Hidden figures: private care in the NHS

ENGLAND
The health service in England is facing one of the greatest financial challenge in its history, and yet the independent sector is increasingly involved with the provision of patient care within the NHS.

The English health service is heading towards a projected £30 billion funding gap in 2020/21; the government has committed £10 billion to help mitigate the situation, although the BMA has argued that in real terms, and factoring in the cuts to other services, the figure is closer to £4.5 billion. Within this climate, one of the few areas where funding is increasing is amongst ISPs (independent sector providers) of NHS care.

We want to find out what this means for the provision of patient care. Building on our 2016 report on privatisation within the NHS we’ve looked into the data behind these headlines. Our analysis uncovered the following key points:

– NHS spending on non-NHS and independent sector provision grows each year (there was an increase of £2.6 and £2.1 billion respectively between 2013/14 and 2015/16);

– The proportion of the total Department of Health budget spent on ISPs is also increasing (from 6.1% in 2013/14 to 7.6% in 2015/16);

– There needs to be more transparency about the level of private provision of NHS services;

– The principal area of spending on ISPs is in the community health sector;

– The NHS relies very heavily on a small number of ISPs despite acknowledged risks from individual ISPs having an excessive market share;

– CCGs spending a higher proportion of their budget on ISPs received worse ratings from NHS England than their counterparts.

The unprecedented financial pressure on the NHS means that any area where funding is increasing needs to be scrutinised and yet, worryingly, the data suggests that this is not happening for ISPs.

Spending on ISPs continues to grow

The graph below shows the total NHS spend on non-NHS provided healthcare (split into ISPs, the voluntary sector and local authorities), as well as what this represents as a proportion of the day-to-day running costs of the health service as a whole (measured through the ‘total resource departmental expenditure limit’ of the Department of Health, or RDEL).

Between 2013/14 and 2015/16 the amount spent on non-NHS healthcare provision grew by £2.6 billion, from £9.6 to £12.2 billion, an increase of 27%. Over the same period the amount spent on ISPs grew by £2.1 billion, from £6.6 to £8.7 billion, an increase of 33%.
Similarly, 7.6% of Department of Health running costs (RDEL) went to ISPs in 2015/16, up from 6.1% in 2013/14. This means that either ISPs are winning a greater share of the contracts being tendered, or that they are winning larger contracts (or indeed both).

There needs to be more transparency about levels of private provision in the NHS

Although the Department of Health report their total spend on both non-NHS providers and ISPs there is a general lack of clarity about what the figures actually mean.

One example is that the ISP figure includes commercial and private sector providers, ISTCs and social enterprises. This is of particular frustration as, subject to certain conditions, the BMA see social enterprises as part of the NHS family. It is important to be able to break down the data and find out the true figure for privatisation across the NHS.

To try and dig deeper into the figures the BMA submitted FOI (freedom of information) requests to every CCG (clinical commissioning group) in England requesting a breakdown of their expenditure on non-NHS services. Of the 209 CCGs, 87 returned comparable data. However, it was not presented in a consistent structure, meaning we had to classify £3.3 billion as miscellaneous as we could not group these expenses without further clarification. Therefore we were not able to confidently provide a more accurate figure for the level of private provision of NHS services.

Greater clarity and consistency in terms of how spending across this area is defined and classified would allow better scrutiny and analysis of this important area of NHS spending — giving patients and the public a more accurate picture of the level of privatisation within the NHS.

The lack of transparency in the data is indicative of the Government’s approach. Another example of this is their guidance for signposting the provision of NHS care by private providers. We have particular concerns about the fact that the NHS logo is displayed on NHS services provided by private companies, albeit alongside their own logo in a supporting position. The Government’s argument for doing so is that it needs to be open and transparent, but we would argue that this is another way that patients may not be aware that levels of private provision are increasing or that their NHS services are being provided by private providers.
ISP are playing an increasingly significant role in providing community health services

Of the 87 CCGs that provided usable data, 24 provided further breakdowns of their expenditure on ISPs by type of service (e.g. mental health, acute care, community health services etc.).

![Proportion of spend on ISPs by type of service (2015/16 prices)](image)

The graph above shows that across the 24 CCGs who provided this data, most of the money spent on ISPs was within the community sector, accounting for 44% of the total ISP expenditure. In 2010/11, ISP expenditure on community health services came to £1.03 billion. In 2011/12 and in 2012/13 it was £1.37 and £1.82 billion respectively. If the percentage spend on community health services (44%) is broadly representative, then it would suggest that total ISP spend on community health services exceeded £3.8 billion in 2015/16 — a massive 271% increase since 2010/11.

At the same time, there is an increasing political ambition to provide more services in the community and treat less patients in secondary care settings. Given this, we expect spending on community health services to increase over the next few years. As this is the area with most spending on ISPs, we are concerned that this could result in an even steeper rise in overall spend on ISPs than we have seen over the last few years. Until more is known about the consequences of using ISPs for NHS care, as well as whether they deliver a similar standard of care, the BMA remains concerned about what the potential effects of this could be.

It is also worth noting that of the 24 CCGs to supply relevant data, every single one had awarded contracts to provide community health services and general and acute care to ISPs, and all but one had contracts with ISPs in the area of mental health. Compared to this, there was more diversity when it came to whether or not CCGs were using the independent sector to provide social care, primary care, and emergency and maternity services. This suggests one of two things: either the independent sector is more interested in offering specific services (presumably those which offer the best opportunity to generate revenue) and is
bidding for (and winning) more of those contracts, or that the NHS is more inclined to award contracts to the independent sector for several specific types of service, perhaps those where the NHS structures are spread the thinnest.

