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Carving up the NHS – Private Sector Diagnostic and Treatment Centres

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UNISON

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This report was researched and written by UNISON

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Introduction

On 12 September 2003, the Government published the names of the preferred bidders for the provision of a variety of privately run Diagnostic and Treatment Centres to the NHS. These schemes form the first stage in the Government's controversial programme of private sector Diagnostic and Treatment Centres that was originally announced in December 2002.

The purpose of this briefing is to set out UNISON's position on the private sector Diagnostic and Treatment Centre programme and question the Government's claim that it is needed in order to reduce waiting lists. The briefing aims in particular to answer the following questions:

- What are Diagnostic and Treatment Centres?
- Why is UNISON opposed to the Government's private sector Diagnostic and Treatment Centre programme?
- If private sector Diagnostic and Treatment Centres are not the way forward, how else can the capacity of the NHS be increased?

1. What are Diagnostic and Treatment Centres?

Diagnostic and Treatment Centres (DTCs) are a new type of surgical unit being introduced to deliver large numbers of routine operations for the NHS. Most DTC cases are conducted on a day surgery basis or require only a short-term hospital stay. Because DTCs do elective work only, they are unaffected by unscheduled demands such as emergency work, enabling them to achieve lower rates of cancelled operations than other NHS hospitals.

Two types of DTC are being established to provide services to the NHS:

- NHS DTCs. Run by NHS providers such as NHS Trusts. There are currently 22 NHS DTCs open and a further 25 planned. In total, the Government estimates that NHS DTCs will provide an extra 150,000 operations per year for the NHS.

- Private (or independent) sector DTCs. Run by private companies or consortia. The first private sector DTC is at Redwood hospital in Surrey and is managed by BUPA. The Government has recently announced a list of preferred bidders for a further series of private sector DTC schemes, and

more are expected to be announced shortly. Overall, the Government expects private sector DTCs to carry out 250,000 operations for the NHS over the next five years.

Patients may be referred to a DTC by their GP, or may be transferred to a DTC under the Government's patient choice initiative if they have been waiting for six months on a hospital's waiting list. DTC patients are able to choose from a range of appointment times.

Private sector DTC programme – preferred bidders

The preferred bidders announced by the Government for the private sector DTC programme are:

- Netcare – the largest integrated private healthcare organisation in South Africa. Netcare will be operating within a consortia with unspecified UK based facilities management and construction enterprises.
- Mercury Health – part of Tribal Group, a provider of consultancy and professional support services to the UK public and private sectors. Mercury will be operating within a consortia that includes Ascent Health, Sanare, Reed Health Group, Match Group, Deluca Medical and Parsons and Tyco.
- Care UK Afrox – a partnership between Care UK, which operates nursing and residential homes in the UK, and African Oxygen Ltd, a medical gases company.
- Nations Healthcare – a US company said to specialise in creating and running day surgery centres.
- Anglo Canadian – a consortia including Calgary Health Region, the University of Calgary medical group, Surgical Centres Inc, Accommodata Ltd, Bowmer and Kirkland, Yorkton Ltd

2. Why is UNISON opposed to the private sector DTC programme?

UNISON believes that there may be a case for the establishment of NHS run DTCs, provided that these are carefully evaluated and do not take money or resources away from other NHS providers. However, we are strongly opposed to the introduction of private sector DTCs for the following reasons:

- Private sector DTCs are part of the introduction of a competitive commercial market into the NHS
- Private sector DTCs will replace NHS hospital activity, undermining the viability of NHS services
- Private sector DTCs will siphon off scarce staff
- Private sector DTCs will be poor value for money

- Private sector DTCs will be run by companies with little experience of delivering public healthcare

3. Private sector DTCs are part of the introduction of a competitive commercial market into the NHS.

Private sector DTCs are part of the introduction of a competitive commercial market into the NHS. Under this market, the NHS will lose its position as the principal provider of NHS healthcare, and will be obliged to compete for patients against a range of other providers, spanning across the public and private sectors. Private sector DTCs are one element of this new diversity of NHS providers, which also includes Foundation Trusts, NHS Trusts and NHS DTCs.

