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Public Money & Management

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/rpmm20

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To cite this article: Mark Exworthy, Neil Lunt, Penelope Tuck & Rakesh Mistry (13 Sep 2023): From commodification to entrepreneurialism: how commercial income is transforming the English NHS, Public Money & Management, DOI: 10.1080/09540962.2023.2243775

To link to this article: https://doi.org/10.1080/09540962.2023.2243775

Published online: 13 Sep 2023.

PUBLIC MONEY & MANAGEMENT
https://doi.org/10.1080/09540962.2023.2243775

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From commodification to entrepreneurialism: how commercial income is transforming the English NHS

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IMPACT

The authors explore the way in which National Health Service (NHS) organizations in England are becoming more entrepreneurial through seeking more commercial income. As a form of commodification, commercialization has become more salient because of tightened public spending and the relaxation of regulations governing the scale of commercial income that the NHS could earn (since 2012). In turn, a stronger entrepreneurial ethos and practice has developed. The purpose and impact of commercialization is examined using secondary data from six NHS organizations (narrating developments post-2012), demonstrating the extent of and their justifications for commercialization. Recent and planned changes are explained. These income-generation activities, which are often set up to support or maintain existing NHS services, may unwittingly accelerate further commercialization—particularly in post-pandemic recovery. The authors conclude that the NHS risks becoming predicated upon commercial logics, thereby undermining public service logics.

ABSTRACT

Commodification of health services involves objects that can be traded—private patients' facilities, treatments for international patients and the development of joint ventures and trading entities. This article explores the extent to which the NHS in England is becoming more commercial in its aims and practices, and how this is being justified. The authors focus on the commercial income of six NHS trusts who are thought to be at the forefront of this development. The income the trusts are generating is examined using the lens of competing institutional logics and of Polanyi's 'double movement' thesis.

KEYWORDS

Commercialization; health services; institutional logics; NHS trusts; public sector entrepreneurialism; public service

The National Health Service (NHS) is often seen as an iconic public service in the UK, denoting the salience of state funding and (largely) state provision of services (Klein, 2013). Over the past few decades, however, successive governments have introduced more market-style relations and commercialism in this (and other) public services, under the rubrics of new public management (NPM) and, more recently, public sector entrepreneurialism (PSE) (Boyett, 1996). Commodification of health services involves objects that can be traded—private patients' facilities, treatments for international patients and the development of joint ventures and trading entities (Sheaff et al., 2020). This article explores the extent to which the NHS in England is becoming more commercial in its aims and practices, and how this is being justified. It does so through the lens of the income that local NHS organizations can earn from commercial sources. We interpret these data in terms of competing institutional logics and Polanyi's (1994) 'double movement' thesis.

The article is organized as follows. First, we examine the recent transition from commodification towards PSE via commercialization, using the lens of competing institutional logics and of Polanyi's double movement. Second, we describe the health policy context in England which has shaped the transition in the NHS. Third, we focus our analysis of the commercial income of trusts who are thought to be at the forefront of this development (as revealed by Exworthy & Lafond, 2021); we use their documentation to demonstrate the extent of recent and planned changes. Finally, we consider this empirical evidence in the light of earlier debates about the extent and direction of entrepreneurialism in the NHS.

From commodification to entrepreneurialism in the public services

The standard narrative of UK public sector reform over recent decades has been the transition from public administration to NPM and latterly towards neo-managerialism (Terry, 1998), the social investment state (Newman & McKee, 2005) and public sector entrepreneurialism (PSE) (Currie et al., 2008; Exworthy et al., 2015; Lunt et al., 2015). Over the past two decades or so, NPM has, we argue, been extended and transformed into PSE (Osborne & Gaebler, 1992).

Precise definitions of PSE are problematic. Most definitions focus on individuals rather than organizations. Currie et al. (2008) suggest that public sector entrepreneurship is distinguished by three agential roles: stakeholder, entrepreneurial and political. For the individual, their role: 'identifies market opportunities within the political landscape, optimizes the performance-enhancing potential of innovation for the public sector organization, and carries

stakeholders in a way that both permits risk and recognizes the stewardship of public sector resources' (p. 987).

These roles involve a dynamic process of identifying and pursuing opportunities for innovation and risk-taking. Organizationally, Boyett (1996) argues that the conditions for PSE to emerge include an uncertain political environment, devolution of power to organizations and the allocation of resource to disaggregated management units. NPM provided this context but arguably PSE extends NPM by incentivizing financial and commercial acumen: 'earning rather than spending' according to Osborne and Gaebler (1992). Often public services are unable to 'earn' given universality (street lighting) or the absence of barriers to access (for example primary education). Some are based on user fees (for example the passport office, street parking). As the NHS has been 'free at the point of delivery', the potential of NHS organizations to earn has been limited by legislation and public opinion.

