**The entrepreneurial state:**

**Service exports in healthcare and criminal justice**

**Introduction**

The relationship between markets and welfare delivery is an enduring theme of social policy analysis and social welfare politics. Primarily this has been a focus on market variations with respect to choice, payment mechanism, provider mix, regulation and incentives. Market-type delivery may serve different aims – some seek lower costs and increased service levels, others focus on the primary goal of increasing user choice (e.g. vouchers) (Blöndal, 2005). This article provides a very different vantage on the marketization of public services, examining overseas export activities within health and criminal justice. It explores the drivers, strategies, opportunities and, risks, of engaging in such market activities with overseas ‘customers’, and differences across policy sector. Focussing on contrasting experiences is an opportunity to understand the complex and differentiated operational and structural environments within which a form of ‘public entrepreneurialism’ is expressed (Morris and Jones, 1999; Sadler, 2000; Currie et al., 2008;Lunt et al., 2015). Operational structures, bi-lateral trade partners and the specific services that are provided combine to generate distinct financial, political and reputational risks. There is a gap in our understanding of such developments and their promotion within the context of austerity. Jarman (2014: 4) for example suggests that emerging within health is a “different decision making model, that of an entrepreneurial state that actively seeks to expand global health markets”. We explore the entrepreneurial state in the UK and its relationship with public sector reputation. Examining activities within two broad settings – health and criminal justice – the paper outlines developments and potential tensions and implications for public sector reputation and risk. This paper is organised as follows.

* First, a brief review of domestic markets in welfare, rise of competitive public services, and public sector entrepreneurship;
* Second, operational and strategic arguments made in support of selling public services abroad, and risks therein;
* Third, a detailed examination of two cases – health and criminal justice services;
* Fourth, a review of implications regarding public sector reputation and risk.

**A new twist on welfare markets**

Across the OECD there has been the rise of the service economy (Wölfl, 2005). In 1948 service industries contributed an estimated 46% to UK GDP, by 2012 this had increased to 78%. The percentage of people employed in UK service industries was estimated to have increased from 44% in 1948 to 85% in 2012 (ONS, 2013). Growth in services is driven by supply and demand side considerations, including high elasticity of demand for some services and significant demographic changes (Wölfl, 2005). The sector ranges across both highly skilled and low skilled activity, encompassing services within consumer, producer (i.e. intermediate) and public markets, and activities that are physical (for example, transport), person-centred (for example, welfare services and personal services), and information services (including media, telecommunications and knowledge activities) (Miles, 1993: 657-8). Under New Public Management reforms hierarchical state provision was challenged and separation of purchaser and providers ensued across public services. Private sector and not-for-profit providers competed to provide services under contract (Mause, 2009), with the state role switching from provider to purchaser and commissioner of such services. As these markets develop and competition is embedded in public services we are seeing the emergence of a new ‘public services industry’ across the range of welfare services which challenges the traditional public sector agenda and involves a commodification of public sector work (Farnsworth and Holden, 2006; Huws, 2008; NAO, 2012; Gash et al., 2013; Gash and Panchamia, 2013; Raza, 2016). For example, since 2008 the ability of non-public providers of healthcare to compete for public contracts increased, culminating in the Any Qualified Provider (AQP) policy from 2012, where NHS patients may choose to have certain routine treatments performed at any hospital, including private sector hospitals (Arora et al., 2013: 14; BMA, 2013).

Such marketization is the result of wide-ranging and deep-reaching economic, social and political challenges, and new forms of service delivery are emerging across many public services including health but also social care, education, probation, welfare to work and childcare. Provision of services within those markets has become more transnational in the sense that an increasing proportion of shareholders in UK companies are overseas investors[[1]](#endnote-1). Public services are also provided by transnational providers: Sodexo, a French-based company is contracted to deliver probation services; Ingeus, the largest provider within the Work Programme which supports jobseekers back into employment, is owned by a US company; the French company, Atos, was contracted to deliver Work Capability Tests for disabled welfare beneficiaries, a contract subsequently awarded to Maximus – an American for-profit provider (Social Enterprise UK, 2012; NAO, 2013; Plimmer, 2014a&b; TUC and NEF, 2015). Such developments puncture a methodological nationalism of the domestic State delivering frontline welfare services[[2]](#endnote-2).

Alongside greater competition from non-public providers including privately-owned public service multinationals *within* UK public services markets there is a push to encourage UK public service organisations themselves to be more entrepreneurial and innovative, including within domestic settings but also internationally. The roots of such activity lie in NPM with entrepreneurship perceived as an engine of change (Sadler, 2000). Traditionally the entrepreneur was viewed as *homo economicus*, a lone wolf, anchored in the private sector, and focused on innovation, risk-taking and proactive behaviour (Morris and Jones, 1999: 74; Kearney et al., 2009: 28; Kim, 2010; Cahn and Clemence, 2011).

