Education and debate

The NHS revolution: health care in the market place Challenges of private provision in the NHS

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Independent treatment centres are set to have a big effect on both the NHS and private sector. Properly managed they could benefit everyone

Whether you believe the NHS is being privatised depends on your view of the founding principles of the NHS. Do your beliefs hinge on the fact the service should be tax funded and largely free at the point of use? If that is all that the NHS amounts to—one of the world's biggest and most comprehensive health insurance systems—then the NHS could, at least in theory, be entirely privately provided. It would, however, remain recognisably the NHS because patients would not pay. That, broadly, is what Tony Blair, Alan Milburn, John Reid, and now Patricia Hewitt, the current health secretary, have all come to believe. The alternative view is that the founding principles include the proposition that the NHS should also be largely publicly provided.¹

Public or private?

Those who hold the view that the NHS should be publicly provided are faced with the challenge that the 30% or so of the NHS budget that does not go on paying staff has always ended up in the private sector through £10bn (\$18bn, €15bn) a year of pharmaceuticals plus beds, drips, files, computers, and much else. Indeed, of the 70% that is spent on pay, a considerable sum goes to general practitioners, most of whom have always

been, and remain, independent contractors not salaried employees.

Added to that, the NHS has long bought some operations from the private sector. And it has long contracted out care for some of its most vulnerable patients, including people who require medium secure accommodation and who are compulsorily detained under the mental health acts, as well as those who still qualify for chronic long term care at the expense of the NHS. Those two businesses alone are worth £760m a year in England to the private sector.²

This is not an argument where either side will ever entirely convince the other. But as the more entrepreneurial general practitioners and consultants take advantage of the new NHS market, creating their own businesses to supply the service, it is one that is more likely to move in the current government's favour than the other way about. One reason for this is that repeated opinion polls show that the public does not mind whether they are treated in a public or private facility, so long as they are treated well.

Can private provision work?

The main practical arguments against the independent treatment centres relate to training, quality of care, and cost. Training can be (and is being) sorted out.³ Training has a price, even for the NHS. If the health service pays, the private sector will provide.

Quality will always be an issue. There are anecdotes (and some documented cases) of treatment going wrong in private sector NHS provision.⁴ But NHS providers are far from error free.⁵ And the independent sector has contractual requirements to provide far more detailed data on outcomes than is currently demanded of any NHS trust or individual consultant.

As the numbers treated by the private sector start to build, outcome data have begun to be announced (Friedland R, Laing and Buisson conference, ISTCs: two years after procurement, London, 13 Sep 2005), although not in a peer reviewed environment. Interpreting the data, given the relatively small numbers involved, will always be difficult. And an added problem, despite the protestations of some surgeons, is that the health service does not generally have NHS-wide data against which to compare the private

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Waiting times for cataract surgery have fallen sharply since treatment centres were launched

sector's performance.⁴ One result of private sector involvement, however, may well be better outcome data all round, which can only be to the benefit of patients.

The price the NHS pays for these operations remains an issue. The key question here is whether the above tariff prices are a transition—something needed to bring in new suppliers in order to create the competitive market—or a permanent feature. According to the Department of Health (although commercial confidentiality has prevented an independent assessment of this), a series of additional private sector contracts to cut waiting lists over and above the independent treatment centre programme (the G-supp contracts) have come in at or under the tariff.⁵ Nuffield, BUPA, Capio, and BMI, the four big UK healthcare providers that lost out in the initial bidding for treatment centres, have each now won a G-supp contract, reacting to the overseas competition by driving their prices down. Given they are handling the “easier” cases that is arguably what should happen.

The big test on pricing will come in the second wave of independent treatment centres. This will double private sector provision of elective procedures and is now under negotiation. Ministers have said there will be no guaranteed volumes for these contracts, thus levelling part of the playing field.⁷ If the private sector believes there is a sustainable market in supplying the NHS—something the department is trying to create⁸—the prices should start to fall to below the NHS tariff. Certainly, for any renewal of these five year contracts, they should come in under tariff. If they do not, the critics will have their argument reinforced.

Future for NHS services

Will private sector provision lead to the closure of NHS departments, or even whole hospitals, as the opponents argue? The answer is perhaps. Hospitals that lose business will, undoubtedly, suffer in the new market. Independent treatment centres could contribute to that. But the risk that they alone will be responsible for hospital closure has been reduced by a progressive dilution of the additionality principle—the requirement that staff must come from abroad and that the operations must be additional to those the NHS would have provided.

Even among the first wave centres, around half the staff will now in fact come on “structured secondments” from the NHS.⁹ The rules for the second wave are likely to be eased even further.¹⁰ And a mounting proportion of the private sector's work is now operations transferred out of traditional NHS facilities rather than genuinely additional.

To the critics, this belies the point of independent treatment centres and fuels the charge that this is privatisation. To the policy's defenders, however, the argument is that it does not matter if much of the work is transferred so long as it is being provided more efficiently and is injecting a degree of competition into standard NHS provision.

Effect of treatment centres

That, economically, is a defensible position. The big public policy question, however, is whether the efficiency gains that treatment centres bring more than

off-set the inefficiencies they may well also generate in a standard district general hospital. As yet, this is unanswerable. If these are the ideological and practical issues, what has been the actual effect of new private sector provision? The answer, so far, is both minimal and massive.

