

## Independent Sector Treatment Centres

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It is difficult to assess whether the steady drip-drip of adverse publicity surrounding independent sector treatment centres (ISTCs) will eventually see them consigned to the political graveyard. These private diagnostic and treatment centres are designed to provide fast-track diagnostic services and relatively simple elective care procedures, free from the vicissitudes of the emergency demand for beds which often obstructs elective surgery in large NHS hospitals. The Department of Health boasted that they would bring about innovation in health care delivery, especially through redesigned patient pathways, offer greater flexibility and choice to patients in the location and timing of their health care and provide vital extra capacity to an over-strained NHS thereby driving down waiting lists. The reality is less rosy.

Far from giving ISTCs a clean bill of health, the Health Select Committee's report, published in July 2006 (1), revealed the policy as a 'leap in the dark', with no clear evidence base, a shifting rationale and the prospect of serious damage to some NHS hospitals and treatment centres.

Although government policy included the establishment of NHS diagnostic and treatment centres (DTCs), these have received neither the policy priority nor the publicity which their commercial sector counterparts have attracted. In the autumn of 2003, then Secretary of State for Health, John Reid, selected several overseas companies, including Capio from Sweden and Netcare from South Africa, to set up treatment centres in the UK. Some £1.7 billion was set aside for financing five years' worth of health care from these providers. By January 2006, 25 ISTCs were either already up and running or shortly to be operational with a further 4 under negotiation. In the main, they are providing ophthalmology (typically cataract removal), orthopaedics (typically hip and knee replacement) and some diagnostics but there is also some general surgery, gynaecology, urology and plastic surgery. These became known as 'first wave' ISTCs when a second phase, worth £3.75 billion, was announced in March 2005, dramatically extending the scale and scope of the ISTC contribution to the UK health economy.

Initially, ISTCs were to be established in areas of inadequate NHS capacity to be identified through a local capacity assessment exercise, the results being channelled up to the Department of Health which would contract with companies accordingly. However, at some point in the implementation process, the Department moved the goal posts and decided to establish some ISTCs to provide not *supplementary* capacity but *competitive* capacity. This means that some ISTCs have been set up where they are not required by local levels of demand and are thus in competition with NHS providers for the same limited pool of patients. Claims that ISTCs have been located in some areas through bullying and imposition have surfaced. The introduction of payment by results

(PbR) enables money in the NHS economy to follow patients. Rather than NHS hospitals being paid in advance for block contracts, providers are paid only after procedures have been performed and only for the procedures which *have* been performed. If the hospital does not perform the procedure because the patient is referred elsewhere, the hospital does not get the associated income. The establishment of ISTCs in health economies where they are not required by demand therefore poses a serious threat to the continued viability of some NHS units.

In fact, despite the vocal claims of the Department of Health for the ISTC contribution to increasing capacity and reducing waiting lists, the Health Select Committee reported that in oral evidence, the Department's representative eventually conceded that ISTCs had made no major contribution to increasing capacity or reducing waiting lists. Further, although patients in some areas have a choice of earlier treatment in a different location, patients are as yet unable to make a choice on an informed basis. The Committee found that despite Departmental claims, ISTCs are *not* necessarily more efficient because, since they take only relatively simple cases and overwhelmingly on a day case basis, they cannot be compared with NHS hospitals on a like for like basis; and there is no evidence for greater innovation or good practice than can be found in the NHS. In response to the Department's boast that the threat of competition itself will have a positive impact on NHS productivity and efficiency, the Committee concludes once again: no clear evidence, the Department having failed both to assess and to quantify the effect of ISTC competition. On the question of safety, the Committee found no statistical evidence for poor clinical standards but deplored the limited scope of clinical indicators currently employed and recommended that ISTCs use the same clinical appointment procedures for candidates from the European Economic Area as the NHS, along with an additional assessment system based on competency.

But there are more serious concerns about ISTCs. Despite the introduction of a competitive market, fixed tariffs (i.e. providers will be paid a fixed amount for a given procedure regardless of their costs) and PbR, ISTCs buck the system. First, they are paid more than NHS units to perform any given procedure and, second, they are guaranteed payment *whether or not* they perform the procedures for which they are contracted. In other words, the market is rigged in their favour. Once again, private companies have secured access to state resources on terms highly favourable to themselves.

