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Operating for Profits:

An examination of the UK government's policy of promoting "Independent Sector Treatment Centres"

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UNISON

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1. Introduction

Under John Major's Conservative government in 1996-97, after 18 years of Tory rule, the NHS was spending just £200 million a year on buying in treatment from private hospitals and clinics. By 2007, if the Labour government's current proposals are carried through, this will have increased tenfold.

New private hospitals and treatment centres are being built, with more planned, and in some cases existing NHS facilities - built with taxpayers' money, or expensively funded through the Private Finance Initiative at the expense of the NHS - are to be handed over to private sector operators as part of the new arrangements.

2. The second wave

One of Patricia Hewitt's very first pronouncements as Health Secretary, just hours after taking office, was a new allocation of £3 billion for the purchase of additional treatment as part of the Government's programme of Independent Sector Treatment Centres.

This second major round of tendering for private contracts, which opened earlier this month, could involve purchasing a further 250,000 operations a year, and almost 900,000 outpatient appointments and diagnostic procedures from private sector providers.

- A brand new state of the art NHS Treatment Centre in Birmingham, not even yet open, is to be handed over to private operators.
- Also facing outsourcing to the private sector is a specialist unit in the new PFI-financed New Forest hospital in Lymington.
- Plans are also being developed to hand over other modern NHS treatment centres, including Ravenscourt Park Hospital in NW London and the SW London Elective Orthopaedic Centre in Epsom, to the private sector.
- In South Yorkshire NHS catheter laboratories in Rotherham and Barnsley could be handed over as part of a cardiology contract.
- "Spare surgical capacity" in NHS hospitals in the South West Peninsula could also be made available for private companies carrying out NHS-funded operations.
- And a huge renal dialysis contract covering much of the north of England could see dozens of NHS units handed over for private operators to refurbish and run for profit.

3. Results of the first round

The first round of Treatment Centre contracts has not yet been completed, with some services yet to come on stream, and there has been no systematic evaluation of the effectiveness or value for money of these projects, which have been centrally decided and funded by ministers and little influenced by local Primary Care Trusts.

However we do know that in at least one case – the scheme to bring in specialist eye surgeons and nursing staff from South Africa to deliver routine cataract operations to NHS patients in Oxfordshire – the project was opposed not only by consultants and other staff at Oxford's

specialist Eye Hospital, the viability of which is seriously undermined by the private sector top slicing a large proportion of its routine work (and revenue), but also by at least one of the local Primary Care Trusts. Huge pressure was brought to bear to force the scheme through, resulting in resignations in the PCT: but there is no evidence that paying more to commission these services privately rather than allowing the NHS to implement its previous plans to deliver waiting times will do anything but undermine NHS efficiency.

Similar questions hang over the scheme that is due to slice off 85% of the orthopaedic caseload from the Brighton & Sussex Hospital, and instead purchase £18m of NHS treatments a year from a newly-created privately run treatment centre. This will leave the NHS with only the most costly and complex cases and emergency work: there is nothing to suggest that this would be more efficient or better value for money, and plenty of grounds to fear that this specialist unit, too, could be rendered financially non-viable by the treatment centre programme. Its closure would not only reduce choice for NHS patients (and create a virtual private sector monopoly) but also force those needing any more complex or urgent treatment to travel many miles to an NHS alternative.

4. Private sector preference

The government plan to funnel new money preferentially into the private sector rather that adopt the cheaper and easier policy of expanding NHS provision, has led to a dramatic expansion of commercial medicine. The private health care sector in the UK has always been a relatively small and marginal operation, feeding off historic NHS waiting lists, poaching NHS staff, shunning emergencies and complex cases, and focusing exclusively on acute (short stay) services: but until recently it was running with only around half of the beds occupied in its (generally very small) hospitals. Now a massive increase in the numbers of NHS patients being treated in private beds means that the traditional paying patients will only represent just over half of the caseload in private beds, with as many as 45% paid for by the NHS. This is effectively a huge cash subsidy to enable the expansion of a private sector which will inevitably draw on the same pool of human and financial resources as the NHS, but divert a percentage of those resources from patient care to pay dividends to their shareholders.

