

BMA

Privatisation and independent sector provision of NHS healthcare



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Executive summary

NHS providers and commissioners are facing unprecedented financial pressures. Every area where spending is increasing needs to be rigorously evaluated. Independent sector provision of NHS healthcare has increased every year for the past five years. More attention needs to be paid to whether it provides value for money, comparable quality and safety to NHS patients, as well as what its impact is on other NHS services.

We surveyed BMA members on their opinions of independent sector provision of NHS healthcare. This report uses these results, as well as data from a number of privatisation indicators, to make eight recommendations regarding independent sector provision of NHS healthcare. Not all the recommendations are new but, given that England now spends nearly £7 billion per year on independent sector provision of NHS services, many are long overdue.

The report shows that there are still a number of unknowns with regard to the independent sector provision of NHS healthcare. The recommendations are a starting point for understanding the effect that using independent sector providers of NHS care has on the NHS as a whole, as well as outlining exactly how important it is that independent sector providers are held to the same standards as NHS providers when providing NHS care.

Key points:

- The BMA supports a publicly funded and publicly provided NHS. We believe that the NHS should be the preferred provider of NHS services and that commissioners should be given full autonomy to choose the most appropriate procurement process for the services that they wish to put in place. Where independent sector providers are already delivering NHS services, the priority should be for them to support the NHS to deliver high quality services.
- The independent sector is playing an increasing role in the provision of NHS-funded healthcare, but limited data means that it is no longer possible to get a full picture of the precise nature of independent sector provision across the NHS.
- More than two thirds (67 per cent) of doctors surveyed were fairly or very uncomfortable with independent sector provision of NHS services. The most common reason being a concern that it destabilises NHS services, closely followed by concerns that it causes the fragmentation of services. Case studies support these concerns, yet a more robust evaluation of the situation is lacking. Doctors are also concerned that the primary motivation for some independent sector providers is profit, rather than providing the highest possible standard of care for the patient.
- Independent sector providers of NHS services should be held to the same standards as NHS providers, including being subject to the same requirements as NHS providers in relation to transparent reporting of both patient safety incidents and performance.
- Safeguards should be introduced to protect NHS patients and services if contracts are terminated early by independent sector providers. Given that the NHS needs to achieve £22 billion annual efficiency savings by 2020/21, it cannot afford to be left to pick up the bill from the failures of independent sector providers.
- An increased reliance on the independent sector by the NHS may have serious workforce implications. Greater numbers of staff will be working in these environments and not receiving the breadth or intensity of training opportunities that they would have done otherwise at an NHS provider.

Introduction

'Privatisation' is not an easy concept to define and there is often a lack of consensus as to what constitutes privatisation in practice. For some, privatisation is the provision of healthcare to NHS patients by the independent sector, while others consider this to be outsourcing. Similarly, the supply of expertise/support to NHS commissioners by the commercial-sector is considered by some as privatisation. At the other end of the scale, privatisation would be marked by an end to the principle that the NHS is free at the point of delivery, moving for example to an insurance-based health system.*

This report focuses on the provision of healthcare to NHS patients by the independent sector in England.

The definition of the independent sector is broad and often unclear. The definition used in this report includes the commercial and private sector, ISTCs (independent sector treatment centres) and social enterprises. This is in order to correspond with Department of Health data on the purchase of healthcare from non-NHS providers. It does not include the voluntary sector, charities or local authorities, all of which would be included in definitions of 'non-NHS bodies' and in some definitions of the independent sector.

NHS commissioners currently have three options for procuring health services for their patient populations, which apply equally to NHS and independent sector providers. First, 'any qualified provider', which allows patients to choose from a list of qualified providers held by their CCG (clinical commissioning group) for a range of elective and community services. Competitive tendering, where CCGs award a large contract for services with their preferred bidder following an open and competitive process. And lastly, 'single tender action', which allows commissioners to avoid advertising contracts when they are 'satisfied' that there is only one capable provider.¹

The BMA believes that the NHS should be the preferred provider of NHS services and that commissioners should be given full autonomy to choose the most appropriate procurement process for the services that they wish to put in place.² This should include the ability to appoint a specific provider or group of providers without competition.

A BMJ investigation[†] analysed over 3000 contracts between April 2013 and August 2014 across all three procurement methods.³ Of the contracts analysed, 195 (6 per cent) were awarded by competitive tender and 80 of these were awarded to independent sector providers. The highest value contracts were awarded to NHS providers to provide acute care. A quarter of the contracts awarded overall were on an 'any qualified provider' basis, which do not include a guaranteed or minimum volume of activity, meaning that the value of these contracts is difficult to ascertain or compare with the value of contracts won through competitive tender. Half of the 'any qualified provider' contracts were held with independent sector providers.

The effect of competition and the different methods of procurement on the NHS is not explored in this report, and it is an area where further work is needed. For example, there is no consensus in the literature available regarding the effect of competition on costs in the NHS, and the lack of comprehensive data is a significant impediment to any such consensus. Estimates for the cost of creating and maintaining an internal market in the NHS range from £4.5 billion⁴ a year to £10 billion,⁵ money that could otherwise have been spent on patient care.

We support a publicly funded and publicly provided NHS and have condemned attempts to privatise the NHS, directly or indirectly, wholly or in parts. Where independent sector providers are already delivering NHS services, the priority should be for them to support the NHS to deliver high quality services. This is particularly important given that the independent sector continues to play an increasing role in the provision of NHS-funded healthcare.

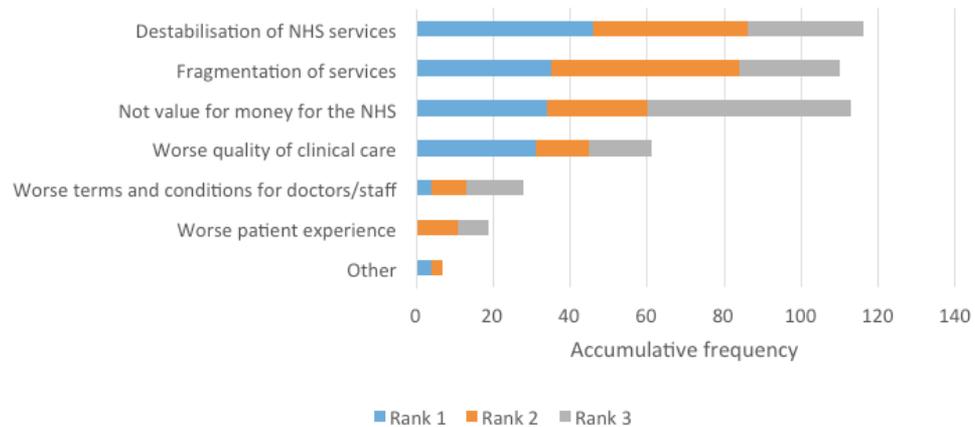
* It is worth noting the free at the point of delivery principle is currently secured in legislation through the Health and Social Care Act 2012.

† The BMJ sent a freedom of information request to all 211 CCGs in England and received a 91% response rate.

Doctors' views on independent sector provision of NHS healthcare

We surveyed BMA members on their opinions of independent sector provision of NHS healthcare. More than two thirds (67 per cent) of doctors surveyed were fairly or very uncomfortable with independent sector provision of NHS clinical services. The most common reason being a concern that it destabilises NHS services, closely followed by concerns that it causes the fragmentation of services (see figure 1).