This value for money matter is an interesting one and reveals both the irrational nature of the policy and the lack of public accountability which accompanies it. The Committee sought to establish whether ISTCs offer value for money - this doesn't mean cheap but financially worthwhile for what they provide. In response, the Department submitted a memorandum which stipulated that VFM was assured through an open and competitive process, selection of the best value offer received and rejection of schemes which were not significantly better value than prevailing spot purchasing rates. The Department explained that it calculated and 'NHS Equivalent Cost' for each scheme as a benchmark since

independent providers are faced with costs such as tax that NHS providers do not have to pay. The Equivalent Cost is based on the fixed tariff adjusted for the delivery model of the independent provider and the Department informed the Committee that the cost of ISTCs was on average 11.2% above the NHS Equivalent Cost. The Department refused to release on the grounds of commercial confidentiality further information on these calculations so that the Committee could not assess for itself whether ISTCs represented value for money. In addition, the Committee was refused sight of the figures in any Business Case on the same grounds.

What we have here is confirmation that the commercial providers cost more to the tax payer to perform the same procedure such that the opportunity cost of this approach to health care provision is significant. Even accepting the 11.2% calculation, this approach means that for every nine patients treated by ISTCs, ten could have been treated by the NHS. Bearing in mind the rather dismal performance of ISTCs against their imputed objectives, we cannot really say this is a price worth paying. Further, they are 11.2% more expensive than an 'Equivalent Cost' which itself is a contrivance, a statistical construct, and not one the Department is prepared to submit for public scrutiny. This must raise an element of suspicion since it could be expected that the Department would release whatever good news it could.

Second, this tussle between the Department and the Committee demonstrates that the incursion of commercial interests in the NHS is occurring not only on an evidence-lite basis but also without adequate accountability checks. The commercial interests of the companies rank as more important than safeguarding the interests of the public. Through contrivance and concealment, for-profit interests acquire their place in the policy landscape. The commercial providers can and will operate in the English mixed economy only when guaranteed advantage upon advantage. On a level playing field, they would fall.

The higher costs of ISTCs and the guaranteed payment arrangements negotiated by the Department at a national level but borne by NHS commissioners (and thus patients) at a local level become a potentially deadly combination for NHS finances and make something of a joke of patient choice. The 'take or pay' dimension in a context of tight financial balances creates a strong pressure on Primary Care Trusts who commission most health care to 'shepherd' patients towards the ISTCs rather than local NHS units. The Committee concludes that the projected scale of the ISTC 'contribution' (some 10% of the total elective workload) 'would clearly affect the viability of many existing NHS providers' (p 36).

The Committee fails to conceal its frustration with both the Department and the Secretary of State for withholding information, misrepresenting the facts and, to put it colloquially, changing their story. The Committee's conclusions are two-sided. On the one hand, it recommends phase two ISTCs be more integrated into the NHS (in terms of shared staffing and facilities and better clinician communication) and expand their role to incorporate training which had been severely undermined in some areas by the removal of routine cases from NHS

units. On the other, it recommends that centres separating elective from emergency surgery should be built 'where there is a need and where.....agreed with the local health community following Section 11 consultation' but suggests non-ISTC options such as NHS DTCs may be superior.

This reference to public consultation is an intriguing one. ISTCs have been located across the country, significantly changing health service delivery, but without any consultation of the public. The Committee has used parliamentary process to challenge the suitability of these centres; it remains to be seen whether the public will use legal process to do the same.

- (1) House of Commons Health Committee (2006) *Independent Sector Treatment Centres, Fourth Report of Session 2005-6 Volume I*, London: The Stationery Office

Extracts from Volume I of the Report

"The Department claims that ISTCs drive the adoption of good practice and innovation in the NHS but we received no convincing evidence" p24

"There are real concerns that the expansion of the ISTC programme will destabilise local NHS trusts, especially those with financial deficits." p46

"The fact that officials and ministers from the Department of Health have provided a range of changing objectives to explain the ISTC programme also suggested the ISTC programme was not a carefully thought-out adventure." p38