Editorials

Privatisation:

an exercise in ambiguity and ideology

Is 'privatisation' a threat to the NHS? What is meant by this term? Does it imply the funding of health care from private insurance and its provision by private firms? What is the evidence about the relative efficiency of private insurance and private provision of care?

The primary purpose of the NHS is to provide citizens with income protection in times of illness. Most civilised and affluent societies, apart from the US, wish to ensure that in time of illness patients will not be bankrupted and care will be provided by state funding either directly or via 'social insurance', which is disguised taxation.

The delivery and funding of health care takes place in markets, where a market is defined as a network of buyers (now primary care trusts, soon to be clinical commissioning groups [CCGs]) and sellers such as hospitals and GP surgeries.

Typically, buyers of care, be they private insurance firms or the NHS, have been weak in managing (that is, controlling) their providers, particularly in accepting the hospital sector's performance with its large variations in clinical practice and high costs.[1,2] Public NHS and private insurance purchasers, commissioners, or buyers of health care tend to be price and quality takers with little leverage on providers. Providers of care, be they in primary or secondary care, typically dominate healthcare markets, that is, they are price and quality makers.

Despite the similarities of public and private healthcare markets, there are furious debates in the US and England about how best to fund and provide health care. The right wing of the Tory party, like its Republican counterparts, sees the reduction of the role of government as an essential way of ensuring personal freedom, which they value above all other goals. They prefer private insurance and private provision of health care.

Collectivists, seeking to ensure income protection of citizens as their primary goal, favour public finance of care. However, when it comes to provision, collectivist systems use a mix of public and private healthcare delivery to patients. For instance, in the Netherlands many hospitals are privately owned and operated. However, these organisations are highly regulated by government which publically funds health care. In many countries in western Europe a mix of public and private provision is common. The UK is somewhat unusual in its dominance of public provision of hospital care.

PRIVATISATION: FUNDING HEALTH CARE

Apart from extreme libertarian ideologues, there is a consensus in Britain that health care should be largely publically financed. Despite this, in times of fiscal stress there is advocacy of subsidies for private insurance 'to ease the burden' on NHS budgets and calls for increased use of patient charging.

A right wing Australian government led by John Howard from 1996 to 2007 introduced large tax breaks to increase private insurance. These have been very successful in increasing private insurance coverage and once established are difficult to remove, as the current Labour administration has found.

Such reforms tend to be inefficient and inequitable.[3] Tax breaks for the purchase of private insurance are subsidies to taxpayers who tend to be more affluent members of society. The opportunity cost of Australian tax breaks is several billion dollars and each time insurance premiums increase (which they do usually more rapidly than inflation) the tax subsidy rises. If these resources had been invested in Australian Medicare (the national government health programme), they may have been used more efficiently and produced more patient care

The short-lived tax subsidies for older people introduced by the Thatcher government and the longer lived Australian tax subsidies for private insurance have clear lessons for policy makers.

User charges are another policy with obvious opportunity costs and advocated by critics of the NHS. This advocacy usually consists of assertions that patients waste NHS resources by their 'excessive' use of services and their demands for care should be constrained by making them pay part of the cost. Thus we have prescription charges and payments for NHS dentistry. Should this be extended to, for instance, visits to GPs and 'hotel' services in hospitals?

The debate about the role of user charges is international and the policy response is determined by the objectives of the government at the time. The conundrum is nicely summarised by three Canadian economists who strongly reject user charges:

'In the present structure of healthcare delivery, most proposals for "patient participation in healthcare financing" reduce to misguided and cynical attempts to tax the ill and/or to drive up the total cost of health care while shifting the burden out of government budgets.'[4]

Those who favour a libertarian approach to health care would of course favour taxing the ill and reducing the budget burden on the state. Collectivists would object as they desire income protection for citizens and regard the State as essential in providing this.

PRIVATISATION: PROVIDING HEALTH CARE

There is no robust evidence that private providers are more efficient than public providers of health care. The ubiquitous characteristic of healthcare delivery, public and private, is clinical practice variation and waste. 'Guestimates' of the magnitude of this inefficiency vary. In England the Department of Health asserts that £20 billion can be saved and recycled to maintain patient care in a period of near zero budget growth. The US literature offers estimates that the 'adoption of conservative, safe practices' could save 15–40 per cent of the vast Medicare budget.[2,5]

The track record of English privatisations is unimpressive. As predicted 15 years ago,

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the Private Finance Initiative is an expensive way of building hospitals.[6] The investments in Independent Sector Treatment Centres increased capacity, were expensive, and led to the creaming of 'routine' patients, with complex and costly patients being treated in the NHS.

The lessons from international experience are that a public–private mix of provision in health care requires extensive regulation, as shown in the Netherlands. Furthermore, this regulation often fails. The lesson for CCGs is clear: they must contract with all providers more carefully because all contractors exhibit greed and self-interest, as Adam Smith noted centuries ago:

'People of the same trade seldom meet together, even for merriment and diversion, but the conversation ends in a conspiracy against the public, or in some contrivance to raise prices.'[7]

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