**Children’s Hospitals in the British NHS:**

**Commercial and international considerations**

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**Abstract**

Patient mobility is a complex phenomenon, involving both outward and inward flows, and treatments that are more and less complex and where choice may be driven by quality and availability rather than solely cost. Public health systems in high- and middle-income countries are facing increasing financial pressures given population ageing, a rapid rise in chronic and non-communicable diseases and fiscal restraint. In this context, the intersection of patient mobility and commodification of care provides opportunities for generating additional revenue, particularly for hospitals with a reputation for clinical excellence and innovation.

The National Health Service is often seen as an iconic public service in the UK, with primarily state funding and state provision of services. Over the past few decades, however, successive governments have introduced more market-style relations and commercialism in the NHS under new public management and more recently, public sector entrepreneurialism. Whereas historically there has been ambivalence around private activity, international patients and joint ventures are identified as a possible route to lessening pressure on NHS resources. Specialist NHS hospitals treat inward medical travellers with complex tertiary procedures (including paediatrics, and heart surgery), and maternity services and ophthalmic surgery.

In this paper, we present documentary research on the case-study of Great Ormond Street Hospital (GOSH), a specialist NHS children’s hospital in London which has a tradition of treating patients travelling from outside the UK. We review the practices around commercialisation in relation to children’s services to offer a novel analysis on specialist children’s services. In so doing we expand academic and policy debates around commercialisation in public health systems and provide theoretical insights drawing on Karl Polanyi’s “double movement” to helps explain the apparent paradox whereby commercial income is increasingly justified by NHS organisations because of an apparent need to support NHS services.

**Introduction**

International patient mobility is a complex phenomenon, involving both outward and inward flows, and treatments that are more and less complex and where choice may be driven by quality and availability rather than solely cost (Exworthy and Peckham 2006; Lunt et al. 2014). Publicly-funded health care systems in high- and middle-income countries are facing increasing financial pressures given population ageing, a rapid rise in chronic and non-communicable diseases and fiscal restraint. In this context, the intersection of patient mobility and commodification of care provides opportunities for generating additional revenue, particularly for hospitals with a reputation for clinical excellence and innovation. Outward medical travel from the UK generates media and professional interest, notably around the complications, risks and lack of information (Davis 2024; MacPhee 2024). However, there has been relatively little academic focus on patient flows into the UK for treatment by private and public providers.

The National Health Service (NHS) is often seen as an iconic public service in the UK, with primarily state funding and state provision of services (Klein 2013). Over the past few decades, however, successive governments have introduced more market-style relations and commercialism in the NHS under new public management and more recently, public sector entrepreneurialism (Boyett 1996; Currie et al. 2008). Commodification of health care involves objects that can be traded - private patients’ facilities, treatments for international patients and the development of joint ventures and trading entities. Whereas historically there has been ambivalence around private activity, international patients and joint ventures are identified as a possible route to lessening pressure on NHS resources (NHS England 2019).

The receptive organisational and political context in the UK (and especially England) has fostered recent policy and economic developments that have accelerated commodification (Lunt et al. 2015). Commodification has become apparent across English NHS organisations, especially in community health, mental health and specialist health care organisations (such as specialist or single specialty hospitals). Exworthy and Lafond (2020) calculated that 14.7% of the income of specialist health care organisations such as children’s hospitals were derived from non-NHS sources (2015-16), comprising income from private patients, training, research and development (among others). (This is above the NHS average of 9.2%). Such specialist organisations might be seen as exceptional category for commercial activities as they care for distinct patient groups and are unlike the traditional in-patient (adult) population of most NHS providers. However, their distinctiveness lies in their specialised treatments (often for rare conditions) and for groups (such as children) who are seen as especially vulnerable.

Specialist NHS hospitals treat, among others, inward medical travellers with complex tertiary procedures (including paediatrics, and heart surgery), oncology, maternity services and ophthalmic surgery. Treatments are also outpatient admission, day surgery, as well as overnight stays and lengthier hospitalisation. Specialist children’s hospitals globally (including those in North America, Europe, and Australia) often treat patients from outside their jurisdictions; this is no different for some specialist NHS providers. Indeed, notwithstanding the complexity of international mobility for child patients, the willingness (of parents or guardians) to travel for children’s health care is much higher than other, adult patients (Exworthy and Peckham 2006).

