A positive partnership – the independent sector and the NHS

Key points

• The independent sector and the NHS are symbiotic and have had a close relationship for many years. This has benefitted patients and saved the NHS significant cost.

• Most of the public do not mind who provides care, as long as it continues to be free at the point of use and of high quality. Take-up of choice is high despite relatively low numbers of patients being offered choice by GPs.

• The independent sector has helped the NHS increase capacity and reduce waiting times. Development of independent sector treatment centres and introduction of patient choice in 2008 resulted in a decrease in waiting times to below the 18 week target.

• Despite a relatively small market share, the independent sector has had a high impact on the NHS, helping ensure it maintains quality while reducing costs.

This Briefing describes the independent healthcare sector’s engagement with the NHS in England in recent years and is intended to provide essential factual background. It includes outline statistics about market share and treatments provided, NHS spend with independent sector providers and examples of key initiatives and areas of innovation involving the independent sector.

Market share

Debate about the independent sector’s involvement in the NHS often gives the impression that the sector’s ‘share’ of NHS activity is more significant in scale than is the case.

Currently, independent sector involvement (excluding GP practices, dentistry and mental health) remains essentially static at roughly 5 per cent of mainstream clinical services:

• in elective care, including diagnostic services, 3.5 per cent of procedures are carried out by the independent sector
• independent sector share of supply in mental health services was £1.33 billion in 2009/10, representing 9 per cent of all mental health hospital and community services
• independent providers play a significant role in a number of other specialist areas of care. One of the most notable examples is the independent hospice movement’s role in the end-of-life care sector
• in primary and community services the independent sector carries out approximately 1.5 per cent of care.

This last figure excludes dentistry and GP practices. GP practices are themselves privately owned small businesses and carry out some 98 per cent of NHS general practice activity, although they generally regard themselves as part of the NHS. Recent estimates suggest that there are some 315 independent GP practices out of a total of around 8,300 practices in England.
Within mainstream clinical services, the principle type of activity is elective care (pre-arranged, non-emergency care that includes scheduled surgery) where some 3.5 per cent of procedures are carried out by the independent sector, either in private hospitals or by specialist treatment centres.

Despite a relatively small overall share of the market, the effect of the involvement of the independent sector for many years has been significant, particularly in some specialties – for example, in orthopaedics (hip and knee replacement surgery) and ophthalmology (cataract surgery) where the market share has been higher and the benefits far-reaching in terms of quality, cost and patient satisfaction.

Cherry-picking

It is important to note that the market share is not determined by the independent healthcare providers themselves but by the restrictions on the types of procedures that the NHS and regulating bodies allow the sector to undertake. Although the independent healthcare providers themselves deliver exactly what they are contracted to deliver, this inevitably restricts the range of services and procedures offered and has led to accusations of cherry-picking.

The reality is that independent providers would welcome the opportunity to do increasingly complex work but are currently faced with a trend towards a reduction in both the range and number of procedures the NHS asks them to do. It is important to consider that in most healthcare systems the bigger cherry-picking problem stems from hospitals seeking to retain highly complex, and high-value, work because of the benefits this has for the institution’s reputation and ability to attract and retain the highest quality staff. That approach is not open to independent providers in the UK as such work is almost wholly retained by the NHS itself.

The other argument which is sometimes put forward under the heading of cherry-picking is that by extracting large volumes of routine procedures from NHS hospitals, the viability of those hospitals is undermined. Given the small percentage of all procedures actually carried out by independent providers, it is hard to see how this argument can have any general validity. However, the real point is that there is a very strong clinical argument for carrying out certain types of routine procedures in dedicated specialist facilities which provide real advantages for patients. This was recognised long before the advent of independent sector treatment centres (ISTCs) under the last Government. Some parts of the NHS set up and supported specialist hospitals – for example, those specialising in orthopaedic care – several decades ago for exactly these reasons.

The restriction on the range of services and procedures also affects patient choice which, although growing significantly, remains limited to the types of procedures covered.

