

## Chapter 75

# Recent Evidence on the Changing Mix of Providers of Healthcare in England

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### ABSTRACT

*English health policy has promoted the diversity of providers of health care to NHS patients in recent years. Little research has been done to map the extent of actual and possible supply. Using data from four local health economies England the authors found that there was a low supply of such organisations, but that it is growing. Despite the greater emphasis placed by policy makers and researchers on non-profits, there were substantially more for-profits. This suggests they should be subject to further scrutiny, as the pressure to increase diversity of supply increases under the Coalition government.*

### INTRODUCTION

Since the 1980s, public services in England and elsewhere have been subject to changes which are labelled 'New Public Management' (NPM) (Hood, 1995). These consist of a range of reforms designed to modernise and render more effective the public sector. The basic hypothesis underlying NPM is that market oriented management of the

public sector will lead to greater cost-efficiency for governments, without having negative side-effects on other objectives, such as access to services. This paradigm has been subject to extensive criticism on the grounds, inter alia, that public services differ in important ways from other services, and that those very characteristics render market like structures inappropriate (e.g. Ransom and Stewart, 1994; Dixit, 2002; Jackson, 2001; Pollock et al.,

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2006). A key element of NPM in England has been the quasi (or internal) market (Le Grand and Bartlett, 1993).

Quasi market health system reforms were introduced in the UK in 1990 by the Conservative government (DH, 1989), partially reversed in 1997 by the New Labour government (DH, 1997), and re-launched by that government with the NHS Plan of 2000 (DH, 2000a), and extended by the Coalition government (Health and Social Care Act, 2012). A key aspect of the reforms introduced by New Labour aimed to encourage a diversity of organisations providing care to NHS funded patients in the English NHS (DH, 2005). Commissioners of NHS services were expected to engage with new providers from the for-profit private sector and the mainly non-profit ‘Third Sector’ including voluntary groups, registered charities, foundations, trusts, social enterprises, and cooperatives. NHS employees were encouraged to consider forming employee-owned social enterprises to provide care services. The promotion of entry and establishment of new providers was designed to stimulate innovation, quality and choice in the provision of health services (DH, 2005). Despite this important development, research aimed at mapping the levels of supply and potential supply from these diverse providers is scant (Bartlett et al., 2011; Mohan, 2011; Arora et al., 2013). As Mohan (2011) explains, it is very difficult to map the extent of third sector organisations and estimates of numbers vary widely, by as much as a factor of nine, depending on what definition is used. While a number of studies have concentrated on the role and experience of the non-profit sector in health service provision (e.g. Kendall and Knapp, 1995; Bradsen and Pestoff, 2006; Hogg and Baines, 2011), there are few studies also including data on for-profits delivering healthcare to NHS patients. Those studies that have been published focus on comparing quality of care delivered by for-profits with NHS providers (e.g. Healthcare

Commission, 2007; Hopkins, 2007; Browne et al., 2008; Perotin et al., 2013) or on commissioners’ and NHS incumbents’ attitudes to for-profits (Allen et al., 2012). On the other hand, there are studies of the scope of participation of for profit organisations in the social care market in England (e.g. Forder et al., 1996; Forder and Allan, 2012.)

The current Coalition government has placed increasing importance on encouraging diversity of supply in the welfare sector (Health and Social Care Act, 2012). The Coalition has in particular emphasised the role “mutual” organizations owned by their employees might play. Though the presumption seems to be that these providers would not be pursuing profit as the central goal of the organization, frequent references have been made by Coalition members to the John Lewis Partnership—a for-profit business entirely owned by its employees—as a model, and even, by the media, to Circle Health, a company that is 49.9% owned by its employees, the majority of its capital being held by for-profit investors. Whether non-state providers are for-profit or non-profit businesses has key implications for the quality and efficiency of healthcare provision, because the different types of organizations have different incentives to reduce costs and/or provide quality. It is therefore increasingly important to understand the extent to which for-profit and non-profit organisations are available to deliver health services to NHS patients. The objective of this paper is to focus on the scale of for-profit and non-profit providers either currently providing healthcare to NHS patients or ready and able to do so, and on recent changes in their numbers. This will give some indication of the likelihood that independent providers will be able to respond to the invitation by the NHS to participate in providing healthcare to NHS patients. The paper reports a unique study of four Local Health Economies (LHEs) undertaken in 2010 in England.

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