In this paper, we present documentary research on the case-study of Great Ormond Street Hospital (GOSH), a specialist NHS children’s hospital in London which has a tradition of treating patients travelling from outside the UK. We review the practices around commercialisation in relation to children’s services to offer a novel analysis on specialist children’s services and expand academic and policy debates around commercialisation in public health systems. The paper is organised as follows. First, we describe the health policy context in England which has shaped the transition in the NHS to greater commercialisation and commodification. Second, we focus our analysis on the commercial activity of GOSH using their documentation to demonstrate the extent of recent and planned changes. Finally, we consider this empirical evidence in the light of pressure on the NHS and debates about the extent and direction of entrepreneurialism in the NHS and implications for public services.

**International patient activity past and present**

Despite the ambiguous place of private activity in the NHS historically, there has been significant international patient treatment within the public health ecosystem, and this accelerated after the 1970s because of increased Gulf state wealth. The Kuwait embassy in the UK supported up to 1000 patients annually, whilst 2000 Qatari patients were treated each year in the UK (Raynor 1986). The 1980s saw competition among Britain, France and Germany for these Middle Eastern patients (Anon 1991), and this intensified during economic downturns from the late 1980s with domestic private activity squeezed and the public sector undergoing significant retrenchment.

Such international patients are treated as booked and planned admissions within NHS facilities, primarily these are pre-paid or through Government or insurer’s ‘Letter of Guarantee’. Most international patient treatments are organised by Embassies and national Ministries and purchasers. Within specialist NHS facilities, private services may be offered within both integrated and standalone facilities. Integrated facilities co-locate activities, thereby ensuring intensive care units and specialist supports are available. Alternatively, treatments may have dedicated facilities with private operating theatre/treatments space and ward facilities.

From 1991 NHS reforms introduced competitive elements in its operation and disaggregated organisations (such as health authorities) into self-governing organisations called NHS Trusts. From the mid-2000s, some of these Trusts evolved into Foundation Trusts (FTs) with greater managerial and financial autonomy (Exworthy et al. 2011). Foundation trusts’ greater autonomy includes the ability to borrow commercially and generate surpluses to reinvest back into patient care (Exworthy et al. 2008; Powell and Harker 2023). A HM Treasury Document (2002) sought to encourage Government departments, agencies and public bodies (including NHS ones) to better utilise their physical and non-physical assets by engaging in commercial services based on them, where appropriate. The Health and Social Care Act (HSCA) (2012) intensified earlier moves towards commercialisation, specifically creating opportunity for Trusts to increase their commercial income and introduced a “wider definition” of non-NHS income (FTN 2014). Clinical services (*eg*. private patient units, international medical patients) are one commercial activity but income may also come from commercial partnerships (*eg*. collaboration with pharmaceutical businesses, IP agreements), and commercial ventures (*eg*. wholly owned enterprises, clinical trials) (FTN 2014; Lunt et al. 2015). Government had previously determined how much non-NHS income FT organisations could earn, typically less than one per cent of their income (FTN 2012). Under the 2012 HSCA, such income simply had to be the minority of overall income.[[1]](#endnote-1) This limit ensured that public/state sources of income remained the majority and sought to negate claims that the NHS would be ‘privatised.’

NHS finances have been deteriorating since the late 2000s and the impact of the pandemic and restrained public sector spending means the NHS continues to pursue productivity gains for further reinvestment. Trusts have been facing the prospect of actual reductions or minimal growth in their budgets for some time and for the foreseeable future (Charlesworth et al. 2023; Warner and Zaranko 2022; Anandaciva 2024). In response, all Trusts must continue to make cost savings and/or increase additional income streams. The 2024 Spring Budget introduced the productivity plan which, along with the NHS Long Term Workforce Plan (NHS England, 2019), aims to boost productivity by 2% per year.

The NHS Long Term Plan (2019) also argued that (commercial) innovations in the NHS could be exported, with the aid of central agencies. Following the Covid-19 pandemic (and because of its financial consequences for the public finances), NHS England (NHS 2022) expects Trusts ‘to actively explore and develop opportunities to recover and, where appropriate, grow their external (non-NHS) income. Whilst 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).