One manifestation of PSE is the commercialization of public organizations who have a degree of autonomy, are working in a quasi-competitive environment, and have revenue sources which are conditional (upon the award of contracts, user selection and/or performance assessments). In this article, we adopt an interpretation of commercialization which refers to both the 'increasing significance of profit orientated service providers in the publicly financed sector' (Mosebach, 2009, p. 69; see also Lunt, 2017), as well as public organizations with motives to increase 'surpluses'. Such commercialization has been accelerated by recent constraints in state funding. Organizations have thus had to contain costs, to improve productivity but also, significantly, to increase alternative sources of income (NHS Confederation, 2021). Given prevailing structural pressures (especially financial), similar commercialization processes can be found across UK public services, including local authority services (such as social housing, refuse collection), education, and social care.

The commercialization of the public sector denotes the interplay of two competing institutional logics (Reay & Hinings, 2009). A 'public service' logic presumes an organization structured to meet public/community needs through a professional bureaucracy whereas a commercial logic privileges competitive and marketized relations. There are signs that the commercial logic is becoming more widespread in many health systems (Bode, 2013). However, one would expect that variations would be apparent in the ability and willingness of providers to be more commercially oriented in their systems, processes and practices. For example, some organizations might have entrepreneurially-minded staff who are willing to take commercial risks (Exworthy et al., 2011). Commercial strategies are likely to entail significant sunk costs and may not be easily recovered through additional income (Bode, 2013). Also, some will see it in opposition to (or, at least, a diversion from) their core function to deliver high-quality, accessible healthcare.

One might also view these competing logics as a tension between markets and social protection. Consequently, the current commercial tension can be re-cast as a double movement. Polanyi (1944) argued that the introduction of social protection measures was a response to the (often dysfunctional) impact of markets. This notion of the double movement is also applicable to the ways in which NPM has sought to reform organizations with a strong public service ethos (Holmes, 2013), through the internalization of commercial strategies by staff and organizations (Kalleberg, 2008). Such an accommodation may be problematic as organizations and staff are conflicted by (potentially contradictory) imperatives. Rhetorically, the public service ethos remains strongly embedded within many healthcare systems, although the morale and resilience of staff have been tested in recent years (NHS Staff Survey, 2023). Indeed, Mosebach (2017) argues that current waves of commercialization in healthcare can be 'understood as a process of dis-embedding and transforming healthcare state out of their Fordist heritage' (p. 5). The current iteration of Polanyi's double movement is therefore a dynamic process in which: 'NPM-led institutional change does not create a coherent institutional framework for public service provision, but a nervous cohabitation of competing logics, leading into an open-ended and two-tiered process of tension management' (Bode, 2013, p. 335).

Entrepreneurialism in the English NHS

From its inception in 1948, the NHS has had an ambivalent relationship with the private (medical) sector (Appleby, 2009). For example, primary care doctors (general practitioners; GPs) secured a status as 'independent contractors', though funded primarily by the NHS. Likewise, senior hospital doctors are able to work in the state sector (NHS) and the private sector. However, strong professional networks and hierarchical arrangements operated in the first few decades of the NHS and so entrepreneurialism was muted.

However, from 1991, the marketization of the NHS introduced competitive elements in its operation and disaggregated organizations (such as health authorities) into self-governing organizations called NHS trusts. Since 1991, NHS trusts have secured funding from contracts with NHS commissioners of services—most recently called Integrated Care Systems for routine services—but also NHS England (a national agency) for specialized services. This combination of funding generates the majority of a provider's income. From the mid 2000s, some of these trusts evolved into foundation trusts (FTs) with greater managerial and financial autonomy (Exworthy et al., 2011).

Recent NHS policy developments have reinforced the emergence of PSE. First, 'patient choice' policy in the early 2000s directed that patients (who required hospital treatment) should be offered a choice of four or five providers, one of which should be an independent provider (i.e. non-NHS) (Exworthy & Peckham, 2006). Second, the policy of 'any qualified provider' (AQP) (from 2008) was an extension of patient choice in that the restriction on the number of providers offered to patients was removed as was the requirement that at least one should be independent (Reynolds & McKee, 2011).

The Health and Social Care Act (HSCA) 2012 intensified the earlier policy developments towards entrepreneurialism. Here, we define such income as including activities which accrue user fees (for example car parking), commercial partnerships (for example collaboration with pharmaceutical businesses, intellectual property exploitation), commercial ventures (for example wholly-owned enterprises, clinical trials), commercial activities (for example land sales, letting retail space on hospital grounds), clinical services (for example private patient units, international medical patients), and services to other

agencies (for example to local government, education and training, research) (FTN, 2014; Lunt et al., 2015; Exworthy & Lafond, 2021).

The HSCA introduced a 'wider definition' of non-NHS income (FTN, 2014). The government had previously prescribed how much non-NHS income these organizations could earn; this usually amounted to less than 1% of their income (FTN, 2012). Now, this had to be the minority of overall income. This limit ensured that public/state sources of income remained the majority and sought to negate claims that the NHS would be 'privatized'. Such fears were not, however, assuaged; some thought that a two-tier health service might flourish, with some trusts being willing and able to take advantage of their entrepreneurial opportunities (Britnell, 2011). Some FTs had already actively sought greater entrepreneurial freedom in their operations, due to previous policies. In any case, the boards of FTs should exert local accountability and are able to veto arrangements in (commercial) income of over 5% (FTN, 2014). Indeed, some might argue that such PSE activity would enhance the experience (and possibly quality) of NHS care for patients and carers. Non-FTs (who are less financially stable) do not have a cap on their private income in the same way as FTs but they are under closer financial scrutiny (Hopson, 2012).