During the 1990s entrepreneurship began to be viewed as having greater currency for the public sector given the dismantling of organisational forms and erosion of traditional public sector practices. The notion of entrepreneurship expanded to both corporate (Sadler, 2000) and public sector (Cahn and Clemence, 2011) settings. No longer considered an oxymoron, public sector entrepreneurship became a leitmotif of the reinventing government movement and forms of NPM (Borins, 2002a,b; Collins and Byrne, 2007; Cahn and Clemence, 2011). In the face of hierarchical and traditionally Weberian organisations were advocated “reforms [which] sought to replace traditional rule-based, authority-driven processes with market based competition driven tactics” (Kettle, 2000: 2).

Osborne and Gaebler’s (1992: 19-20) 10-point manifesto for entrepreneurial government identified the importance of mimicking private sector attitudes, strategies and approaches and transactions. Given unique public sector features, those charged with being entrepreneurial encounter a different context compared to the private sector, including environmental context and organisational structures (multiple stakeholders; governance, scrutiny and accountability; and market insulation). Second, there are differences in goals (these being multiple, changeable, social and political rather than solely profit maximisation). Third, differences are evident in the wider values of public service as compared with the private sector. For Boyett (1996: 49): “Entrepreneurship occurs in the public sector where there is an uncertain environment, a devolution of power, and at the same time re-allocation of resource ownership, to unit management level”.

Competing uses of ‘entrepreneurial’ co-exist within the policy milieu. Entrepreneurship came to be seen as synonymous with the *leadership* required*,* as against traditional administration and forms of transaction management, that would steer new public sector organisations. There is discussion of *policy entrepreneurs –* those political actors who promote new policy ideas within the public sector (Roberts and King, 1991; Mintrom, 1997) and who display policy insights, define problems, build coalitions, and lead by example(Mintrom and Norman, 2009).

Embedded within discussions of ‘entrepreneurial government’ and ‘policy entrepreneurship’ hides a more literal pocket of entrepreneurial activities – focused on income generation – and captured by Osborne and Gaebler’s Chapter *Enterprising Government as ‘Earning Rather Than Spending*’. They suggested “We have 15m trained spenders in American government, but few people who are trained to make money” (1992: 195-6). In this article we explore one form of UK state entrepreneurship – export of domestic social policy expertise and services. Whilst it is rare for government-owned service organisations to compete globally (Dunning, 1989: 18; Porter, 1990: 247), processes of liberalisation, deregulation and privatisation during the 1990s challenged such orthodoxy within utilities. A number of mainland European public services, (including electricity, telecommunications and postal services), traditionally national-bound organisations under State ownership and control, sought to expand overseas (Clifton and Díaz-Fuentes, 2008).

As Raza notes, ‘One of the most fundamental pillars of the neoliberal transformation of the last 30 years has been the commodification of public goods and services’ (Raza, 2016: 204). The contribution of the services sector to trade grew rapidly in the 1980s as a result of liberalisation (particularly within communications and professional services) and the emergence of greater vertical specialization (Miles, 1993; UNCTAD, 2015). Trade in services rose from US$2 trillion to US$5 trillion 2004-2014 (UNCTAD, 2015). Governments (such as the UK and US) opened up markets as a result of New Public Management influences (Vandermerwe and Chadwick, 1989; Raza, 2016). Further to the liberalisation agenda advocated by right-wing domestic interests, has come support from international organisations such as IMF and World Bank, and there is also the emergence of the European Single Market. Liberalisation resulted from shifts in regulatory regimes that flowed from GATT, the Uruguay Round, and Trade in Service Agreement (TISA) (Miles, 1993; UNCTAD, 2015; Raza, 2016) and such agreement are seen as core features of an emerging anti-democratic constitutional governance structure (Sinclair, 2014).

Selling services into overseas markets occurs against the backdrop of liberalisation and marketization and may also be placed within the ‘Entrepreneurial Government frame’. Support for public sector entrepreneurship and leadership gained traction under New Labour’s modernization agenda. A HM Treasury Document (2002) sought to encourage Government departments, agencies and public bodies to better utilise their physical and nonphysical assets by engaging in commercial services based on them, where appropriate. Exploiting commercial potential could occur in diverse ways – selling existing goods and services; developing new goods and services from existing assets; licensing and leasing arrangements; and sponsorship activities.