UNISON believes that, far from leading to improvements, the marketisation of the NHS will have an adverse effect on NHS patients and will undermine core principles at the heart of the NHS. In particular, the new market will generate the following harmful effects:

- greater inequalities in patient care, as private providers cherry pick the most profitable patients and hospitals become winners or losers in the market

- reductions in the quality of NHS care, as private sector providers seek to drive down costs

- the erosion of the capacity of the NHS to continue providing certain services as work moves away to other providers

- higher costs, due to producer induced demand and private sector pressure for higher prices

4. Private sector DTCs will replace NHS hospital activity, undermining the viability of NHS services

When the private sector DTC programme was first announced, it was presented as a means of increasing the number of operations in order to bring down waiting lists. However, the Government has now admitted that of the 250,000 operations to be provided through the programme, 115,000 will be operations that were already due to have been carried out in NHS hospitals.[1]

Under the private sector DTC programme, private contractors will be given contractually guaranteed minimum volumes of work which will last for periods

[1] DoH press release, "250,000 NHS patients to receive quicker treatment in new treatment centres," 12th September 2003.

of up to five years. As a result, once a contract has been agreed by the Department of Health, Primary Care Trusts will have no option except to commission services from the private sector DTC provider, even if they would prefer to use the local NHS hospital. In the recently publicised case of the Oxford Eye Hospital, local Primary Care Trusts attempted to pull out of the negotiations for a national chain of private sector DTCs, realising the additional costs that it would entail. However, they were told that this could not be permitted, on the grounds that their withdrawal would create 'insurmountable problems' with the viability of the scheme.[2] How this fits in with the Government's agenda of devolution and local decision-making is not clear.

The NHS hospitals from which work is transferred will lose their routine cases, leaving them to deal with only more difficult and specialist cases. This will negatively affect these hospitals in a number of ways:

- There will be a reduction in overall volumes of work, leading to reduced funding and potentially causing staff redundancies. In some cases, the work transferred may amount to over 50% of a department's total caseload.

- The transfer of routine work will have a knock-on impact on hospitals' ability to undertake non-routine work and other activities such as research and training. This is because funding for routine work cross-subsidises other areas and because hospitals will lack the critical mass to continue to offer their current range of treatments and services.

- Junior doctors in NHS hospitals from which work is transferred will no longer be able to develop their skills by undertaking routine cases. This will undermine these hospitals' ability to provide adequate training.

- The non-availability of routine cases will make it more difficult to maximise the use of operating time and resources. Currently, more straightforward cases are used to complete surgical lists, as well as to spread the load on ward teams and to ensure that beds are utilised in the most effective manner.[3]

Case Study: the Oxford Eye Hospital

Up to 50% of Oxford Eye Hospital's cataract work is to be transferred to a national chain of DTCs undertaking work in ophthalmology and run by the private sector. The transfer follows an original expression of interest by two local PCTs in having an NHS DTC in their area. This was allegedly wrongly translated by the Department of Health into a proposed contract with the private sector DTC chain for 10,000 cataracts over three and a half years – more than the expected number of cataract cases in the entire North Oxfordshire population over the same period.

Oxford Eye Hospital, which has beacon status for its achievements in cataract surgery, calculates that if the planned transfer of work takes place, it will lose revenue of between one and two million out of a total turnover of £5 million. This could have the following potential effects:

- The hospital's ability to manage chronic eye disease could be severely limited
- Outreach clinical services may have to be curtailed or withdrawn
- The hospital may be unable to support the implementation of the national service framework

5. Private sector DTCs will siphon off scarce staff

The intention of private sector DTCs was originally to add to the capacity of the NHS by making use of staff from the private sector and overseas. However, the Government has now said that up to 70% of staff in private sector DTCs will be allowed to be seconded from NHS organisations[4]. This will deplete the number of staff available to NHS organisations, and contradicts previously given assurances that private sector DTCs would not use NHS staff.

The Government claims that no staff will be seconded to private sector DTCs without the agreement of local Trusts. However, NHS hospitals which have had their work compulsorily transferred to private sector DTCs may in reality have little option apart from agreeing to second their staff or making them redundant. It is also unclear whether staff themselves will be able to refuse to be seconded to work in private sector DTCs, and if so what alternatives will be offered to them.