**The NHS is heavily reliant on a small number of ISPs**

73 CCGs responded to the FOI request with details about individual contracts awarded to non-NHS providers. Of these, 52 had contracts with BMI worth at least £50,000, while 49 had similar sized contracts with Spire (by far the two providers with the most NHS contracts amongst the CCGs in question - the closest competitor was Ramsay Health Care, who had contracts with 28 CCGs).

The fact that the NHS is heavily reliant on a small number of ISPs is concerning. In particular, as, although Spire and BMI are currently returning profits, they are both owned in part by either private equity firms or investment funds, whose business structure often relies on either substantial amounts of debt or short-term investment strategies. For example, when the private equity firm Cinven purchased Spire from BUPA in 2007 it was by taking out £1.4 billion worth of bank loans. Since then, Cinven have sold their stake in Spire and it is now owned by multiple investment funds. Over the last four years Spire’s net income has seen a lot of fluctuation — though they posted a net income of £60 million in 2015, in 2012 the company made a net loss of £130 million and in 2014 their profit was only £6 million. The potential risk is that at any point investors may leave looking for a more stable investment. Similarly, General Healthcare Group, the corporate name for BMI, have a substantial £1.5 billion debt secured against their hospitals.

In 2011, the financial difficulties of Southern Cross, the private care home provider, meant that the company responsible for 9% of the care home market collapsed. Though the implications for the NHS were mitigated by the swift intervention of the Government, the case of Southern Cross illustrates the risks for the NHS of relying on any one company to such a large extent. A Department of Health consultation published the following year warned of the dangers of allowing independent companies to gain an excessive market share, as the more contracts a company wins, the more severe the implications are for the NHS should that company fail to meet the terms of those contracts.

Both BMI and Spire currently receive a substantial amount of their income from the NHS (41.6% and 29.6% respectively). As with Southern Cross, a reduction in the amount of revenue received from the NHS or local authorities could have serious implications; in the case of Spire, this has already happened. When the NHS scaled back the amount of work it was outsourcing to Spire in 2015 the value of the company’s shares fell by 14%.

Another example of a private provider not meeting the terms of their contract affecting the NHS is Circle’s management of Hinchingbrooke Hospital in Cambridgeshire. Circle became the first ISP to run a NHS hospital when it won a ten year contract to take over Hinchingbrooke in 2012. Just three years later the company withdrew from the contract on the basis that their involvement became “unsustainable”. The deficit created during Circle’s stewardship of the hospital was far in excess of the £7 million that the company was contractually liable to cover, and the NHS was left to foot the remainder of the bill.
CCGs spending higher proportions of their budget on ISP services typically received worse ratings from NHS England than their counterparts

The CCGs that spent the most on ISPs in 2015/16 were more likely to be rated as inadequate by NHS England. On average, CCGs rated as inadequate spent almost 2.4% more on ISPs than their counterparts rated as outstanding, and 4.1% more than CCGs rated as good. The per capita spend on ISPs was also highest amongst CCGs receiving an inadequate rating from NHS England\(^{19}\); on average, CCGs rated as inadequate spent £27 more per patient on ISPs than those rated outstanding, and £53 more than CCGs rated good. This emphasises the need for better data to scrutinise the quality of patient care at ISPs. However, it is important to note that this is a relatively small sample, with only four CCGs with an outstanding rating in the sample, so a wider analysis would need to be done to verify these findings.

The data also cannot answer the question of causality: are CCGs with poor ratings struggling because they rely to a greater extent on ISPs, or are those CCGs responding to pre-existing problems by spending more heavily on independent sector provision? If the former, then this would imply a link between poor performing CCGs and greater reliance on ISPs; if the latter, then this would suggest that struggling CCGs see ISPs as a means of fixing problems with local provision. In either instance, the BMA would argue that the focus at poor performing CCGs should be on improving the quality of local NHS provision, rather than using ISPs to address gaps in services.
References
1. bma.org.uk/connecting-doctors/b/the-bma-blog/posts/fully-funded-nhs
2. The definition of the independent sector is often unclear. The definition used within this report includes the commercial and private sector, ISTCs (independent treatment centres) and social enterprises. This is to correspond with Department of Health data on the purchase of healthcare from non-NHS providers.
5. That they employ their staff on NHS terms and conditions and have stemmed from NHS bodies or are genuinely socially accountable to the local community or to patient organisations.
6. england.nhs.uk/nhsidentity/faq/how-do-we-brand-nhs-services-provided-by-a-third-party-2/
7. Other Contractual Services’ is a CCG categorisation, and no clarification was provided to explain what this included.
8. The Nuffield Trust (2014): Into the Red? The state of the NHS’ finances. Financial figures in the report were adjusted to 2012/13 prices – these have been adjusted again to 2015/16 prices.
9. Ibid.
11. markets.ft.com/data/equities/tearsheet/financials?s=SPI:LSE
14. Ibid.
17. ft.com/content/8fcb0204-47fc-11e5-b3b2-1672f710807b
18. circlehealth.co.uk/about-circle/media/a-statement-on-hinchingbrooke
20. CCG population data is from NHS England, Overall Weighted Populations CCGS 2016-17.