

# **‘One modest brick’? Independent sector treatment centres, accountability and the re-commercialisation of the NHS**

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## **1. Introduction**

In this 60<sup>th</sup> year of the National Health Service, the first health system in the world to offer free health care to all its citizens, it might be worth examining one of the lesser quoted principles of Aneurin Bevan’s great institution. This relates to the transfer of a ‘whole segment’ of activity from private enterprise and individualism to collective goodwill, public enterprise and public administration. The ‘invasion’ of the private and individualistic was, for Bevan, the practical expression of nothing less than the articulation of a ‘new society’ (Bevan, 1952:106).

Chief architect of the NHS, Bevan (1952) was blunt in his assessment of the contribution to health care made by commercial interests:

*“The field in which the claims of individual commercialism come into most immediate conflict with reputable notions of social values is that of health.” (p 98)*

*“Abuse occurs where an attempt is made to marry the incompatible principles of private acquisitiveness with a public service. (p108)*

*“A free Health Service is a triumphant example of the superiority of collective action and public initiative applied to a segment of society where commercial principles are seen at their worst.” (p109)*

So there can be little doubt regarding Bevan’s views and the compromises he made in the practical arrangements of the NHS were to be addressed, he said, through “decreas[ing] the dependence on private enterprise”.

What prompted my recollection of these acerbic comments was reading Stewart Player and Colin Leys' new book *Confuse and Conceal: The NHS and Independent Sector Treatment Centres*. The publication of this first detailed academic analysis of the genesis and character of the policy offers a useful moment to reflect on the way in which information is withheld, distorted and manipulated when the state seeks once again to re-introduce the values of commercialism.

## **2. Independent sector treatment centres and commercialism in the NHS**

Independent Sector Treatment Centres (or ISTCs as they are known) have been with us since 2003 and were introduced ostensibly to expand capacity and drive down waiting times. They are commercially owned and operated surgical treatment centres offering fairly routine fast-track elective surgery and some diagnostic procedures exclusively for NHS patients. Wave 1 of the ISTC programme, which saw the first centre open in October 2003 and the scale of which is discussed below, focused principally on routine orthopaedic, ophthalmic and general surgery. All of the companies contracted in wave 1 are based overseas and bring many of their staff from overseas. Phase 2, announced in March 2005, broadened the scope of procedures and expanded significantly the diagnostic element. Phase 2 was expected to deliver 'up to' 250,000 elective procedures per year with a further 150,000 procedures offered through an Extended choice Network at a cost of around £3 billion and two million diagnostic procedures annually at a cost of around £1 billion (Department of Health, 2006a). The full picture for phase 2 is still incomplete but in late 2007, four schemes had become operational and negotiations were underway with around another dozen schemes, far fewer than originally announced for phase 2 (Gainsbury, 2007).

They are important to health care in England because they mark a second attempt to restructure secondary care in the NHS in a way that reintroduces commercial interests. (The first was the not very successful but nonetheless Rubicon-crossing *Concordat* in 2000 with the traditional UK private health sector which was instigated by former Secretary of State, Alan Milburn and created a

framework for the purchasing by NHS Trusts of health care from private hospitals.)

For more than 50 years after the creation of the NHS in 1948, secondary care was provided by the NHS on a non-commercial basis and according to professional judgements of patients' needs. Any encroachment on that principle arose from individual consultants seeking to promote their private practices and individual patients seeking to define their own need as greater than that of other citizens on the waiting list. The use of pay beds persisted as a defiance of the equity principle but whilst this has been a constant irritant by those who want to see the founding principles of the NHS implemented in undiluted form, the significance of this in terms of financial value as a proportion of overall NHS income has remained limited.

ISTCs, however, represent something very different. They are a *deliberate* government policy to abandon the non-commercial principle and to reintroduce commercialism with vigour into the English health service. If this ISTC policy had stood on its own, its significance may have been more symbolic than real. However, it comes as one of a series of pro-commercial policy initiatives over the past twenty years which have gradually reshaped the nature of the NHS: the contracting out of cleaning, catering and other 'support' services in the mid 1980s; the replacement to a considerable extent of state-funded and state provided geriatric health care by means-tested, largely *non*-state provided social care in the 1980s and 1990s; and the replacement of publicly owned NHS hospitals with privately owned and maintained PFI hospitals are just three milestones over this period.