Acknowledging the complexity and political sensitivity of international commercial activity, it is seen as an opportunity to improve NHS services in ways that include revenue, reputation, research and funding, recruitment and retention, and reach (NHS Confederation 2021, 4-5). Governance of international income require that Trust Annual Reports detail the impact of such commercial income for its core business (DH 2011) and increases of 5% or more in private sector income require board level approval (DH 2011).

***The case of GOSH***

GOSH is a prime example of a children’s hospital engaged in international patient activity, as illustrated by earlier research (Exworthy et al. 2024). Engaging in international patient activities requires *capability* (acknowledged expertise and reputation), *opportunity* (removal of external constraints and positive encouragement) and *motivation* (institutional interest in, and arrangements for, raising additional income). These are evidenced through our case study of GOSH which employs over 5,350 staff and has an operating income of £560million (Annual reports and accounts 2022-23). The hospital has 53 dedicated private beds across three wards, and its International and Private Care directorate includes 221 clinical and non-clinical staff. GOSH is an iconic children’s hospital and NHS institution. It was featured in the London Summer Olympics’ opening ceremony, a performance which heavily ‘mythologised the foundation of the NHS’ (Baker 2014, 415). The narrative was one of:

“praising the solidarity of the Welfare State by choosing a very emblematic NHS hospital—Great Ormond Street Hospital Children's Charity or GOSH—thus apparently emphasizing the caring and disinterested quality of the institution”(Lambert-Charbonnie 2018).

During 2023-24 GOSH generated its highest ever income from private patients, with a 44 per cent rise on the previous with income now at £78.9m (Clover 2024). The 2023-24 private income was triple that recorded 2010-11, and a higher proportion of overall income compared with the earlier period (Clover 2024). This amount refers solely to consultants that undertake private patient services as part of their NHS activities, consultants may also bill their private patients directly using a Trust-provided billing service, but this is separate from the amount in the Annual Accounts (GOSH FOI request, 23 October 2019, FOIRQ5420). In 2019-20 the caseload of international and private patients was 5,742 children from 107 different countries (1,114 inpatients; 16,482 outpatients) treated at the hospital.

As a Foundation Trust, GOSH is required to publish annual reports and accounts that detail the year’s operations (including business model and governance arrangements) and performance. All Foundation Trust annual reports and accounts are presented to the House of Commons in a parliamentary session (NHS Providers 2020).

The annual report is primarily a narrative document, providing an account of the Trust’s activities and performance over the last financial year. It is an opportunity to overview its achievements across the year and identify the challenges ahead. The annual accounts include statements on comprehensive income, financial position and cash flows (HMFA 2024). Foundation Trusts also produce strategic plans for a five-year period, written by the board of directors in consultation with patients, staff and public. Such strategic documents focus on vision and mission, values, and the planning that will help achieve overall objectives. These documents are made publicly available by Foundation Trusts. We collated these documents from the Trust and conducted a content analysis of documentation, from 2014 and 2024. This study did not involve human participants but focussed on organisational strategy and practice. It did not include Patient and Public Involvement within its research design. Data were obtained from (but not restricted to) documents relating to the Trust commercial strategies such as strategic plans, annual reports and accounts, and operational plans (see Table 1). Our findings were therefore shaped by our criteria for selecting potential documents and the availability of online documents. However, like other public bodies, NHS organisations increasingly publish material online (Gorsky 2015). Inevitably, some documents (especially those commercially-confidential and older documents) are not online and all documents reflect the authorship of senior managers (with their institutional and personal agendas) (Bryman 2012; Gorsky and Mold 2020; Shaw et al. 2004). The previous regulatory body, Monitor, criticised the existing quality of strategic and operational planning activity by Foundation Trusts and established stronger guidance and tools to inform process and reporting (Monitor 2013).

Whilst these documents are produced relatively routinely by large Foundation Trusts and contain some uniform reporting there are also differences and nuances for each Foundation Trusts. Documents trace emergent commercial thinking, and illustrate how it is realised in a concrete manner through organisational decisions, roles and practices. For example, another Foundation Trust, Moorfields, sought to realise commercial income from overseas ventures and its Dubai and Abu Dhabi activities are thus discussed in its 2018/19 annual report and accounts, both in the overview of performance as part of the chief executive’s statement. There is narrative analysis of its investment in overseas facilities and equipment, contractual arrangements, as well as research activities and partnerships integral to the initiative (HMFA 2024).

 In future research, documentary data could usefully be complemented by observation of board and strategy meetings and by interviews with key staff (and perhaps patients). Access to primary data collection sources may, however, be difficult.

