UK public opinion on reasons to oppose healthcare privatisation: a failure of neoliberal persuasion and discursive politicisation

Abstract

Opinion surveys have consistently shown that the British public does not support National Health Service (NHS) privatisation, but we know less about *why* this is. Studies in this area have been limited, despite the importance of the topic for healthcare, its associated workforces, public health, inequalities, (de)politicisation and democracy.

We analyse the first open-ended representative survey of UK citizens' motivations for opposing privatisation. Public opinion is contrasted with previous academic assumptions – supported by quasi-market theory – that opposition to privatisation is overwhelmingly concerned with services being free at the point of delivery. Instead, we find the largest single reason for dissent is the extraction of profits.

Drawing on political governance perspectives**,** which advocate a wider scope of actors be included in such analyses, we consider public sphere institutions that have been neglected in recent studies. Thus, we examine our evidence in relation to patient representatives, health think-tank policies and the operation of discursive politicisation. Furthermore, we assess trade unions' political communications strategies and their 'public service approach', in the light of our results.

Our findings raise significant challenges for actors, such as non-executive commissioners. There are important implications for public sphere policy here in acknowledging the full extent of the public's concerns about privatisation.

NHS, public health, privatisation, public opinion, inequality, democracy

Introduction

John Curtice and Oliver Heath (2009) have provided data showing that the British public, overwhelmingly, do not support National Health Service (NHS) privatisation. And this result has been consistently replicated, latterly, for instance, within a Patients Association report (2019). However, in the years following the 2009 publication, negligible academic resources have been devoted to finding out why the public hold this view. This is despite six interlinked factors reflecting our broader concerns:

- new technologies having enabled cheaper mass qualitative data collection (BBC 2018)
- the increasing significance of healthcare privatisation policy (Powell and Miller 2014)
- a World Health Organization (WHO) focus on fostering the 'participation of wider society in the development … of government policy' (World Health Organization 2014)
- public health research uncovering further connections between health and wealth inequalities (Marmot et al. 2020)
- globally significant research showing that privatisation has contributed to increasing wealth inequality (Piketty 2014)
- evidence confirming that falling trade union power also exacerbates this inequality (Deaton 2019).

This article addresses the gap in research on the reasons why the British public continue to oppose healthcare privatisation. Despite this opposition, privatisation has continued (Powell and Miller 2013). This situation is salient to considering the operation of democracy. Analysis of privatisation, and the dismissal of dissent within this process, involves a range of issues including: theories of public engagement in politics and (de)politicisation (e.g. Wood and

Flinders 2014); government policy and democracy (e.g. Merkel 2019; Frangakis et al. 2009; Lukes 1974); political justifications and state capture (e.g. Feigenbaum et al. 1998; Cordelli 2020); and NHS-specific denationalisation discussions (e.g. Pollock 2004; Powell and Miller 2013; Powell and Miller 2014). A better understanding of public opposition to privatisation can help to shed light on processes that curtail dissent.

Trade union political communications and campaigns to oppose privatisation have made strategic switches over the past four decades. The switches may, or may not, mirror wider public concerns (Davis 2002; Hermann and Flecker 2013). Qualitative data as to what the public think can help assess both such communications and government rebuttal strategies, with the latter having perhaps 'become more covert in their support of privatization' (Frangakis et al. 2009).

[Insert Figure 1 here]

Wood and Flinders (2014) suggest drawing in a wide scope of policy actors in assessing opposition to privatisation (Figure 1). In so doing, they identify a Gramscian perspective that highlights hegemonic, ideological networks (Wood and Flinders 2014). In the governmental sphere, analysts have scrutinised UK party-of-government policy in some detail (Parker 2013; Exworthy et al. 2016). But researchers have paid less attention to the public sphere. Nevertheless, certain public sphere institutions are intimately connected to the NHS. They can influence policy; providing a conduit for aspects of public opinion to be articulated. Among the wider health policy community are 'think-tanks' such as The Health Foundation and The Nuffield Trust. We consider a similar London-based, charity think-tank, The King's Fund. It is illustrative of an ideal type of actor (Feigenbaum et al. 1998 after Max Weber), not directly answerable to the public in the 'party of government' sense. But its position carries