The independent sector also has to work with a playing field that is not level in relation to NHS providers. The issue of how to create a ‘level playing field’ has been the subject of discussion for some years and the exact calculation of the economic and financial factors involved is complex and still needs further work. However, independent studies have established that the overall ‘tilt’ is firmly against the independent sector. There are a number of reasons for this, but it is primarily because the major advantage and value of the public sector pension arrangements far outweighs all other factors.¹

Despite this ‘tilt’, the independent sector and the NHS are symbiotic and for very many years have enjoyed a long-standing and close relationship which has benefitted patients both directly and indirectly, while saving the NHS, and the taxpayer, significant cost. This relationship has included a wide range of additional services such as the coordination of patient care across different services, the
supply of medicines to hospitals, which is a growing industry, and the home supply of complex medicines, which also incorporates managing patient compliance.

**What has been achieved?**

- High-quality care and patient satisfaction.
- Increased capacity and reduced waiting times.
- Improved patient safety.
- Improved contracts providing better value.
- Patient choice.

**Quality and patient satisfaction**

Patient satisfaction figures show that 96 per cent of NHS patients using independent facilities for elective surgery consistently rate the care they receive as “excellent” or “very good”. The comparative figure for NHS facilities is 79 per cent.²

Feedback on the NHS Choices website (150,000 responses) shows that nine of the top 20 highest rated NHS hospitals recommended by patients are run by the independent sector. There are no independent sector hospitals in the bottom 20.

Rightly, healthcare academics and professionals stress the importance of clinical outcomes. Independent work done for NHS Partners Network shows that in ISTCs outcomes are consistent with, or better, than the NHS average even after adjustment for case mix. There is no evidence of poorer outcomes. This position is likely to have improved further since the research was carried out (to end 2009) as the ISTCs have acquired experience and early teething problems over appropriate referrals have been resolved. In addition, robust comparative data from across the independent sector for a wider range of procedures is taking time to build up but will be available shortly.

The Care Quality Commission’s (CQC) annual state of healthcare and adult social care in England report 2010–11 found compliance rates for 11 of its 17 core quality outcomes. Compliance rates for independent hospitals and clinics averaged 91 per cent compared with 72 per cent for NHS hospitals. Independent sector rates exceeded those of the NHS for every single outcome considered by the CQC.³

Figure 1 highlights comparative reported compliance rates for five core quality outcomes that we know matter to patients.
‘Waiting times may be seen by clinicians and system managers as open to management on the basis of clinical prioritisation and cost control’

Capacity and waiting times
Increasing capacity and reducing waiting times was one of the justifications both for the ISTC programme and for the Extended Choice Network (ECN). In practice, for many years before the introduction of free choice for patients in 2008, independent hospitals had helped NHS trusts when NHS capacity was unable to cope.

As a result, average waiting times have consistently decreased. By early 2011, waiting times had fallen to just below the last Government’s 18 week referral to treatment target, which remains enshrined in the NHS Constitution. During this period, the independent sector carried out over 2 million elective procedures, without which it is hard to see how the waiting time problem could have been effectively addressed.

The latest available figures from the Government’s preferred measure of “average” waiting times is shown in Figure 2.4

Waiting times may be seen by clinicians and system managers as open to management on the basis of clinical prioritisation and cost control. However, delayed operations routinely cost more in the long run and, for patients, waiting times equate to longer periods in discomfort or pain, reduced activity and possibly reduced or no income.

Patient safety
Of the top ten NHS hospitals rated on cleanliness through NHS Choices, nine are independent facilities.5 In clinical terms, latest figures for independent sector hospitals6 reported MRSA and C. difficile rates are respectively 0.39 and 3.71 per 100,000 bed days and discharges. Latest reported NHS figures7 are 3.7 per 100,000 for MRSA and 51.1 per 100,000 for C. difficile. Even allowing for reporting differences, this demonstrates that certain categories of patient can be treated at much lower risk in an independent sector hospital than in a busy, less controllable NHS environment.

Figure 2. Estimated inpatient average waiting times4

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Figure 2. Estimated inpatient average waiting times4
Studies show that cleanliness, specifically hospital acquired infections, is the highest patient concern when faced with going into hospital.

