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Public/Private Partnerships in Health in the UK: Theory and Practice

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ABSTRACT

One of the most fundamental and the oldest issues in the provision of health care throughout the world has been the issue of the role of the public and private sector of health care, and the relationship between them. This paper describes issues associated with the concept of health oriented partnerships in the United Kingdom and seeks to contrast public and private partnerships both in health and in health care. In the United Kingdom it is suggested that health care is conceived by the population to equate to the National Health Service(NHS) with "add on" private health care for certain sectors of the community and within certain well defined clinical parameters. This paper can provide us with valuable information on the characteristics of UK health care systems, current health policies as well as issues relating to the public and private partnerships in health/ health

care in the UK, thus offer important policy implications for the improvement of Korean health care system which lacks health-oriented coordinations and partnership between public and private sector very considerably.

Key words : partnerships, health care, NHS, public sector, private sector

I. Introduction

One of the most fundamental and the oldest issues in the provision of health care throughout the world has been the issue of role of the public and private sector of health care : How much should the government be involved in direct provision of health care? How much should be the provision of health care be left to the market mechanism? What are the measures to make desirable equilibrium in the provision of health care between the public and private sectors? This paper mainly describes issues associated with the concept of health oriented partnerships in the United Kingdom and seeks to contrast public and private partnerships both in health and in health care. In this context the WHO definition of Health could best be described as a positive concept which involves i) Social well-being, for example issues concerned with welfare, housing, food, education ii) Psychological well-being, for example issues concerned with mental health, stress free, balanced outlook on life iii) Physical well-being, for example state of health, absence of illness. These dimensions above could be viewed as present or absent in a greater or lesser degree along a line with issues at the other end of the line relating to health care and the organization or management of hospitals/ institutions. In other words, the concept goes from a state of positive health to issues about the organization or services. In the United Kingdom it is suggested that health care is conceived by the population to equate to the National Health Service(NHS) with "add on" private health care for certain sectors of the community and within certain well defined clinical parameters.

Ⅱ. Partnership and Working Together

In considering partnerships between public and private sector, it is important to contextualize such issues around a definition of partnership which focuses on element of the contractual relationship between two or more organizations within a joint venture and with shared responsibilities and objectives. While there are few organizations within either health or health care which do not work together in some shape or form, it is suggested that this is not necessarily the same as acting in partnership where may be much more clearly defined element of success would certainly be deemed to include the following:

- A preferably written agreement or contract between the parties concerned which describes the aims and objectives.

- An agreed programme of action which encompasses not only targets and outcomes but milestones of achievement and which can act as a useful audit tool in relation to monitoring performance.

- The development of mutual respect and trust engendered by an equality of relationship between the parties which, in turn, builds on the necessary degree of confidence to task issues forward.

- Commitment and support at either Health Authority or Chief Executive level coupled with the delegation of responsibilities and a commitment to the objectives with, as appropriate, support by means of resources which may range from very modest to a more sophisticated investment programme. The quantum of resources, however, it is suggested, does not reflect the value to be derived from the partnership function.

- Sharing information on an "open book" basis with no hidden agendas.

- Ensuring that the decision making process advances the objectives of the partnership which are both transparent and undertaken jointly.

- A realistic acceptance of certain issues within the organizations concerned which may reflect their differing responsibilities, lines of accountability and the limitations that may exist in organizations and their

differences in term of the methodology of working.

- A very clear senses and understanding both of the economic environment and the political factors which surround the partners which in turn may necessitate a considerable flexibility of approach.

Overall, it is suggested that the bottom line test is to ensure that the outcome is greater than the sum of the parts and that there are very clear, valid reasons identified for working within a partnership context which are unlikely to be achieved by sole action.

Ⅲ. National Policies

With the advent of the new Labor Government in May 1997, a considerable degree of change has taken place within the national policies applying to the broader concepts of health and health care in the United Kingdom and to the relationship between the public and private sector of health etc as evidenced under the former Conservative administration (Priestley 1995). Some of the key aspects of policy in 1999 can be found stated in the following policy documents:

- *The New NHS: Modern and Dependable (1997)* which is a major reforming document which confirms the cessation of the former policy of the internal market within health care in the UK, GP fundholding, competition, etc as espoused by the Conservative Government and is replaced by a central concept of collaboration in health and health care, particularly between those concerned with commissioning health care and those providing health care. Considerable emphasis is also placed on the centrality of Primary Care, reducing waiting lists and times, focusing on clinical excellence and highlighting the partnership concept as being at the center of the care process.