some hegemonic force as its work is cast as authoritative and evidence-based (Wood and Flinders 2014). Given this, it may reinforce 'taboos' and help position an 'Overton window'. In other words, it can influence the range of discourse on a policy deemed as acceptable (Lukes 1974; Lynch 2019). The King's Fund is an educator of professionals, ranging from public health specialists through to unelected NHS commissioning body non-executives, representing patients. It was the publisher of ground-breaking research on inequalities in health in the 1980s (Lynch 2019) and has led work on public opinion and the NHS (Burkitt et al. 2018). But it is uncommitted on the extent to which it 'privileges voice', or responds to public opinion, on the privatisation issue (Exworthy et al. 2016). The King's Fund (2021), at the time of writing, says that: 'Provided that patients receive care that it [sic] is timely and free at the point of use, our view is that the provider of a service is less important than the quality and efficiency of the care they deliver.' Darzi (2018) and Duckett (2001) echo this perspective. It can be argued this is an example of 'pragmatic privatisation', which according to Feigenbaum et al. (1998, pp.164–5) is depoliticised, but could have a significant social impact. The think-tank's stance may, in turn, reinforce hegemonic positions in nearby organisations. Following Speed and Gabe (2020), we consider whether this position, alongside those of patients' voice institutions, reflect our survey results. Furthermore, the trade unions' perspective again is posed here as an ideal type, representing workers experiencing privatisation. We examine the implications of our survey for trade union communications.

We start by looking at the background and context to privatisation, quasi-market theory, rising inequalities and political communications. We also review the literature on what academics consider to be the deleterious effects of privatisation from socioeconomic and public health perspectives, in order to contrast this with public opinion. This provides the

bases for our hypotheses. We then describe the methods used in surveying a representative sample of more than 2,000 UK citizens and present our results. Our discussion section focuses on the single largest reason for hostility to NHS privatisation, namely, private profit extraction. This has important implications for organisations attempting to acknowledge and align with public opinion, for agencies' wider public health policies and for future research on public opinion in different countries, such as the USA.

Definitions, history and actors – a neoliberal context

We define healthcare privatisation as private companies or businesses running NHS hospitals and delivering health services that had previously been delivered by the NHS (UK state). This definition is not uniformly adhered to (Flecker and Hermann 2011; Powell and Miller 2013). Nevertheless, as is argued, privatisation includes the shift of 'productive processes undertaken by the state into the hands of private companies. Clearly privatisation involves enhanced prospects for profits and accumulation within the private sector' (Frangakis et al. 2009, p.71).

Public opposition to privatisation has been credited with reining in the Conservative Party Prime Minister, Margaret Thatcher, from seeking to scrap the UK's Beveridge-inspired healthcare model and introducing health insurance, which was mooted in 1979 (Klein 1985). Nevertheless, NHS outsourcing to the private sector began in the early 1980s, before other European countries (Hermann and Flecker 2013, p.192). Initially this affected less-qualified, lower-paid staff (Cousins 1988). Meanwhile, the health service was divided by a 'purchaser-provider split' in 1991 — a move informed by the theory of 'quasi-markets' (Le Grand and Bartlett 1993). Furthermore, by 2004, the Department of Health was ordering 'purchasers' to buy from private as well as state providers (Powell and Miller 2014).

In this context, this paper considers the implications of the observation that quasi-market theory avoids discussing for-profit providers within its schema and treats privatisation as something of an irrelevant footnote (Le Grand 2004, p.3). Quasi-market theory is based on assumptions regarding public opinion such as that citizens are not concerned with private profits, they are only interested in quality and whether health services are free. Hypothesis two (H2), below, tests this assumption. The ongoing relevance of this is that while NHS actors and international consultancy firms have subsequently challenged the quasi-market model, and championed integrated 'accountable care organisations', they have not excluded private profit extraction. By 2014, private consultancies were receiving UK state funding in increasing amounts to promote integrated models (NHS England 2014; Kirkpatrick et al. 2019).

Meanwhile, the constitution of NHS health boards was changed in 1990 to diminish democratic participation by excluding trade union representation and elected councillors. The government and the NHS have since appointed commissioning body non-executive members, giving them responsibilities for public health, overseeing contracting and representing the public (Pollock 1995). Local sources from across England show these individuals have often endorsed privatisation (Change.org 2015). Healthwatch is a further state-funded service-user public sphere advocate that reports patients' views, as is The Patients Association (2019), whose perspectives we shall consider later.

Given this background and to understand the parameters of opposition, next we review the academic literature to delineate a typology of anti-privatisation perspectives, starting with those focused on the workforce. As indicated, this is so we can then assess which aspects of the public's and public sphere actors' views, and argumentation, relate most closely to the literature or diverge from it. In turn, we highlight issues concerning the narrowing of

democratic participation to help contextualise the relationship between policy in the public sphere and the reasons why the public oppose privatisation.

Reasons for opposing privatisation

Workers' rights perspectives

Research has suggested that privatisation tends to lead to increasing job insecurity, temporary work, 'self-employment' status, wage differentials, wage reductions, elimination of benefits, weakening of pension schemes and training provision, work intensification and job losses (Frangakis et al. 2009; Hermann and Flecker 2013). Some evidence has suggested workloads are not as high in the UK private healthcare sector as they are in the NHS. But other international studies have found that nurses and newly hired and migrant workers may often be paid less in private services (Hermann and Flecker 2013).