Costs and NHS spend with the independent sector

- Responding to a recent Parliamentary question from Greg Mulholland MP on 28 February 2011, Health Minister Simon Burns cited the latest figures from NHS commissioners’ accounts showing that the NHS spent £7.5 million on non-NHS provider services in 2009/10 out of a total spend of just £100 million.\(^8\),\(^9\)

The first wave of ISTC contracts was established with pricing for the relevant procedures set at levels which were above the standard NHS tariff by varying amounts. However, these contracts often included exceptional requirements, reflecting the fact that there were new arrangements, and additional bundled services, which are usually priced and charged for separately, making a simple comparison misleading. Many of these contracts also had guaranteed volumes.

Both these elements have proved contentious, with assertions that the NHS has wasted money. However, there needs to be recognition that quoted ‘overpayments’ of £252 million only equates to 0.02 per cent of the total NHS spend on elective care over the five year period of the initial contracts. What is often overlooked is that these contracts were only secure for a five year period and an approach to contract pricing was needed that made it possible to invest in the short timescale on offer. This is in contrast to mainstream NHS contracts which at that time were seen as effectively indefinite in duration.

It is interesting to note that the utilisation level of ISTCs during the period when full volume/demand management was in place, and in the hands of primary care trusts (PCTs) and referrers, remained stubbornly lower, at about 87 per cent, than subsequently, when utilisation was driven solely by patient and referred choice (see below). The average utilisation rate has now risen to 97 per cent.

When free choice for elective care using independent hospitals was introduced from April 2008 (subsequently the Extended Choice Network) it was at standard NHS tariffs and wholly on the basis of patient/referrer choice without any guaranteed volumes.

Currently, almost all procedures carried out by the independent sector are at standard tariff, although some still include additional bundled services, which provides the NHS with better value. As the original ISTC contracts have been retendered at the end of their initial five year terms, the new contracts have been at full demand risk, with no volume guarantees, leaving only a few still operating on the original basis for the remainder of their contract periods.

Patient choice

Independent research has consistently shown that the public has a low level of concern about who provides their care as long as it continues to be free at the point of delivery and of a high quality. Independent research carried out by Brunswick Research\(^10\) just before the general election in 2010 showed that:

- 74 per cent of patients did not mind who owned or ran NHS services providing the quality is right and services remain free at the point of use
- 85 per cent of respondents agreed that NHS services should continue to be free at the point of use.

This is further confirmed by the take-up of choice under the NHS Choose and Book arrangements for elective surgery. In January 2008, 1,438 patients exercised the option to choose and there were 81 eligible independent hospitals. By January 2011, the figure had increased to 16,788, with 158 independent hospitals participating (see Figure 3). It has taken place despite the fact that only some 50 per cent of patients are aware of being offered choice by their GPs.
Although problems with the take-up of ISTC capacity have been much criticised, these were primarily due to the reluctance of GPs to refer patients to them in the early years. Growing familiarity and confidence in the quality of care has changed this, and with most ISTCs now operating at full demand risk, in other words dependent on patient choice and GP referral, their use in the final quarter of 2010 moved to 97 per cent of the original planned capacity.

Primary care

Although the independent sector ‘share’ is small in primary care, the impact of the sector has been valuable.

The key benefits include:
- ease of access
- effective partnership models
- partnerships with foundation trusts
- effective governance and quality.

Ease of access

Innovations such as walk-in centres have provided an alternative form of access for many patients whose lifestyles do not conform easily to the traditional patterns of GP practices. But it is not only a matter of lifestyle. Many cities with large immigrant communities have to respond to cultures in which walk-in access is the normal way of securing primary care. Patients have indicated that they like the walk-in model, and walk-in centres have improved access for many. Traditional service providers often have no particular motivation for providing these services. In contrast, the new providers do. There is also some evidence that these centres relieve pressure on A&E departments by reducing the number of patients who would use A&E by default. In one new walk-in centre, 40 per cent of new registrations were previously unregistered with a GP and presented with significant co-morbidities and unmet need. Some 10 per cent of attendances were for contraception and sexual health, demonstrating local demand for accessible primary care.

In addition, independent sector hospitals have a very strong record of working with GPs within their different catchment areas to ensure patients have the easiest possible access to their services.

Partnership models

If the future is to be about integration and cooperation then a range of commercial primary care
providers have shown they can create commercial and service partnerships that support better integrated care. Integration is not dependent on having single providers or on the type of provider, but on good commissioning and contracting arrangements, which are usually stronger if they result from initial competition.