While NHS staff seconded to private sector DTCs will be on NHS terms and conditions, private sector DTCs will be able to set their own terms and conditions for the staff that they directly employ. This will create a two-tier workforce, with some categories of NHS staff getting more than their privately employed colleagues and others possibly getting less. Already, leaked material produced by the Department of Health suggests that ophthalmic surgeons employed by the new private sector ophthalmology DTC chain will be probably be paid more than their NHS counterparts, a situation which the Department attempts to justify on the grounds that they 'work a lot harder.'[5] This is unacceptable.

In addition to the secondment of NHS staff, a further concern is that private sector DTCs will poach scarce staff from other organisations who need them. This may take place in the following ways:

[4] As reported in the Guardian, "New clinics' reliance on NHS staff under fire", September 11th 2003.
[5] Liberal Democrat Briefing Paper, Dr. Evan Harris MP, 5th September 2003, Paper C

- At UK level, there are concerns that some NHS staff may be attracted to move to private sector DTCs as a result of the more regular working hours that these offer, although it is also thought that other staff are likely to prefer the greater variety of work offered by traditional forms of NHS hospital. The Government publicly maintains that private sector DTCs will be contractually barred from poaching NHS staff, but appears to acknowledge privately that there are limitations to the extent to which legal safeguards can be achieved[6].

- At the international level, there is a real risk that private sector DTCs will deprive developing countries of much-needed healthcare professionals. Two of the preferred bidders for the private sector DTC programme are South African companies, although they maintain that staff from South Africa will be brought to Britain on rotation on the understanding that they will subsequently return home. South Africa is one of the countries on the Department of Health's list of developing countries from which it has undertaken not to recruit.

6. Private sector DTCs will be poor value for money

Private sector DTCs will be poor value for money, piling up extra costs on Primary Care Trusts, on central government and on the NHS hospitals from which work is transferred.

Private sector DTCs will not be bound by NHS national tariffs, the Government's new system of standard payments to NHS providers that is being introduced across the NHS. Instead, they are being given the freedom to negotiate their own price levels with the Department of Health[7]. The Government has refused to release details of the prices that it has so far agreed with the preferred bidders for the private sector DTC programme. However, the available evidence suggests that these are significantly in excess of the national tariff costs:

- The Government says that the programme will cost £2 billion over 5 years and will deliver a total of 250,000 operations[8]. This works out as a total of £8000 per operation, substantially higher than NHS costs for most procedures.

- Figures published by Dr Evan Harris MP in relation to the proposed private sector DTC chain for the provision of ophthalmology services suggest that in

[6] Ibid.
[7] Prices may differ from national tariff prices at least for the duration of the contracts awarded, which is 5 years. The Government says that private sector providers who wish to provide services to the NHS over the medium to long term would be expected to do so at national tariff prices, but gives no firm commitment as to when this rule will be applied. See *Implementing the new system of financial flows - payment by results: technical guidance 2003/4*, paras 29 & 30.
[8] DoH press release, 12th September, 2003.

August 2003, the procedure price being offered by the private sector provider was £799, compared to the national tariff cost of £756[9].

National tariff costs are based on average costs across NHS hospitals. In some cases, the actual prices being charged by local NHS providers from whom work is being transferred to the private sector DTCs may be lower than the national tariff levels. Clearly, where this is so, the value for money provided by the private sector DTC provider will be even worse.

UNISON calls on the Government to publish the details of the prices negotiated with the private sector DTC providers, so that these can be compared against NHS prices.

DTCs and the NHS pricing system

There are three levels of prices relevant to the cost of activity provided by private sector DTCs: NHS tariff prices, actual NHS hospital prices, and actual private sector DTC prices. These are related as follow:

NHS tariff prices: These are nationally set price levels based on average NHS hospital costs. They are being introduced progressively from 2003/4, but do not yet apply to most existing NHS hospital activity.

Actual private sector DTC prices: These will typically be higher than NHS national tariff prices. NHS tariff prices will not be applied to private sector DTCs until at least 2008.