Additionally, it is not merely the historic context which confers a significance upon ISTCs but also the current policy framework within which they sit. This embraces the contracting out of even more support or back-office functions (sometimes to overseas suppliers); the establishment of health centres by private companies and the contracting out of GP services to global corporations, among others, following the introduction of the new GP contract and the historic ending of the GP's responsibility for 24 hour patient care; the externalising of community health services (including therapists, health visitors and district nurses) so that they can compete in the emergent primary and community care

market; the incorporation of giant multinational companies into the commissioning process itself; and the extension of patient choice to allow patients to choose from *any* hospital in England providing it meets quality and tariff requirements.

In other words, ISTCs matter not because they are a breach of the non-commercial principle but because they are one modest brick in the wall of commercialism which is currently transforming the National Health Service into something new. And yet, this is a tricky business for government which, although committed to the reintroduction of the profit motive and more individualised and consumerist notions of health care (a “commodity privately bought and sold” rather than an “act of collective good will and public enterprise” to reverse Bevan’s, (1952:106) sentiments), must still find ways of presenting this to the public as a benefit to all.

### **3. Mismanaging information: trying to find out about ISTCs**

What is striking about the introduction of ISTCs is how difficult it has been to obtain a clear picture of what is happening in terms of even quite basic facts. On a number of occasions, information has been put into the public domain by the Department of Health which, it subsequently transpires, is inaccurate and/or misleading. A number of observers have contrasted the claims made for ISTCs and the reality of the policy as implemented (e.g. Health Committee, 2006; Ruane, 2006a; Unison, 2007), although perhaps Player and Leys (2008) shine the spotlight most unattractively of all.

It is clear that public information about ISTCs has been kept to a minimum. Certainly, the Health Select Committee’s Inquiry into the ISTC programme (Health Committee, 2006) increased several-fold the amount of information in the public domain, with written and oral submissions from the companies themselves, trade unions, professional associations, academics, individual members of the public, doctors and NHS employees as well as the Department of Health and the then Secretary of State, Patricia Hewitt. All of this evidence is available via the House of Commons website. However, even this extensive array of facts, figures and opinions has not been able to escape the shortcomings of omission and inaccuracy.

We still do not know, for instance, what the capacity of ISTCs is despite their importance in some health locales: we do not know how many staff they employ and how many beds they hold. We do not know the contractual terms on which they have been engaged. We do not know whether their services are of high quality. We do not know whether they represent good value for money or even how value for money has been calculated. We do not know how much their procedures cost and how this compares with similar NHS procedures. We cannot even be sure how many procedures they have conducted.

### ***How many procedures have been contracted for?***

If we consider how many procedures have been contracted for, the sense of a gap between the official position and the reality on the ground is compounded by the lack of clarity regarding the official position in the first place. The Department of Health (Growing Capacity June 2002) claimed that Wave 1 ISTCs would provide 170,000 Finished Consultant Episodes (FCEs) per year over five years at a cost of £1.6 billion in total. In practice, however, *precisely* how many have been contracted for remains unclear. The Department of Health's initial written evidence to the Health Committee in early 2006 supplies figures organised by different provider (Department of Health, 2006:17-35). However, although the figures supplied are described as relating to 'activity', 'procedures' or 'diagnostics', these categories do not seem to be used consistently, with the term 'total procedures for contract' sometimes including diagnostics and sometimes sitting alongside the sister category of 'total diagnostics for contract'. A quick addition of the figures described as 'total procedures for contract' gives a sum of in excess of 1.2m but this sum appears at odds with figures revealed by a Freedom of Information Request a year later and which organised the number of contracted procedures by specialty and revealed a much smaller total of only 879,000 procedures over five years (Player and Leys, 2008:9). There is no mention whatsoever in the Department's oral evidence to the Health Committee in 2006 of primary care procedures being contracted from ISTCs although the written submission refers to 150,000 minor injuries units and 100,000 walk-ins. More of this later.