The reports, strategies and plans for GOSH were primarily analysed drawing on the six-stage thematic analysis approach advocated by Braun and Clarke (2006). Documents also included GOSH marketing statements and supporting information (*e.g.* available on its website). We familiarized ourselves with the documents (including context, audience and meaning), coded sections of documents and then generated potential themes. Following a review of themes, consolidation and labelling, we completed the analysis using narrative statements drawn from the reports to illustrate themes wherever possible (Braun and Clarke 2006). Given this process, themes were identified in an inductive (data-driven) manner and were firmly grounded in the documents. Throughout analysis we remained alert to the range of contributions qualitative inquiry offer, including conceptual definitions, typologies and classifications, and furthering our understanding of form and nature (process, system, attitudes, behaviours), and explanations (Miles and Huberman 1984).

Reviewing the documentary material for GOSH, we identify four themes relating to international patient activity: support for the NHS, strategy, branding and reputation, and risk.

***Mitigating falling revenue and supporting the NHS***

The hospital has experienced a long-term decline in the proportion of its overall revenue coming from the NHS, with reduced funding for specialised services and resource shifts from health to social care. As a specialist Trust, GOSH has long expressed concern about how reduced funding could impact retention of specialist staff and its brand (Annual report and accounts 2014-15). The HSCA enables them to diversify their income streams, mitigate shortfalls and to reduce reliance on NHS-related income and thereby to sustain and improve NHS services (through the reinvestment of surpluses). This has been a recurrent theme throughout the past decade with a broader income base as potential mitigation for reduced public funding.

“This year, as the NHS struggles to meet the costs of specialist care, we will in part draw on the contribution from private patients to balance our financial position…The funding we receive for NHS activity is not sufficient to cover the cost of delivering it, and we rely on the contribution from private patients to balance our financial position” (Annual report and accounts 2018-19)

Recent policy developments and workforce demands are seen to place strain on public resources:

“2023/24 saw continued pressure on activity levels due to the impacts of industrial action and the drive to reduce waiting lists, which had increased during the pandemic. Whilst expanding NHS activity, GOSH has continued to work towards recovery of the private patient side of the hospital.” (Annual report and accounts 2023-24, 36)

Commercial activity is seen to be closely integrated with an on-going commitment to a public service logic of delivering NHS services to NHS patients, and so private activity supports the NHS. The public service focus is a condition of their regulatory licence and private activity cannot be cross subsidised by the public sector, a point acknowledged by GOSH:

“We do not prioritise the care of private patients over NHS patients. Clinicians operating their private practice at GOSH must ensure this is separate from their contracted hours paid for by the NHS. There are separately funded beds for International and private patients outside of NHS funded beds” (cited in Clover 2024).

The rationale for international activities is presented as primarily financial (although this is invariably interrelated with reputation, recruitment and retention). There is no mention of private patients offering a more distinctive case-mix of patients or cases of rarer diseases for example.

***Strategy and organisation***

There is a competitive global environment for specialist paediatric services (for example *Newsweek* analysis ranks leading hospitals including Children's National Hospitals in the US, Boston Children’s Hospital, Hospital for Sick Children, Toronto, Alder Hey in Liverpool) (Newsweek 2024). How institutions strategise and organise to respond to this environment is key to their commercial activities. The growth of international and private patient numbers necessitated the creation of an organisational sub-division in GOSH, led by an executive director, thereby de-coupling of commercial strategies from NHS strategies:

“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.” (Annual reports and accounts 2021-2022, 25)

Staff are appointed to these divisions from private/commercial organisations (often for their commercial acumen) (Lunt et al. 2015; Hodgson et al. 2022).

Entrepreneurialism is also evident in organisational models that sit outside mainstream NHS structures. GOSH opened a regional office at Dubai Health Care City in 2006 aiming to develop international business and to offer continuity to patients travelling from the region. The Gulf Office receives request for treatment and advises on specialty and clinician, supports planning and follow up, and deals with administration, including liaising with Embassies and insurers.

An earlier strategic plan outlined that GOSH derives “very little” commercial income other than its international and private patients (IPPs) and has expressed interest in wider commercial income opportunities: “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.” (Five-Year Strategic Plan 2014–19). For example, GOSH is:

“developing an education strategy that will leverage its unrivalled brand identity internationally and nationally by commercialising 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 2014-2019; emphasis added).