The high comparative prices charged by private sector DTCs will be transmitted to Primary Care Trusts, NHS hospitals, and central Government in the following ways:

Primary care trusts: Primary care trusts will be expected to pay for activity commissioned from private sector DTCs at national tariff levels, with the Department of Health funding the difference between the actual price charged by the private sector DTC and national tariff prices where (as will normally be the case) the DTC price is higher. This does not however guarantee that Primary Care Trusts will not face higher costs, as in some cases work will be transferred to private sector DTCs from NHS hospitals whose prices are in fact below the national tariff levels. In these instances, PCTs will have to find the money to make up the difference between the actual cost that they were previously paying the NHS hospital and the cost of the activity transferred at national tariff levels.

NHS hospitals: As discussed above, NHS hospitals from which work is transferred will have money withdrawn from them, causing potentially massive reductions in their budgets unless they are able to find alternative work. Furthermore, it has been suggested that where activity is withdrawn, this may be at the national

[9] Liberal Democrat Briefing Paper, Dr. Evan Harris MP, 5th September 2003.

tariff rate, even where the actual price paid to NHS hospitals for activity is below this. (For example, an NHS hospital might in the past have been paid for cataract activity at a rate of £685 per operation, but have money withdrawn from it at the national tariff rate of £756.) This will mean that NHS hospitals whose prices are below national tariff levels will suffer a double blow, not only receiving less work, but also losing out as a result of the mechanism through which it is withdrawn.

Central government: Central government will have to find the money to fund the difference in cost where private sector DTC prices are higher than national tariff prices. In addition, there may be pressure on central government to give additional financial support to PCTs and NHS hospitals, to compensate them for any losses they may suffer as a result of work being transferred to private sector DTCs.

7. Private sector DTCs will be run by companies with little experience of delivering public healthcare

None of the companies selected to run private sector DTCs have prior experience of providing universal public healthcare services such as the NHS. Of the seven preferred bidders so far announced by the Government:

- virtually none have any experience of the NHS
- most have experience only of private healthcare
- many of the companies involved in the consortia have no experience in healthcare at all
- nearly all of the participating companies operate on a for-profit basis

Given this background, it is reasonable to question whether the companies that will provide private sector DTCs really have the skills and public service ethos needed to successfully deliver the kind of service that the public expects from the NHS.

8. If private sector DTCs are not the way forward, how else can the capacity of the NHS be increased?

The Government justifies the use of private sector DTCs on the grounds that the NHS cannot expand its in-house activity fast enough to deliver the additional activity needed to drive down waiting lists. However, the evidence suggests that with the right management and investment, in-house NHS activity could be expanded sufficiently to meet the Government's targets without the need to resort to forms of private sector provision such as DTCs. More needs to be done by the Government, together with staff, unions and patient organisations, to work out strategies to ensure that this is achieved.

In-house NHS activity can be increased in two ways: through the better use of existing resources and through additional investment in staff, buildings and equipment. Areas in which these could be achieved include:

- Reducing the number of cancelled operations. Currently, 10% of planned activity in a week does not take place in the average NHS Trust, with rates approaching 40% in some Trusts[10]. Procedures may be cancelled for a variety of reasons, ranging from inadequate pre-assessment to patients failing to turn up.

- Better provision of support and resources to help NHS Trusts and local authorities tackle delayed discharges. According to statistics collected by the Audit Commission, an average NHS Trust has 5% of its beds occupied by patients whose transfer has been delayed.[11]

- Action to tackle staff shortages by investing more in training of existing staff. A recent UNISON survey indicated that 75% of Health Care Assistants would like to train as nurses – yet there is currently very limited financial support to enable them to do so.

- Better curbs on the ability of the private sector to poach NHS staff.

- Bed numbers. There is evidence to suggest that in some areas where private sector DTCs are being introduced, NHS Trusts are limited in their ability to achieve Government targets not by staff shortages, but by lack of beds. The Government needs to make available sufficient capital investment to ensure that all NHS hospitals have enough beds. This should include ending PFI, which has been shown to be the cause of bed shortages in new hospitals.

[10] Waiting for elective admission: review of national findings, Audit Commission, June 2003.
[11] Bed management: review of national findings, Audit Commission, June 2003.

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