Private sector providers in England:

The implications of Independent Sector Treatment Centres

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Summary: Over the last few years, private sector providers have begun to have an increasing role in the NHS. This article outlines the advantages and disadvantages of private sector involvement following the introduction of one such initiative, the independent sector treatment centre. It further discusses how we should learn from the mistakes made and apply what we have learnt to the proposed government reforms that have been outlined in the recent White Paper "Equity and Excellence: Liberating the NHS". There are certainly potential benefits to be gained from private sector involvement; however, we must take care not to develop a segregated, two-tier NHS that disregards the principles on which it was originally founded.

Key words: NHS, private, commissioning, reforms, ISTCs

The National Health Service (NHS) is the publicly-funded health care system in the United Kingdom. In 2002, there were already sixteen NHS-run treatment centres. They vary in the scope of care provided but centre mainly on the provision of elective surgery, together with diagnostic and outpatient services. As part of reforms in the first years of the previous Labour government, bids for such services were invited from the private sector. These new Independent Sector Treatment Centres (ISTCs), while privately owned, have contracts to treat NHS patients.

The ISTCs were designed with several objectives in mind. Their main focus was to reduce waiting lists, thus moving towards the 'patient centred' model proposed in the *2000 NHS Plan*. Additional proposed benefits included encouragement of reform within the NHS by providing competition, facilitating innovation and reducing spot purchasing prices*, thus improving value for money.

There have been two phases or 'waves' of ISTCs procured by the Department of Health (DH) throughout England and Scotland, with the first ISTC opening in 2003. This was followed by further procurement with the first of the second wave opened in 2007. The locations for the new ISTCs were identified by local service commissioners. The criteria for an ISTC was either a lack of capacity or long waiting times. In the first wave 25 fixed site and two mobile site ISTCs were opened. The second wave was originally intended to develop 24 schemes but this was subsequently reduced to just ten with the DH stating that the extra capacity was no longer required.[1,2] This article aims to discuss the implication of contracting out clinical services to the private sector, using the introduction of ISTCs in the English health care system as an example.

What are the implications for health care professionals?

During the first wave, ISTCs were unable to employ staff who had worked in the NHS in the preceding six months. This resulted in ISTCs being staffed largely by overseas doctors. This led to questions regarding not only the quality of their training, but also their suitability to be working with potentially unfamiliar NHS techniques and processes. The policy was heavily criticised by the British Medical Association (BMA) and the Royal College of Physicians, with suggestions that the procedures ensuring adequate competence were not rigorous enough.[1,3] It has also been suggested that this policy hindered integration between ISTCs and NHS trusts; in fact staff mobility was key to cooperation between the two providers. The rules were subsequently relaxed during the second wave and NHS staff can now, albeit with some restrictions, work in ISTCs.

Although all doctors employed by an ISTC are required to be registered with the General Medical Council, there is no equivalent to the NHS Advisory Appointments Committees to act as a quality control mechanism. Consequently, ISTCs take on responsibility not only for recruitment, but also professional development and appraisal, an area where the Healthcare Commission in 2007 identified some shortfalls.[4]

With regards to training, concerns have been voiced by senior surgeons that the transfer of 'straightforward' elective procedures, suitable for training junior doctors, from NHS hospitals to ISTCs has impacted negatively on training.[5] The

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* Treatment in the private sector which is purchased by the NHS on an ad hoc basis in order to cut waiting lists.

apparent efficiency of ISTCs may also in part be accounted for by a lack of responsibility for training which, although time consuming, is extremely important. A solution is to place junior doctors in ISTCs where they can be trained in a 'high volume, low risk' arena; subsequently ISTCs in the second wave were obliged to include a training component if requested by postgraduate deans.

Innovative workforce management, such as in the case of Blakelands NHS treatment centre, includes regular staff consultations and multi-tasking, and has led to a four day working week by maximally utilising theatres and clinic rooms, leaving Fridays for administration.[6] Based on case studies of individual ISTCs, it certainly seems that novel workforce management is increasing efficiency and there are lessons to be learned for the NHS where clinical and administrative agendas are not always well integrated.