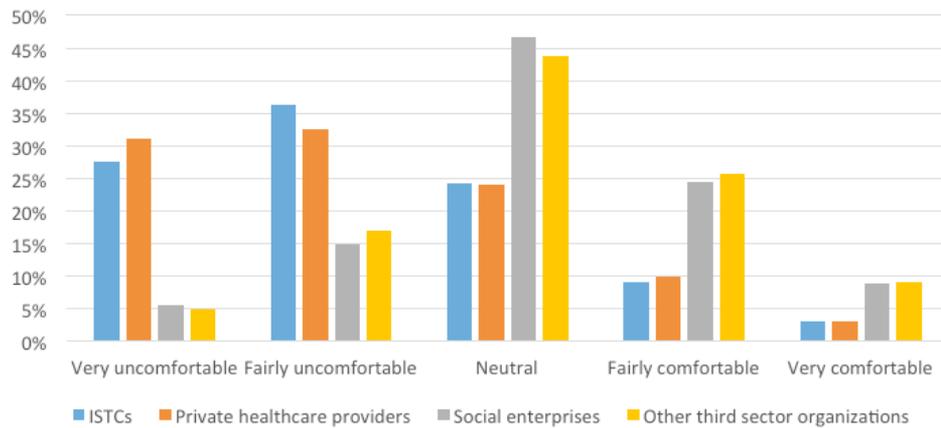
Figure 1: Reasons why doctors are uncomfortable with independent sector provision of NHS clinical services



A quarter (24 per cent) of respondents said that no NHS money should be spent on independent sector provision of healthcare. However, the survey did show that not all doctors were uncomfortable with independent sector provision of NHS healthcare. 19 per cent of respondents were neutral and 14 per cent either fairly or very comfortable with it. The primary reason for this was that it reduced the pressure on NHS services, particularly at times of high demand. The second reason was patient choice, with some respondents stating that as long as the independent sector was held to the appropriate governance and quality standards they could see no problem with it providing NHS care.

The survey also revealed that doctors do not view the constituent parts of the independent sector equally (see figure 2). For example, 47 per cent of respondents were neutral towards social enterprises and 33 per cent were either fairly or very comfortable with them. Whereas only 13 per cent of respondents were either fairly or very comfortable with private healthcare providers, and only 12 per cent with ISTCs. And, whilst outside of our definition of the independent sector, charitable and voluntary organisations were viewed similarly to social enterprises.

Figure 2: How comfortable are doctors with NHS services being procured from different provider types.



See Annex 1 for the full results from the survey.

Privatisation monitoring data

As well as carrying out a survey into doctors' opinions of independent sector provision of NHS services, the BMA has been monitoring a number of privatisation indicators for several years. In order to cover the wide range of definitions held about the privatisation of healthcare the indicators cover the following:

- Spend on provision of healthcare services split by NHS, independent sector, voluntary sector and local authorities (England)
- Funding for independent acute medical/surgical hospitals and clinics from NHS patients (UK)
- NHS hospital income from private patients (UK)
- Number of APMS (alternative provider medical services) contracts and patients registered with APMS practices (England)
- Financial protection from the costs of healthcare (UK)
- Private medical insurance and OOP (out-of-pocket) payments (UK).

The figures show that the total amount spent on healthcare provided by non-NHS bodies, and specifically from independent sector providers, has increased over the last five years. In 2014/15, £6.9 billion was spent on procuring NHS clinical services from the independent sector, which is a 5.4 per cent annual increase (see table 1). This compares to a 2.4 per cent increase in total spend on services. Spending on the independent sector has been proportionally increasing between 2010 and 2015, although at a slower rate the last couple of years.‡

‡ The data for 2013/14 and 2014/15, since CCGs were established, is presented in a different format from previous years so it is important to be aware of potential limitations in the comparison.

Table 1: Total commissioner spend on independent sector providers for the following services and as a proportion of Department of Health total spend on services (2014/15 prices).⁶

- General and acute services
- Accident and emergency services
- Community health services
- Maternity services
- Mental health services
- Learning and disability services
- Primary care services

Year	Total (£bn)	Trend	Proportion (%)	Trend
2009/10	4.55	–	4.3	–
2010/11	5.09	↑ 12%	4.7	↑ 11%
2011/12	5.64	↑ 10%	5.2	↑ 11%
2012/13	6.46	↑ 15%	6.0	↑ 14%
2013/14	6.56	↑ 1%	6.1	↑ 1%
2014/15	6.91	↑ 5%	6.3	↑ 3%

Previous data from PCTs' (primary care trust) financial accounts showed how much was spent on different services. For example, in 2012/13, spend on independent sector provided community services totalled 18 per cent of PCT spend on community services overall. This is compared to hospital services, where only 3.6 per cent of PCT spend was on independent sector provided care. The most rapid increase in spending on the independent sector was in providing community health services. Unfortunately, this level of detail is no longer available.

In addition, NHS funding to the independent acute sector has grown (see table 2), as well as the number of APMS (alternative provider medical services) contracts and patients registered with APMS practices (see table 3).

Table 2: Total and proportion of overall funding for independent acute medical/surgical hospitals and clinics from NHS patients.⁷

Year	Total (£bn)	Trend	Proportion (%)	Trend
2010	1.03	–	25.0	–
2011	1.14	↑ 11%	26.2	↑ 5%
2012	1.35	↑ 19%	29.0	↑ 11%
2013	1.55	↑ 14%	29.7	↑ 2%

Table 3: Number of APMS contracts for GP services and as a proportion of all contracts.⁸

Year	Total	Trend	Proportion (%)	Trend
2010	262	–	3.1	–
2011	276	↑ 5%	3.3	↑ 5%
2012	260	↓ 6%	3.2	↓ 3%
2013	271	↑ 4%	3.4	↑ 6%
2014	290	↑ 7%	3.7	↑ 8%

Yet, in financial protection terms, the UK NHS continues to provide coverage for 100 per cent of the population. This appears to show that there is no direct effect from increased independent sector provision of healthcare on the principle of a health service that is free at the point of use. In addition, all measures of cost preventing patients from receiving care have decreased (see figure 3).

Figure 3: Financial protection indicators⁹**Key**

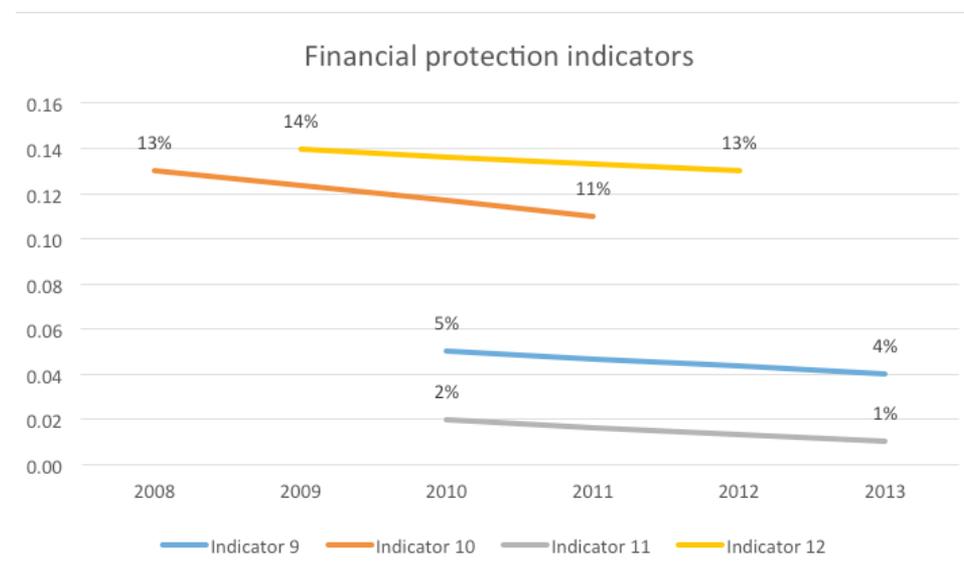
Indicator 9: Percentage of adults who reported cost as the reason for at least one of the following in the past year:

- not filling a prescription
- skipping a recommended medical test, treatment or follow-up
- not visiting doctor or clinic despite having a medical problem

Indicator 10: Percentage of sicker adults who reported cost as the reason for at least one of the activities described in the previous indicator in the past year

Indicator 11: Percentage of patients who had serious problems paying or were unable to pay medical bills in past year

Indicator 12: Percentage of primary care doctors reporting that patients often have difficulty paying for medications or other care



See Annex 2 for the full set of privatisation indicators.