The UK is not alone in pursuing such activities – the Singapore Cooperation Enterprise for example offers a “single window of access for foreign partners who are interested in Singapore’s public sector expertise” (SCE, 2015). It provides study visits, training, consultancy for projects and capacity building, aiming to lead in public sector collaboration projects with overseas countries, foster long-term partnerships with these governments and generate economic spin-offs for the private sector[[3]](#endnote-3).

The primary focus of this paper is the delivery of these export activities and the risks generated. In particular, how is one element of service trade – public entrepreneurship – best understood and how does it impact on the reputation of public service organisations? Currie et al. (2008) conceptualise public entrepreneurship as having three dimensions: political (understand, assess and predict the political landscape); entrepreneurial (to identify and exploit opportunities); and stakeholder (to resolve internal and external interests). When acting in concert these activities distinguish entrepreneurs from public sector managers. Drawing on findings within education, health and higher education they suggest with respect to healthcare: “claims about the ability to invest and disinvest may be fanciful. Political sensitivities around equity of healthcare provision to the population and meeting local population needs may not converge with the development of high surplus healthcare services” (Currie et al., 2008: 1000). Whilst in broad agreement with this view, the public sector is not a single operational structure (Sadler, 2000) and there is value in examining pockets of activity. Similarly, De Zilwa (2005: 391) refers to Universities as ‘hybrids’ where parts may exhibit different levels of entrepreneurialism, whilst for Bernier (2014: 254):

The public sector is viewed as having too many rules or being too risk-adverse to offer opportunities to entrepreneurs. But it is possible that within the state apparatus, some organisations are, or should be, a better environment than others for entrepreneurs.

To date, commodification and competitive international activities arising from State social policy institutions have received little attention. Whilst the export of goods involved in service delivery are well established (such as medical devices, pharmaceuticals, and technology) the export of services themselves (including knowledge and expertise) signals new departures in a global era. Although service export revenues are relatively small compared with domestic budgets, such activities nonetheless raise questions concerning the appropriate public sector role vis-à-vis global competition for ideas, labour and services, and the challenge of safeguarding reputation.

**Income, reputation and soft power**

Moves towards liberalisation, efforts to ‘reinvent’ government, the salience of NPM, and the contemporary setting of austerity, provide drive and institutional grist for such export activities. These include an emphasis on competition, elevation of private sector management styles (including innovation) and disaggregation of units within the public sector, and greater discipline and parsimonious resource use (Hood, 1991; Osborne and Gaebler, 1992; Kim, 2010). There is a relatively limited literature around service export by the public sector. Australian debates during the mid-1990s focused on utilities and rail industry consulting, commercialisation products, using Intellectual Property overseas (Garrett, 1995), and health services export (Benavides, 2002). Hill (1996: 72) went as far as to suggest: “Most Australian states as well as the Commonwealth government are seeking to export their skills in one form or another”. Benefits included return on taxpayers’ investments in public servants and facilities; opportunities for downstream procurement; providing staff opportunities; complementing private sector activities; generating good will and earnings; and supporting wider export service (Garrett, 1995; Hill, 1996). High-level political involvement could allow a project agreement to become a longer term partnership or twinning arrangement (Hill, 1996: 76).

In the UK context health services have been at the forefront of exploring opportunities for service export. Healthcare UK, launched August 2012 and supported by the Department of Health and UK Trade & Investment, encourage overseas investment and activities from within the NHS in order to provide profit streams for reinvestment in core NHS services (HM Treasury, 2011) (Leonard, 2012; Edwards, 2013;Lunt et al., 2015). (It also promotes the interests of private sector industry[[4]](#endnote-4)). Healthcare UK identifies benefits of overseas trade in NHS services:

*In helping to improve the quality of global healthcare provision, NHS organisations can generate additional financial resources which can be reinvested… International activity also enhances the global reputation of the NHS and your organisation. It provides development opportunities for UK staff…* (Healthcare UK, 2015).

Export is also said to encourage innovation and improvements, offer a ‘larger footprint in the global health labour market’, and potentially improve the delivery of services to diverse NHS patient groups in UK. In short, purported benefits are financial, developmental, strategic, indirect *and* reputational[[5]](#endnote-5).

Counter-arguments to public sector involvement are commercial and regulatory; including activities delivering relatively little or no return, or involving unfair competition because public activities become continuously underwritten by taxpayers and carry no tax obligations (Wilkins, 1994). Alongside financial and governance risks are political ones of accountability, exposure *and* reputation. Wilkins (1994: 176) identifies that there are: “political imperatives that public sector agencies be generally regarded as having “got it right” at home before they get involved in overseas opportunities”. Similarly, Healthcare UK outlines a requirement to ‘uphold the values of the UK and NHS at all times’. Selling government services into wider markets is subject to requirements of propriety and legality, and commercial activity must be deemed an appropriate use of resources and activities and meet Parliamentary and public expectations (HM Treasury, 2002; NAO, 2006).