One origin of these perceived negative outcomes has been found to be a loss of collective bargaining and falling trade union membership density (Hermann and Flecker 2013), while price-based bidding for contracts has risen (Ascher 1987; Frangakis et al. 2009; Hermann and Flecker 2013). Suppressing trade unions has been shown to be a political aim of privatisation (Frangakis et al. 2009, p.257). And temporary workers have been understood to be more difficult to unionise, leading to a further loss of bargaining power (Hermann and Flecker 2013). Thus, there is a clear tranche of negative outcomes for workers associated with privatisation.

Impact on inequalities and public health, and the role of profit

Developing from this workers' rights analysis, a central argument identified above against privatisation from a political economy perspective is that it increases economic inequality

(Piketty 2014, pp.183–4). Overall, privatisation has shifted power in favour of capital and weakened labour (Frangakis et al. 2009, p.75). These issues are important from a public health perspective, since wealth and health inequalities are linked (World Health Organization 2005; Marmot 2020).

The public sphere actors that we are interested in generally aim to champion public health. From a public health perspective, trade unions have been associated with reduced income inequality (Deaton 2019) and increased solidarity (Putnam 2000). Related to this, participation in policymaking is also considered a salient aspect of effective strategies to close the health inequalities gap (World Health Organization 2014). And union and political participation are linked (Kerissey and Schofer 2018). Meanwhile, increasing wealth inequality diminishes participation and democracy (Piketty 2021). Areas of financial influence on policymaking include, for example, utilising corporate lobbying, research, networking and media capture (Geoghegan 2020). The privatisation of state planning roles is also a factor in depoliticisation (Figure 1) and in curtailing democratic processes (Wood and Flinders 2014). And here Cordelli (2020) makes no distinction between the undemocratic influence of private and charitable bodies (Robertson 2013; Kirkpatrick et al. 2019; Oliver 2019; Geoghegan 2020).

The role of private firms and profit, hitherto, has not been closely linked in the healthcare literature to public opinion. Lobbyists for the private sector have emphasised ‘value for money principles’ that the discipline of profit-seeking affords (Speed and Gabe 2020). Nevertheless, researchers have identified that privatisation is inefficient, emanating from this requirement to extract profits (Price 2016). Furthermore, information asymmetries are created, while higher transaction costs are involved (Whitfield 2006; Hermann and Flecker 2013, pp.48, 198; Tunney and Thomas 2015). There is the concern that firms’ allegiances may

be to other actors and not to the public (Hermann and Flecker 2013, p.27). And consultancy companies stand to gain from the fees and commissions that processes of privatisation have generated (Frangakis et al. 2009, pp.66, 72).

Significantly, an additional major concern about privatisation is that it increases the chances of extra top-up payments for services. Cutting funding while maintaining quality might exert pressure to bring in explicit or hidden charges (Pollock 2004, p.39). Globally, healthcare privatisation has been associated with increased healthcare payments, disproportionately affecting the less well-off (Price 1988, pp.703–716). Further political economy research has highlighted a concern that transparency is lost as privatised services' complex mergers and acquisitions result in the public, academics, law enforcers and politicians losing a grip on who owns, runs and reaps profits from what (Hermann and Flecker 2013; Piketty 2021). Private companies' accounts are not as open as public services' finances (Tunney and Thomas 2015). Global hedge funds or '[s]hareholders put pressure on companies to achieve high levels of return on investment' (Hermann and Flecker 2013, p.80). Thus, a zero-sum game emerges whereby those who have bought shares gain more, often at workers' expense (Frangakis et al. 2009, p.72). This profit is then privately controlled and may be used for wasteful, high-carbon and antisocial purposes (Frangakis et al. 2009). Therefore, 'shareholding democracy', or 'popular capitalism and the ownership of shares by the ordinary man [sic]' is something of a contradiction (Letwin 1988, p.27). Moreover, shareholders are also often anonymous and unaccountable, a criticism Keynes made (Sayer 2016), and this nurtures tax avoidance – an obvious problem for state-funded services (Bayliss and Gideon 2020). Chilling research from Australia, in addition, reveals the racist attitudes of shareholders who have profited from minority ethnic and female healthcare workers (Hanson and Tranter 2006).

Furthermore, providing public subsidies, in the form of, for example, equipment, research and infrastructure, is a contentious area as this process further supports private owners (Frangakis et al. 2009, p.254). Additionally, if salaries fall below a certain level, then states may pay social assistance, thus making privatisation even less efficient for the state as a whole (Hermann and Flecker 2013).