***Brand and reputation***

Traditionally, the NHS had a passive orientation to commercial income (Osborne 2020) whereas private and international activity necessarily elevates marketing and proactively engages overseas markets. The private health sector has longstanding expertise derived from involvement in general surgical marketing and experience of negotiating with insurance companies. Foundation Trusts on the other hand have traditionally been more hampered by limited marketing budgets and internal perceptions about private work. Research suggests FTs were wary of using their autonomy and were cautious about entrepreneurial activities, with most being risk-averse despite their apparent managerial freedom. This highlights the distinction between ability and willingness in analysing freedom from hierarchical control and impact on innovation (Exworthy et al. 2011).

GOSH has engaged significantly with marketing and brand development. The hospital developed a “referral app” in English and Arabic to “increase brand awareness” allowing search of services and consultants, launched in 2017 but no longer available. The hospital has been looking beyond established markets, including China, receiving advice on a marketing plan, content and messaging strategy: “With our help, Great Ormond Street Hospital has established its brand visibility in China, leading to increased enquiries from patients and partnerships” (emergingcomms.com). The Foreword of the latest Annual report cites the *Newsweek* rankings of hospitals that places GOSH in the top 3 best specialized hospitals for paediatrics (Annual report and accounts 2022-23). These are examples of entrepreneurial agency that seek to identify treatment markets and routes to access such opportunities.

A bespoke brand identity is increasingly developed aside from the NHS identity. Prospective international patients exploring private activities on the GOSH website, are re-routed to overseas-hosted sites that carry no mention of the NHS. The International Patient Centre page and Gulf office website dispense with the NHS logo and carry an alternative branding. GOSH is framed as “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”. Whilst many London-based Trusts use their NHS brand capital and geographical location to attract patients from other countries, a small number of Trusts, including GOSH, develop a parallel approach that leverage their distinctiveness. GOSH’s reputation and location deliver advantages not available to most NHS Trusts, and the spread of commercialisation is highly variegated across specialist services. Indeed, a grouping of London Specialist Hospitals, all part of the NHS, partner to promote their specialist or single speciality provision (cancer, heart and lung, orthopaedics, ophthalmology, and paediatrics) (see, <https://londonspecialisthospitals.com/>).

***Revenue streams in international healthcare***

Generating revenue from international activities carries risk and uncertainty that must be appropriately managed. The Trust undertakes significant amounts of work for governments including Qatar and Kuwait, routed through the countries’ London embassies. Typically, international income is not subject to contracts – unlike more continuous core NHS income and so activity may be more volatile. In 2019 marketing roadshows were mooted for Russia, China and India and with hindsight the unpredictability of geo-politics and trade relations for such planning is clear. High-income activity is predominantly embassy-driven and large debts may still be run up. By 2017, GOSH was owed £30million by private patients (Clover 2017), and there was legal action in 2019 against Libya to recoup up to £46million that was owed. Covid-19 travel restrictions impacted private income and during 2020-21 income fell to £37million, down from £65million the previous year. The 2022-23 Annual report and accounts is candid in its assessment:

“Global events have had a detrimental impact on the level of private income we receive through I&PC. A recovery plan is in place. The Trust has both a Commercial and a Clinical Innovation Director who are focused on developing relationships with partner organisations across the world and leveraging resources/income for the Trust. They will ensure intellectual property arrangements are in place and are working closely with I&PC to re-establish its position in the market after the Covid-19 pandemic.” (150, emphasis added)

GOSH documents include statements about the importance and use of international and private income, in effect seeking to manage perceptions of internal and external stakeholders concerning private activities and benefits. The precise contribution (profit margins on such activity) is less clear:

“All income made from IPP work is reinvested into NHS Services. The Trust does not centrally hold the level of information requested [profitability margins]. We have to bear in mind that profitability margins are not held in a verified format and would be subject to conjecture and outside the spirit of your request for information.” (GOSH FOI request 23 October 2019, FOIRQ5420).

**Discussion**

Treating international patients within the NHS is an example of public sector entrepreneurship. As Currie et al. (2008) suggests such entrepreneurship adopts three agential roles: stakeholder, entrepreneurial and political. This entrepreneurial agency:

“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” (987).