Some argue that PSE is a form of or the precursor to privatization of the NHS (Leys & Player, 2011). Notwithstanding the problematic definition of privatization (Powell & Miller, 2014), the boundaries between public and private care in the NHS have not been clearly demarcated in theory or practice (Appleby, 2009). For example, in the 1980s, some ancillary NHS services (such as hospital laundry, catering and cleaning services) were 'contracted out' to the private sector in search of financial savings (Goodwin & Pinch, 1995). By contrast, 'top-up payments' (whereby patients might pay for specific additional services like experimental drugs which were not funded by the NHS) have been rejected as antithetical to the NHS (Bloor, 2008); however, some dental treatments in the NHS do, for example, entail co-payments.

The entrepreneurial NHS? Empirical evidence of commercial income in six foundation trusts

Financial context of the NHS

NHS finances have been deteriorating since the late 2000s, an era of relative surplus. Since the Global Financial Crisis, the NHS experienced the lengthiest spending restraint in its history: between 2009–2010 and 2018–19 health spending rose on average 1.5% per year in real terms, as against the long-term average increase of 3.6% per year (King's Fund, 2022). By 2018–19, 'nearly half of trusts were in deficit', amounting to a cumulative deficit of £571 million (NHS Providers, 2019). The impact of the pandemic and restrained public sector spending means the NHS continues to seek productivity gains to support further reinvestment. Despite planned spending increases of 2% in real terms (Health Foundation, 2022), a survey of senior NHS leaders revealed that 91% were not confident that their trust would end 2022–23 in a better financial position than it ended in 2021–22 (NHS Providers, 2022).

By 2022–23, the cumulative impact of previous funding decisions had increased the financial strain on the NHS, notably in terms of capital spending and pay settlements (which led to recurrent industrial action).

Thus, trusts have been facing the prospect of actual reductions or minimal growth in their budgets for some time and for the foreseeable future. Also, all trusts must continue to make cost savings and/or increase additional income streams. The latter is our focus here. The NHS Long Term Plan (2019) argued that (commercial) innovations in the NHS could be exported, internationally. NHS England/Improvement is encouraging trusts:

> … *to actively explore and develop opportunities to recover and, where appropriate, grow their external (non-NHS) income. While continuing the focus and priority on core NHS service delivery, it is expected that the NHS will return to working towards securing the benchmarked potential for commercial income growth, overseas visitor cost recovery and private patient services* (NHS, 2022, para. 151).

Methods

We aimed to investigate how far trusts were exploiting the HSCA 2012 to increase their commercial income and their justifications for doing so, and how they were responding to post-pandemic pressures. We collated publicly-available documents from a sample of NHS organizations across England. We conducted a content analysis of documentation, primarily available from the organizations' websites, from 2014 and 2022. Data were obtained from (but not restricted to) documents relating to each trust such as strategic plans, annual reports and accounts, and operational plans. For each document, a keyword search was conducted, using the following terms: income; private; commercial; surplus/profit; entrepreneur; austerity. As we sought insights into the entrepeneuralization of the NHS, this search seemed appropriate but it did involve a wider definition of 'commercial income' beyond the HSCA.

This sample was deliberately atypical, seeking to discern patterns of commercialization from those trusts which were thought to be at the forefront of this development. The sample was a function of previous commercial income, organizational size, prestige and specialization. Trusts were thought, *a priori*, to be those which would demonstrate entrepreneurial behaviour since they have experience of or a reputation for seeking private patient income, and/or have developed an organizational brand awareness. Six were selected to illustrate a diversity of organizational types of entrepreneurialism: four are specialist providers, four have long been front-runners in the top ten of private patient income (Clover, 2015); four are based in London; all are FTs. They included (in alphabetical order):

- The Christie NHS Foundation Trust (specialist).
- Great Ormond Street Hospital (GOSH) for Children NHS Foundation Trust (specialist).
- Guy's and St Thomas' NHS Foundation Trust (GST) (general).
- Moorfields Eye Hospital (MEH) NHS Foundation Trust (specialist).
- The Royal Marsden NHS Foundation Trust (RM) (specialist).
- University Hospitals Birmingham (UHB) NHS Foundation Trust (general).

Although these findings should prompt further research, we acknowledge the limitations of this study. First, defining

what constitutes 'commercial income' is a complex and contested process. Data can also be problematic; some trusts (for example MEH) present non-consolidated accounts whereas others (for example the RM) do not, making direct comparisons problematic. Also, the sample of atypical NHS organizations was expected to act entrepreneurially but it would be necessary to examine change over a longer period and compare with other NHS organizations to see how far commercialization had become internalized. Two of the sample (GST and UHB) had undergone organizational mergers in the study time frame, potentially complicating our conclusions. Moreover, our focus offers little insight into the value of commercialization to stakeholders inside and outside the organization (see Hodgson et al., 2022). Also, this article only reports the documentary evidence from the sample; there is a need to explore the motivations and behaviours of such decisions by staff. Moreover, while NHS funding retains broad public support (Buzelli et al., 2022; Wellings et al., 2022), we know little about public perceptions of NHS commercial strategies. Finally, the latter part of the period was marked by the Covid 19 pandemic which severely affected trusts' strategies.