### ***Have ISTCs enhanced patient choice?***

Some of the main criticisms and shortcomings of ISTCs have been well aired over the past few years (e.g. Unison, 2003; BMA, 2005; Ruane, 2005; 2006a; 2006b; BBC, 2006; Wallace, 2006). Again, the contrast between rhetoric and reality seems undeniable. The policy has been presented to the public as one of driving down waiting times and expanding patient choice. In reality, the impact of ISTCs on waiting times was strenuously challenged by some witnesses before the Committee who pointed out that waiting list initiatives and extra funding within the NHS had been the main contributors to driving down waiting times and that the relatively modest numbers of procedures executed by the ISTCs had been too small to make much of a difference. In theory, ISTCs diversified providers of routine elective procedures thereby conferring greater patient choice. In practice, the 'take or pay' element of the contract (guaranteeing the ISTCs their income for five years regardless of whether they performed the contracted procedures) forced PCTs - which had been required to divert their commissioning away from traditional NHS providers and towards the new ISTCs - to find ways to shepherd patients towards the private treatment centres, thereby *constraining* patient choice. In some instances, they have done this by providing financial 'incentives' for referring GPs. Although ISTCs are supposed to have expanded capacity for treating NHS patients, the absence of data relating to the numbers of staff they employ and the numbers of beds they maintain does not readily confirm this. Further, the disclosure that, despite the so-called 'additionality' clause preventing private companies from poaching NHS staff, some 25% on average of all staff in wave 1 ISTCs had in fact been transferred on a temporary basis from the NHS again weakens the claim for expansion. In one ISTC, in Waltham forest, the figure is 83% (Player and Leys, 2008). The additionality clause has been dropped for phase 2 except in shortage professions.

### ***Has capacity overall reduced?***

Although the Department's evidence to the Health Committee underscored the importance of local NHS involvement in capacity planning in determining the scale and location of ISTCs across England, the evidence of other participants in the Inquiry contradicted this. First, it emerged that Departmental negotiations with companies had commenced long before local involvement in the planning exercise was initiated (Player and Leys, 2008); second, it became clear during the Inquiry and since (e.g. BBC, 2006) that some ISTCs had been located in parts of the country where they

were not needed for capacity reasons and that some PCTs had been extremely reluctant to sign up to them (e.g. HSJ, 2005). The claim by the Head of the Commercial Directorate of the NHS, Mr Ken Anderson, that expanding capacity was the primary objective of the ISTC programme was hotly disputed by other witnesses and doubted by the Committee itself.

Indeed, Player and Leys make the point that ISTCs have resulted in a *reduction* in capacity. How is this? There are several contributory factors: the transfer of NHS activity to ISTCs and the diversion of NHS funds away from NHS providers, (including new NHS owned treatment centres at least some of which have been made unviable by the transfer of patient activity to ISTCs); the higher cost of procedures in these commercial treatment centres such that a given amount of expenditure secures fewer procedures than would have been the case had they been commissioned from NHS providers, combined with the underperformance of ISTCs relative to contractual expectations. In other words, since they are paid for out of NHS funds, ISTCs incur a substantial *opportunity cost*. In addition, they undermine the capacity of traditional NHS units through the loss of activity and staff skills.

In relation both to this and to the impact on NHS owned treatment centres, there is a paucity of data in the public domain although anecdotal evidence (for instance, Southampton Hospital (BMA, 2006) in the former and Ravenscourt (Mulholland, 2005) in the latter) points to the reality of the problem if not its scale. The Committee's final report concluded that ISTCs 'would clearly affect the viability of existing NHS providers... [and] may lead to unpopular hospital closures under reconfiguration' (Health Committee, 2006: Vol. I paras 96, 99). The Report also disclosed that the Department of Health had carried out an analysis of the possible effects of ISTCs on NHS facilities but had refused to share its findings with the Committee (2006: para 95).

### ***How much under performance?***

One of the biggest gaps between political claim and practical reality relates to the actual performance of ISTCs. The under-performance of ISTCs relative to the numbers of procedures they have been contracted to provide has been a continuing bug-bear of the policy's critics. The *Health Service Journal* revealed in September 2006 that the ISTCs open in April 2006 were performing only 59%

of the procedures needed to fulfil the terms of the contract, assuming they were contracted to perform the same number each year of the five year contract (Moore, 2006). That is, of the 78,242 procedures necessary (including some MRI work), only 46,073 had been performed. The Department of Health disputed the figures at the time but did not produce its own figures to refute the *HSJ*'s analysis, repeating instead its habit of conflating ISTC figures with those of other initiatives, this time the performance figures for the General Supplementary contracts, to produce a more impressive picture. In addition, the Department of Health defended ISTC performance in the light of 'ongoing contract management where we work with providers to shift the capacity to the future' (cited by Moore, 2006: 14) although it did not indicate whether ISTCs had demanded extra payment for this.