The reputation of public sector bodies is thus both opportunity and risk when engaging in international activities. Carpenter and Krause (2012: 26) define organizational reputation as a “set of beliefs about an organisation’s capacities, intention, history, and mission that are embedded in a network of multiple audiences”. Such reputation they argue is four-fold: *performance* reputation – the ability of an organization to deliver and do a job; *moral* reputation – being viewed as compassionate and honest; *procedural* reputation – that norms and rules are followed; and *technical* reputation – having requisite skills for complex challenges. They suggest public sector bodies will prioritise particular aspects of reputation (2012: 27). Involvement in export activities complicates how reputation is perceived by audiences that are both internal and external to the organization, and because such audiences are domestic and international.

Service export activities target individual customers (for example individual students or patients), but also include private and public organisations (for example, training places purchased by Ministries for employees and block contracts purchased for patients). Advice, consultancy, and system infrastructure expertise is also provided to Ministries and state agencies. Export potentially intersects with international development activities – for example purchasing funded by European Union or international sponsors such as World Bank (see Barry and McFarlane, 2014; also Benavides, 2002). Figure 1 details types of public service exports for health, education and probation using the Global Agreement on Trade in Services (GATS) framework (Chanda, 2001; Sauvé, 2001). Whilst education and health are relatively well established across export Modes, this is less so for criminal justice activities. Whilst all Modes involve some activity crossing of national borders, IT development clearly underpins new opportunities for ‘presence’ and is germane to all Modes in providing the core service itself, or flows of information, knowledge, financial data and suchlike (Miles, 1993; 667-8).State involvement within service trade is clearly towards highly skilled activities, including face-to-face delivery of treatment, education and training, as well as knowledge activities and, albeit limited, overseas investment. Modes themselves present wider opportunities and risks in accessing wider markets. For example, providing health and education services under Mode 2 presumes there is excess capacity in the system and that domestic populations do not experience reduced service quantity or quality. Countries engaging in Mode 4 activity when educators and health professionals move abroad risk losing essential skills and system capacity (Yeates, 2009; Lunt et al., 2013).

**Study design and empirical data**

We explore here health and criminal justice as export activities, presenting them as two case studies (Mabry, 2008; Exworthy and Powell, 2012). The health data is a subset of data from a wider study focussed on both inward and outward travel for medical treatment undertaken in the English NHS and involved interviews with individual managers within Foundation Trusts (Lunt et al., 2014). An element of snowball and convenience recruitment was used. For NHS providers, we identified Trusts who were seen to have a longstanding interest in, or aspiration to further develop, international patient work and export. The NHS Confederation, an employer organisation, circulated a call from the project team to members for interviewees. Interviews were conducted face-to-face and lasted 25-60 minutes. Interviews were usually recorded and transcribed. Discussion is based on data gathered from seven Foundation Trusts, based on semi-structured interviews with 16 individuals, 13 NHS managers, and three key stakeholder discussion with individuals who have significant experience of international patients flows, including a Department of Health official and a business consultant with significant expertise around NHS and private activity. Despite being a convenience sample, there was some sample diversity ranging from Trusts with a significant proportion of income from international work and wide-ranging aspirations, to those where income and interests were more marginal. Such a range helps us gauge the spread of interest in entrepreneurialism and associated entrepreneurial behaviours. The health case also drew upon documentary and official policy documents (Bowen, 2009; Scott, 2004; May 2011).The study interview data was analysed using the ‘framework method’ of thematic analysis and together with documentary material was used to inform the health case study and verbatim quotes are presented within the writing of the case (Ritchie and Lewis, 2003)[[6]](#endnote-6). The criminal justice case consisted solely of desk-based review – incorporating parliamentary and official documents – reflecting the limited life-cycle of this sector’s overseas activities.

***Case 1: the experience of health service export***

There has long been a stream of income derived from international patients treated in UK public and private facilities – a system export for the UK system with revenue generated for the domestic system from overseas patients (Lunt et al., 2011; Lunt et al., 2015). The number of overseas patients being treated within the NHS expanded during the 1970s as a result of growing oil wealth with significant patient flows from Middle East including Kuwait and Qatar (Roberts, 1991). NHS facilities treat international patients as booked and planned admissions which are pre-paid or financed through an Embassy or insurer ‘Letter of Guarantee’. Treatments include complex tertiary procedures (e.g. paediatrics, and heart surgery), and also maternity services and ophthalmic surgery, encompassing outpatient admission, day surgery, as well as overnight stays and lengthier hospitalisation (see Competition & Markets Authority, 2014, 3.51)[[7]](#endnote-7).