The effect is minimal because, even now, more than two years after the preferred providers were announced, most of the centres are only just starting to operate. Between them, they have done around 70 000 procedures out of the 5.5 million elective operations that the NHS does a year. Even if you take the numbers by which the NHS waiting list has fallen—by 300 000 since 2002—their numerical contribution is small.

On that basis, ministers' claims of a “massive” effect look hollow. Take cataract surgery, where Netcare's mobile units were one of the first practical results of the programme. Waiting times for cataract surgery in England have tumbled, close to the point of invisibility. Yet Netcare's total contribution to this has been under 20 000 out of the 300 000 cataract operations that the NHS performs each year. On its own, it has barely dented the numbers.

The alternative explanation, however, is that while they have had a limited effect on the numbers, they have had a huge effect on behaviour. Faced by the threat of competition, ophthalmic surgeons and NHS managers have raised their game. The same, it is argued, applies in other areas such as orthopaedics. NHS managers, usually off the record, and private sector providers, are not short of examples where they say the arrival of an independent treatment centre locally has suddenly made conversations with NHS consultants about how services are organised and how waiting times can be cut much easier. As Simon Stevens, Tony Blair's former health adviser, has put it, if NHS consultants did not perform the operations there was “A bunch of Germans coming round the corner who would.”¹¹

In Exeter, for example, NHS patients who had been told they would have to wait months for a hip replacement suddenly found themselves being offered one at the local NHS hospital within days or weeks of an independent treatment centre opening up nearby. Equally, NHS managers have reportedly found it much easier to negotiate cheaper fees with their consultants for extra work, with payments well below the standard BUPA rate, whether that extra work is undertaken internally in the NHS or as a “structured secondment” to an independent treatment centre.² At the moment, this evidence is largely anecdotal. It is the outcome, however, that competition is intended to produce.

Response of private sector

But if hard evidence from within the NHS on the effect of these policies is limited, persuasive evidence is available from outside—the reaction of the UK private sector to the arrival of overseas competition. All four major providers have restructured their business. Nuffield Hospitals and the Swedish owned Capio have made winning NHS contracts a core part of their operation. BUPA has sold nine of its hospitals because it believes they cannot adapt to the new NHS market and the effect that is likely to have on the private one. Like the other providers, it is installing the NHS “choose and book” information technology system, to ensure patients

can gain access to its beds as patient choice arrives. BMI, the biggest single private hospital operator, having initially stood back from this market, has since publicly apologised and seems to be a serious bidder for the second wave of treatment centres.¹² All four UK operators have now provided procedures to the NHS at tariff prices or below through the G-supply contracts.

These are decisions taken by hard headed business people, backed variously by City lenders and venture capitalists, who believe something important is happening here. Their money and their jobs are on the line.

The opponents of the government's policy will say this is merely the private sector lining up to make a killing from the NHS. The counter argument is that rising NHS spending, falling waiting times, and increasing competition look set to transform UK health care in both the public and the private sectors.

Already, there has been a 10-20% reduction in the 200 000 or so people prepared to pay each year out of their own pocket for private treatment.¹³ The health department expects most of these to return to the NHS by 2008.¹⁴ Unpublished analysis for the Healthcare Commission suggests that by 2010, half of all the independent sector's business could be coming from the NHS, against less than 10% last year.¹⁵ The numbers who don't pay directly, but are covered by their own or their company's private medical insurance, could fall by 15%, the study suggests.¹⁵ And, anecdotally, the fees NHS consultants can charge for extramural work— whether on NHS or private patients—are also falling, to the point where Derek Machin, chairman of the BMA's private practice committee, has repeatedly warned that private practice could disappear in some parts of the country.¹⁶

For all this to happen, the private sector has to believe that beyond 2008, when current rates of NHS spending growth are likely to halve, NHS provision will remain a sustainable market. At the moment, they are behaving as though that will be the case, while worrying that it will not.

A better future?

What all this heralds is a much less comfortable time for many NHS institutions and staff (and for many in the private sector as well). It presents new challenges, but also new opportunities, for surgeons and anaesthetists. Elective surgery is only a small part of the NHS's business. But the limited evidence to date suggests that potentially a big gain is on the way in swifter access to elective care for NHS patients as well as, perhaps ironically, lower prices for private care as the market reacts to the competition that the private sector is helping engender from the NHS for private medical insurance. Both sets of patients should in time get better data on outcomes.

The price for all this may well be disruption of established NHS services locally. How bad that is, and how well it is handled, may well decide whether the outcome of this policy is judged to be a success or a failure.

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Summary points

The government believes that use of private providers does not undermine the principles of the NHS if care is free to patients

Insufficient data are available to determine the effect on quality of care, although the changes should result in better outcome data for both NHS and private care

Independent treatment centres have had a much bigger effect on waiting lists than can be accounted for by the number of procedures they performed

Costs of procedures seem likely to fall

The effect on local NHS services is likely to determine the success of the policy

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Human and animal health

Human and animal health: strengthening the link

On 26 November the *BMJ* and the *Veterinary Record* plan simultaneous publication of theme issues exploring the link between animal and human health and ways in which the medical and veterinary professions might work together more closely. Our theme issue will cover a wide range of topics from zoonoses and the management of venomous snake bites to the benefits of pet ownership and the eradication of infectious diseases. We are keen that the two theme issues will stimulate a timely debate and discussion between the professions.

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