Findings

The entire sample stated their on-going commitment to a public service logic of delivering NHS services to NHS patients. They claimed that this remained their primary purpose (not least because it is a condition of their regulatory licence). Yet, a major concern of the sample trusts was reconciling this purpose with the sustainability and improvement of these services in a restricted financial context. However, they presented and marketed themselves in different ways. All six trusts saw the possibilities afforded by the HSCA 2012, claiming that it enabled them to diversify their income streams, to reduce reliance on NHS-related income and thereby to sustain and improve NHS services (through the reinvestment of surpluses).

It might be expected that commercial activities would generate a higher degree of risk than 'normal' NHS services. Trusts recognized the volatility of commercial income sources and often stipulated that such activities should be deemed as 'low risk'. Long-term contracts were used to mitigate risks (for example GST and Christie). The term 'low risk' applied to reputation and finances. Trusts stated that they took pride in their reputation and stipulated that any commercial activities should be aligned with this. Maintaining reputation was especially pertinent for commercial activities which were seen to be deviating from direct patient care (Lunt, 2017). Moreover, trusts often stated that such reputations should be used as leverage in obtaining more favourable deals commercially (for example international private patients). Reputational risks were recognized particularly among the specialist trusts. Specifically, the London-based trusts seemed to use their brand reputation and geographical location to attract patients from other countries. In more recent years, some trusts (such as MEH) have been developing a non-NHS brand identity.

Next, we examine the case studies to explore the extent and nature of their commercial income strategies. The financial data of these case studies are summarised in Table 1.

The Christie NHS Foundation Trust

This Manchester-based trust specializes in oncology and employs over 1500 staff. In 2020–21, Christie derived most of its income from patient care, amounting to £326 million, with £310 million (95%) of this coming from its only English commissioner (NHS England). Overall trust income (2020–21) was £403 million. Christie have long argued that pressure on NHS finances mean that it necessitated income diversification so long as it was deemed low risk. Commercial income, Christie argued, was needed to 're-invest in NHS services' (Five-Year Strategic Plan, 2014–19). The Christie 'brand' could thus be used as 'leverage with potential commercial partners' (Five-Year Strategic Plan, 2014–19).

These partners include HCA International, SYNLAB and Alliance Boots. The Christie Pathology Partnership (CPP) is a joint venture between SYNLAB providing clinical laboratory services and the trust. Commencing in 2014, the partnership will run for 10 years and operates out of the existing Christie pathology laboratories, where around 70 staff have transferred from the NHS to the CPP (Christie Hospitals Trust, 2022). Its partnership with Alliance Boots has developed pharmacy services focused on oncology. Christie has also become 'one of the largest performers of commercial drug trials in the UK' (Annual Report and Accounts, 2014–15).

Documents identify the importance of surpluses to support public provision: 'Any surplus derived from the limited diversification of income has helped support the Trust in delivering high quality healthcare services for our patients' (Annual Report and Accounts, 2021-2, p. 32). Christie argues that 'We aim is to maximize opportunities for generating surpluses from non NHS funded cancer services to reinvest in NHS provision' (christie.nhs.uk).

Table 1. Commercial income in six NHS FTs 2016–17 and 2021–22.

	2016–17			2021–22		
	Total income (£ million)	Commercial income (£ million)	% of total income	Total income (£ million)	Commercial income (£ million)	% of total income
Christie	264.732	68.489	25.87	403.116	81.998	20.34
GOSH	581.243	130.243	22.41	542.745	63.563	11.71
GST	1446.51	364.315	25.19	2639.456	441.056	16.71
MEH	221.958	58.226	26.23	283.779	77.236	27.22
RM	370.659	177.204	47.81	562.915	297.556	52.86*
UHB	811.877	170.273	20.97	2066.179	269.145	13.03

Sources: Trusts' own documents and authors' analyses.

*Note that RM share of commercial income is above 50%. Although the HSCA prevented trusts from exceeding half their income from non-NHS sources, the definition used here is wider, in order to highlight the extent to which trusts have become entrepreneurial.

In some reports the notion of surplus gives way to profit. In 2010, Christie entered into a joint venture with HCA International Ltd to provide private oncology services. By 2016–17, this generated £5.0 million 'profit' (Annual Report and Accounts, 2016–17, p. 30). In 2022, this joint venture is still operating. Auditors Annual Report, 2020–21 (p. 6) commented that 'The Trust's financial plans are reliant on significant non-NHS income to support its activity; from profit distributions from joint ventures [most significantly, the Christie Private Clinic]'.