Under the auspices of the body Healthcare UK there are more strategic and coordinated attempts to support international activities of NHS Trusts and organisations, including attracting international patients. Export activity has received further impetus from NHS Foundation Trusts having autonomy to offer clinical and non-clinical services to institutional partners and patients both within the UK and overseas. As public benefit corporations Foundation Trusts have freedoms to own their land, undertake public or private borrowing, run joint ventures with the independent sector (including strategic alliances and open local offices), and make surpluses and losses. Any surpluses must be used to benefit NHS patients who remain the core responsibility of hospital boards and NHS facilities cannot be used to cross-subsidise international activities. It is a moot point whether the primary rationale for Foundation Trusts was competition or governance freedom, but some NHS Trusts have developed innovative approaches for delivering services to international patients and fostering international partnerships. A small number opened branches overseas or partnered with commercial interests and healthcare developments in the Middle East. Great Ormond Street Hospital established a regional office at Dubai Health Care City in 2006. Imperial College London Diabetes Centre opened its Abu Dhabi facility in 2006 (and later Al Ain), specialising in diabetes treatments, research and training. As an example of Mode 3 activity (see Figure 1), Moorfields Eye Hospital opened a facility in Dubai Health Care City (Moorfields Eye Hospital Dubai) that operates as an overseas arm of the hospital (see,Lunt et al., 2014) and would fit Dunning’s (1987) definition of a multinational enterprise – owning or controlling activities in more than one country.

Whilst difficult to disentangle spending within private and public sectors for medical treatment, together they are estimated in the range of £192-325 million annually for the UK health economy (Lunt et al., 2014). Placed alongside the overall NHS budget the contribution is relatively minor but for a small number of London-based NHS teaching and specialist hospitals this income constitutes a significant proportion of their overall revenue. (Great Ormond Street Hospital earns around 80 per cent of revenues from overseas patients and the Royal Marsden about 20 per cent) (Plimmer, 2015; also Lunt et al., 2014; GOSH, 2016).

Since the global recession there has also been a growing domestic debate about the extent to which NHS organisations can become more innovative, entrepreneurial and deliver more for less in challenging strategic and operational environments (White Paper, 2011). This financial impetus led to growing interest in how NHS organisations might better balance the demands on their resources, including identifying and seeking additional income from other sources (see Gregory et al., 2012; Lyons, 2014). The interview data collected from NHS managers identified the broader commercial imperatives facing the NHS, with treating international patients and wider international activities, seen as a means to an end (improving services for NHS patients and developing NHS facilities). The current financial climate for the NHS was viewed as a major challenge, and commercial income, private patient income and international income were seen as possible routes to ameliorating pressure on stretched NHS resources. Thus as one manager said:

‘I think going forward all NHS organisations are financially challenged in some way or other . . . . Our best chance is actually by growing income from the private sector which will be used to subsidise the NHS’ (NHS15).

Within policy NHS innovation is identified as a route to supporting ‘growth in the life sciences industry’ and generating economic growth (Coalition Government, 2011: 7). In 2012 the amount of income Foundation Trusts can raise from private activities (private patient income, external business ventures such as commercialisation of R&D, training and consultancy) increased to 49% of turnover (Health and Social Care Act 2012). Any major increase in private sector income (increases by 5% or more of its total income) requires board level approval (Competition & Markets Authority, 2014, Appendix 3.1).

The potential of the NHS to exploit the power of its international reputation and financially gain from the NHS ‘brand’ when marketing NHS services to overseas patients has been recognised (White Paper, 2011). This was captured within interview data. For example, the importance of moral and procedural reputation of the NHS is apparent in a comment of a manager that:

A lot of those countries feel it’s quite politically supportive to actually send their patients through to NHS facilities rather than to direct private facilities (NHS3).

There was also statement of the importance of safeguarding the unique NHS brand that existed at a national level and also hospital Trusts’ own identity. As one manager suggested:

‘We’re actually very protective of that brand so we tend not to formally partner with people overseas NHS19).

Another interviewee identified that the attraction of the hospital to overseas patients and collaborators was its performance and technical reputation:

‘The number one factor is the super-specialised doctors we have in London Teaching Hospitals having these links with the referring doctors in Kuwait, or the Emirates or Saudi Arabia’ (NHS1).

Healthcare UK’s strategy emphasises the national system of healthcare; identifying public policy as a potential asset (with the NHS model and brand thereby paralleling UK Universities for education and research)[[8]](#endnote-8). Healthcare UK advances trade and partnership options with private and public interests; pursuing both hard (infrastructure; investment; devices), and softer (education and training; advice; regulation) export opportunities. The NHS is effectively the UK health system brand that consists of its people (employees including clinicians and policy-shapers), its processes (organisation delivery, training, techniques, work practices), and wider cross-national policy example and influence.

