Independent Sector Treatment Centres: a leap in the dark

The recently published House of Commons' Health Committee's report on Independent Sector Treatment Centres (ISTCs), is yet another indictment of the introduction of privatisation into the NHS.

The committee, examined both the Phase 1 implementation of ISTCs and some of the changes that had been made in Phase 2. Its brief was to examine the effect of ISTCs on NHS services and their effectiveness in terms of value for money, reduced waiting times for elective surgery, increased innovation, and improved training for medical staff.

The report's conclusions were almost entirely negative. Although there had been a great deal of hype associated with the establishment of ISTCs, the committee found they had achieved very few of the goals that they had been set. The report concluded that 'ISTCs had not made a major direct contribution to increasing capacity' (page 3), that they were 'not necessarily more efficient than NHS treatment centres' (page 3) and that there was 'no convincing evidence' (page 3) that they were driving the adoption of innovative practice in the NHS. Furthermore, the committee cast significant doubts on the claim that ISTCs provide value for money but were unable to make a firm judgement because the Department of Health would not release to them important financial information concerning the ISTCs, because of alleged 'commercial confidentiality' (page 4). In conducting its investigation, the MPs were denied access to information on a number of occasions by senior figures in the Department of Health.

PHASE 1

The establishment of ISTCs

At the start of 2002, the Department of Health announced a programme of building NHS Diagnostic and Treatment Centres (DTCs) in order to reduce patient waiting times and provide more diagnostic centres in the community. Forty-six centres were planned and it was decided that each centre would receive funding according to 'the number of patients seen' (page 10).

Just 6 months after this announcement the Department of Health became convinced, or was convinced, that the private sector should become involved. It stated its intention to put £1.7 billion at the disposal of private companies to build and run a series of DTCs. The rationale for Phase 1 according to Patricia Hewitt, was to 'bring new capacity into the NHS' (page 11). In assessing Phase 1, the Committee tried to determine if the objectives set by the Government had been realised and examined some of the issues raised by witnesses in their submissions to the committee.

Waiting lists

The intention in Phase 1 was to locate the new ISTCs in areas where there were long waiting lists, or few NHS DTCs facilities.

The Department of Health claimed to the committee that the new ISTCs had drastically reduced waiting times, a claim hotly denied by the Royal College of Ophthalmologists who maintained that waiting times for cataract surgery reduced before cataract ISTCs had become operational (page 17).

The Committee was also dubious about the Department of Health claims. They discovered that up to December 2005 ISTCs had performed just 44 000 elective surgical procedures. This was expected to expand to 170 000 by the time Phase 1 was completed, but compared with the NHS's 5.6 million per year it was a very small percentage of the total.

The Report was doubtful that ISTCs were even necessary, given their small impact. Many of them worked 'significantly below capacity' and one visited by the MPs in Gillingham and run by Mercury Health, was running at 50% of its capacity (page 18).

In the Phase 1 contracts ISTCs were paid irrespective of how many procedures they completed. This had an unsettling effect on the NHS, as primary care trusts, who had paid in advance, had a powerful incentive to use ISTCs rather than NHS treatment centres. According to NHS Elect this had two disadvantages: it meant NHS Centres were under-utilised and, because of this under use, NHS treatment centre unit costs were raised. It was clear that ISTCs were not only more expensive, but their existence had the long-term effect of raising NHS costs.

Even Bob Ricketts, the person responsible for introducing ISTCs, was dubious about their impact:

> *'I have been very clear that the majority of the contribution even in cataracts was from the NHS … I would certainly want to go on record as saying that ... the majority of the facilities were NHS facilities.'*
> (page 19)

The Health Committee's conclusions were that ISTCs were not fulfiling their objectives, despite the claims of the department:

> *'ISTCs have not made a major contribution to increasing capacity … It is far from obvious that the capacity provided by the ISTCs was needed in all the areas where Phase 1 ISTCs have been built, despite claims by the Department that capacity needs were assessed locally.'* (page 19)

In an interesting caveat the Health Committee also questioned the Department of Health objectivity when looking at the ISTC programme:

> *'There is also concern that 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.'* (page 19)

Quality of care, standards and training

The quality of care in ISTCs was another

area looked at by the Committee. As ISTCs in the first phase were disallowed from employing NHS staff, many of those working in ISTCs were from abroad. This had led to complaints that they were unfamiliar with NHS procedures and experienced language problems. Both the British Medical Association and the Royal College of Surgeons raised concerns that ISTCs could not manage complications that could arise in elective surgery, and in some cases patients had been referred back to the NHS.

The Report made little comment on this as there was very little evidence available, but what it did say on the matter again criticised the judgement of the Department of Health:

> *' … in the absence of the necessary comparable data from both NHS* treatment centre*s and ISTCs, there is not the statistical evidence to suggest that standards are different. The Department should have ensured that such data were collected from both providers.'* (page 30)

Over the issue of training the Report was again critical of the Department of Health claims that ISTCs 'offer an ideal training environment over more traditional NHS settings' (page 30).

The Phase 1 developments did not require the ISTCs to train clinical staff. Some training was undertaken by ISTCs and Mercury Health was singled out for praise in this area, but most ISTCs did not provide any training at all for medical staff.

Value for money

The value for money argument in favour of ISTCs was the one most vaulted by the government and the Department of Health. The Chief Executive Officer of Care UK, Mr Mike Parish, asserted that NHS personnel were too expensive in comparison to staff recruited from overseas by private health care companies:

> *' … we would still look to bring doctors in internationally because, frankly, the cost-base of UK doctors is not competitive; it is too high.'* (page 33)

Salaries are also more 'flexible' in ISTCs, an example being the lower pay of anaesthetists, who, in the NHS, enjoy equal pay with surgeons.