Service user, or consumer, perspectives

So much for workplace and ownership concerns. However — influenced by public relations specialists — some unions, alongside professional bodies, came to accept the idea that anti-privatisation strategies employing a 'public service approach' in a united front with users, would gain more traction among the public than worker-focused tactics. There is indeed evidence that healthcare consumers are opposed to privatisation because they believe it leads to a worsened service. A European cross-country survey indicates most users thought healthcare privatisation would not improve quality, with the less well-off more critical (Hermann and Flecker 2013). For the unions to highlight the detrimental impact on consumers would also leverage 'media subsidies'. (The context here is that opponents of privatisation had been relatively poorly resourced to promote their messages, with media subsidies, including mainstream press coverage, being less likely (Davis 2002).) This approach was based partly on conventional wisdom that the public is hostile to union militancy, with workers seen as 'self-interested' (Coderre-Lapalme and Greer 2016, pp.263 268–274). This contrast between consumer and staff-related concerns is considered in our fourth hypothesis (H4). In broadening opposition, union political communications also sought to employ claims to a national and community interest, encouraging a public service ethos (Davis 2002). Privatisation was seen to potentially undermine national unity. It was 'selling off the family

silver', including to foreign investors (Letwin 1988; Frangakis et al. 2009), leading to work moving overseas (Hermann and Flecker 2013). Meanwhile, private competition and rivalry eroded a public service ethos of cooperation (Frangakis et al. 2009, p.63). More recently in the UK, a campaign called We Own It, backed, but not mainly financed or controlled by unions, has combined opposition to shareholder profit with highlighting consumer concerns. Other small pressure groups have adopted similar strategies (Hall and Lister 2020; We Own It 2021).

Privatisation, public sphere organisations and public opinion

As we have seen, privatisation is contentious and has implications for democracy. Public hostility to privatisation appears to have been sustained for decades. **Our Hypothesis 1 (H1), testing this, is that: opposition to privatisation will continue to mirror Curtice and Heath's (2009) findings, including on the variations by income that they found.** Nevertheless, as indicated, there is an extremely limited academic literature on public opinion and *reasons* for opposing NHS privatisation given the significance of the NHS for the British public and the size of its workforce. Yet, there is a unique article that does touch on the issue – that of Powell and Miller (2013). These researchers conclude that the public's main concern regarding privatisation, composited with other actors' views, is that: 'The "bottom line" appears to be the "free at the point of use" principle'. That is, the public's key objection to privatisation is based on the cost to individuals. (Caveats are added to this tentative conclusion concerning different definitions and the extent to which some actors stand on principle, pragmatism or evidence.) Our second hypothesis, therefore, aims to assess their findings. **Hypothesis 2 (H2) is that: the most frequent reason respondents will give for opposing privatisation will be to maintain free access to services.**

Given the influence of quasi-market theory and its sidelining of the significance of placing private providers on the choice menu, we also posit **Hypothesis 3 (H3) that: the public will not be concerned to restrict 'for-profit' providers.**

Finally, based on political communications strategies opposing privatisation**,** pursued by actors such as trade unions, we consider **Hypothesis 4 (H4) that: the public are more likely to oppose privatisation based on consumer issues, such as quality, rather than staff-related concerns, such as conditions of employment.**

Overall, our aims can be summarised as being, firstly, to augment research finding that more than 70% of the public oppose this privatisation (e.g. Curtice and Health, 2009); and secondly, to test the assumptions behind the academic literature on public opinion and NHS privatisation (Curtice and Heath 2009; Powell and Miller 2013; Le Grand 2004; Davis 2002). Finally, based on political governance perspectives (Wood and Flinders 2014), we aim to analyse whether influential public sphere institutions' policy on privatisation clearly articulates this public opinion (Mouffe 2005); we appraise its consistency with public opinion and public health interests. In so doing, we provide justifications for updating policy to reflect public health and democratic concerns (Lynch 2019). Furthermore, we also aim to inform debates on trade union political communications (Davis 2002).

Methods

In order to follow up on the Curtice and Heath (2009) survey, Ipsos MORI contacted an online sample of 2068 people in the week of June 8th 2020. The organisation maintains a body of registered volunteers. From this pool, it drew a representative sample of the public based on the Office for National Statistics' (ONS) mid-year estimates and Ipsos's algorithm. Thus, our

sample reflected ONS weightings, such as for age, gender, ethnicity, education and region. Social grade (or 'class') is based on occupation. This only approximates to the class statistic used in the Census (NS-SEC), which includes workplace relations (Ipsos 2009). Participants informed Ipsos of their personal data, such as salary, employment and education. Respondents did not self-select for the survey and were unaware of the content prior to reviewing the questions (Ipsos MORI correspondence to first author 21/04/20).

The initial question asked for views on NHS privatisation. This worked to identify those opposing privatisation: ASK ALL

Q1. To what extent do you support, or oppose, the privatisation of the National Health Service (NHS) by the Government, or do you have no feelings either way?