Recommendations

At a time when all NHS providers and commissioners are facing unprecedented financial pressures, more attention needs to be paid to independent sector provision of NHS healthcare, such as whether it provides value for money, comparable quality and safety to NHS patients, as well as its impact on other NHS services.

This report uses the privatisation indicators, as well as the results from the survey, to make a number of recommendations regarding independent sector provision of NHS healthcare.

Recommendation 1: NHS England should collect data on levels of independent sector provision of NHS services by sector (ie community services, acute services, etc).

The indicators we have been monitoring show that the level of independent sector provision of NHS services in England is increasing year-on-year. In 2014/15, the Department of Health published figures that showed that £6.9 billion was spent on procuring NHS clinical services from the independent sector, representing 6.3 per cent of total spend that year.¹⁰ This is a 5.4 per cent annual increase, compared to only a 2.4 per cent increase in total spend on services. Nearly half of doctors (49 per cent) found this level of independent sector provision either higher or much higher than they expected.

Previously, in data from PCTs' financial accounts, it was possible to see how much was spent on independent sector provision in different sectors. These figures showed that the most rapid increase in NHS spending on the independent sector was in community health services. This level of detail is unfortunately no longer available and therefore it is no longer possible to get a full picture of the nature of independent sector provision across the NHS.

Recommendation 2: Before any independent sector provider is chosen as a preferred bidder there should be a thorough impact analysis taken to ensure that the decision will not destabilise existing NHS services or cause disruptions to the patient pathway.

The most common reason for why doctors were uncomfortable with the independent sector providing NHS services is a concern that it destabilises NHS services and providers. One example relevant here relates to recent events in West Sussex. In 2014, an independent provider, Bupa CSH,[§] was chosen as the preferred bidder for a £235 million musculoskeletal services contract by Coastal West Sussex CCG, amid much controversy around the effect that it might have on the local NHS services. An independent assessment, undertaken after the contract preferred bidder was announced, showed that the impact of the loss of musculoskeletal services would result in Western Sussex Hospitals NHS Trust, who had previously provided the service, falling into deficit over the next five years.¹¹ Bupa CSH have subsequently withdrawn from the process because of the impact assessment and the CCG is working with existing providers to introduce the proposed service.

This case study shows the potentially destabilising effects that independent sector provision of NHS care can have on existing NHS providers. The impact assessment also raised concerns about a provider being contracted for outpatient activity but not for the corresponding inpatient service. Although this relates to the detail of the contract specification rather than the independent sector provider itself, it is a common issue when independent sector providers are involved with NHS care. This is another reason why it is important to conduct a full impact analysis before the preferred bidder is chosen to make sure that it does not cause either a fragmented service or a disrupted patient pathway.

[§] Bupa CSH is a partnership between Bupa and CSH Surrey. CSH Surrey is an employee-owned community health service that was the first social enterprise to come out of the NHS.

Recommendation 3: During any procurement process that involves an independent sector bidder, CCGs should carry out a full risk assessment for what might happen if NHS staff do not wish to TUPE (transfer of undertakings under present employment) to an independent sector provider and how this might impact on the continuity of service provision.

Our survey showed that doctors have concerns that the primary motivation for some independent sector providers is profit, rather than providing the highest possible standard of care for the patient. This could potentially affect their willingness to work for independent sector providers, as may have been the case with dermatological services in Nottingham. In 2012, Rushcliffe CCG chose Nottingham Treatment Centre, an ISTC run by Circle, to deliver dermatology outpatient services that had previously been provided by Nottingham University Hospitals NHS Trust (NUH). It was expected that NHS consultants would TUPE to the independent sector provider, in order to maintain the service they were already providing. However, there was strong reluctance to working for an independent sector provider and only three of the 11 consultants eventually transferred. Contractual and service issues at NUH meant that many of the consultants who had not transferred took posts outside of Nottingham¹² and, in January 2015, specialist inpatient care for dermatological emergencies at NUH was transferred to an alternative site in Leicester.

The process has left dermatology services in Nottingham at near collapse, with an inability to recruit to substantive posts and an on-going reliance on locum posts. Teaching and training opportunities on both sites have greatly diminished and clinical research has been cut back. Although an independent review judged that the procurement process was fair and that Circle had successfully provided the services they were commissioned for, it judged doctors' unwillingness to be transferred to an independent provider, with possibly different values, a valid concern and one that was not considered in advance.¹³

Recommendation 4: Independent sector providers of NHS services should be subject to the same requirements as NHS providers in relation to transparent reporting of both patient safety incidents and performance.

- i. **This should be a requirement of registration with the CQC.**
- ii. **The Health and Social Care Information Centre should be responsible for making performance data available for both independent sector and NHS providers.**
- iii. **The requirements for all providers of NHS services to publish Quality Accounts should be properly enforced for independent sector providers. All Quality Accounts should be required to be externally audited rather than just those by NHS providers.****
- iv. **All providers of NHS services should be covered by the Parliamentary and Health Service Ombudsman.**
- v. **All providers of NHS services should be covered by the Freedom of Information Act.**

The total number of NHS funded elective surgical procedures in independent sector hospitals grew from 400,000 in 2012 to 490,000 in 2014, a 23 per cent increase,¹⁴ with some independent sector providers now treating only NHS patients.¹⁵ Given this trend, the need for independent sector providers to be subject to the same requirements as NHS providers becomes imperative.

** A Quality Account is a report about the quality of services by an NHS healthcare provider. The reports are published annually by each provider and are available to the public.

There have repeatedly been calls by health industry experts for the scrutiny of independent providers to be increased. In their report *'Patient safety in private hospitals – the known and the unknown risks'*, the Centre for Health and the Public Interest make a number of recommendations for ways to improve the lack of information known about the independent sector.¹⁶ These include independent providers being subject to the same requirements to report patient safety incidents as NHS providers and to report on their performance in the same way as NHS providers. They also call for the remit of the Parliamentary and Health Service Ombudsman to be extended and the scope of the Freedom of Information Act to cover all independent providers in respect of anything related to treatment of NHS patients. These recommendations would help make independent sector providers subject to the same standards as NHS providers and we echo them in this report.

Recommendation 5: The CQC should develop a more standardised approach to regulating independent sector providers in line with NHS providers.

In April 2015, the CQC (care quality commission) in England adopted a similar approach for the inspection of independent sector providers to the one used for NHS providers, with the aim of holding the independent sector to the same standards as the NHS. Although this is a step in the right direction, the Centre for Health and Public Interest evaluated the 15 inspection reports that had been published by July 2015 and found both significant patient safety risks and a 'lack of systematic collection and reporting' by the CQC.¹⁷ The report calls for the CQC to develop a 'much more standardised approach to addressing patient safety risks in private hospitals' if it is to make patients feel confident about the increasing levels of NHS healthcare being provided by independent sector providers.

Recommendation 6: Safeguards should be introduced to protect NHS patients and services if contracts are terminated early by independent sector providers.

In 2012, the management of Hinchingsbrooke Health Care NHS Trust was franchised to an independent sector provider, Circle, on a ten year contract. In March 2015, Circle handed management of Hinchingsbrooke back to the NHS following financial pressures and a critical CQC report that resulted in Hinchingsbrooke being put into special measures, leaving the NHS to deal with the consequences. One of the arguments for exploring franchise options in the first place was to make the trust financially sustainable and to repay the cumulative deficit. However, the Committee of Public Accounts found that the savings projections promised by Circle were overly optimistic and unachievable.¹⁸ They also expressed concern that Circle's bid had not been properly risk assessed. This can be seen in the fact that the NHS were left with the operational risk when the franchise failed. Circle were only liable to cover financial deficits of up to £7 million over the ten years, which was far below the total deficit incurred during the three years Circle was in charge. Given that the NHS needs to make £22 billion of efficiency savings a year by 2020/21, it cannot afford to be left to pick up the bill from the failures of independent sector providers.

Recommendation 7: The Department of Health should carry out a regular review of admissions from independent sector providers to the NHS to determine the nature and cost of these incidents.