- The consultative paper *Partnership in Action (1998)* which develops partnership within the framework described earlier, particularly between Health agencies and Social Services/Local Government and provides alternative models such as lead commissioning of services, pooling of budgets, integrated service provision, etc to facilitate much closer relationship and joint

working between key governmental agencies with a desired flexibility of action.

- *Modern Local Government - In touch with People (1998)* which seeks to radically reform many issues associated with Local Government including changing the political structure, separating the executive and "black bencher" roles, enhancing local democracy and financial accountability etc. Most importantly, it underlines the duty expected of partnership, both with the public and private sectors.

- *Our Healthier Nation (1998)* which seeks to improve the Health of the Population as a whole by adding Years to Life and Life to Years, and improving the health and well-being of the poorest section of society, which as is stated should be delivered by "a national contract for better health ... the government, local communities and individuals will join in partnership to improve all our health"

- The *Health Service Bill (1999)* which, amongst other things, provides for a statutory duty of partnership both between the agencies which constitute what has become know as the local NHS Health Economy, ie Health Authorities, NHS Trusts, Primary Care Groups, primary care services etc, but also between the NHS and with Local Government agencies with particular reference to Social Services, Education, Housing, etc.

What is interesting, however, is that these major policy documents do not concentrate on relationships between the public and private sector of health/health care but, generally speaking, ignore these issues and the possibilities for collaborative action accordingly.

Ⅳ. Public/Private Healthcare Mix in the UK

At this stage it is important to review the public/private healthcare mix within the United Kingdom based on the premise that approximately 80% to 90% of all clinical interventions in the UK are carried out within the public sector National Health Service and thus a correspondingly minor component, ie some 10% - 20%, within the private sector. Some comparators can be gleaned from Table 1 which on a rather selective basis compares the public/private mix within health care as at 1998/1999.

〈Table 1〉 Public/Private Mix : Summary of Selected Markets

MARKET	Year to which relates	Basis of partition	Public finance/ private supply %	Public finance/ private supply %	Private finance/ public supply %	Private finance/ private supply %
Elective surgery - UK residents(1)	1992/93	Cases	86.4	0.2	1.5	11.9
Long term care of elderly in residential settings	1998	Cash	26	35	2	37
Acute psychiatric treatment (2)	1998	Beds	91	3	small	6
Psychiatric rehabilitation & long term nursing/residential home care of mentally ill people(3)	1997	Beds	33	67	small	small
Long term nursing/residential home care of mentally handicapped (3)	1996	Beds	36	64	small	small
Maternity - UK residents (4)	1995	Births	99	small	small	1
Abortions - UK residents (5)	1997	Cases	51	22	small	27
General Practice (6)	1996	Consultns	97	0	0	3
Pharmaceuticals (7)	1995	Cash	61	0	5	35
Dentistry	1989	Cash	62	0	27	10
Ophthalmics	1988	Cash	24	9	0	67

Sources : Grant, C. (1985). Private Health Care in the UK Economist Intelligence Unit, Report No 207
Willams B (1996). Personal Communication
Laing's Healthcare Market Review 1998-99 (1998)

From this it can be seen that the dominant focus of the provision of health care services clearly rests within what is described as public finance/public supply, ie the NHS, although there are significant contributions in relation to services which are publicly financed but privately supplied, ie where the NHS commissions and finances services which are provided within the private sector. These dominantly relate to services such as the long term care of the elderly, psychiatric rehabilitation etc. One exception within the above analysis is in relation to the long term care of the elderly in residential settings where there are significant components both of services provided by the NHS and those NHS commissioned but supplied privately, and also those services which are both financed and provided on a private sector basis. The

reference to ophthalmic services is rather distorted as that relates mainly to optometric practitioners where the situation has always been very largely a service which is both privately financed and privately provided (Laing 1998).