By privatisation, we mean private companies or businesses running NHS hospitals and delivering health services that had previously been delivered by the NHS. In general, do you…

1. Strongly support
2. Tend to support
3. Neither support nor oppose
4. Tend to oppose
5. Strongly oppose
6. Don't know

Then respondents were asked an open-ended question on why they had stated their position:

ASK ALL WHO HAVE AN OPINION AT Q1 (Q1=1-5)

Q2. You said that you [IF Q1=1-2 ‘support’ IF Q1=4-5 ‘oppose’ IF Q1=3 ‘have no feelings either way’] about the privatisation of the NHS, where private companies or businesses run NHS hospitals and deliver health services previously delivered by the NHS. Why do you say that?

Please write [type] in all relevant answers:

[OPEN ENDED]

Ipsos MORI supplied the anonymised data, including typed verbatim comments, to the researchers in SPSS format. Quantitative analysis was undertaken using the same package. We used the chi-square statistical test to compare distributions of categorical variables. We also undertook qualitative analysis with the objective of addressing the research hypotheses in a replicable manner. The answers to the question ‘why do you oppose NHS privatisation?’ provided a recording unit that the authors then coded via qualitative content analysis to assign 13 nominal deductive categories (Table 2). We outline some ‘prototypical text passages’ from the most frequently identified category in the results (Mayring 2014, pp.88–94, 95, 97). The spelling is corrected in the examples provided. The coding of categories of reasons for rejecting privatisation entails some subjectivity. Therefore, the two researchers separately coded 10% of the sample and agreed the categorisation and resolved the coding differences between us. The remaining sample was jointly coded.

Our method may be subject to several further challenges. Firstly, our definition of privatisation provided to the respondents may be critiqued (Powell and Miller 2013). We addressed this point above. Secondly, the period when the survey was undertaken was one where NHS workers were being praised for their courage. However, this does not invalidate the results, it merely provides context. Indeed, regarding hostility to privatisation, it is notable the survey was undertaken before corruption allegations with respect to Covid contract awards to the private sector emerged (Bailey et al. 2021). Thirdly, it can be suggested that the

importance of the context and wording of questions means that different language can produce diverse results (Lewis 2001, pp.11 297; Powell and Miller 2013). Alternative findings, for instance, may arise from questions that imply that there will be a loss of personal access to care (Timmins 2005). So, for context, we reproduce the questions asked above. Finally, it can be objected that the overall pool of Ipsos Mori respondents are self-selecting. However, the surveying organisation has experience of reducing bias by ceasing data collection when targets in sub-groups are met, and it was able to improve representativeness by accessing a comparatively large sample. In summary, possible problems with the data include some potential bias in the sample, time-period, questions and analysis. Nevertheless, we suggest that the method is clear and replicable and it is on this basis that a range of conclusions are drawn.

Findings

For and against privatisation

The overall quantitative data picture from our 2020 survey clearly upholds the findings of Curtice and Heath (2009). It shows a decisive majority opposing privatisation, with 73% rejecting, and only 15% supporting (p<0.001).

The class differences also may corroborate these earlier findings – but the definitions are not fully compatible (see Table 1). In 2020, the social grade A (upper middle) support privatisation the most and reject privatisation the least**.** (As with the 2009 data, the lowest 'class' grade shows an increase in acceptance compared to the next grade.)

[insert Table 1 here]

Table 1: Support for privatisation by social grade

Alongside this, regarding income, as with the Curtice and Heath (2009) data, support for NHS privatisation also fell with lower incomes. In 2009, those researchers found 17% of people with a household income of below £15,000 supported NHS privatisation, compared with 14% identified in this 2020 data. Our results appear to indicate the increased isolation of high earners from mainstream opinion. As far as opposition to privatisation goes, every income band showed more than 70% opposition to the policy, aside from those earning £100,000 or more. Here, however, the majority (58%) were still opposed, but 29% supported the move. Opposition to privatisation was somewhat higher in the North of England and Scotland and lowest in London. There were no significant differences by gender and, by age, opposition increased from 68% among those under 55, to 84% in the 55-75 age band. As Curtice and Heath (2009) do not report on privatisation by age, or ethnicity, we do not explore this here. However, further research on the topic could be undertaken in the future. Overall, thus, hypothesis 1 is broadly upheld.

Reasons to oppose privatisation – qualitative data

However, strikingly, hypothesis H2 — that 'the most frequent reason given for opposing privatisation will concern free access to services' — was not met. This hypothesis was derived from Powell and Miller (2013), and the finding has wide implications for public sphere actors. Nor was hypothesis H3 met. This was based on the assumptions of quasi-market theory, that 'the public will not be concerned to restrict 'for-profit' providers'.