Our survey revealed that doctors are concerned that independent sector providers only take on low-risk procedures, leaving the NHS to deal with any complications. On average around 6,000 patients a year are admitted to NHS hospitals following treatment in a non-NHS hospital, with approximately 2,500 of these being emergency admissions.¹⁹ Unfortunately, these figures do not give either the reasons for admission or any information about whether these admissions are for NHS patients. This makes it difficult to measure what the cost is to the NHS for dealing with complications related to NHS care delivered at independent sector providers.

The facilities at independent sector hospitals do show that they are often not equipped to deal with complications from surgery. In 2011, five of the 17 private hospitals providing inpatient care in Central London had no "critical care" beds.²⁰ Sir Bruce Keogh's review of the

regulation of cosmetic surgery also supports this point of view; it says that 'it can be argued that the business model of cosmetic surgery providers relies to some extent on the NHS being there to act as a safety net to treat clinical complications'.²¹ Although this review is mainly focused on private patients, without having more information about admissions from the independent sector to the NHS we are unable to determine whether this model is also true for NHS patients.

Recommendation 8: The NHS Standard Contract should be amended to include a clause requiring independent sector providers to contribute towards the education and training of the NHS workforce – either financially or by virtue of making available suitable opportunities. This would be in addition to the existing requirement to support the work of HEE (Health Education England) and LETBs (local education and training boards).

Our survey showed that doctors have serious concerns relating to the education and training of doctors, nurses and other clinicians working at independent sector providers. The lack of training opportunities for medical and nursing staff who work at independent providers was raised repeatedly, given the reduced caseload available. An increased reliance on the independent sector by the NHS will mean greater numbers of staff working in these environments, and not receiving the training opportunities that they would have done otherwise in an NHS hospital. Similarly, there were worries that staff at independent sector providers work in isolation from other colleagues and other parts of the health system. This undermines continuity of care for patients and hinders doctors' ability to work within and across clinical teams.

Conclusion

In the context of an increasingly pressured environment across both health and social care, every area where spending is increasing needs to be rigorously evaluated. Independent sector provision of NHS healthcare has increased every year for the past five years.

This report shows that there are still a number of unknowns with regard to independent sector provision of NHS healthcare. The recommendations contained in this report are a starting point for understanding the effect that using independent sector providers of NHS care has on the NHS as a whole. They also outline exactly how important it is that independent sector providers are held to the same standards as NHS providers when providing NHS care.

Many of the recommendations laid out in this report are not new. Yet, given that nearly £7 billion is now spent on independent sector provision of NHS services each year, it is clear that several of them are long overdue.

The BMA supports a publicly funded and publicly provided NHS but we believe that these recommendations will help to ensure that, where independent sector providers are already delivering NHS care, the priority remains for them to support the NHS to deliver high quality services.

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Annex 1

Independent sector provision of NHS healthcare

BMA member survey
November 2015

Background

- The BMA manages an online panel of approximately 3,000 member doctors.
- The panel is broadly representative of the main areas of medical practice and is used for quarterly tracker surveys on topical health questions.
- This analysis is of the one-off questions on independent sector provision of NHS healthcare included in the November 2015 quarterly tracker survey.

Methodology

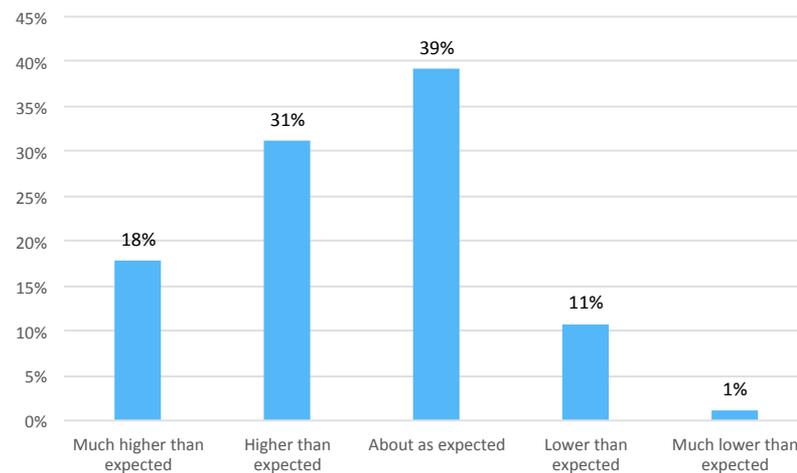
- The quarterly tracker survey was sent to a random sample of 1,016 panel members (excluding students and retired members).
- Panel members were emailed a link to the online survey between 25 November and 17 December 2015.
- 463 replies were received, a response rate of 46%. Of these responses, 19 were removed as they were not currently working, giving a final response rate of 44%.
- For a full break-down of the results see the [BMA quarterly tracker survey \(Q4, November 2015\)](#).

Independent sector provision of NHS clinical service

Definition

- For the following questions, the independent sector includes ISTCs (independent sector treatment centres) other private providers (eg Bupa, Virgin Care) and social enterprises.
- In 2014/15, £6.9 billion was spent in England on procuring the following clinical services from the independent sector, representing 6.3% of total NHS spend:
 - General and acute services;
 - Accident and emergency services;
 - Community health services;
 - Maternity services; and
 - Mental health services.

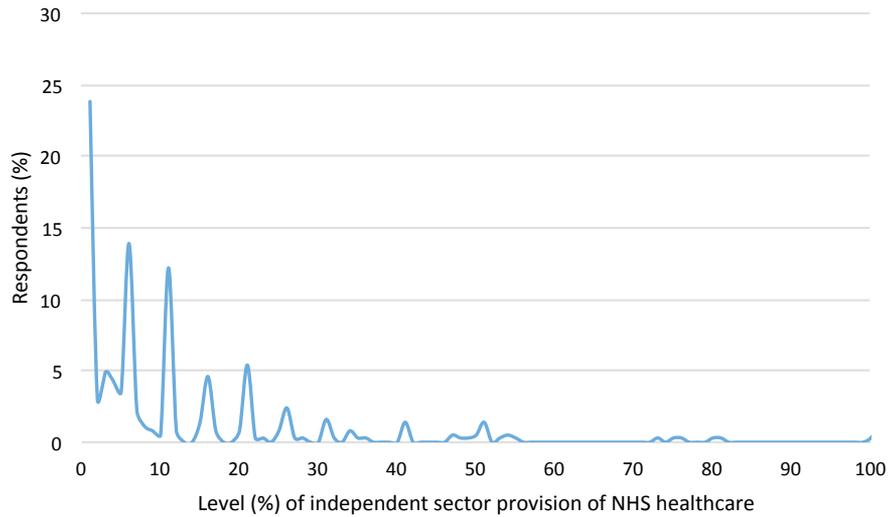
Q1 – How does the current level of NHS spending compare with your expectations?



Overall, nearly half of respondents said that the current level of spending on independent sector provision of NHS services was higher/much higher than expected (49%).

39% of respondents said that the current level of spending was about as expected.

Q2 – What do you consider to be an appropriate level of independent sector provision of NHS healthcare?



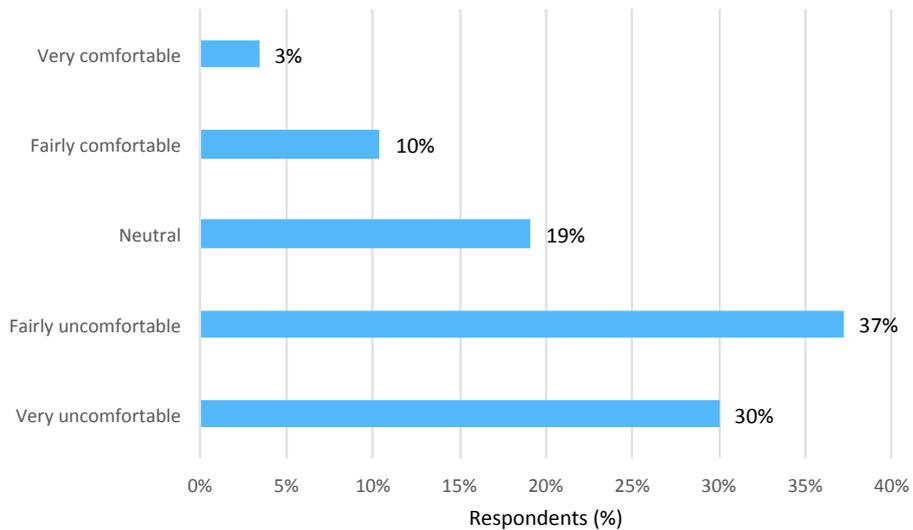
Respondents were asked to use a scale of 0% – 100%.