However, when the *HSJ* repeated its investigation a year later, it found that by the end of March 2007, ISTCs had still fallen short of expected performance by a total of 50,000 procedures. To be specific, ISTCs had been predicted by the head of demand-side reform at the Department of Health, Mr Bob Ricketts, to perform 117,000 procedures up to March 2007 but, instead, ISTCs had performed 67,000 and some ISTCs were operating at only around 50% of contracted value (Moore, 2007). Along with this less than outstanding performance should be noted the lengths to which journalists at the *Health Service Journal* had to go to build the picture they did. For the first analysis, data needed to be collected from parliamentary answers, Freedom of Information Act requests, public documents and newspaper reports. In the absence of any official publication, the *HSJ*'s 2006 report provided the first national picture of ISTC performance. The 2007 investigation was based upon FOI requests of PCTs (although not all the PCTs could provide the information requested) as well as answers to parliamentary questions.

The lack of transparency surrounding performance had featured, too, in the Health Committee's inquiry. The Committee complained in its report that "the figures relating to the ISTC programme and its productivity have been subject to a degree of misrepresentation, witting or unwitting, in some of the Department of Health's public statements" (Health Committee, 2006: Vol. I, para 36). Player and Leys (2008:25-27) assemble a variety of datasets relating to alleged performance – that is, relating to how many procedures ISTCs have

actually performed. They bring together and contrast in tabulated form data supplied by the Department of Health to the Health Committee Inquiry; the Department of Health in response to two Freedom of Information Requests; Mr Ivan Lewis, Minister of Health in response to a Parliamentary Question posed by Mr Andrew Lansley MP; and the Department of Health to the Healthcare Commission for its report on ISTC quality of care. They reveal that the figures supplied by the Department of Health are highly problematic since figures for both elective and diagnostic procedures erroneously include procedures undertaken outwith the ISTC programme (as part of a separate set of commissioning called 'General Supplementary' contracts). As a result, the figures supplied by the Department inflate the actual performance of ISTCs. Additionally, the Healthcare Commission claims on the basis of figures provided by the Department of Health that 140,485 primary care procedures had taken place by April 2007. The response to a subsequent FOI request reveals that "within the ISTC programme primary care is delivered through six commuter focussed walk-in centres and one ISTC, which has a minor injuries unit and walk-in centre". It is not clear why walk-in centres are considered "within the ISTC programme".

### ***Do ISTCs offer value for money ?***

The data on costs and performance suggest ISTCs may not represent value for money, especially when you add to the mix the fact that ISTCs cherry-pick only the comparatively easy to treat patients, leaving the more complex cases to the traditional NHS. In other words, they are paid more to do less and even not doing what they are paid to do. The Department of Health admitted in its written evidence to the Health Committee that ISTCs were paid 11.2% above the 'NHS Equivalent Cost', this premium seen as necessary 'for the purpose of seeding a new market' (Department of Health, 2006:4). Although the Department of Health was asked by the Health Committee to supply details of its value for money calculations, it refused to do so even in private session. It would not even disclose the contents of a review it had commissioned to review whether the VFM methodology was being consistently and correctly applied. This flouting of Parliamentary accountability went without significant challenge from the Committee chairman. One of the greatest potential benefits of the ISTC programme is its 'galvanizing effect' on NHS units – competition as a spur to greater efficiency and productivity – but in fact the Health Committee

found that the department had made no attempt systematically to assess and quantify the effects of competition from ISTCs on the NHS” (Health Committee, 2006: Vol. I para 56) Given the problems with this policy outlined above, it may be safer to assume that ISTCs are poor value for money, certainly in wave 1, unless and until the Department of Health demonstrates otherwise. Contracting arrangements have been altered for phase 2 such that the guaranteed income element is now more qualified and training may be included.

#### **4. Commercialisation and ‘reputable notions of social values’**

Do we, then, see ISTCs as an instance of commercial principles ‘at their worst’? Can we describe them as a form of abuse of the health service? We can observe that they have arguably distorted priorities in the health service since, although the NHS is guided by the principle of equity of access on the basis of need, ISTCs serve only the relatively routine cases but have diverted funds away from NHS units which do have a responsibility for treating all patients however complex the needs. They have also distorted public sector priorities through central imposition regardless of the needs of local health communities.

Second, they have not offered the public good value for money. Instead of the values of public service, we find a high cost and highly risk-averse approach, at the expense of NHS patients who must pay through health care foregone. Demand risk has remained with the public sector and the transfer of some NHS activity to ISTCs has left parts of the NHS with spare capacity. Third, they flout the principles of democratic accountability since their demands for commercial confidence and the Department of Health’s demands for commercial confidence arising from the character of the competitive capitalist market result not only in the withholding of contractual information from the public (and academics) making a public and an independent academic assessment of value for money impossible but also the withholding of information from Parliament’s democratic watchdog, the Health Committee, so that its own assessment could not be completed.

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