[insert Table 2 here]

Table 2: Reasons for rejecting NHS privatisation

Instead, what triggered respondents most was precisely that profits would be extracted from the provision of NHS services. Among the prototypical passages were these:

'This would be unacceptable. We shouldn't have to answer to shareholders and allow profit to be made out of ill health.' [referring negatively to shareholders]

'Because good healthcare is not compatible with neoliberal profit-making.' [referring negatively to neoliberalism]

'Profiteering is at the expense of good patient care.' [referring to profiteering]

'Because it means that more money is being wasted in profit than is being spent directly on good healthcare.' [seeing profit as a waste of money]

We can see patterns of logical argumentation, or discursive reasoning (Figure 1), emerging in the responses. We find a moral objection to making money out of ill health. There is a mistrust of profit motives. Respondents did not regard shareholders' involvement in healthcare as legitimate. Profit-making might reduce quality and increase the likelihood of fees. And profit was seen as a waste of taxpayers' money.

Respondents often regarded the issue of charging individuals for healthcare as a long-term political project, which they opposed. An element of concern over government subterfuge was detectable in some responses. Participants also considered the less well-off would be harder hit. Among other prototypical passages, one suggested: 'It'll end up with us having to pay and then only those who can afford healthcare will receive it.' In addition, there were a small number of discrete answers linking an increase in privatisation with a rise in inequalities.

However, perhaps as respondents felt secure that they would not, in the short term, face charges, this issue was surpassed by profits.

As for divisions by social grade, we found that two of the middle-grade groups (Bs middle and C1s lower middle) were more likely to mention profit, at 31%. But in no social grade did profit get mentioned by less than 15% of the group.

Furthermore, concerns about charging increased among lower income groups. Across income bands £15,000-£99,999 24% of adults who did not support privatisation gave costs for individuals as a reason. This figure increased to 30% among those earning less than £15,000 and was 17% among those earning more than £100,000.

Extending to hypothesis H4, derived from union political communications strategies — that 'the public are more like to oppose privatisation based on consumer issues, such as quality, rather than staff-related concerns, such as conditions of employment' — we found that this was met. Contrary to the findings of our literature review, there was limited recognition that staff conditions might deteriorate with privatisation. In addition, while the NHS has been held up as a 'national religion' (Tunney et al. 2021), issues of national pride were not reported as reasons for not privatising, so much as 'not wanting the health system to follow a USA model'.

Discussion and conclusion

We have followed up on the Curtice and Heath (2009) report to answer in more depth why people who do not support NHS privatisation (73%) think as they do. We show that over a decade later there was enduringly high opposition to this privatisation and that the UK public were concerned about private profits extracted from state funding of the NHS to a greater extent than previously reported. What are the implications of this? We consider ramifications

for public sphere actors, neoliberalism, public health, and trade union perspectives. Firstly, within the (de)politicisation framework (Figure 1), a network of public sphere policy-community organisations is challenged by this finding, which 'exposes an illusion of consensus' and 'provides a reality check' (Mouffe, 2005; BBC 2018). The Patients Association (2019) and Healthwatch (2017), for instance, while already finding public hostility to privatisation, have not translated this into a coherent national policy. The King's Fund, with its important public health role and interest in resonating with public opinion, is found to be conflicted between these areas and a narrower 'expertised' perspective (Wood and Flinders 2014 – after Habermas 1996). Strong public objection to privatisation and profit-making by NHS-contracted services appears to be at odds with The King's Fund's 'pragmatic' approach.

Public sphere actors, such as those commissioning body non-executives who endorsed outsourcing, have played a part in the hegemonic reinforcement of ideological perspectives that align with neoliberalism and contradict public opinion (Smith et al. 2013). Actors' alignment can pull inwards to concurrence with a Conservative government and media or outwards towards a dissipated public opinion (Figure 1). Our evidence calls into question the extent to which such actors have considered, listened to and acted on public opposition to privatisation.

Moreover, a significant proportion of the sample held that privatisation, which currently maintains the 'free at point of delivery' formula, risks increased charges in the future. Thus, an important finding was that participants expressed long-term concerns over further creeping co-payments. This idea is backed up by Cordelli (2020), who finds when private companies, or charities, are involved as major providers they can exercise political pressure, such as to increase charges (Cordelli 2020).

Secondly, if neoliberalism aims to enlarge the realm of the market, then the extension of capitalist for-profit firms into healthcare services previously delivered by the state is part of that project. We found respondents shared a negative perspective on the merits of this process. Forty years on from the initial NHS outsourcing of the early 1980s, the free-service formula, while hugely important, is also clearly not the only issue that concerns those surveyed at this juncture. Neoliberal ideology has failed to convince a dissipated public voice. A significant proportion of participants rejected top-slicing of profit as an unjustifiable use of taxpayers' money. Interestingly, a King's Fund report discusses similar findings: 'Outsourcing NHS care to the private sector and the legacy of private finance initiatives were cited as examples of waste' (Burkitt et al. 2018). However, it has not so far translated this understanding into clear policy.