These are echoed within Trust documents: processes of identifying and pursuing opportunities for innovation and risk-taking, combined with the emphasis on managing relationships and understanding the context of NHS activities. Such commercialisation has been accelerated by recent constraints in state funding with organisations having to contain costs, to improve productivity but also, significantly, to increase alternative sources of income not least given Covid impacts (NHS Confederation 2021). Specialist and single specialty hospitals are well placed to take advantage of opportunities, given their motivation *and* capabilities.

The commercialisation of the public sector sees the interplay of two competing institutional logics (Reay and Hinings 2009; Besharov and Smith 2014). A ‘public service’ logic rests on an organisation structured to meet public/community needs through a professional bureaucracy whereas a commercial logic elevates competitive and marketised relations. One might also view these competing logics as a tension between markets and social protection. Consequently, the tension can be re-cast as a ‘double movement.’ Polanyi (1944) argued that the introduction of social protection measures (such as collective provision of public services) was a response to the (often, dysfunctional) impact of (free) markets:

“the liberal movement, intent on the spreading of the market system, was met by a protective counter-movement tending towards its restriction” (144)

This notion of the ‘double movement’ is also applicable to the ways in which NPM has sought to reform organisations with a strong public service ethos (Holmes 2013). While institutional logics can be seen as competing, Polanyi’s double movement helps explain the apparent paradox whereby commercial income is increasingly justified by NHS organisations such as GOSH because of an apparent need to support NHS services. The market and social protection measures are closely inter-linked. This may unwittingly accelerate further commercialisation particularly in post-pandemic recovery despite avowed claims to be supporting the NHS. However, the double movement is contingent on how an organisation negotiates capability, opportunity and motivation, set within the context of its own health system nationally.

The development of commercialisation is nuanced, and the primary focus on patient care is underlined within (documentary) statements of how the non-NHS income is used to underpin the delivery of core NHS services. The NHS still provided the bulk of the GOSH income, a stipulation of the HSCA. However, the infiltration of commercial logics into the logics of the ‘core’ public services are hard to sustain in the longer term and the NHS may risk become increasingly predicated upon commercial logics, thereby eroding public service logics. Commercialisation is nuanced in a second way in that we address the experience of one specialist NHS provider whose geographical and sector capabilities present a privileged position not open to alternative NHS providers, irrespective of their motivation and perceived opportunities.

Despite reporting headline activities there are several gaps in our understanding that merit further investigation. This paper reports on a single case-study and inevitably, there is a lack of empirical generalisation; hence, we seek to underpin our analysis through a conceptual lens of Polanyi’s double movement. Therefore, we call for further research not only to widen the evidence base but also to test out further the theoretical perspectives which we advance here. For instance, we have scant knowledge of the precise working of referrals, clinical networks and the nature of global “choice” and “competition” including clinician and manager attitudes to these (cf. Hodgson et al. 2022). This includes the role of Embassies and Governments, as well as potential charitable and philanthropic sources of funding. Alongside the focus on international patients, the emerging scope of wider commercialisation projects (including clinical trials, IP and education) would also benefit from more detailed exploration.

Whilst NHS funding retains broad public support (Buzelli et al. 2022), we know little about public and professional perceptions of NHS commercial strategies. To what extent do commercial logics reported in the documents become internalised among all NHS staff for example (Hodgson et al. 2022; Merz et al. 2024). Enhancing NHS services may lead to further changes in the organisational structures, processes and culture of the NHS which might undermine that aim. This might involve focusing on areas of activity (*eg*. specific disease or populations groups) which would facilitate more commercial opportunities. Organisational attention might thus be skewed towards more ‘profitable’ areas, especially if 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 organisations may unwittingly help to accelerate (further) the commercialisation of the NHS. This paradox may still apply even though these Trusts may not necessarily breach the cap set by HSCA. Much would depend on the role of agency; if NHS staff might feel that commercialisation 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 (as manifest in organisational documents). This agential focus can, however, distract attention from the effects of decentralisation by successive governments, thereby framing NHS financial crises as ‘local’ issues rather than systemic failings.