24% of respondents thought that no NHS money should be spent on independent sector provision of NHS healthcare.

14% of respondents thought that 5% was an appropriate level of independent sector provision of NHS healthcare; 12% of respondents thought that 10% was an appropriate level.

How comfortable are doctors with independent sector provision of NHS clinical services?

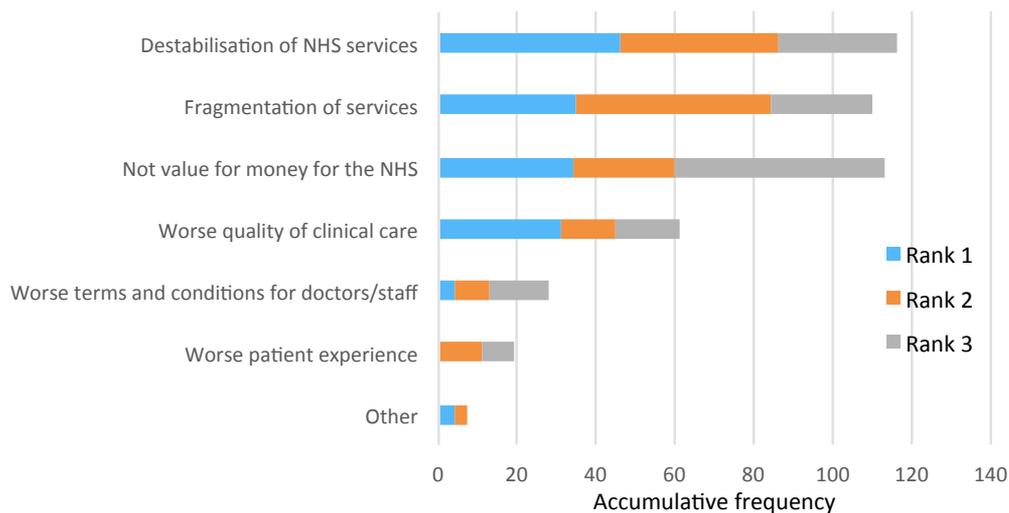
Q3 – How comfortable are you with independent sector provision of NHS clinical services?



Over two thirds of respondents (67%) were either fairly uncomfortable or very uncomfortable with independent sector provision of NHS clinical services.

Only 13% of respondents were either fairly comfortable or very comfortable with independent sector provision of NHS clinical services.

Q3a – Reasons why you are uncomfortable with independent sector provision of NHS clinical services



This question only applied to respondents who answered 'fairly uncomfortable' or 'very uncomfortable' to question 3. Respondents were asked to rank in order of importance the top three reasons why they are uncomfortable with independent sector provision of NHS clinical services.

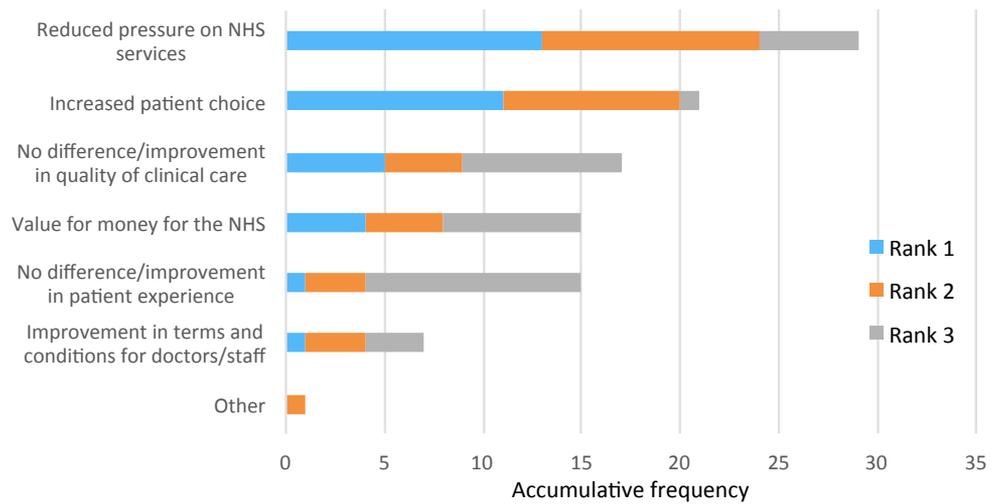
The three main reasons why doctors are uncomfortable with independent sector provision of NHS clinical services, in order of importance, were:

- Destabilisation of NHS services
- Fragmentation of services
- Not value for money for the NHS

Written comments showed that the following issues are also of significant concern for doctors:

- Profit is the primary driver for independent sector providers rather than quality of care;
- Loss of resources (financial and otherwise) that should be re-invested in the NHS;
- NHS has to deal with after care including dealing with any complications;
- Lack of training opportunities and career management for staff;
- Lack of transparency and accountability across the sector;
- Disruption to the patient journey and continuity of care.

Q3b – Reasons why you are comfortable with independent sector provision of NHS clinical services



This question only applied to respondents who answered 'fairly comfortable' or 'very comfortable' to question 3. Respondents were asked to rank in order of importance the top three reasons why they are comfortable with independent sector of NHS clinical services.

The three main reasons why doctors are comfortable with independent sector provision of NHS clinical services, in order of importance, were:

- Reduced pressure on NHS services
- Increased patient choice
- No difference/improvement in quality of clinical care

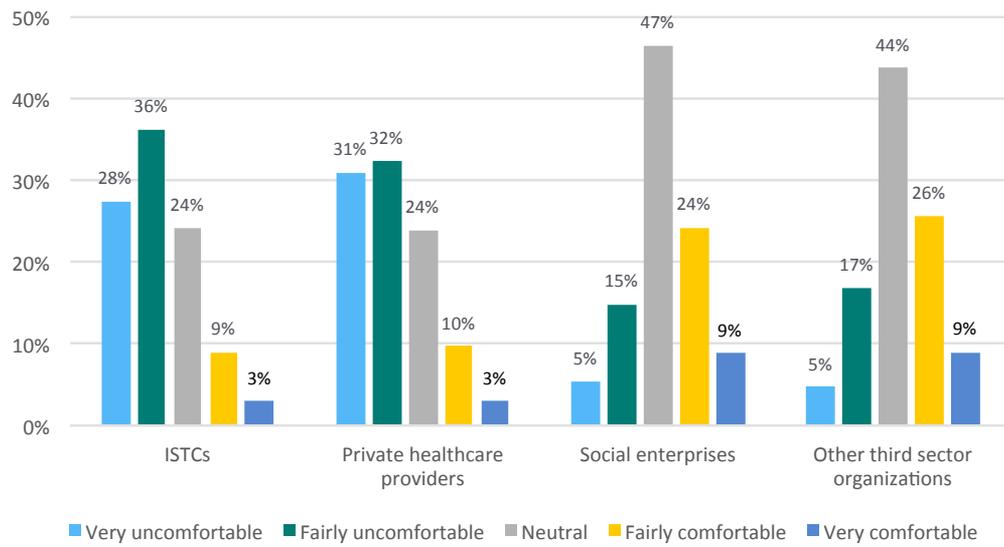
How comfortable are doctors with different non-NHS providers?

Definitions

For the following questions, the definitions below were given:

- **ISTCs (independent sector treatment centres)** are treatment centres that are owned by private organizations outside of the NHS.
- **Private healthcare providers** are private sector organizations that normally provide care outside of the NHS (eg Bupa, Virgin Care).
- **Social enterprises** are businesses that provide care to NHS patients, where surpluses are typically reinvested rather than being paid to shareholders. They may be employee owned organizations, cooperatives or mutuals.
- **Other third sector organizations** may include voluntary groups or charitable organizations that provide care to NHS patients.

