The NHS revolution: health care in the market place

Use of private health care in the NHS

Nicholas Timmins

The UK government is committed to use independent providers to help reduce waiting times for NHS services. Will the benefits outweigh the risks?

The NHS is going through the biggest revolution in the way its services are delivered since its foundation in 1948. The key ingredients are payment by results, patient choice, foundation hospitals, and the deliberate injection of independent treatment centres and private sector providers into the NHS. Between them, they add up to the creation of a supplier market in UK health care. Surrounded by a clutch of new inspectors and regulators—the Healthcare Commission, Monitor (which oversees foundation hospitals), the National Institute for Health and Clinical Excellence, and others—these changes offer a far more sophisticated but also a much more open and aggressive version of the “internal market” that the Conservatives tried in the 1990s.

Of the various elements in the current reforms, arguably the most important is payment by results. This involves the creation of a national tariff for treatment that allows money to follow the patient and is based on average NHS costs. It is this which makes everything else possible. But it is the use of the private sector that has generated the loudest controversy, probably because it is the most visible part of the revolution. It provides the biggest direct challenge to existing NHS staff, and it breaks up what has been (or rather what has been seen to be) a public sector monopoly in the delivery of clinical services. Here I examine the history behind the change and its effect on the NHS.

Controversial reform

At the Labour party conference in September, the government faced a heavy defeat over the private sector's growing role. Paul Miller, chairman of the British Medical Association's consultants committee, has called the planned transfer of some NHS units to independent sector management, “The start of a massive privatisation of the provision of health care in the NHS.”¹ A small survey of NHS managers back in January, while not necessarily representative, showed that three quarters believed that the government's use of the private sector did not represent good value for money.²

By contrast, health ministers from Alan Milburn and John Reid onwards have claimed that independent sector treatment centres are contributing to a “massive fall” in NHS waiting lists.³ Their role is being expanded to the point where within a few years they will provide more than £1bn (\$1.8bn; €1.5bn) worth of business annually for the private sector, accounting for 500 000 NHS elective operations (around 10%). Several hundred million pounds a year more is to be spent on private provision of diagnostics.

Rationale for independent treatment centres

The origin of treatment centres lies in the capacity planning the Department of Health undertook in the wake of the NHS Plan, published in 2000.⁴ The health service had by then been promised record sustained growth in spending in order to bring UK health expenditure up to the European Union average. The health department's planners, however, concluded that the NHS did not have the capacity to supply the extra million or more procedures needed each year to hit the target for waiting lists at that time, let alone the 18 weeks that has since been set for 2008 as the maximum wait from patients seeing their general practitioner to surgery for elective care. The service lacked both doctors and facilities.

Long before 2000, the NHS had been buying somewhere between 60 000 and 80 000 procedures annually from the private sector. The cost was around £100m.⁵ These operations, however, were poor value for money. Although the BMA strongly contests the argument, good evidence showed that, working in their own time in private practice, NHS surgeons and anaesthetists were charging the highest fees in the world per procedure.⁶

And UK private hospitals were selling these operations to a distressed purchaser: NHS managers, who at the end of the financial year were suddenly desperate to hit waiting list targets. Each year, managers might, or might not, have business for their local private hospital. The private sector could not plan. And the result was that the public sector often found itself paying 40%, and sometimes more, above average NHS costs for each operation it bought.⁷ At those rates, Alan Milburn, then health secretary, was not prepared to put extra NHS cash into the existing UK private sector. He regarded both consultants' fees and private sector

This is the first in a series of articles examining the government's planned market reforms to healthcare provision

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Huntingdon NHS treatment centre—a state of the art facility

HUNTINGDON NHS TREATMENT CENTRE

Summary points

Current changes in the NHS are creating a supplier market

Increased use of the private sector has created controversy

The government argues that the private sector is needed to increase capacity

Concerns have been raised that NHS services cannot compete on an equal basis

prices as “a rip off.” He feared that any expansion of existing private provision on those terms would be more likely to encourage NHS consultants to maintain or lengthen NHS waiting lists rather than reduce them (personal communication).

His answer, and that of Simon Stevens, Tony Blair’s health adviser in Downing Street, was to create a new network of independent sector treatment centres. These were modelled, ironically enough, on the NHS’s ambulatory care and diagnostic centre at the Central Middlesex Hospital, which was itself modelled on the factory-like, fast track surgery centres developed in the United States and elsewhere. Between them, Milburn and Stevens trawled the world, looking for non-UK providers to bid.⁸

When the initial contracts were let—worth £500m a year for five years to provide something over 200 000 procedures annually—the result was a seismic shock for the UK private sector. None of the big four hospital groups (BUPA, BMI Healthcare, Capio, and Nuffield) won a contract. The contracts went to overseas providers, such as the South African owned Netcare and Afrox, or to UK start-ups working with them or US and Canadian partners. The initial demand was that these new centres had to provide additional operations to those the NHS would have provided, supplied by staff brought in from abroad rather than drawn from the NHS. Their arrival has generated a lot of heat but also some light.

Effect on NHS services

Key criticisms include the fact that in order to recognise their start-up costs, most of the first wave of treatment centres are being paid around 15% above the NHS price list, or tariff. They were and are guaranteed volumes of patients. And primary care trusts have effectively been told to ensure their operating slots are filled, on the grounds that the NHS will pay for them whether or not they are used; some slots have already, on occasion, been unfilled (P Miller, Laing and Buisson conference, ISTCs: two years after procurement, London, 13 September 2005). However, NHS facilities are not paragons of virtue when it comes to wasting resources. Only around half the operating slots in NHS day surgery units are used, according to the Healthcare Commission.⁹

The new centres have produced accusations that overseas clinical staff are not up to the job.¹⁰ But some of that criticism has emanated from NHS consultants who could see their private work evaporate as the new operators helped cut NHS waiting times. There are complaints that training is being damaged as routine

surgery moves out of NHS facilities. Critics say the price per case in treatment centres, although much lower than the NHS was paying before, is above the tariff and thus represents poor value for money. One reason for this is that the centres tend to take the simpler cases: those suitable for day surgery or orthopaedic patients who have lower anaesthetic risks and few coexisting illnesses. The NHS is left to deal with the more complex cases but only gets paid at the tariff—the average cost per case.

NHS Trusts, including foundation hospitals, are not allowed to compete for these contracts. This is because the government wants to expand the market of NHS suppliers and because allowing state subsidised entities to bid may fall foul of European competition law. Thus, the NHS providers argue they do not have a level playing field with the private sector. Indeed, as primary care trusts have been required to use those independent treatment centres that are already open, many NHS centres (of which there are many more than the privately run ones) have been operating half empty and losing money.¹¹ That only fuels concerns that the transfer of routine surgery to the private sector could destabilise existing NHS hospitals. In a world where money follows the patient, the result could be NHS hospital closures.

There are, therefore, arguments of both principle (is this privatisation of the NHS?) and practicality around the private sector’s involvement. In next week’s article, I will consider these in more detail.

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Endpiece

Medicine’s need

Where lowland is, that’s where water goes. All medicine wants is pain to cure.

Delicious laughter: rambunctious teaching stories from the Mathnawi of Jelaluddin Rumi (1207-73).

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