.[45]

Evidence, not ideology

The evidence available does not support a substantial role for the private sector in healthcare. Where non-public sector provision is used, it should be limited to small and medium enterprises and to minor contributions. This has wider implications for the UK, with an equivalent case for bringing general practice fully into the state sector.

Given the evidence against private providers, why is a marketised healthcare model being introduced progressively to the UK? The legalised opening up of the NHS to private sector providers through the 2012 Health and Social Care Act has given rise to all of the consequences we describe. [46] We suggest the only plausible explanations are lack of understanding of the empirical evidence, personal self-interest, or ideological belief. If the UK is to retain a high quality, efficient, effective, equitable health service, the evidence and implications of the current direction of travel must be widely understood and acted on.

Conclusions

Debate centred on a simple public-private dichotomy is unhelpful, but there are multiple, cogent reasons why the UK is best served by a health service that is both predominantly publicly funded and provided. A market in healthcare increases the likelihood of inequity and exploitation, with suboptimal care for both rich and poor. The creation of complex, fragmented networks of providers impedes attempts to monitor quality, patient outcomes, and other measures of effectiveness. The public sector is progressively destabilised as private providers offer higher pay and select easier cases but contribute little to training. Cost efficiency is compromised by the rise in transactional costs, public monies being diverted to profit, and public sector bail out when things go wrong.

Key messages

- The UK is best served by a health service that is predominantly publicly funded and predominantly publicly provided
- Non-public providers, whether large organisations or individuals, should be confined to minor, not major contribution
- Evidence shows that major non-public sector provision impedes monitoring of quality and effectiveness and leads to inequity and exploitation, with suboptimal care for both rich and poor
- This contributes to progressive destabilisation of the public sector, poor cost efficiency, loss of focus on population health, and damage to the wider national economy

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