V. Comparative Factors within the Public and Private Health Care Sectors

Turning to comparisons between the public and the private health care sectors, it is suggested that these can be divided into two areas of interest. Firstly, those concerned with health care or service issues and thus factors surrounding the provision of services and, secondly, what might be called "health of the public" issues which is a more holistic concept and very much relates to the point made at the beginning of this paper. However, initially it is important to consider the characteristics of the NHS/public sector component of health care and Table 2 summarizes the position as at 1998/99 in a brief overview of that element of the market.

From this it can be seen that a relatively small percentage of GDP, ie 6.5%, is spent on public health care which is small in comparative terms with other Western European systems and many would say an inadequate investment albeit that it may be an increasing part of overall public expenditure. Issues might be characterized as focusing on access as demonstrated by the numbers of patients waiting and the average waiting time for patients to be treated and seen, particularly within the Hospital sector, which is, no doubt, characterized by factors associated with

〈Table 2〉 Public Sector Characteristics

	VALUE	COMMENTS
% NHS Spend of total public expenditure	12 %	
% of GDP spent on health care	6.5 %	Small
Hospital/Community health services/ FHS	£37.6 BN	Consistent growth
Number of inpatients /day cases	11M	Demand
Number of outpatients	11M	Outstrips
Number of consultations in primary care	270M	Supply
Number of inpatients waiting 12 + months	60,000	Reducing
Average waiting time	5 Months	Static

being part of a huge organization subject not only to bureaucratic rule and obligations, but a basically open ended demand.

By contrast some of the characteristics If the private health sector within the United Kingdom as demonstrated in Table 3 indicate that growth is perhaps static or limited in some respects with regard to the provision of elderly care services and it may not now be enjoying the significant growth factors which were evidenced during the 1980s and early 1990s concomitant with the political philosophies prevailing. When the issues relating to the provision of services between the two sectors are compared, then a very clear and sharp contrast can be easily derived.

The characteristics of the public sector of health care as evidenced within the National Health Service are clearly focused on the following concepts:

- The organization of health care on a nation wide whole systems basis including secondary and tertiary care with supporting primary care services, ambulance services and a positive element of health focused within Health Promotion.

- The organization of health care being based dominantly on primary care, general practitioners and tertiary care with supporting primary care service, ambulance services and a positive element of health focused within Health Promotion.

- The planned organization of health care services so that they aim to be economically comprehensive in nature and thus reflect not only local needs and requirements, but also those of a regional and national focus.

〈Table 3〉 Private Sector Characteristics

MARKET FACTORS : 1997	VALUE	COMMENTS
Acute hospital care	£2322 M	Static
Psychiatric services	£94 M	Static
Elderly care : Nursing home	£3257 M	Limited growth
Private medical insurance	£1958 M	6.4 M people 3.4 subscribers Static
Primary medical care	3.5 % of all consultations	Small share

- The fact that services are funded through taxation and are generally free at the point of delivery with exceptions such as the provision of drugs in primary care, dental services, etc.

- The fact that services are available to all citizens of the UK and to visitors to the UK who might need emergency care.

1. NHS - Public sector characteristics

- Vast Organization : 750,000 Staff
- Market forces 1998/99 : 80% - 90% of Health Care

2. Private health sector characteristics

- Percent of total health care in UK within independent sector : 10 % - 20 %
- Major problem concerned with excessive demand for services and paucity of some aspects of supply, particularly in relation to certain clinical areas such as oncology and certain occupational groups of staff such as nurses, paramedical staff, etc.
- Health has a very high profile political issue within the UK and is probably equal with education in terms of internal political publicity.

By contrast, the private sector of health care is much more market oriented focusing on specific segments of health services with particular reference to acute and elective surgery and long term care for elderly people where very significant contributions are made to the overall pattern of services. Smaller areas of service in the fields of psychiatry but also in niche markets such as terminations of pregnancy, can be noted. What might be surprising is that elements of primary health care, albeit within an organizational purview within the National Health Service, have significant components of private section provision. Services such as community pharmacy and optometry may be regarded as private sector provided and organised, albeit with significant public investment, and dentistry is now at approximately a 50/50 level of public and private sector provision (Grace 1996).

Complementary medicine has always been private sector provided and certain elements of out of hours services for general practice are within much of the country organised by private companies or GP Co-operatives, although the service are provided and paid for within the NHS. A new element which has been noted is the provision of services such as walk in clinics,

particularly in London at major rail termini and now in shopping areas, to provide for people to obtain advice and treatment within the primary health care sector on a "drop in" basis (Devlin 1998).