Great Ormond Street Hospital (GOSH) for Children NHS Foundation Trust

GOSH is a children's hospital in London which employs more than 4,300 staff and has an operating income of £542 million (Annual Reports and Accounts, 2021–22). The hospital has 53 dedicated private beds and the International and Private Care Directorate employs over 200 clinical and non-clinical staff in London.

GOSH has seen a long-term decline in the proportion of total revenue coming from the NHS, as some funding has moved from health to social care and because of limited growth of commissioning for specialized services and reduction in tariff prices. As a specialist trust, GOSH was concerned about the consequences for the retention of specialist staff and its brand (Annual Report and Accounts, 2014–15). It was, therefore, seeking to diversify its income stream. For example, GOSH is: 'developing an education strategy that will leverage its unrivalled brand identity internationally and nationally by commercializing with appropriate education and other activities *to offset* any reduction in NHS funding, as a result of any government limitations or reductions in investment in the NHS' (Five-Year Strategic Plan 2014–19; emphasis added).

This strategic plan noted that GOSH derives 'very little' commercial income other than its international and private patients (IPPs). With NHS funding sources becoming more limited, commercial income was seen as an opportunity: 'The strength of the GOSH brand brings with it opportunities to generate commercial income, which very few other NHS providers will have to the same degree'.

Income from IPPs comprised 11.1% of trust revenue in 2013–14 (with an expectation that it would rise to 13.36% by 2015 (Five-Year Strategic Plan, 2014–19). By 2016–17, growth of IPP was 14.1%, equivalent to £7.2 million (Annual Reports and Accounts, 2016–17, p. 28). Such income growth generated some risk given many IPPs came from the Middle East (ditto, p. 67); indeed, by 2017, GOSH was *owed* £30 million by private patients (Clover, 2017). The vagaries of geo-politics and trade relations could also threaten international patient flows and Covid 19 has had a detrimental impact on the level of private income received through international patients (with an overall fall in non-NHS private patient income from £37.40 million in 2020–21 to £24.91 million in 2022). The growth of IPP also necessitated the creation of an organizational sub-division, led by an executive director. GOSH (Annual Reports and Accounts, 2021–22, p. 25) re-asserted that: 'Our International and Private Care (I&PC) directorate is an important component of the overall funding model for GOSH. It enables the Trust to invest in enhancements to services and facilities that drive benefits across the NHS and maintain our status as a world-class provider of paediatric services'.

Since 2006, GOSH has also operated a regional office in Dubai (Lunt et al., 2015) to support relationships with foreign sponsors in the Middle East. The presentation of GOSH's private activities on its website is noteworthy, re-routing enquiries to overseas sites that carry no mention of the NHS and with GOSH framed as 'Great Ormond Street Hospital (GOSH) is a globally renowned children's hospital, championing innovation across more than 60 clinical specialties and providing ground-breaking treatments for the rarest and most complex conditions'. The International Patient Centre page and Gulf office website do not carry the NHS logo but utilize another branding logo.

Guy's and St Thomas' NHS Foundation Trust (GST)

GST employs 23,500 staff and has an annual turnover of over £2.6 billion (GST, 2022). In 2022, it ended the year with a small surplus of £0.2 million against the £5.5 million surplus control total agreed with NHS England. Its non-NHS patient earnings in 2022 were £54 million.

Generally, GST has been increasing its non-NHS income to reduce its reliance on NHS income. Although this London-based trust sought to develop commercial activities to enable income diversification, it sought those which represented a low financial and reputational risk. It aimed to: 'create commercial gain from the physical and intellectual assets of the Trust for the benefit of our NHS services, *without* incurring significant financial or reputational risk' (Annual Reports and Accounts, 2013–14; emphasis added).

Arguing that commercial activities were a 'fundamental part of the strategic framework', the Five-Year Strategic Plan 2014–19 claimed that: 'Commercial activities and partnerships *specifically* enable us to diversify our income streams and support us to be an operationally and financially sustainable organization so we can provide exceptional care to our NHS patients' (p. 3; emphasis added). One advantage of a 2021 merger with Royal Brompton and Harefield hospitals was the commercial expertise in management of private patient services of Guy's and St Thomas' Private Healthcare (Annual Report, 2021–22, p. 30).

GST sought to develop longer-term commercial contracts (for example with the Ministry of Defence) to offset risk in these activities (Annual Reports and Accounts, 2013–14). A strategy of income diversification reflected the 'constrained financial environment nationally and in the NHS' which presented a 'significant risk that we [the trust] are not fully recompensed for the work we undertake' (Five-Year Strategic Plan 2014–19, p. 7). Their plan was therefore 'to diversify our income base to generate additional income to invest in NHS clinical services' (ditto, p. 11).

GST created Guy's and St Thomas' Enterprises Ltd to oversee its commercial activities. This entity provided non-clinical services for the trust which comprised capital, estates and facilities services. These services have also been further commercialized, for example through Lexica Health and LifeSciences Consultancy Ltd which deliver services to other NHS trusts, and non-NHS organizations. There are a number of other joint centres, including with Viapath and Synlab UK and Ireland (pathology).