To foster an expansion of private care to enable it to "develop a sustainable market", ministers have set out to bring in commercial health care companies from around the world, and also offered private hospitals very generous contracts, paying up to 40% above the prevailing costs within the NHS, lavish subsidies towards start-up costs for new private hospitals, and guaranteed payment even for those private providers who treat fewer patients than planned.

5. Staff issues

The second wave of Independent Sector Treatment Centres offers slightly less generous subsidies to private hospitals than the first, but promises the security of five-year contracts for the winners, while also relaxing the initial restrictions on poaching NHS staff to help run the new private units. As the Department's own document explains, the new schemes have gone well beyond the notion of expanding NHS capacity, and are now seeking to transfer existing NHS work to private treatment centres. This is the pretext under which the staffing restrictions have been eased:

"Providers will be able to use NHS staff when providing the Services for Schemes where there is transferred activity. Where there is transferred activity it is expected that the amount of NHS staff time available to the Provider (as a proportion of the Provider's total staffing requirement) will be approximately equal to the amount of transferred activity as a proportion of total activity to be delivered by the Provider."

However the new proposals also make it easier to employ NHS-trained professional staff even where there is no transfer of activity:

"Providers will only be prohibited from recruiting NHS staff in specialties facing workforce shortages. Work is ongoing to identify any further shortage professions."

"All doctors, nurses and other healthcare professionals (whether or not in shortage professions) will be permitted to use their non-contracted hours to work for Providers, subject to first fulfilling their NHS commitments."

The outcome of these changes seems certain to be a further loss of vital frontline staff from existing NHS hospitals, forcing Trusts to fill more vacancies with high-cost agency staff or cut back on the services they provide – again reducing patient choice.

6. International experience

Experience in other countries around the world confirms that it is never cheaper or better value to bring in the private sector to deliver health care services.

In Australia, where years of government subsidies to private health insurance has now led to private hospitals conducting a majority of waiting list surgery, average costs of private treatment are higher, and the public sector carries the majority of the complex and costly cases.

In Korea, where the private sector is hugely bigger than the public sector, children can be vaccinated in public sector health centres for a third of the price charged by private clinics; costs for ambulatory care patients range from one third to half the cost of private treatment, and those needing treatment for chronic diseases pay as little as a fifth of the fees charged by private hospitals. Public hospitals also treat a tenfold higher proportion of poor patients funded by the Medical Aid Programme.

In France private sector hospitals are free to "cherry pick" the most profitable and least demanding specialties, leaving emergency treatment, psychiatric care, major operations, life-saving treatment and research to the public sector hospitals. It is frequent for private sector providers to transfer more complicated cases to public sector hospitals.

7. Conclusion

The harsh reality is that there is no evidence to support the underlying rationale for the government's cultivation of a new role for independent sector companies in the provision of NHS care. None of the claimed justifications holds water:

- Independent sector treatment centres, which run for the benefit of company shareholders in the UK and around the world, offer no cash savings, but generally higher costs while taking on only the most minor and uncomplicated surgery.
- Far from relieving pressure on the NHS, this diversion of resources cuts across the necessary training of specialist doctors and nursing staff, jeopardising some centres of medical education, such as Oxford's Eye Hospital.
- Far from delivering new and expanded services and capacity the private sector is increasingly competing to capture existing NHS caseload, diverting vital funds from NHS to the commercial sector.
- Any apparent increase in private sector provision seems certain to herald corresponding reductions and cancellations of plans to expand and develop NHS services.
- Any eventual reduction in waiting times that may arise after such schemes are introduced will be achieved only at the expense of higher costs and longer delays than would have been necessary for an expansion of mainstream NHS care.
- Far from enhancing patient choice, the imposition from central government of these plans to privatise the provision of certain sectors of elective treatment runs the risk of destabilising and forcing the closure of popular local units and even whole hospitals, which offer comprehensive care including emergency services to a wide section of the public.
- Opinion polls have repeatedly found that the first choice of most voters is to maintain local access to a full range of high quality NHS services.
- Before rushing to commit another £3 billion to a second round of privatisation, the very least Patricia Hewitt and her ministers should do is commission a full and objective, public evaluation of the impact of the first round of treatment centres, including their impact on the wider NHS.
- Without evidence that it can deliver any of the promised improvements, the Independent Sector Treatment Centre programme should be halted and the resources invested in staff, facilities and equipment to enable NHS Trusts to meet the 18-week target for waiting times.

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