It is interesting that public sector initiatives in 1999 have including the funding of "walk in" primary care centers and a National Health Advice telephone service, NHS Direct, *HSC 1999/028,* indicating a political desire to expand the concept and scope of the public sector primary care element very considerably, albeit not without professional controversy (Jellinek 1999).

Overall, however, any analysis would be characterized by considerable geographic variations and a patch work approach without any significant local or national context of organization other than demand factors. Seemingly, the perennial issues of demand for staff, particularly in areas of high technology skills etc, coupled with an inadequate supply of many of the professions concerned, tend to affect the NHS more than the private sector which to a very large extent has grater flexibility in terms of pays rates etc and therefore the ability to recruit staff on advantageous terms.

Other factors of note are the fact that private sector health care facilities can be and are provided within NHS hospital and, indeed, some modest expansion of this facility has taken place recently which enables the NHS to derive income from renting out the facilities concerned mostly to their own medical staff for private work. Health Authorities also have a statutory function of registration and regulation of standards, particularly in relation to private sector nursing homes and hospitals, all of which have to be registered with the Health Authority concerned.

It would not be exaggeration, however, to indicate that there is no co-ordinating policy evidenced in theory or practice between the public and private sector of healthcare which co-exist, somewhat uneasily and separately - a factor which is reflected in the lack of any declared national policy in this area.

Ⅵ. Comparative factor within "Health" Concepts

Turning to issues relating to health and health of the public, then it is suggested that much greater evidence can be derived of the partnership function in practice. Many of these partnerships are between

different agencies within the public sector, eg health and social care, Local Government, education sector, etc. It is becoming more common place, however, particularly with regard to relatively new concepts such as Health Action Zone, EL(97)65, that partnerships will include not only the above but also the non statutory and voluntary sectors, local communities and where interest and enthusiasm can harnessed, the private sector which can sometimes be the manufacturing sector as distinct from private health care. In a different sense, the private sector in relation to developing information system has been the driving force behind much of the work which has been carried out and there is not a NHS Healthy Authority or NHS Trust in the country which could run its information systems without systems having developed within a private sector context.

Pharmaceutical companies, which are one of the success stories of the manufacturing sector within the United Kingdom, are keen to purse public/private sector concepts such as disease management systems in eg asthma, diabetes which seek to ensure that clinical organization and services are focused on all the elements of treating the disease concerned from onset through to conclusion and to track the clinical pathways of patients in association with appropriate therapeutic interventions. The mutual benefits are perhaps self evident.

Two of the more broadly based developments within the partnership concept are, firstly, the very significant emphasis aimed at ensuring the greater empowerment of the community in the healthy and social care field so as to restore confidence to that sector of the community, ie the poorest off in economic and therefore programmes of community developed and empowerment seek to ensure that citizens, generally at the poorer end of society, are encouraged and supported by aiming to play a greater role in issues affecting their local community environments. Secondly, the advent of a major programme of economic and environmental regeneration which is funded and sponsored by Government but which seeks to leverage in private sector investment in addition to public sector contributions to improvement of standards, facilities, infrastructure, services, etc has had one of the biggest impacts in cementing the concepts of partnerships in a very real way. These are evidenced by a whole range of programmes such as Single Regeneration Budgets focusing on a geographical area of activity, Sure Start

programmes aimed at children under five years of age, Early Excellence Centres in the Education field and Health Action Zones as indicated earlier which relate to the holistic concept of Health as a central core of society action as a binding mechanism to synthesise sectoral action. Common elements running throughout these programmers are the commitment of the agencies to act in a co-ordinated and integrated manner, but equally demanding an innovative and flexible approach to maximize the outcomes and to the involvement of the health sector as an essential core element. It ids the environment and services but also a local emphasis on forging new and stronger partnership relationships which hopefully will outlive the original investment programmes. The more farsighted cities are capitalizing on these initiatives to generate collective multi sector support for visionary longer term developments eg *City of Stoke on Trent 20/20 Vision (1998)*. The key issue is to ensure that "Health" is on the agenda for all the parties involved.