What are the implications for health care users?

One of the main stated objectives of the introduction of ISTCs was to provide a more patient centred system. The separation of emergency from elective procedures ensures that patient appointments and procedures do not have to be cancelled if an emergency case is admitted. Since ISTCs concentrate on specific procedures, streamlined patient care pathways with efficient pre-operative processes have led to high ratings in patient satisfaction surveys. However, one may also argue that patient satisfaction outcomes have no demonstrable correlation with health outcomes and although clearly important, they should be given less importance than other indicators.

Under new initiatives, patients are able to choose where they have their procedure performed, however, they are not given any information regarding the quality of care provided, thus their choices are not informed, questioning whether it is really patient choice or government waiting list targets that have driven ISTCs. ISTCs have been criticised by clinicians for providing inferior care with a low level of monitoring and governance, for example, the British Orthopaedic Association has stated that more revisions of operations are required when patients are treated at ISTCs.[7] This statement however has not been supported by the National Centre for Health Outcomes Development (NCHOD),[8] and in fact the chief executive of the Healthcare Commission warned that it is difficult to form such conclusions since the data is not directly comparable.[1]

ISTCs were intended to reduce waiting times by both adding capacity and introducing competition, consequently stimulating productivity within NHS facilities. Although in certain specialties ISTCs account for a substantial proportion of activity, nationally, ISTCs account for only 2% of NHS elective activity, indicating that they have not been a significant contributory factor to the reduction in waiting times.[9] Additionally, an analysis by the King's Fund found no difference in the rate at which waiting times were reduced when comparing areas with and without ISTCs.[10]

How are they financed?

Funding for ISTCs is negotiated by the DH in the form of five year contracts and payment is made based on the NHS national tariff, together with a further premium to cover capital costs. During the first wave, ISTCs received a 'take or pay' guarantee meaning that they received the full contracted value from PCTs irrespective of whether or not they reached activity targets, a payment strategy which has been heavily criticised. The DH informed the House of Commons that Wave 1 ISTC providers received, on average, payments that were 11.2% greater than the NHS equivalent cost which incorporates other NHS costs such as pensions [1]. The payment structure was modified in the second wave and although the full contract value is no longer guaranteed, ISTCs still receive guaranteed fixed value payments from the DH.

There have been further criticisms with regards to both under and over-commissioning of services. Poor initial needs analysis and projected demands have resulted in flawed commissioning and under-utilisation of ISTCs. The Ravenscourt Park treatment centre in London was forced to close just four years after opening. It was operating at just 50% capacity and failing to be cost-effective. Improvements in integrating referrals, both vertically and horizontally, from the NHS are certainly required in order to prevent other centres facing a similar demise. Over-commissioning has also been a problem, with more procedures being commissioned than individuals on current NHS waiting lists, with resultant negative financial consequences.

Criticisms even extend to include selection policies, with some ISTCs being allowed to choose less complex cases, leaving the NHS with complex cases together with longer, more expensive inpatient stays. There have been calls by the BMA for the payment structure of selective ISTCs to be altered to reflect this.

Is the data comparable?

ISTCs are required to provide data regarding quality outcome and monitoring to the DH in the form of performance indicators; however, the DH retains the publication rights of these data. Some authors have concluded that the data provided by the ISTCs are of poor quality, and as discussed below, not directly comparable with NHS data. This clearly needs improvement, and following recommendations by the Healthcare Commission in 2007,[4] changes have been made to reporting methods in ISTCs; despite improvements in the last two years, the quality of data is still not equivalent to that collected by NHS providers making comparisons difficult.[11]

Regulation of the ISTCs, as for the NHS, is carried out by the Care Quality Commission. However, whilst NHS providers are required to meet 'core standards' together with 'developmental standards', ISTCs are only required to meet the 'National Minimum Standards'. A new registration system has been introduced in an attempt to standardise regulation but there are now new 'improvement standards' which will still only be applicable to the public sector. Whilst these discrepancies in required standards and data publication remain, quantitative comparisons are impossible. The variation in case-mix between ISTCs and NHS facilities is also marked, making even qualitative comparisons challenging.[12]