Q4 – How comfortable are you with NHS services being procured from different provider types?



Respondents do not view different non-NHS providers equally.

Most respondents were fairly or very uncomfortable with both ISTCs (64%) and private healthcare providers (63%) delivering NHS services.

However, respondents' views were more mixed about both social enterprises and other third sector organizations. The majority of respondents were neutral about these providers, 47% and 44% respectively.

Annex 2

Monitoring levels of
NHS privatisation

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Background

This report monitors, via a range of indicators, independent sector provision in the NHS and/or reduced financial protection for patients and the public from the costs of healthcare.

The baseline for monitoring the data has been set at 2009 (where possible), the year before the former government came to power. In order to cover the wide range of definitions held about the privatisation of healthcare, the report includes a wide range of indicators, as follows:

- Spend on provision of healthcare services split by NHS, independent sector, voluntary sector and local authorities (England)
- Funding for independent acute medical/surgical hospitals and clinics from NHS patients (UK)
- NHS hospital income from private patients (UK)
- Number of APMS (alternative provider medical services) contracts and patients registered with APMS practices (England)
- Financial protection from the costs of healthcare (UK)
- Private medical insurance and OOP (out-of-pocket) payments (UK)

Some indicators are only available until 2012/13, the final year before PCTs (primary care trusts) were abolished and CCGs (clinical commissioning groups) established so direct comparisons have not always been possible.

Data summary

The data shows that the total amount spent on healthcare provided by non-NHS bodies, and specifically from independent sector providers, has increased over the last 5 years. NHS funding to the independent acute sector has grown, as well as NHS hospital income from private patients. The number of APMS contracts and patients registered with APMS practices has also increased.

Yet in financial protection terms the UK continues to provide coverage for 100% of the population. This appears to show that there is no direct effect from increased independent sector provision of healthcare on the principle of a health service that is free at the point of use. In addition, all measures of cost preventing patients from receiving care have decreased. The UK has the fourth lowest out-of-pocket health expenditure as a share of household consumption within the OECD.

Provision of healthcare (England)

- In 2014/15, £6.9 billion was spent on clinical services delivered by the independent sector, representing 6.3% of total spend that year (see indicator 1). This represents a 5.4% annual increase compared to only a 2.4% increase in total spend on services. £3.5 billion, or 3.1% of total spend was on voluntary and other sector provision over the same period (see indicator 2).
- Total purchase of healthcare from non-NHS providers, which includes independent, voluntary and other sector provision, has increased to £10.4 billion. This represents a rise from 8.9% of total spend in 2013/14 to 9.4% in 2014/15.

Acute care (UK)

- The amount of funding from NHS patients to the independent acute sector rose 14% to £1.6 billion in 2013 from £1.4 billion in 2012. The proportion of funding that this represents overall (29.7%) remained relatively stable (see indicator 3).
- Elective procedures are likely to make up the majority of NHS activity undertaken in the independent acute sector. Yet as a proportion of NHS elective procedures, the percentage carried out by the independent sector remained relatively low in 2014 at 4.4% (see indicator 4).
- There was a 2.6% annual increase in NHS hospitals' income from private patients from 2012 (£522 million) to 2013 (£537 million) and this has been increasing at a similar year-on-year rate since 2009 (see indicator 5).

- There are currently no NHS trusts with a non-NHS management franchise in England after Circle announced it would withdraw from the contract at Hinchingsbrooke in January 2015 as their 'involvement in Hinchingsbrooke does not have a sustainable future in its existing form'.¹ The franchise arrangement came to an end in March 2015 (see indicator 6).

Primary care (England)

- The number of APMS contracts in 2014 was 290: a 7% increase from the previous year. APMS contracts represent 3.7% of all contracts for GP services in England, up from 3.4% a year before. The number of patients registered with an APMS practice rose by 12%, to 1.1 million. The proportion of patients registered with an APMS practice as a whole remains relatively low at 2% (see indicators 7 and 8).

Financial protection (UK)

- The percentage of adults for whom cost was a barrier to receiving healthcare fell by 20% between 2010 and 2013 (see indicator 9).
- In 2014, 1% or fewer patients had serious problems or were unable to pay medical bills (see indicator 11). This compares with fewer than 13% of adults in France, and nearly a quarter (23%) in the US.
- Out-of-pocket (OOP) health expenditure as a share of final household consumption dropped from 1.6% to 1.4% between 2009 and 2013. The UK has the fourth lowest OOP expenditure of the OECD countries, the average being 2.8% (2013) (see indicator 13).
- The UK continues to provide coverage for a core set of health services to 100% of the population (see indicator 14).
- The number of people covered by private medical insurance in the UK dropped by 9% between 2009 and 2015, although the associated spending has fluctuated (see indicator 15).
- The total funding for the independent acute sector from self-pay patients rose by one-third this year, and the proportion of funding to the independent acute sector that this represents rose by 17% (see indicator 16).

Total commissioner spend (England)

Indicator 1: Total commissioner spend on independent sector providers for the following services and as a proportion of Department of Health total spend on services² (2014/15 prices)³

- general and acute services
- accident and emergency services
- community health services
- maternity services
- mental health services
- learning disability services
- primary care services⁴

1 Circle Health (2015). *A statement on Hinchingsbrooke*.

2 Department of Health total spend on services includes running costs for the Department of Health and other arm's length bodies.

3 Where financial figures are based on 2014/15 or 2014 prices, they are based on the GDP deflator published on 10 July 2015. HM Treasury: GDP deflators at market prices, and money GDP: July 2015 (Summer Budget 2015).

4 It has been assumed that primary care services does not include GP, dentistry, ophthalmic and pharmaceutical services.

Year	Total (£bn)	Trend	Proportion (%)	Trend
2009/10	4.55	–	4.3	–
2010/11	5.09	↑ 12%	4.7	↑ 11%
2011/12	5.61	↑ 10%	5.2	↑ 11%
2012/13	6.46	↑ 15%	6.0	↑ 14%
2013/14	6.56	↑ 1%	6.1	↑ 1%
2014/15	6.91	↑ 5%	6.3	↑ 3%

Source: The Health Foundation (2015). *Evolution, revolution or confusion? Competition and privatisation in the NHS*, Department of Health (2015). *Annual Report and Accounts 2014-15*.

The independent sector includes ISTCs (independent sector treatment centres), other private providers and social enterprises.

Overall spending in 2014/15 on independent sector providers totalled £6.91 billion – up 5% since 2013/14. However, this represents just 6.3% of the total spend on services, the vast majority of which goes to NHS bodies (90.6%). Spending on the independent sector has been proportionally increasing between 2010 and 2015, although at a slower rate in the last couple of years.

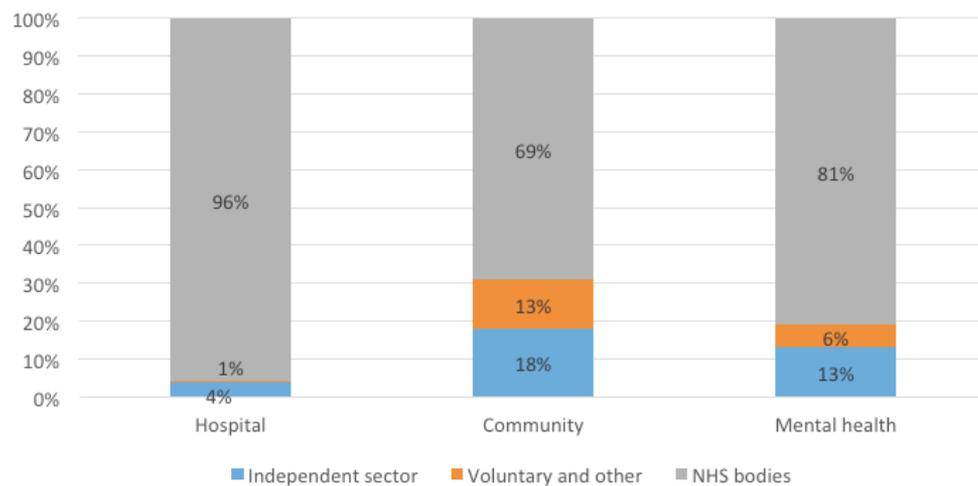
The data for 2013/14 and 2014/15, since CCGs were established, was presented in a different format from previous years so it is important to be aware of potential limitations in the comparison.