Moorfields Eye Hospital (MEH) NHS Foundation Trust

MEH is a specialist eye hospital based in central London, but operating across 32 sites (Annual Report and Accounts, 2016–17). It has a staff of over 2,000. It had an annual turnover of £222.0 million in 2016–17: a rise of 9.9% on the previous year (Annual Reports and Accounts). By 2021–22, total income has risen to £283.8 million (Annual Report and Accounts, p. 15), with a 'surplus for the year' of £19.4 million.

MEH has two commercial divisions: Moorfields Private and Moorfields Eye Hospital Dubai. The trust argues that these units exist 'entirely to augment and support' healthcare to NHS patients by generating income from outside the NHS, which can then be 'reinvested' in services for all its patients (Annual Report and Accounts, 2016–17).

The trust recognized the volatility of commercial activities. For example, while they planned to expand MEH Dubai and MEH Private, the board of MEH agreed to close the production facility of MEH Pharmaceuticals in 2015 (Annual Reports and Accounts, 2014–15), entailing a one-off financial loss which was met from 'current and accumulated commercial profits' (Annual Report and Accounts, 2014–15).

MEH introduced a commercial directorate in 2016–17 to maximize its commercial income with a rationale that so doing would 'benefit [of] our core NHS business' (Annual Report and Accounts, 2016–18, p. 45). This is further justified thus: 'Surplus from this non-NHS activity is *reinvested* to benefit all our patients' (ditto, p. 25; emphasis added).

The Five-Year Strategic Plan 2014–19 anticipated a steady proportion of revenue coming from non-NHS sources: 19.9% in 2013–14 compared with 20.0% in 2018–19. However, income from private and overseas patient activities in London and the United Arab Emirates increased by £12.9 million (53%) to £37.2 million (2020–21), increasing by £6.3 million above the pre-pandemic 2019–20 level (Annual Report, 2021–22).

MEH formed a partnership with United Eastern Medical Services (UEMedical) in Abu Dhabi to establish Moorfields Eye Hospital Centre in Abu Dhabi in 2016. It uses its own logo on private sites and alongside the NHS logo on NHS sites.

Towards the end of 2022, Moorfields Private began to offer services from within Harley Street area (a traditional area of private medicine in London). It was said to complement MEH, 'with a number of treatments not being available on the NHS and with 'financial surplus [is] re-invested into Moorfields Eye Hospital to support NHS patients and services'.

The Royal Marsden NHS Foundation Trust (RM)

RM was one of the first trusts to be awarded FT status in 2004 and so considered one of the best performing NHS organizations at the time. In 2016–17, it employed 3,928 staff and had an 'overall income' of £370.7 million, generating a 'surplus' of £5.6 million (Annual Report, 2016–17, pp. 37 & 10).

In 2008, RM earned 29% of its income from non-NHS sources (Appleby, 2009), increasing to over 30% in 2015–16 (Exworthy & Lafond, 2021). This London-based FT—specializing in cancer diagnosis and treatment—was the highest earner from private patient income, generating £76.8 million in 2014–15 (up 29% from £59.8 million in 2012–13); the 2014–15 figure amounted to about 20% of its total revenue (Clover, 2015). RM noted that NHS services were funded below cost price (thus requiring cross-subsidy from commercial income sources). RM claimed to be 'in the highest quartile of NHS providers for the costs of delivering specialist services' (Operational Plan, 2014–16). However, its services to NHS commissioners were reimbursed at only 80% of the cost, leading to a loss of £27 million per annum. Like others, RM argued that margins in commercial income was a '*vital* source of support for NHS services' (Annual Report and Accounts, 2014–15; emphasis added).

The trust planned to increase its annual commercial income to over £100 million, from around £70 million (Operational Plan, 2014–16). Even based on 'patient care income from private patients' and 'overseas' patients, it appears to have done so by 2020–21. It argued for 'an appropriately separated private [business] model and increased presence in attractive international markets' (Five-Year Strategic Plan, 2014–19).

The RM Annual Report (2021–22) claimed that 'The financial performance of the Trust has been greatly impacted by the Covid 19 pandemic, with a reduction in commercial income' (p. 23) but our analysis suggests that it increased to reach 52%. While this would seem to breach the HSCA, our definition of commercial income is broader. Indeed, trusts need to affirm that they have not breached the HSCA:

> *The income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes. The Trust has met this requirement, with 67 per cent of its income deriving from the NHS* (Annual Report, 2021–22, p. 39).

Its Annual Report 2021–22 outlines a new private diagnostic and treatment facility. Its private care revenue experienced a 'strong recovery' during 2021–22, with income rising 38% on the previous year and 4% above target.

RM's Private Care Strategy (2013) was deemed essential to its longer-term viability (Five-Year Strategic Plan 2014–19). RM described its strategy to 'exploit the brand and our expertise to generate new areas of business'; it claimed that its separate unit 'exists entirely to augment and support the case we provide to NHS patients by generating income from outside the NHS which can then be re-invested in services for all our patients' (Annual Reports and Accounts, 2013–14; emphases added). This was reinforced more recently: RM will 'capitalise on the strength of The Royal Marsden brand and reputation' (Five-Year Strategic Plan, 2018/19–2023/24, p. 71). The *Financial Times* reported that RM earned £132.6 million from private patients in 2019–20, an increase of 9% from the previous year and up 44% from 2016–17 (Plimmer, 2021).