With lower staffing costs, no training programme, and inferior pensions, it may be assumed that ISTCs are far less costly than the equivalent NHS treatment centres. However, that assumption would be wrong and this was also highlighted by the Committee who queried why ISTCs were paid 11.2% above the NHS equivalent cost. The MPs met with a brick wall of 'commercial confidentiality' as the Department of Health:

> *' … has declined to disclose the detailed figures which it used to establish the NHS Equivalent Cost on the grounds that "to release information on the detailed process would jeopardise the ability of the Department and the NHS to secure the best value for money in the next round of procurement".'* (page 37)

In their summing up of Phase 1 the MPs agreed with a number of witnesses that the Secretary of State for Health had 'made a leap in the dark' over ISTCs in 2002. It was:

> *' … based on a hunch that the advantages brought by the private sector were worth paying a significant premium for.'* (page 38)

Without the available evidence denied them by the Department of Health, the Committee was unable to come to any conclusion as to whether or not ISTCs provided value for money. The tone of the report reflects the committee's exasperation:

> *'… since we do not know the details of the contracts, what figure was used for the NHS Equivalent Cost or how it was arrived at, and since the benefits of ISTCs have not been quantified, it is impossible to assess whether ISTC schemes have in practice proved good value for money.'* (page 38)

The only option seemed to be to hand the matter over to the National Audit Office to make an investigation. This recommendation was made in the Report.

PHASE 2

At the time of the Report, Phase 2 had already commenced and was at an advanced stage. In response to some of the criticism of Phase 1 the Department of Health had introduced a number of improvements, principally the integration of ISTCs with the local NHS and the introduction of staff training. The committee found that there was near unanimous agreement that the ISTC should be sited near to NHS facilities in order to more easily integrate NHS staff and medical support and, unlike Phase 1, ISTCs could recruit NHS staff but only outside their NHS contracted duties.

The Committee was keen to defend the pay and conditions of NHS staff and suggested that consultants working non-contracted hours in ISTCs should be paid NHS rates. The Report also stated that if the ISTCs were to be fully integrated into the NHS then issues of pay, pensions and conditions must be addressed by the Department of Health.

The Department of Health had acknowledged that training had been practically non-existent in Phase 1, and agreed for Phase 2 that a training programme should be an integral part of any ISTC. The committee supported this decision, recommending that it should be part of any contractual agreement and of the same standard to that offered in the NHS.

Therefore, over training and the integration of the ISTCs into the NHS there was virtual accord with both the

Department of Health and most of the witnesses agreeing that this was a desirable process and would ameliorate some of the anomalies that had beset the Phase 1 development.

However, the question mark over value for money, in all its aspects, remains a significant issue for Phase 2 and this was reflected by witnesses and in the final report.

The Department of Health told the committee that ISTCs are to be established where there is a local need. This could lead to problems as the committee heard from the Chief Executive of West Hertfordshire Hospitals NHS Trust. He explained that the Trust was £43 million in debt and the proposed introduction of an ISTC:

> *'... would cost the local NHS around £15 million in income and would necessitate the closure of its facility in St Albans, as it would become redundant.'* (page 44)

Given this sort of evidence from NHS Trust Managers, the committee found it hard to equate the Department of Health view that ISTCs helped the local health economy. In response to the Phase 1 criticism that ISTCs were paid more per treatment than NHS Centres, the Department of Health had now agreed to 'taper' these payments.

The Committee attempted to explore what 'tapering' meant in practice, but concluded that the Department of Health will 'continue to pay more than the NHS Equivalent Cost for Phase 2 ISTCs.' NHS providers argued strongly to the Committee that bids from private companies should only be accepted if they provided services more cheaply than the NHS equivalent and queried why ISTCs should continue to be paid a substantial premium when the advantages they were supposed to bring had not been proven.

CONCLUSIONS

The Report concluded that both Phase 1 and 2 of the scheme seemed to be without any coherent strategy. Neither the Department of Health nor the Secretary of State had answered the Committee's concerns. The position of both seems to have altered and the Committee was still not clear as to why ISTCs had been introduced. There was no justifiable financial evidence that they had seen that warranted the spending of £5 billion on the new venture. The Report suggested other options that could have been used instead. These included new NHS treatment centres, greater utilisation of existing NHS facilities out of hours, and local arrangements with the private sector to run treatment centres.

It seems clear that ISTCs were established for ideological reasons and that they are a product of the present government's presumption that privatised companies necessarily provide a better service than state-run facilities. With this as its guiding principle it is no wonder that the Secretary of State for Health decided that £5 billion of tax payers' money should be redirected to the private sector in the expectation that they would build cost-effective treatment centres that would swiftly eliminate queues for elective surgery and provide innovation and training.

In their first test these centres have been found wanting in their productivity, their cost, their ability to train, and their effect on the local health economy. The outcomes of the Health Committee's investigation are damning. After examining the representations of the advocates of the ISTCs, their supporters in the Department of Health, NHS trust managers and other professionals, the conclusion reached is that the ISTCs have not performed well and that better — and possibly cheaper — options should have been tried.

We may never know the true cost of treatment centres run by the private sector. The Report reveals a Department of Health clouded in secrecy, refusing to disclose, even to MPs, the real costs of ISTCs. If they are so cost-effective, one might ask, why doesn't Patricia Hewitt supply us with that information?

It makes you wonder.

Mike Squires

REFERENCE

All citations refer to the following report:

House of Commons Health Committee. *Independent Sector Treatment Centres. Fourth Report of Session 2005–06.* London: The Stationary Office, 2006. http://www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/934/934i.pdf (accessed 31 Jan 2007).