Notably, respondents turned the tables on a key assumption of quasi-market theory. This being that if citizens are given a choice they will want outcomes improved via market incentives that control worker-led bureaucracies to make financial savings (Le Grand 2004). Rather, many of those surveyed saw profit-seeking engendered by privatisation as the problem, not the financial solution. Some particularly identified hedge funds, shareholders and profiteers as concerns. Shareholders, from respondents' anti-profit perspective, were seen more as 'scroungers' than as providing any useful contribution to healthcare. By noting the unknown and unaccountable shareholders, our respondents also picked up on similar themes to Piketty's notion of the unknown in hyper-capitalism (2014).

Thirdly, moreover, there is another contrast between respondents and public sphere actors. On the one hand, these actors (e.g. Darzi 2018) appear to 'buttress' neoliberal government policy in sidelining the wider public health implications of privatisation. A cluster of public

sphere actors in the health field have not been concerned with the impact of privatisation on wealth inequalities and, consequently, health inequalities. Thus, the overarching inequalities context provided by Piketty (2014) and Marmot (2020) has been ignored. In contrast, respondents saw the broader implications of privatisation as relevant. While they did not highlight the implications for public health specifically, the survey shows that the extraction of profit and, for some, profiteering – in other words how services are structured and delivered – matters. And those surveyed were concerned particularly about the implications of privatisation for the less well-off.

Fourthly, trade unions are also actors in the public sphere and there are implications here for their political communications. Context for this was provided in our review of healthcare privatisation, which chronicled that as union power waned, the prominence of other public sphere actors increased. Meanwhile, the lower income health workers' voice is now simply heard less. Nevertheless, unions, and to some extent professional bodies (Speed and Gabe 2020), have consistently opposed privatisation. Although our results do not identify particular public support for focusing on workplace conditions, the data indicate that concerns are not focused exclusively on narrow consumer matters. As we have found, respondents' objections to privatisation extend to political economy perspectives, shared with unions, on profit-extraction. The evidence shows that communication strategies fusing profit concerns with consumer issues, as We Own It has followed, might play to a strength of feeling. Moreover, limited public recognition of poor working conditions could be addressed further with public health partners.

In reflecting on recommendations for actions based on these findings, we can also take into account Speed and Gabe's analysis (2020). They demonstrate how clear policy positions and

dialogue between public sphere institutions can help prevent governments from ignoring public opinion and moving further into compromised practices (Bailey et al. 2021). Moreover, in Piketty's research, industrial democracy is central to challenging rising wealth inequality. We might, therefore, recommend a reinvigorated public sphere dialogue between, for example, The King's Fund, similar think-tanks, trade union stakeholders and academics to consider co-ordinated action on the deepening inequalities regime, of which privatisation is a part (Lynch 2019; Piketty 2021).

Overall, we have fulfilled our aims of updating and critiquing literature that assumes the priorities of the public in opposing privatisation. And we have highlighted relationships between public opinion, public sphere actors and wider public health concerns. We have provided a more expansive analysis of public opinion on opposition to healthcare privatisation in the UK than has hitherto been available. Public objections are more fundamental and nuanced than previously considered. The reasons for government non-action on public opposition to privatisation might be seen as part of the compromises of political office that the public should not be naïve about (Flinders 2010). Nevertheless, previous research shows privatisation itself has muted lower-income workers and paid them less (Feigenbaum et al. 1998; Hermann and Flecker 2013; Frangakis et al. 2009, p.75). A contradiction exists between the sidelining of public opinion covering the problems of privatisation and the pursuing of public health goals to reduce inequalities, since privatisation increases wealth inequality (Piketty 2014). Public sphere institutional actors may have been helped to downplay long-term public opposition (e.g. Curtice and Heath 2009) by assuming that objections to privatisation have predominately been concerned with the NHS remaining 'free at the point of delivery' – a Rubicon that they might maintain has not been crossed. Thus, an 'illusion of

consensus' between spheres is harboured (Mouffe 2005; Wood and Flinders 2014). Our opinion survey overturns this chimera and potentially contributes to a process of holding actors to account (BBC 2018; NHS Leadership Academy 2013).

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Figure 1: Politicisation and depoliticisation (adapted from Wood and Flinders, 2014 and Hay, 2007)

Privatisation-related issues:

- Public opinion surveys can reveal aspects of the private sphere where opinions are normally held in isolation. Surveys may operate to politicise, depoliticise or to hold to account (BBC, 2018).