University Hospitals Birmingham (UHB) NHS Foundation Trust

UHB is the single largest hospital site in the UK, with over 1,200 in-patient beds. It employs more than 9,000 staff. It had an 'operating income' of £811.3 million (2016–17), generating a surplus of £24.7 million (Annual Report, 2016–17, pp. 9 & 13) but, by 2020–21, its income had risen to £2,066.2 million (largely through the merger with other local trusts), and generating a surplus of £34.8 million (representing 1.7% of total revenue) (Annual Reports and Accounts, 2021–22, p. 13).

In 2015, UHB documents revealed that the trust was concerned that NHS funding would not be sufficient to

sustain its services and sought to generate surpluses from non-NHS income from commercial and international activities (Annual Report, 2013–14). For example, UHB runs three commercial divisions: Pharmacy@QEHB, Assure Dialysis services, and UHB Facilities Ltd (Annual Reports and Accounts, 2014–15). In doing so, these income sources would 'support the provision of NHS healthcare' (Annual Reports and Accounts, 2014–15).

NHS (and local government) income generated £605.6 million (82.7%) of UHB's total revenue (Annual Report and Accounts, 2014–15). Non-NHS 'clinical' income contributes a further £8.9 million (1.2%) and this includes private patients, provision of healthcare to the military and costs recovered from insurers under the Injury Cost Recovery scheme. Other income sources include education services (£30.7 million; 4.2%) and research activities (£24.3 million; 3.3%) (Annual Report and Accounts, 2014–15). By 2016–17, 81% of UHB's income was funded by NHS commissioners within England, with a further 2% from NHS patients outside England, private patients and costs recovered from insurers (Annual Report, 2016–17, p. 13). It was also noted that 'private patient income' was £3.9 million, 'education levies' totalled £30.6 million, research income amounted to £25.6 million and 'services provided to other organizations' generated £11.7 million (ditto, pp. 13 & 14). Private and International Patient income was £3.9 million (Annual Report, 2020–21). The Competition and Markets Authority (2017) adjudicated on the arrangements for a planned private patient unit between UHB and HCA International. The CMA conclude that it will take 'no action with respect to this planned PPU' (p. 1).

Discussion

The case studies demonstrate the growing impact of commodification with respect to commercialization and thus PSE. Next, we examine the findings in relation to our conceptual frames of institutional logics and double movement.

PSE is a consequence of the NPM variant which had been implemented in the English NHS in recent decades. Quasi-markets and other commercial activities (for example out-sourcing) have been adopted in the NHS since 1991 and the 1980s respectively. Yet, the logic of PSE had not previously been implemented extensively. This may have been because there was a wariness of exploiting the opportunities of PSE for fear of being seen as undermining the spirit and ethos of a much-valued public service (Exworthy, 1998). However, in the past decade, various policy and legislative measures have enabled PSE to become more established in the practices and attitudes of politicians, civil servants and local agents.

Nonetheless, PSE in the English NHS has been moderated by the distinctive composition of executive and professional (clinical) interests (Currie et al., 2008). Organizations' primary focus on patient care underpinned (documentary) statements from our entire sample; all the trusts reiterated that non-NHS income was used to underpin the delivery of core NHS services. Such support was largely financial (rather than, say, private patients offering a more distinctive case-mix of patients or cases of rarer diseases). Trusts argued that their primary focus was still on NHS services (consistent with the requirement/logic of the HSCA 2012). Yet such claims were, arguably, made to assuage any concerns that commercial activity would distract from 'core' NHS services. The NHS still provided the bulk of their income, a stipulation of the HSCA. The protection of 'core' services is significant in financial and reputation terms since financial surpluses of commercial activities help to cross-subsidise NHS services (Lunt, 2017).

While such commercial plans were built into trusts' strategies, the degree of transparency (in accounts and public understanding) is problematic. Trusts needed to balance new pressures between international geo-politics, as well as domestic challenges (in terms of funding and NHS commitments). For example, Walpole et al. (2020) note that little attention has been paid to the governance of private income:

> *In theory, any financial gains made by trusts will be used for improvements that will benefit NHS patients. Yet the Department of Health and Social Care and NHS England do not provide guidance on how to ensure that benefit is obtained, how to avoid detriment, or how private income should be accounted for.*

Walpole et al. (2020) point to various data limitations (availability, access, analysis) that are blocks to transparency around effects of private patient care in the NHS. Variation in tariffs and questions of hidden cross-subsidy hamper detailed analysis.

PSE strategies are thus being facilitated by a growing commercialization within increasingly autonomous organizations as manifest by organizational structures and dedicated appointments. Structures and processes have often remained notionally separate through the formation of commercial divisions, thereby de-coupling commercial strategies from NHS strategies. Some staff have been appointed to these divisions from private/commercial organizations (Lunt et al., 2015; Hodgson et al., 2022). NHS trusts competing for international private patients may beg the question of whether there should simply be one PPU 'brand' for the whole NHS. The commercial logic may still permeate into other parts of the organization. The separation of 'core' services and commercial activities may be sustainable if the latter continue to generate surpluses but both may be threatened if losses are incurred.