Priority markets for future international partnerships included China where health restructuring creates opportunities for construction, R&D and primary healthcare. These were Mode 3 and Mode 1 opportunities – there was no expectation that Chinese patients would travel for treatment under Mode 2 arrangements (see Figure 1). The Gulf region has strong trade and historical links with the UK and is also seeking to develop domestic healthcare in order to stem the flow of publicly funded treatment abroad for patients who require specialist care and complex surgery. In competing within such markets, reputation is a lubricant and becomes increasingly important in driving trade relations. Healthcare UK typically uses government-to-government agreements with countries in order to promote UK health providers. It reported £556 million of business agreed during 2013/14 – securing £281 million for private business, £218 million public sector business, and £35 million purely NHS business. In 2014/5, £749m was generated from 26 projects with three NHS and public sector projects accounting for £70million (Healthcare UK, 2014, 2015).

Potential risks of international activities, including treating international patients, are both financial and reputational. Whilst embedded relations are crucial in fostering embassy and government institutional links there are some concerns of unpaid bills for medical treatment. For example, in the wake of the Greek economic crisis King’s College Hospital reported that private patients from the country owed it £1.8m (Health Service Journal, 2011). However headlines such as ‘*Overseas patients owe NHS £60m’* (Daily Telegraph, 2011) are more difficult to interpret. It is unlikely these amounts relate solely to planned and booked admissions, and headlines fail to separate uncollected EU monies from individuals receiving treatment under EU citizenship rights for planned and emergency treatments rather than private, out-of-pocket payers and non-EU Governments. Further, NHS managers point to public misunderstanding around the role of NHS private patient activity, including international patients, and its impact on public waiting lists, and also internal perceptions and hostility about private work. Noteworthy is that unlike doctors and surgeons practicing in a private capacity (for example within independent hospital settings), treating international patients within NHS facilities has positive revenue implications that directly benefits the employing NHS Trust. A number of managers were keen to reiterate this rationale about why they sought to attract international patients and engage in overseas ventures. For example:

‘Why else would we be having a commercial operation if it wasn’t to deliver a surplus that we can then reinvest on the NHS side?’ (NHS19)

‘We’re in the business of making a profit after we have done our core job which is making people better’ (NHS5).

‘It helps us launch services or buy kit that we couldn’t buy otherwise and employ people that we may not be able to employ’ (NHS16).

There was acknowledgement of the importance of ensuring such outward-facing activities did not disrupt or disadvantage access for local patients. This included:

‘Demonstrat[ing] that you’re doing it with additional capacity and it’s not making NHS patients wait and you’re doing it in a way that generates additional income which then goes to benefit patients’ (NHS1).

Similarly:

‘You have to balance. You cannot compromise our NHS responsibility. That is number one responsibility of the hospital. What we’re trying to do in these difficult times is manage the whole element of trying to achieve the overheads and costs that we have and manage that in a way that we at least generate some additional monies’ (NHS3).

There are also potential sensitivities about types of treatments being offered, particularly NHS organ donations being used for private treatments for foreign patients (Daily Telegraph, 2013).

In summary, there are clear reputational considerations associated with international patients and health export more widely – performance, procedural, moral and technical. Activities must not deter and should actively contribute towards organizations’ ability to deliver core services. Norms and rules must be adhered to (for example public/private patient transplantation decisions), and bills settled in full. Inevitably, the line between procedural and moral considerations soon blurs. Finally, any NHS financing or service models being transferred abroad (e.g. experience of Public Private Partnerships or ICT system development) must be seen to have delivered within the UK context. These points notwithstanding there is, at present at least, relative policy acceptance and institutional support (Foundation Trusts and Central Government) for NHS export activities.

***Case 2: criminal justice***

Just Solutions International (JSi), a team within the Commercial Development Group of the National Offender Management Service (NOMS) provides a contrast to the experience of international healthcare activities. JSi offered a range of consultancy and training around prisons and probation, including the design of offending and re-offending programmes, and licensing of intellectual property that arose from NOMS activities (NAO, 2016). JSi was mandated with ensuring a commercial return on any work contracted for overseas governments (with generated income reinvested in core justice services), and to undertake a ‘brand establishment’ exercise.

