

The myths of NHS privatisation: a commentary on factoids, policy zombies and category errors

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In November 2020, ‘Defend Our NHS Wirral’ (DONWirral) announced ‘The end of the NHS’, reporting that in April 2021 the NHS would be replaced by 42 regional ‘integrated care systems’ (ICS).¹ In June 2021, with the NHS continuing to see patients, do operations and pay staff, DONWirral’s prediction was updated: ‘In April 2022 our NATIONAL health service will disappear, to be replaced by 42 “integrated care systems”, each under the accelerating control of giant corporations (including American health insurance companies)’.

The death of the NHS as we know it has been predicted for decades, starting with Bevan’s fears in 1951 that the NHS would be mutilated by legislation. In the 1997 general election, the Labour Party claimed variously that there were only seven days or – 24 hours – left to save the NHS.²

Imminent death was also forecast in 2001, in 2012 with the Health & Social Care Act, and during the 2015 general election when Labour claimed that the NHS would become ‘unrecognisable’ if the Conservatives won; they did and it didn’t. An entire industry has been built around doom-laden prophecies yet neither death nor mutilation have occurred.

When ideas become accepted as facts even though they may not be true, they become *factoids*. Factoids are assumptions or speculations repeated so often that they are considered true.³ The imminent demise of the NHS is one such factoid.

Fear of privatisation

Klein asks⁴: what is it about the NHS that prompts linguistic excess and muddle, apocalyptic prophecies and premature obituaries? And does this dramaturgy matter?

His answer is:

...precisely because the NHS is such a cherished national institution, politicians in opposition...

have an incentive to exaggerate its failings. NHS professions do the same. Since NHS professionals cannot easily exit they must use voice to make the case for more resources and less pressure. What better way to make such a case than by dwelling on shortcomings and failings?

The NHS evolves through a succession of crises – exaggerated failings – usually resolved by extra resources. *Saving the NHS* is an inappropriate response to a crisis manufactured for benefit. *Saving the NHS* is a *policy zombie*, an intellectually dead, failed idea that nonetheless persists.⁵

Underlying the rhetoric of doom is the insistence that the true nature of the NHS is being betrayed. Bevan’s Garden of Eden has been defiled, and we are in a Manichean world of good battling evil.⁵ This resonates with Swift’s critique⁶ of the belief there is an extensive but hidden conspiracy of dark forces working against the NHS.

Greer responded to Klein’s questions about rhetoric and drama.⁷ Predictions about death of the NHS are to be expected in politics as long as the NHS is tangible and popular enough for them to work. This is the NHS paradox; the stronger and more popular the NHS is, the more it will be presented as being weak and at risk of failure or capture by commerce.

Privatisation’s meanings

Definitions and operationalisations of ‘privatisation’ are often implicit, unclear and conflicting, resulting in multiple, competing conceptions. The spectrum of definitions stretches from a narrow, one-dimensional focus on transfer of assets from public to private sectors, to multi-dimensional models including provision, finance and regulation.⁸ The former is easy to understand; NHS facilities and services are sold to commercial organisations. Apart from land sales there has been no sale of NHS assets to the private sector.

More complex definitions conflate ‘privatisation’ with market mechanisms introduced to incentivise change. This conflation follows the late Zigmunt Bauman’s use of the word ‘privatise’ as shorthand for the competitive health care market that commodifies services and labour.⁹ From this perspective, features that could be part of or favourable to privatisation, become privatisation – a *factoid*. Introducing market mechanisms like performance indicators is not the same as selling off publicly owned resources; the belief that they are is a *category error*.¹⁰

Other complex definitions include Mixed Economy of Welfare models that take account of how and by whom services are provided, funded and regulated.⁶ Although there are disputes about when ‘privatisation’ began, it is clear from Mixed Economy of Welfare modelling that public–private relationships were built into the fabric of the NHS from its foundation. The monolithic public sector NHS is a *myth* – a collective narrative that is false. Our real mixed economy health service has been in crisis in one form or another for much of its history.¹¹

If public–private relationships are intrinsic to the working of the NHS, mechanisms like contracting out may be harmless. After all, the NHS been contracting out general practitioner services (as well as those of dentists, opticians and pharmacists) since 1948. In fact, the growth of contracting out to the private sector has been small despite the impetus for ‘privatisation’ built into the 2012 Health & Social Care Act.

In 2006/2007, 2.8% of NHS spending went to private providers, rising to 4.4% in New Labour’s last full year in government and 4.9% in the first year of the Coalition. About 7.6% of NHS revenue spending in 2015/16 went on purchasing care from private providers.¹² In the three years from then to the Covid-19 pandemic, private spending flatlined, with the combined non-NHS spend of Commissioners and Trusts being under 8%.¹³ The Chief Executive of the NHS predicted in 2015 that the proportion of NHS work going to the private sector would be unlikely to increase beyond ‘the margins’.¹⁴ He has been proved right.

Labour’s predicament

The New Labour governments of 1997–2010 encouraged the contracting out of some NHS services and the use of private providers of acute care – especially when trying to reduce waiting times. New Labour’s strategy was to downplay the Service aspect of the NHS (its structure, organisation and procedures) in order to strengthen its National character (better

experiences and outcomes for patients). For those for whom Service was crucial to the NHS’s identity, New Labour’s emphasis on National characteristics seemed like treason, and fed the belief that a cross-party conspiracy existed to accelerate the NHS’s demise.

Trades Unions (including the BMA and the lower levels of NHS management) tend to focus on Service, while professional bodies like the Royal Colleges, and the public, focus more on quality of care – that is, on the National. Organisations defending the NHS are heavily influenced by Service professionals, hence their pre-occupation with processes not people. This ‘provider capture’ is commonplace in civil society organisations and is also a problem for the Labour Party, which needs to take a National stance.

Conclusions

Contracting out can be in the interests of NHS patients when private contractors have resources (including know-how), competences or a flexibility that the NHS lacks.³ The real argument about the scale and nature of contracting out must surely be about the managerial capacity of the NHS to ensure value for money and good service delivery, not about the supposedly corrosive nature of privatisation (a *factoid*). As one NHS general practitioner put it:

Piecemeal outsourcing of services ... doesn’t reflect an underlying Machiavellian plan to undermine public ownership of the service, but these debates can risk blinding us to a bigger picture ... what type of service will give the country the best health outcomes.¹⁵

Powell sums up the pre-Covid state of the NHS:⁸

After nearly three decades of doom-saying what do we have? An NHS that still provides a universal service, free at the point of use, and is as far removed from a US style insurance system as any other health service on the planet.

Klein adds: ‘Arguments about the true nature of the NHS are at best a luxury, at worst a distraction from a debate about the issues and choices ahead’.

Declarations

Competing Interests: None declared.

Funding: None declared.

Ethics approval: Not applicable.

Guarantor: SI.

Contributorship: Both authors conceived the commentary jointly, contributed to drafts and agreed the final version.

Acknowledgements: None.

Provenance: Not commissioned; editorial review.

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