Partnerships with foundation trusts
There are a growing number of partnerships with foundation trusts providing a wide range of benefits to both the NHS and to patients. One such partnership produced an estimated saving for the PCT from the previous service of between £300,000 – £400,000 over the contract term.

Governance and quality
The major independent providers of large-scale urgent and out-of-hours care have the systems and governance infrastructure in place to provide the security and assurance of patient safety that are vital for these services. The need for providers to have these systems in place has been highlighted by incidents where locum doctors have provided out-of-hours care that has fallen far short of acceptable standards. These cases clearly demonstrate the need for providers to have very robust safety and governance systems in place, which is the norm for larger independent sector companies in this field. As a result, many of the large-scale urgent care contracts have moved to providers who have the necessary governance structures and can deliver the safety systems required.

Community services
- The independent sector provides for-profit and not-for-profit community services. Independent sector services have been notably innovative in this field.

There are a range of independent sector providers, both for-profit and not-for-profit in the community services sector. Although many are small and only deliver services locally, the potential impact and benefits from the innovation which the sector can bring to this area of care are striking.

The effects of competition
- Competition and integration are not mutually exclusive. They can support each other.

Innovation in community services
An independent study of four services in the West Midlands delivered in people’s homes rather than in hospital found that the innovative approach had the potential to save the NHS up to £1.2 billion a year if developed nationally. In terms of patient satisfaction, 66 per cent believed their symptoms had improved relative to receiving care in a hospital setting and 86 per cent thought their overall quality of life was better. None thought their quality of life had deteriorated when compared to in-hospital care. From a clinicians’ perspective, 100 per cent of consultants said they would continue to refer appropriate patients to the scheme.
Developing and delivering integrated care to patients is becoming the priority in many health economies, but it has not been a strong feature in the traditional UK NHS model. There are numerous examples of highly competitive industries where effective integration and user safety are key features – for example, aviation and food provision. With an appropriate regulatory framework, competition and integration can be mutually supportive. Indeed, robust competition used in conjunction with strong commissioning which insists on integrated care for the patient constitutes one of the best approaches.

Much is written about the effects of competition, but because the market share of the independent sector has remained small the evidence base has been relatively narrow. However, two recent academic studies do show real and significant benefits:

- A study by the Centre for Market and Public Organisation at the University of Bristol concluded that:

  “Hospital competition, under the recent NHS reforms, which introduced a fixed priced market, did lead to an increase in the quality of hospital services, as economic theory would predict. This rise in quality has undoubtedly led to an increase in consumer welfare.”

- A study by a team at the London School of Economics found that:

  “These figures strongly suggest that the reform intensified competition and that intensified competition post-reform led to increased quality. The paper subjects this hypothesis to rigorous testing and examines, in contrast with most of the prior literature, not only deaths from AMI as the measure of quality but a range of other quality measures and at other outcomes, including hospital utilization and expenditure. We find that the introduction of competition led to an increase in quality without a commensurate increase in expenditure.”

In addition, it would be wrong to overlook anecdotal experience in this respect. It has been reported that in many areas where ISTCs opened productivity and working practices almost immediately saw significant improvements in neighbouring NHS hospitals. Similar shifts in performance have also been observed in GP practices near to new ‘Darzi centres’ or new market entrants.

Workforce and training

The independent sector enjoys the support of a large number of healthcare professionals despite the impression to the contrary usually given by the British Medical Association (BMA) and others. Nearly 45,000 clinicians, including surgeons, other medical specialties, nurses and other healthcare professionals, deliver NHS care from an independent sector platform.

Independent providers wholly employ some healthcare professionals, while others work either part-time or on the traditional consultant model. These clinicians wholeheartedly subscribe to the principles of the NHS Constitution but believe in the advantages for patients of a plural provider system with alternative approaches to delivering care.

One of the characteristics of the independent sector is the generally very high level of staff satisfaction, which is due in part to the fact that clinical staff tend to have more time to spend actually caring for their patients. Research has demonstrated that high levels of staff satisfaction are linked to high-quality patient care.