**Conclusions**

As our case study of GOSH illustrates, several specialist NHS organisations are becoming more entrepreneurial in their activities, in terms of commercial income where commercial capabilities, motivations and opportunities align. Commercial logics are thus becoming hard-wired into NHS accounting systems. We have discerned a shift in language to justify such income and explored how they justified such entrepreneurialism with a public service ethos. Further evidence needs to corroborate such provisional findings from GOSH and to explore whether and how commercialisation is developing in non-specialist and non-acute settings. Understanding such activities through the three lenses of commercialisation (capabilities, opportunities and motivations) offers a structural vantage that complements the three agential roles of public entrepreneurship (stakeholder, entrepreneurial and political) (Currie et al. 2008).Whilst the majority of funding will still come from public/state sources it is implementing entrepreneurial strategies which are seen as essential to underpin core NHS services. In turn, this will re-orient the organisations and their staff with a potentially detrimental effect upon a public service logic.

We ask whether the development of this commercial logic will foster a more hybrid logic in which a public service logic is inter-linked with (and possibly inter-dependent upon) a commercial one, as Polanyi’s ‘double movement’ thesis might imply. Both would seem to rely on each other for their effective functioning; the public service logic needs a commercial income to support its activities whilst the commercial logic requires the reputation and infrastructure of the NHS. 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) privatisation, the commercialisation of the NHS is a more insidious process such that it normalises such activities and recasts NHS activity in terms of commercial opportunities. External top-down reform becomes redundant if NHS organisations themselves normalise the commercial logic; external reform is obviated in favour of reform from within. This will have consequences for aspects of public service logics such as staff identity and morale, and public perceptions of the NHS as a public institution. It will also have consequences for a single uniform NHS logic, as differences emerge in setting where there are varying combinations of capability, opportunity and motivations. Despite its place as a world-leading institution with an established reputation for quality and innovation, GOSH is facing the challenge of resource constraint and staffing that afflict the wider NHS. The interplay of capability, opportunity and motivation will shape its place in the global market for paediatric services.

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1. The 2022 Health and Social Care Act added nothing further on commercialization and commodification caps, governance or reporting.

**Table 1: Key documentary sources**

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| --- | --- |
| Title  | Website |
| GOSH Five-Year Strategic Plan (‘Above and Beyond’) 2014–19  | <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/390626/GOSH_Publishable_Summary_Strategic_Plan_1415.pdf> |
| GOSH Strategic Plan 2020 to 2025 | <https://media.gosh.nhs.uk/documents/20_08_Hospital_Strategy_launch_materials_update_A6_BOOKLET_ST2.pdf> |
| GOSH Annual report and accounts 2014-15  | <https://media.gosh.nhs.uk/documents/Download_a_copy_of_Great_Ormond_Street_Hospitals_Annual_Report_201415.pdf> |
| GOSH Annual report and accounts 2016 to 2017  | <https://media.gosh.nhs.uk/documents/GOSH_Annual_Report_and_Accounts_2016_to_2017.pdf> |
| GOSH Annual report and accounts 2018 to 2019  | <https://media.gosh.nhs.uk/documents/GOSH_Annual_Report__and_Accounts_2018_to_2019.pdf> |
| GOSH Annual reports and accounts 2019 to 2020 | <https://media.gosh.nhs.uk/documents/Great_Ormond_Street_Hospital_for_Children_FT_Annual_Report_2019_20_FINAL_to_Pa_DxsZyRk.pdf> |
| GOSH Annual reports and accounts 2021 to 2022 | <https://media.gosh.nhs.uk/documents/Great_Ormond_Street_Hospital_for_Children_NHS_FT_2021_to_2022_Annual_Report_FI_N7MjMqJ.pdf> |
| GOSH Annual reports and accounts 2022 to 2023 | <https://media.gosh.nhs.uk/documents/Great_Ormond_Street_Hospital_for_Children_FT_Annual_Report_202223_FINAL_VERSIO_33xZbh6.pdf> |
| GOSH Annual Report and Accounts 2023 to 2024 | <https://media.gosh.nhs.uk/documents/GOSH_Annual_Report__Accounts_202324_FINAL_VERSION.pdf> |
| GOSH FOI request, 23 October 2019, FOIRQ5420 | <https://media.gosh.nhs.uk/documents/FOIRQ5420_Final_Response.pdf> |
| <https://www.emergingcomms.com/case-studies/great-ormond-street-hospital/><https://www.gosh.com.kw/><https://www.youtube.com/channel/UCwSua6u7SmufFBIh5aURI8Q>https://londonspecialisthospitals.com/ | Additional key online sources  |

 [↑](#endnote-ref-1)