Further implications for the health system

Encouraging innovation is certainly the case in some ISTCs, for example, Boston and Gainsborough Treatment Centre implemented a new technique for general anaesthesia which decreased post-operative side effects and enhanced recovery time with subsequent improvements in patient care as well as improved productivity measures for the ISTC.[6] Many prominent surgeons have argued that these, and analogous techniques, have previously been evaluated in the NHS, and they are neither original nor innovative and have no discernible impact on service delivery [1].

There are suggestions that some NHS providers have responded to a new ISTC

in their area by improving service delivery and increasing productivity; a joint report from the Audit Commission and Healthcare Commission found that in some cases, competition introduced by ISTCs provided "a useful tool to engage clinicians and work with them to deliver change".[9] The House of Commons Health Committee concluded that the effects of competition may have been one of the greatest benefits of ISTCs, but criticised the government's lack of systematic evaluation of this effect and recommended that the National Audit Office should conduct an evaluation.[1]

A review of the first Scottish Regional Treatment Centre by Allyson Pollock and Graham Kirkwood in 2009, resulted in a damning report which criticised lack of data, payment methods and wastage of funds. Extrapolating from the Scottish data, they estimated that in England, up to £927 million may have been paid for treatments that were never actually carried out and recommended that there should no further signing or renewal of contracts until a comprehensive evaluation addressing their concerns has been undertaken and published.[13]

New proposals for reform

The economic crisis and its financial implications for all public sector services, including the NHS, has prompted the recent publication of a government White Paper outlining radical NHS reforms.[14] The paper includes plans for phasing out PCTs and SHAs and replacing them with General Practitioner (GP) consortia. With all GPs being part of a local consortium, these new consortia will be responsible for commissioning services for the majority of NHS services, including elective and emergency hospital care. Commissioning will be based on knowledge of local needs, thus theoretically avoiding the previous problems with over-commissioning of services and subsequent financial waste. Importantly, the role of purchasing services for primary care will be the responsibility of the NHS commissioning boards. A crucial flaw in this system appears to be the lack of input to the consortia from secondary and tertiary care providers or public health specialists as well as the lack of competency and experience of GPs to manage commissioning of specialist areas such as mental health.

Economic regulation will come from Monitor, and consortia will be accountable to the NHS commissioning board. The role of Monitor will include licensing providers and regulating prices as well as promotion of competition in health care, a feature which has been viewed negatively by some, including the BMA. Concerns stem from the fact that encouraging competition rather than the quality of health care may adversely impact on patient care. An essential remit of Monitor must therefore be to ensure that no advantage, financial or otherwise, is given to private providers, as has clearly been the case in ISTCs. Also, the use of 'any willing provider' of health care services rather than encouraging NHS providers builds on the ISTC precedent of involving the private sector in NHS care, an approach that has so far not demonstrated a significant or consistent improvement in health care. The involvement of several small providers will require highly skilled integration to avoid providing fragmented health care to patients.

The new plans once again focus on increasing patient choice with regards to choice of provider, diagnostics and maternity services, as well as choice of a named consultant-led team with quality of care being reported by both clinical outcomes and patient reported outcome measures (PROMs). Although patient choice is important, the reforms fail to outline tools for data collection or their validity. As with ISTCs, it can be argued that PROMs do not correlate with health outcomes and PROMs should not be used in isolation to judge good quality care. Moreover, in order to avoid the problems with data reporting that have been experienced with ISTCs, there need to be clear and comparable guidelines and regulations for both commissioners and providers.

In addition, all NHS trusts are set to be granted Foundation Trust status thus encouraging what the government has termed 'employee-led social enterprise'. Currently, Foundation Trusts have a cap on income derived from private rather than NHS services. The White Paper aims to abolish this cap and whilst theoretically beneficially to staff and patients, in reality, removal of restrictions encourages private sector involvement which faces the same hurdles as other private sector initiatives already mentioned in this article.