In the independent sector, a number of providers have been able to achieve significant improvements in staff engagement and satisfaction, with direct benefits to the quality of patient care. This includes situations where staff have transferred across from the mainstream NHS.
It is also important to remember that many independent providers are already heavily engaged in training clinicians. However, the scope of this is to some extent constrained by two factors: the number and range of procedures that sector is permitted to perform, and an historic reluctance, which is now changing, by the NHS to utilise training opportunities in the independent sector.

Some major independent hospitals take NHS junior doctors on rotation and there is also significant nurse training. ISTCs make a good training environment precisely because they provide the high volumes of procedures needed for those in training to achieve full competence quickly. The independent sector is no different to any other in that good companies welcome the ability to provide training because it motivates and develops staff and ‘puts something back’ into the wider system.

**Figure 4. International comparisons: mortality rate – deaths per 1,000 inhabitants in 2010 (see over)**

<table>
<thead>
<tr>
<th>Country</th>
<th>Mortality rate&lt;sup&gt;15&lt;/sup&gt;</th>
<th>Private healthcare sector</th>
<th>Key principles</th>
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<tbody>
<tr>
<td>France</td>
<td>8.4</td>
<td>The private hospital sector in France has 36% of acute beds. The not-for-profit sector operates 9% of all beds.</td>
<td>Liberalism and pluralism: patients are allowed to choose the provider. Providers are allowed to compete against each other and to fail.</td>
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<td>Spain</td>
<td>8.2</td>
<td>Around 15–20% of specialised provision is contracted out to private hospitals. Around 40% of private hospital discharges are funded by the national health system.</td>
<td>Devolved model with significant use of the private sector. Increasing shift towards a patient-led system, including capitation payments, which is raising much interest across Europe.</td>
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<td>Netherlands</td>
<td>8.2</td>
<td>Private healthcare providers are primarily responsible for the provision of services. Responsibility for long-term care is delegated to private institutions.</td>
<td>Managed competition. Patients are treated as consumers.</td>
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<tr>
<td>Denmark</td>
<td>9.8</td>
<td>Niche provision.</td>
<td>Mainstream healthcare provision is almost wholly state-funded and state-provided.</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>9.0</td>
<td>Public and private provision historically largely separated.</td>
<td>Mainstream healthcare provision is state-funded and 95% state-provided (treating GP practices as within the NHS).</td>
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Discussions on international comparisons often focus on the USA but the whole structure and culture of healthcare there is fundamentally different. It is to the social democracies of Western Europe that we should look when considering the relationship between pluralism, the use of a range of different types of provider, and performance of the different healthcare systems.

When one does so, even recognising the problems in making international comparisons in healthcare because of the societal and historical differences, the main indicators (from the World Health Organization and Eurostat) do suggest that the more pluralist systems of, for example, France, the Netherlands and Spain, are making better progress on a number of fronts than those countries, such as the UK and Denmark, that have favoured an overwhelmingly state-funded and provided system. Other

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**Figure 5. Mortality rate from all causes per 10,000 inhabitants from 1980–2009**

![Graph showing mortality rates from 1980 to 2009 for various countries.](image)

Source: WHO/Europe, European mortality database (MDB), July 2011

**Figure 6. Mortality rate – deaths per 1,000 inhabitants in 2010**

![Bar chart comparing mortality rates in 2010 for France, Spain, Netherlands, Denmark, and UK.](image)

Source: Eurostat statistics in focus 38/2011
The discussion about the role of the independent sector in the NHS has been poorly grounded in evidence and fact. It has failed to recognise the symbiotic nature of the relationship between the sectors. As a result, the debate has created false impressions and unjustified concerns among the public. A more measured, considered discussion is needed that respects the long-standing reality that the sectors have always, and will always, need to work together. In an age when all health economies face similar problems, we cannot afford to engage in prejudice or ignore facts, including the most relevant international comparisons.
NHS Partners Network

NHS Partners Network (NHSPN) was established in 2005 and incorporated into the broader NHS Confederation in June 2007. The network represents a wide range of independent sector providers of NHS services, ranging through acute, diagnostic, primary and community care. Its members are drawn from both the 'for profit' and 'not for profit' sectors and include large international hospital groups and small, specialist providers. All members are committed to working in partnership with the NHS and to the values set out in the NHS Constitution.

For further details about the work of NHSPN, visit www.nhsconfed.org/nhspn or email NHSPartnersNetwork@nhsconfed.org