Ⅵ. Private Finance Initiative(PFI)

Although the NHS invests significant amounts of capital funds, these are usually targeted at the maintenance of small building etc and small projects based on the redevelopment of existing facilities. One of the key strategies of Government, both under the former Conservative Government and now continuing under the new Labor Government, has been the development of the Private Finance Initiative as recently demonstrated in the capital investment strategy for the Department of Health, *HSC 1999/113*, which clearly indicates that the investment of private funds in the capital stock and infrastructure of public health services is a central plank of Government policy.

In 1999/2000 over £600 million will be invested from private sector finance sources and the first two tranches of PIF programmes and the London review schemes will total some £2.2 billion of investment with a further 12 schemes totalling £941 million being progressed towards formal contract. Overall, over the period 1998/99 - 2000/01, capital developments within the NHS will be deprived as follows :

NHS capital	£5.327 billion
PFI	£1.660 billion
TOTAL	£6.987 billion

Simply put, the development of new hospitals and secondary care services in this country is now very dominantly dependent upon investment from the private sector within the PFI initiative and with long term commitments being given by the NHS, accompanied by sophisticated and management programmes, to support these moves. This policy, however, has raised major concerns at the long term cost and implications for NHS, with significant doubts cast upon its sustainability (Warden 1995, Dawson and Maynard, 1995).

Ⅷ. Conclusion

From the above review of the relationship between the public and private partnership in health and health care in the United Kingdom in 1999, key themes and policies can be identified. Central to the relationship of the public and private sectors is the fact that there does not appear to be any specific national policy or statement which can be identified which has indicated what the relationship between public and private health and health care might be - the conclusion to be drawn is that this is an issue which the Government does not feel is either important or appropriate for consideration at present and which may reflect the extreme political sensitivity attached to the subject which issue partly contributed to the demise of the former Conservative government.

Secondly, in relation to Health strong partnerships are observed with the public sector being dominant within partnership alliances and a strongly developing holistic concept of health now being very much on the agenda of other agencies such as Local Governments, Higher Education, etc. The success of social, economic and environmental regeneration programmes and the involvement of health within such concepts and action has significantly engendered this approach and, in turn, has spawned a wide industry of community development programmes with a complexity of actions which do not commend themselves to national management but to local organic growth.

Thirdly, another notable factor is the use of private sector finance to the development of public sector infrastructure which is one of the continuing policies of the new Labour Government and without which public health infrastructure simply would not advance. In contrast, public/private partnerships relative to Health Care to a

very significant extent are felt to reflect co-existence rather than integration and are much less likely to be determined as enshrining the concepts and success factors of partnership as indicated earlier but are much more likely to be within the realm of "Working Together". Overall it would be true to indicate therefore, that in 1999 the NHS and the public sector of Health Care is clearly the dominant of the health care system with a vast range of comprehensive and integrated services and the private sector by contrast, is segmented and is seen as a secondary and supplementary component of health care. The two sectors, however, do not generally operate within a partnership or contractual relationship, but a state of mutual co-existence, not it should be said in a hostile or aggressive relationship but equally not one which seek to synthesise the parts to a co-ordinated whole, and not relationship of equals.

Finally, in respect of actions which may be other than short term or of a relatively inconsequential nature, success can really only be derived within health based/oriented partnerships by mutual determination of the contractual relationship and the setting of desired outcomes within an agreed framework of objectives.

The health care system of a country is a product of medico-social culture which reflects the overall pattern of historical development of the country. Thus, caution is necessary when we compare health systems and draw lessons from another health care system's experience. As reviewed above, UK health care system has been one of the strongest examples of a publicly funded low cost health care service in Western Europe, although there are also significant contributions of private sector with particular reference to long term care for elderly people. By contrast, Korean health care system can be described as the weakness of public sector and the overwhelming predominance of private sector of health care. These characteristics of Korean health care system places, in particular, the low income class, both in the urban and rural, a serious barrier to access to health care. In order to overcome these problems, the expansion of the public sector as medical provider is further required up to a higher level than before. And various measures and concepts to strengthen the partnership such as Health Action Zones in the UK should be also developed in Korea. In this context, the UK experience holds valuable lessons for heath care policy makers in

Korea which lacks health-oriented coordinations and partnership between public and private sector very considerably.

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