Our evidence highlights four implications of ways to conceptualize PSE, which would benefit from further empirical investigation:

- First, commercial logics are evident but it is not clear how far they have become internalized among all NHS staff (Hodgson et al., 2022). PSE might be relatively isolated within particular organizations (or sub-divisions), although there is the possibility of greater permeation as NHS finances appear to be worsening. Much would depend on the role of agency; if NHS staff might feel that commercialization was the 'only' way of retaining a public service logic, then this might be different to those staff who pursue an avowedly commercial logic from the outset.
- Second, there is a question of whether pervasive commercial discourses are always inimical to the delivery of high-quality public services (Appleby, 2009). Our sample of organizations, for example, deliver high-quality services, according to the financial (NHS Improvement) and quality (Care Quality Commission) regulators. We did not consider such apparent 'benefits' nor the value that they might bring in this analysis.
- Third, the balance between multiple, local objectives is constantly in flux (Currie et al., 2008); the current balance

between stakeholder, political and entrepreneurial roles seem to be privileging the latter. However, though apparent in our sample, this may not be apparent in all NHS trusts, especially those less able to take advantage of commercial opportunities (such as private patient income). The spread of commercialization is likely to be highly variegated.

- Fourth, the stated aim to enhance NHS services may, due to PSE, prompt further changes in the organizational structures, processes and culture of the NHS which might undermine that aim. This might involve focusing on areas of activity (for example specific disease or populations groups) which would facilitate more commercial opportunities. Organizational attention might thus be skewed towards more 'profitable' areas, especially when undertaken as part of a joint venture or formal partnership. There is thus a paradox between the need (identified by trusts) to increase commercial income precisely to support or maintain existing NHS services. In doing so, these organizations may unwittingly help to accelerate (further) the commercialization of the NHS. This paradox may still apply even though these trusts may not necessarily breach the cap set by the HSCA 2012.

These tensions can be interpreted in terms of Polanyi's double movement and competing logics. The era of NPM (including commodification and, latterly, PSE) implies another iteration of the double movement from a state-led system to a marketized one. However, this is misleading because the private sector and commercial practices have always been implicated in the NHS and recent market-based initiatives have been heavily influenced by social networks (of patients and clinicians, for example) and hierarchical systems (Exworthy et al., 1999). Indeed, Holmes (2013) argues that this binary opposition is false given the ways in which power relations are reproduced through social practices. For example, case study trusts relied heavily on their (NHS) reputation to exploit commercial opportunities and so were wary to exploit all commercial opportunities (Lunt, 2017). The extent to which they do will depend on (*a*) the ability and willingness of NHS staff to act entrepreneurially; (*b*) the tolerance of the public to commercial practices in/by the NHS; and (*c*) the degree of government encouragement to pursue commercial ends.

While the public service logic has generally been dominant in the NHS, the commercial logic has become increasingly pervasive (Grönroos, 2019). Although the majority of trusts' income remains from NHS sources, new commercial opportunities have been developed over the past decade. This article shows that this commercial logic has been developed over time such that a hybrid logic might be emerging in which a public service logic is inter-dependent upon a commercial one. Both would seem to rely on each other for their effective functioning; the public service logic needs a commercial income to support its activities while the commercial logic requires the reputation and infrastructure of the NHS. This hybridity might be appealing, but governance issues remain in terms of the stewardship of public money (transparency and accounting) and the consequence of any financial losses. Moreover, at the moment, the hybrid logic might be deflecting some public attention and scrutiny from the NHS finances as the trusts' commercial income lessens the NHS's problematic financial situation (Exworthy & Lafond, 2021).

The inter-dependency and hybridity of these competing logics might denote a more pervasive effect upon the NHS. Rather than implementing (often controversial) government reforms or (even more controversially) privatization, the commercialization of the NHS is a more insidious process which normalizes such activities and recasts NHS activity in terms of commercial opportunities. External top-down reform becomes redundant if NHS organizations themselves normalize the commercial logic; external reform is obviated in favour of reform from within.

Conclusions

In this article, we have charted the ways in which some NHS organizations are becoming more entrepreneurial in their activities, in terms of commercial income. Commercial logics are thus becoming built into the infrastructure of NHS accounting systems. We have identified a shift in language to defend such income and explored how entrepreneurialism has been justified with a public service ethos. Although this was an atypical sample, there is a clear direction towards commercialization through diversifying income sources. While the majority of their funding will still come from public/state sources, NHS organizations are implementing entrepreneurial strategies which are seen as essential to underpin core NHS services. In turn, this will re-orient the organizations and their staff with a potentially detrimental effect upon a public service logic.

The tension between public service and commercial imperatives has long been apparent but the logic and consequence of them has become more acute recently. The likely intensification of this tension will reveal further the impact (intended or otherwise) of such strategies upon 'core' public services.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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