Conclusion

The introduction of independent providers into the NHS, traditionally thought to be the foundation of public sector services in the UK, has certainly had effects on both health care users and providers as well as the health system as a whole. However, despite a heightened awareness of costs, efficiency and accountability, the changes have been insufficient, and at times ill thought out.[15] The expected outcomes such as 'value for money' have been not been achieved, and in fact there are many cases of financial waste. Despite recognition and remedial action of problems from the first wave, many would argue that the changes do not go far enough, and that the intended benefits are yet to materialise. Even a reduction in waiting times cannot be attributed to the introduction of ISTCs. Theoretically, ISTCs could have achieved much more, but a lack of appropriate needs analysis, flawed procurement and poor integration with existing NHS services has produced disappointing results. Perhaps increased utilisation of existing NHS treatment centres which are already well integrated, or using NHS facilities out of hours, would be a more cost-effective and efficient way of meeting demands.

Furthermore, the recently outlined reforms are likely to come at a significant cost and at a time that the NHS has been required to make efficiency savings in excess of £20 billion, one wonders if this is the most appropriate time to be once again, introducing radical re-structuring programmes.

There are beneficial effects of cooperation with the independent sector, but for ISTCs to succeed and truly encourage NHS reforms there needs to be equal regulation and transparency for all providers. By introducing inequalities in human resources, infrastructure, data provision and financing, we are in danger of creating a two tier system in which the NHS loses. Patients need to make an informed choice and commissioning needs to be based on outputs rather than projected inputs. This, together with appropriate recruitment and training, should help to integrate ISTCs and other private sector providers into the NHS more effectively, thus pushing forward and reaping the benefits of reform, rather than creating an uneconomical system that has promised far more than it has delivered.

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Five barriers to physician workforce development in Uzbekistan

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Summary: The 1998-2005 health system reform in Uzbekistan aimed to increase efficiency, self-financing mechanisms and develop the private sector. However, the reform process has also had implications for the physician workforce, including the low number of medical school graduates employed as physicians. This article identifies five key barriers that contributed to the poor alignment between the number of medical graduates in the country and the number of working physicians. It presents recommendations for improving the health resource planning process in the country.

Keywords: health care reform, physician supply and demand, education, health workforce planning, Uzbekistan

The Uzbek health system has undergone significant change since the country became independent in 1991. Following independence, health system reforms were introduced with the aim of adapting to the challenges of the new social, political and economic environment. The reforms placed an emphasis on increased efficiency, self-financing mechanisms and private sector development.

The Uzbek health system includes public, private and other non-public entities. The voluntary National Health Insurance Programme provides support for both public and private services. Private practices and clinics have rapidly been set up in an effort to mobilise additional resources, increase efficiency and improve quality. Since 1994 1,075 health care entities, including hospitals, ambulatory clinics and solo practices, have been privatised. In 2004, there were 1,165 hospitals with a bed capacity of 142,900; of these the private sector accounted for 141 hospitals (12.1%) with a bed capacity of 3,000 (2.1%).[1] However, a higher proportion of ambulatory clinics are under private control – 1,220 of 5,536 clinics (22%).[2]

Medical education and graduates

In Uzbekistan, as in many other countries, aligning the development of the physician workforce to match the needs of the emerging health care system is a complex challenge. A substantial portion of medical graduates are not employed in the profession. Even though legislation requires five years of practice in the public sector before a physician can enter private practice, of the 2,571 graduates of medical schools in 2005, only 895 (36%) entered medical practice in the public sector[1] (Figure 1). While a small number of graduates went to work for the pharmaceutical industry, the majority of graduates entered other professions, emigrated or ended up being unemployed. This loss of expensively educated medical professionals is a major issue for human resource development in the country.

The cost to the individual of a medical education is high. The tuition fee for each of the seven years in training is ~US$800–850. An individual entering the general workforce directly from a high school or community college can expect to earn about $1,200 per year. The opportunity cost of a medical education is therefore

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