In the data from 2012/13 and earlier, which was from PCTs' financial accounts, it was possible to see how much was spent on different services. For example, in 2012/13 spend on independent sector provided community services totalled 18% of PCT spend on community services overall.⁵ This is compared to hospital services, where only 3.6% of PCT spend was on independent sector provided care. PCTs' figures showed that the most rapid increase in spending on the independent sector was in providing community health services.

Unfortunately this level of detail is no longer available so this report cannot say whether this is still the case. NHS England should request that this data is collected by CCGs as it shows important information about where the independent sector is most prevalent in the English healthcare system. This is recommendation 1 in the accompanying report on independent sector provision of NHS care.

5 Nuffield Trust (2014). *Into the red? The state of the NHS' finances*.

Figure 1: PCT spending by type of provider (2012/13)



Source: Nuffield Trust (2014). *Into the red? The state of the NHS' finances*.

Indicator 2: Total commissioner spend on voluntary and other sector providers for the following services and as a proportion of Department of Health total spend on services (2014/15 prices)

- general and acute services
- accident and emergency services
- community health services
- maternity services
- mental health services
- learning disability services
- primary care services

Year	Total (£bn)	Trend	Proportion (%)	Trend
2009/10	3.64	–	3.7	–
2010/11	3.97	↑ 9%	3.7	↑ 8%
2011/12	3.35	↓ 16%	3.1	↓ 15%
2012/13	3.37	↑ 1%	3.1	±0
2013/14	3.03	↓ 10%	2.8	↓ 11%
2014/15	3.45	↑ 14%	3.1	↑ 12%

Source: The Health Foundation (2015). *Evolution, revolution or confusion? Competition and privatisation in the NHS*; Department of Health (2015). *Annual Report and Accounts 2014-15*.

Overall spending on voluntary and other sector providers totalled £3.45 billion in 2014/15, of which £2.9 billion was on local authorities. This represents just 3.1% of total spend, an increase from the previous year and is partly explained by the greater role that local authorities play in the provision of healthcare since public health functions were transferred to local government in April 2013.

The data limitations arising from the difference between CCGs' and PCTs' accounts described in the previous indicator are also relevant here.

Acute care (UK)

Indicator 3: Total and proportion of overall funding for independent acute medical/surgical hospitals and clinics from NHS patients (2014 prices)

Year	Total (£bn)	Trend	Proportion (%)	Trend
2010	1.03	–	25.0	–
2011	1.14	↑ 11%	26.2	↑ 5%
2012	1.35	↑ 19%	29.0	↑ 11%
2013	1.55	↑ 14%	29.7	↑ 2%

Source: LaingBuisson. *LaingBuisson Healthcare Market Review*.

While the amount of funding to the independent acute sector from NHS patients rose by 14% in 2013, the proportion of funding that this represents overall only rose by 2%. This can be explained by increases in other funding sources to the independent acute sector, and inflation of prices for private sources of funding.

Elective procedures via the 'any qualified provider' procurement route are likely to make up the majority of NHS activity undertaken in the independent acute sector. Yet indicator 4 shows that the proportion of NHS elective procedures carried out by the independent sector remains low, at 4.4% of all such procedures carried out.

Indicator 4: Estimated total number of NHS funded admissions for elective surgical procedures in UK independent acute medical care hospitals and as a proportion of all elective surgical admissions

Year	Number	Trend	Proportion (%)	Trend
2012	400,000	–	3.8	–
2013	400,000	±0	4.1	↑ 8%
2014	490,000	↑ 23%	4.4	↑ 7%

Source: LaingBuisson. *LaingBuisson Healthcare Market Review*.

The number of NHS elective procedures carried out by the independent sector rose by 23% in 2014, but the proportion that this represents of all NHS elective procedures increased by only 7%. This can be explained by a likely increase in the number of elective procedures carried out by the NHS, showing growth in activity both within the NHS and non-NHS sectors. At 4.4%, the proportion of NHS elective procedures carried out by the independent sector remains low.

However, if looked at over a longer time frame independent sector provision as a proportion of NHS funded elective surgical admissions has increased significantly. It accounted for just 0.35% of all procedures in 2004/05 compared to 4.4% in 2014 (Source: Laing Buisson).

The main motivation for the independent sector in carrying out more procedures on behalf of the NHS is likely to be the decline in its core business or funding sources (ie private medical insurance, see indicator 15).

Indicator 5: Total NHS hospitals income from private patients (2014 prices)

Year	Total (£m)	Trend
2009	476	–
2010	482	↑ 1%
2011	507	↑ 5%
2012	522	↑ 3%
2013	537	↑ 3%

Source: LaingBuisson. *LaingBuisson Healthcare Market Review*.

NHS hospitals' income from private patients in 2013 rose by 3% in real terms to £537 million, which was similar to the increase over the previous two years.

Since April 2013 NHS Foundation Trusts have been able to raise up to 49% of their income from non-NHS sources (as set out in the Health and Social Care Act 2012). It does not seem like this has had a significant impact on the level of income raised in NHS hospitals from private patients as the increase is in line with previous years. As we go forward and there is more data, the question of whether this legislative change has had any impact will become clearer.

Indicator 6: Number of NHS trusts with a non-NHS management franchise (England)

The Health and Social Care Act 2012 also exempts NHS trusts with a non-NHS management franchise from having to become an NHS Foundation Trust, although there is no fixed timeline for remaining NHS trusts to achieve NHS Foundation Trust status and it is unlikely that more than a handful will do so over the coming year.

There are currently no NHS trusts with a non-NHS management franchise after Circle announced it would withdraw from the contract at Hinchingsbrooke in January 2015 as their 'involvement in Hinchingsbrooke does not have a sustainable future in its existing form'. The franchise arrangement came to an end in March 2015.

Primary care (England)**Indicator 7: Number of APMS contracts for GP services and as a proportion of all contracts**

Year	Number	Trend	Proportion (%)	Trend
2009	173	–	2.1	–
2010	262	↑ 51%	3.1	↑ 50%
2011	276	↑ 5%	3.3	↑ 5%
2012	260	↓ 6%	3.2	↓ 3%
2013	271	↑ 4%	3.4	↑ 6%
2014	290	↑ 7%	3.7	↑ 8%

Source: Health and Social Care Information Centre (2015). *General and personal medical services, England 2004-2014*.

APMS is a contractual route that allows a wide range of providers to deliver GP and other primary medical services. It provides the opportunity for locally negotiated contracts and allows NHS commissioners to contract with non-NHS bodies such as commercial, voluntary and mutual sector providers, social enterprises and public service bodies, as well as GMS and PMS practices, NHS trusts and NHS foundation trusts.

The number of APMS contracts in 2014 was 290: a 7% increase from the previous year. APMS contracts represent a proportion of 3.7% of all contracts for GP services in England, an 8% increase on 2013. However, this data does not tell us who holds APMS contracts. For example, some APMS contracts will be held by groups of GPs, others by companies such as Virgin Health and some by joint ventures spanning different sectors. There is also a requirement for core NHS values to be fully protected and secured regardless of who holds the contract.

Indicator 8: Number of patients registered with an APMS practice and as a proportion of all registered patients

Year	Number	Trend	Proportion (%)	Trend
2009	367,256	–	0.7	–
2010	611,815	↑ 67%	1.1	↑ 57%
2011	765,210	↑ 25%	1.4	↑ 27%
2012	877,427	↑ 15%	1.6	↑ 14%
2013	1,007,901	↑ 15%	1.8	↑ 13%
2014	1,113,012	↑ 12%	2.0	↑ 11%

Source: Health and Social Care Information Centre (2015). *General and personal medical services 2004-2014*.