The background to JSi lies, at least partially, in the growth of policy tourism and learning visits (Hudson and Kim, 2013), with NOMS previously receiving around 10 visits per month from overseas officials managed by the NOMS International Unit. Early phases of international engagement within the sector were seen as ‘individualistic, reactive, highly localised and certainly not structured or systematised’ (Barry and McFarlane, 2014: 15). Interest in NOMS’ expertise raised problems of volume, oversight, response procedures, and potential loss of public sector Intellectual Property (NAO, 2016, para 15-16). The JSi business case identified commercialisation of ‘knowledge, skills, products and services’ including IT (especially the Case Management Assessment and Tracking system), probation services, rehabilitation interventions, and other consultancy such as prison design, prison building and procurement. Then Secretary of Justice, Chris Grayling, stated “In response to interest around the world, we are setting up Just Solutions International – a social enterprise – to enable this service to be delivered in a commercial manner” (2013). He argued that structuring JSi as an arms-length company limited by guarantee (with a major stake held by NOMS) would allow JSi to respond to opportunities and innovate. The NOMS’ Board (November 2013) opted instead for activities to be an internal function to avoid diverting commercial staff and given the lack of investment funding available (NAO, 2016, para 33). JSi was expected to move from an “incubation period” where it relied on Foreign & Commonwealth Office (FCO) for business referrals, to offer services (consultancy, training, intervention and intellectual property) to a global client base (para 31).[[9]](#endnote-9) JSi undertook consultancy for the Royal Oman Police, Libyan prison design, and contracts for Nigeria and Australia, and wider opportunities were identified in Africa, Middle East and South America (NAO, 2016: para 34).

The initiative unravelled in 2015 when the public flogging of writer in Saudi Arabia drew media and political attention to JSi’s £5.9m contract bid to advise on training and staffing of Saudi prisons. The Secretary for Prisons and Probation, responded:

*part of the rationale for our work with other countries is to impact positively on human rights practices….Our correctional services provide a gold standard in human rights… It has been government policy for many years to work with overseas governments and help them develop their criminal justice systems*[[10]](#endnote-10).

Controversy was fuelled by an unwillingness to release contract terms or MOU details because of perceived commercial sensitivities. JSi was formally closed under direction of Minister of Justice, Michael Gove (16th September 2015). JSi experience suggests that reputational risks for criminal justice are, first and foremost, moral ones, and secondly relate to performance and procedures.

There are some echoes of criminal justice activities within the field of international policing. A Home Affairs Select Committee visit to UAE identified involvement of British police in training overseas forces and noted how there was ‘international recognition of British Policing as a world-class brand’ (Home Affairs Committee, 2013). The Committee encouraged the College of Policing to develop such activities internationally, in part “to provide a revenue stream to help make the College a sustainable organisation”. Since late 2012 the College has undertook work with Saudi Arabia for training within the MENA region. Again routine commercial details (e.g. individual countries involved) are not disclosed. The Home Affairs Committee (2016) continues to suggest the College “seek to broaden business opportunities in both new and existing markets in the UK and overseas" which might include delivering training internationally”.

**Summary: asymmetry of reputational risk**

In drawing together preceding discussion four points merit further comment. First, *is* the nature of these outward-facing activities appropriately conceptualised as export or does some alternative interpretation, for example international aid, provide a better description? We noted potential overlap when activities are funded from aid programmes – however governments still retain discretion about where they choose to purchase such services. Moreover, institutional leads for these export activities are UK Trade & Investment, Health, Foreign & Commonwealth Office and export-mandated organisations (e.g. Healthcare UK and JSi), rather than the Department for International Development. Finally, countries purchasing health and criminal justice services are not confined to lower and middle incomes countries, but include those with developed health and criminal justice systems. Whilst not aid there is, particularly around knowledge exchange activities, an element of paid policy transfer, and these should be seen as contributing to the play of *soft power*, ‘The ability to affect what other countries want tends to be associated with intangible power resources such as a culture, ideology, and institutions’ (Nye, 2004: 77). Such intangibles are used for attraction and persuasion and to secure cooperation and realise foreign policy objectives (Nye, 2004; 2008; Rothman, 2011). Offering advice around system organisation and delivery processes may lead nations to emulate action, policies and goals of the role-model nation (Gallarotti, 2011). Such role modelling within health, criminal justice and policing is explicitly given by UK organisations as rationale for incursions into international activities. However, it is important to acknowledge the role of income generation; crucially such overseas activities cannot be cross-subsidised by domestic ones.

A second consideration, does income generation contribute to the financial bottom line? Overseas commercial activities are encouraged by the context of austerity, although income generated raised pales alongside education sector exports worth £17.5bn to the UK economy (Conlon et al., 2011). For decentralised organisations (e.g. Foundation Trusts) income generation can be significant and activities may bring clinical benefits, including surgical learning and wider staff development opportunities. Export narratives contain assumptions of direct UK public benefit (contributions to the local health economy, public revenues and economic growth) to justify system branding and national promotion. To date however the evidence is not strong and future empirical investigation must clarify forms of health export (and indeed any other forms of service export) that best support a State’s ability to deliver accessible and high quality services to its own citizens.