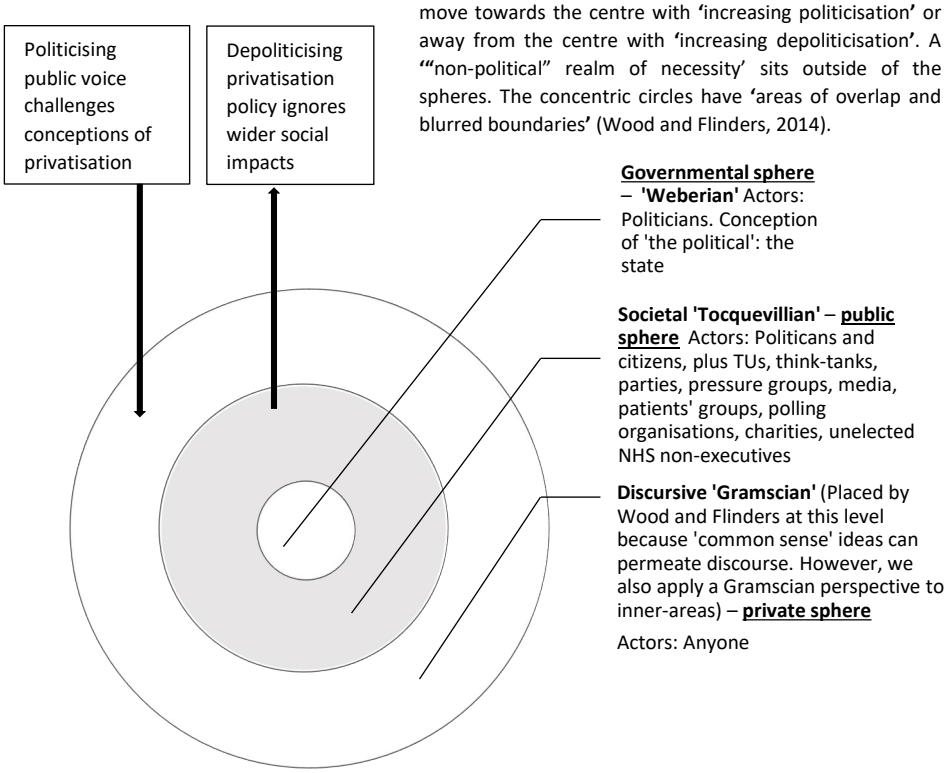
- Public sphere institutions can be depoliticised on this issue by ignoring public opinion and deferring to government policy, or vice versa.

- (De)politicising movement between levels is influenced by access to financial resources, differentials in precarious living conditions and wealth inequalities (Geoghegan 2020; Piketty 2021a).

- Public sphere institutions, such as charities, are shaped by the state. Trade unions' (TU) resources to influence politicisation have been systematically curtailed by privatisation and legislation since the 1980s (Frangakis et al. 2009).

- Discursive opinions on reasons to oppose privatisation may be unregistered or be interpreted to avoid politicisation and 'issueness' (Wood and Flinders, 2014). An example of this is when NHS commissioning body non-executives do not seek or respond to public opinion on privatisation.

- Actors and agencies may form strategic alliances at different levels, e.g., TUs, 'think tanks' and public health institutions.



'De(politicisation) shifts issues off (or onto) agendas'. Issues move towards the centre with 'increasing politicisation' or away from the centre with 'increasing depoliticisation'. A '"non-political" realm of necessity' sits outside of the spheres. The concentric circles have 'areas of overlap and blurred boundaries' (Wood and Flinders, 2014).

Using this framework highlights that public opinion is not buttressing institutions of the public sphere (Wood and Flinders, 2014). That is, rather than upholding and concurring with societal institutions' policies, there is a disjuncture with public opinion and some gaps between the spheres. Neoliberal ideology fails to fully permeate public opinion, yet philosophically discursive opinions, or reasoning, of individuals in the private and public arenas fails to politicise influential public sphere organisations' policies.

	A Upper Middle	B Middle	C1 Lower Middle	C2 Skilled Working	D Working	E Lower level	Total
Does support NHS privatisation	21	105	79	35	36	31	307
Does support NHS privatisation %	**32%**	**19%**	**11%**	**14%**	**12%**	**22%**	**15%**
Neither supports nor opposes	7	68	85	31	36	21	248
Neither supports nor opposes %	**11%**	**12%**	**11%**	**12%**	**12%**	**15%**	**12%**
Does not support NHS privatisation	37	387	582	188	228	91	1513
Does not support NHS privatisation %	**57%**	**69%**	**78%**	**74%**	**76%**	**64%**	**73%**
Total	65	560	746	254	300	143	2068

Table 1: Support for privatisation by social grade

Reasons for rejecting NHS privatisation **Note: respondents were able to give more than one answer**	**Number**	**% of total reasons given**
Profit issues	430	21
Cost for individuals would increase (includes in the longer term)	382	18
Restates does not agree with privatisation	248	12
Increases inequality	225	11
Standards would fall	147	7
Current system fine	133	6
Other or no answer	130	6
Private companies have failed	105	5
Cost of service to taxpayer etc increase	79	4
USA is a bad model	79	4
Accountability decreases (includes corruption increases)	49	2
National pride	48	2
Poorer staff conditions	27	1
Total numbers of reasons given Percentages rounded	2,082	100

Table 2: Reasons for rejecting NHS privatisation