The number of patients registered with an APMS practice rose by 12% from 2013 to 2014 to over 1.1 million. The proportion of all registered patients that this number represents has also risen, by 11%. However, the number of patients registered with an APMS practice as a proportion of all registered patients in England remains relatively low at 2%.

Financial protection and private medical insurance (UK)

Tracking financial protection indicators over time will help monitor signs of erosion of the principle that the NHS offers a universal, comprehensive health service, free at the point of use. There are of course a number of potential confounders for these indicators including the impact of the recession and unemployment on people's ability/willingness to pay prescription charges and/or travel costs associated with accessing NHS services. It may also reflect the legitimate contraction of the NHS benefits package (ie priority setting by NHS commissioners in the context of resource constraint).

Indicator 9

Percentage of adults who reported cost as the reason for at least one of the following in the past year:

- not filling a prescription
- skipping a recommended medical test, treatment or follow-up
- not visiting doctor or clinic despite having a medical problem

Indicator 10

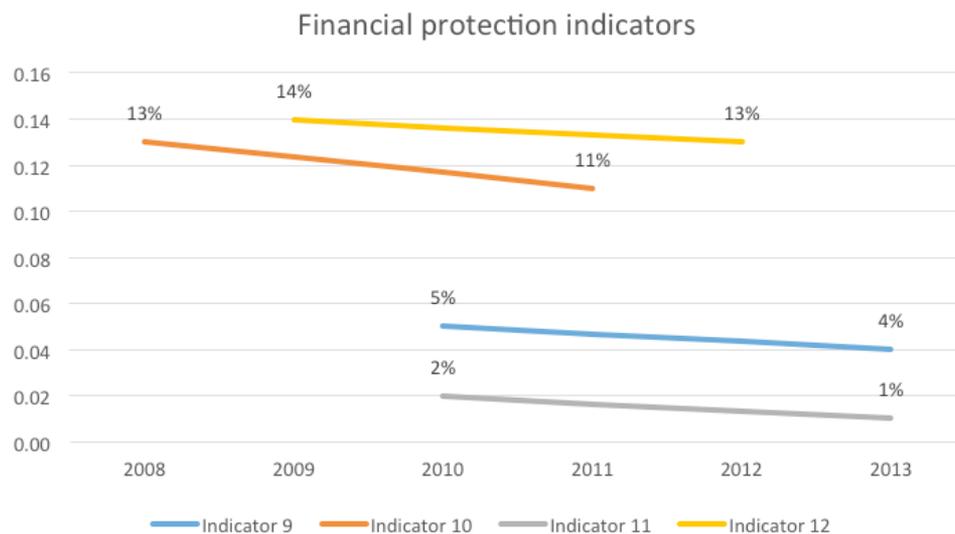
Percentage of sicker adults who reported cost as the reason for at least one of the activities described in the previous indicator in the past year

Indicator 11

Percentage of patients who had serious problems paying or were unable to pay medical bills in past year

Indicator 12

Percentage of primary care doctors reporting that patients often have difficulty paying for medications or other care



Source: Commonwealth Fund. *International Health Policy Survey of Adults/Sicker Adults, International Health Policy Survey of Primary Care Doctors*.

The percentage of adults for whom cost was a barrier to receiving healthcare has decreased for both sick and healthy adults (indicators 9 and 10). This pattern was also seen in the percentage of primary care doctors reporting that patients often have difficulty paying for medications or other care (indicator 12). In 2013, 1% or fewer patients in the UK had serious problems paying or were unable to pay medical bills (indicator 11). This compares with fewer than 13% of adults in France, and nearly a quarter (23%) in the U.S.⁶

Indicator 13: Out-of-pocket (OOP) health expenditure as a share of final household consumption

Year	Percentage	Trend
2009	1.6	–
2010	1.8	↑ 13%
2011	1.5	↓ 17%
2012	1.3	↓ 13%
2013	1.4	↑ 8%

Source: OECD. *Health at a Glance*.

OOP health expenditure as a share of final household consumption has declined in the UK between 2009 and 2013, to 1.4%. The UK has the fourth lowest OOP expenditure of the countries in the OECD, behind France, Netherlands⁷ and Turkey, the average being 2.8% (2013).

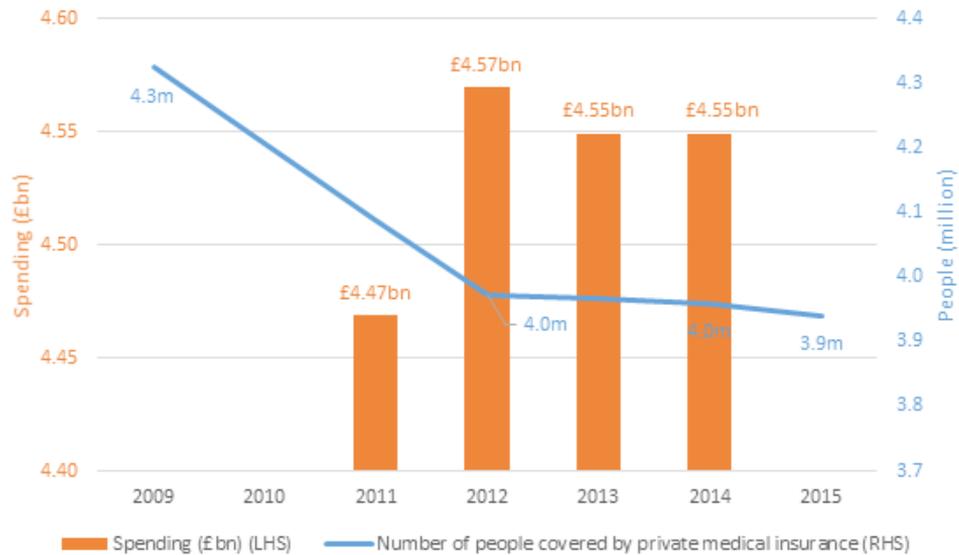
⁶ Commonwealth Fund (2013). *International health policy survey*.

⁷ The value for the Netherlands is underestimated as it excludes compulsory co-payments by patients to health insurers (if these were taken into account it would double the share).

Indicator 14: Percentage of the population with health insurance coverage for a core set of services

17 of the 35 OECD countries, inclusive of the UK, provide 100% population coverage for a core set of health services (2013). This refers to public health systems that are either tax-financed or funded through social health insurance. Those countries that do not have 100 per cent population coverage include Germany (88.8%), the Netherlands (99.8%) and the United States (34.5%).⁸

Indicator 15: Number of people covered by and spending on private medical insurance and company-paid medical expenses schemes (2014 prices)



Source: LaingBuisson, *LaingBuisson Healthcare Market Review*.

The number of people covered by private medical insurance and company-paid medical expenses schemes in the UK dropped by 9% between 2009 and 2015, while the associated spending has fluctuated. This can likely be accounted for by price inflation, case mix and intensity.

⁸ OECD Indicators. *Health at a glance*.

Indicator 16: Total and proportion of overall funding for independent acute medical/surgical hospitals and clinics from self-pay patients (out-of-pocket payments) (2014 prices)

Year	Total (£m)	Trend	Proportion (%)	Trend
2009	–	–	13.5	–
2010	573	–	14.0	↑ 4%
2011	635	↑ 11%	14.6	↑ 4%
2012	656	↑ 3%	14.0	↓ 4%
2013	857	↑ 31%	16.4	↑ 17%

Source: LaingBuisson. *LaingBuisson Healthcare Market Review*.

The total overall funding for the independent acute sector from self-pay patients rose by 31% in 2013. This is a logical trend given the data shown in indicator 15. As the number of people covered by private medical insurance declines, you would expect OOP payments to increase. As a proportion of overall funding to the independent acute sector OOP payments represents 16.4%, this is a significant increase on the previous year after several years of stagnation. As in the previous indicator this could be due to price inflation, case mix and intensity.

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