Third, organisational settings provide both opportunities and constraints for developing international agendas. Bernier (2014: 256) notes public entrepreneurship requires a new organization or activities and these potentially rub against legal and regulatory barriers or generate internal resistance. What Carpenter and Krause call the ‘internal politics of reputation’ (2012: 31) entails competition among small units for resources, tasks, and status. In light of these insights, and supported by JSi experience, it would appear that the closer to the core of government, the more risk avoidance and upholding rules is valued, and ‘entrepreneurship and innovation are, thus, less likely to occur closer to the centre (Bernier, 2014: 259).

Fourthly, there is what we label ‘the external politics of reputation’. Leveraging social policy opportunities overseas uses a brand – intangible assets that are reputational. There is acknowledged growth of reputation and brand management in the public sector (Wæraas and Byrkjeflot, 2012), but there is both power in the brand as well as significant risk. Constraints for example include a different and continually shifting public sector bottom line as a result of political mission and political interference (e.g. Currie et al., 2008: 998).

There are tensions when balancing entrepreneurial activities with democratic values and institutional roles (Bellone and Goerl, 1992: 131). Whilst all elements of reputation (performance, moral, procedural and technical) have potency and potential to disrupt and embarrass, there is particular political risk of exposure regarding bi-lateral partnerships and types of activity that may swiftly undermine moral reputation. Similarly, failure to reveal the content of ‘commercial contracts’ downgrades accountability and transparency, and leads to an erosion of procedural reputation. Such recognition pivots to the importance of upholding the Rawlsian publicity principle; and as Luban (1998: 155-6) writes, ‘public debate and scrutiny are highly desirable, and the inability of policies to withstand publicity is suspicious’. Export of social policy services, including knowledge services, is likely to remain marginal and be viewed as somewhat unusual, particularly the closer to the centre that they are. Somewhat inevitably the public sector will be a less forgiving environment for entrepreneurial mistakes (Currie et al., 2008: 996) and reputation remains strongly asymmetrical; slow to build up but easily lost. In the balancing that constitutes service export activity it would be well to remember Jarman’s (2014: 7) comment on the entrepreneurial state, ‘backlash is always possible’.

**HS&DR Funding Acknowledgement**  
This health project discussed in this article was funded by the National Institute for Health Research Health Services and Delivery Research Programme (project number 09/2001/21).

**Department of Health Disclaimer**  
The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the HS&DR Programme, NIHR, NHS or the Department of Health.

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1. According to ONS overseas investors have increased stakes in UK firms by 10 percentage points over past five years 2010-15 (ONS, 2015). [↑](#endnote-ref-1)
2. China’s State Owned Enterprises have engaged in a major strategy of overseas expansion, acting like private-sector multinationals (undertaking both greenfield investment and Merger & Acquisitions) mainly within resources markets but also high tech enterprise (see Liao and Zhang, 2014). [↑](#endnote-ref-2)
3. Its expertise includes affordable housing, e-government, health management, and public administration, management and reform. [↑](#endnote-ref-3)
4. NHS Overseas Enterprises was established in 1988 as the ‘international marketing arm of the NHS’ (Benavides, 2002). There was also a Health Care Sector Group from 1995 focussed on public and private opportunities. NHS Global 2010-12 was the forerunner of Healthcare UK (Lunt et al., 2015) [↑](#endnote-ref-4)
5. Note some differences with private sector export rationale – where avoiding domestic overdependence, buffering downturn and economies of scale are more likely. [↑](#endnote-ref-5)
6. We sought NHS ethical approval to interview representatives of NHS organisations in the localities selected. The full Ethics application ‘Implications for the NHS of inward and outward medical tourism’ was submitted to Sheffield Research Ethics Committee for consideration and approval (11/H1308/3). Local research and development approval and appropriate letters of access were then gained for each of our final fieldwork locations. Informed consent was a fundamental part of the study approach. [↑](#endnote-ref-6)
7. There are 83 Private Patient Units within NHS hospitals – most offering services to international patients. [↑](#endnote-ref-7)
8. Sataøen and Wæraas (2015) cite Kornerberger’s (2010) idea that we are living in a ‘brand society’ and managing and protecting reputation is key. [↑](#endnote-ref-8)
9. JSi received its first official mention in documents in December, 2014: ‘JSI is the commercial brand for the NOMS promoting products and services to international justice markets” (UKTI Security Exports Strategy of 2014: 19, 25). [↑](#endnote-ref-9)
10. Andrew Selous, response to written questions (10 February 2015) [↑](#endnote-ref-10)