Using the private sector to help the NHS – is Labour intent on repeating the mistakes of the past

Wes Streeting, Secretary of State for Health and Social Care, has made it very clear that Labour will invest in the private sector in an effort to improve NHS performance. This means both increased use of private providers and embracing health care entrepreneurs. The party manifesto states that Labour will use spare capacity in the independent sector to ensure patients are diagnosed and treated more quickly. However, the proposition that the private sector has spare capacity and that this could be used without any adverse consequences for the NHS has been strongly contested.

In fact, an article in the British Medical Journal drew attention to the reality that we just do not have the information on private sector staffing, hospital capacity, outpatient services, and prices, all of which are necessary to understand the implications of boosting private sector activity on the healthcare workforce, demand for services, and healthcare quality. David Rowland of the Centre for Health in the Public Interest has also set out how Labour's plans have the potential to increase the risk of the NHS becoming a 'poor service for poor people' not least because one consequence of the private sector business model is prioritisation of well-off patients.

Darzi review

Lord Darzi has carried out an 'independent' investigation into the performance of the NHS. Streeting has described this exercise as 'the survey, before we draw up plans to rebuild it anew, so it can be there for all of us when we need it, once again'. He went on to say that the review would be aimed at diagnosing the problem so ministers could 'write the prescription'. [Darzi published 12 September – see KONP initial analysis here] However, diagnoses from expert 'think tanks' are hardly in short supply.

For example, the last government commissioned the King's Fund to explore why the NHS could not tackle the care backlog, only to be told it was down to austerity, years of denying funding, too few staff, too little equipment and too many outdated buildings. Lord Darzi has reached the same conclusions. But Streeting, Starmer and Reeves are using the findings as 'symptoms' of a 'broken NHS' to pursue their pre-determined treatment plan of 'reforms', austerity and use of the private sector.

Evidence-based treatment

In the modern era, treatment (even when offered by ministers) has to be more than just writing a prescription and must be evidence-based. This means firstly using a scientific methodology to sift through data. The best available science is then combined with the insights from clinical experience of healthcare professionals, together with the values of patients in order to come up with the best plan. It is already known that most of the public are opposed to private sector involvement in the NHS. Ways of exploring the views of patients should include engagement with trade unions and civil society organisations. Labour currently appears not to be looking at evidence from its own past experience and

what might be learned from previous public-private partnerships. A crucial example here are Independent Sector Treatment Centres (ISTCs) introduced under the Blair government.

Independent Sector Treatment Centres

Under Tony Blair, New Labour advocated using NHS funds to pay for treatment in the independent sector. This began in 2000 when Health Secretary, Alan Milburn, signed a 'concordat', through which the simplest elective (i.e. non urgent) cases could be sent by health authorities to be treated in private hospitals (although often at much higher cost). At the time, Milburn said: "It is intolerable that spare capacity in the private sector is not used in the NHS to ensure patients receive care in as timely a manner as possible". Unlike Streeting, he stopped short of saying only middle class lefties could be opposed to the plan! The British Medical Association pointed out that the concordat did not address the fundamental problem of shortage of doctors and nurses.

The concordat was followed by contracts with the private sector to provide Diagnostic and Treatment Centres and then ISTCs, initially to be run and staffed by overseas companies. Many campaigners warned from the outset that the creation of a new, government-sponsored independent sector could seriously weaken existing NHS hospitals, depriving them of vital income and disrupting the training of doctors by hiving off many routine operations to tiny private units. Such adverse effects are currently being seen in relation to outsourcing elective care, with ophthalmology and cataract surgery being a striking example.

Justification for ISTCs was based on claims they would increase elective capacity available to the NHS and reduce waiting lists and times; reduce charges in the private sector; increase patient choice within the NHS; encourage best practice and innovation; stimulate reform within the NHS through competition. Payment arrangements heavily favoured the private sector: while NHS units were only paid per patient, ISTCs were given five-year contracts that ensured they would be paid a guaranteed fee whether or not the planned number of patients turned up. This meant they were paid 11.2% above the NHS average, despite leaving complex patients to the NHS. It also led to GPs being pressurised to refer to ISTCs because the primary care trusts (PCTs – commissioners of hospital services at the time) had to pay for activity whether or not it was used.

In addition, there were serious concerns raised about the quality of care related to staffing issues, with the NHS then having to pick up the pieces. Many clinicians considered that ISTCs had an adverse effect on local services. Data was lacking, and failed to support government claims that independent sector treatment centres offered high productivity, high quality health care, or value for money.

What did the experiment with ISTCs achieve?

The House of Commons Health Select Committee reported on ISTCs in 2006. The findings are striking and worth quoting:

'We concluded that ISTCs had not made a major direct contribution to increasing capacity. ISTCs have had a significant effect on the spot purchase price and increased patient choice,

offering more locations and earlier treatments. However, without information relating to clinical quality, patients are not offered an informed choice. We found that ISTCs have embodied good practice and introduced innovative techniques, but good practice and innovation can also be found in NHS Treatment Centres and other parts of the NHS. ISTCs are not necessarily more efficient than NHS Treatment Centres. The Department claims that ISTCs drive the adoption of good practice and innovation in the NHS, but we received no convincing evidence which proved that NHS facilities are adopting in any systematic way techniques pioneered in ISTCs…… The Department of Health has carried out analysis of the possible effects of the ISTC programme on NHS facilities, but it has refused to disclose the analysis to us. Phase 2 ISTCs may lead to unpopular hospital closures under 'reconfiguration' schemes…. We are not, however, convinced that ISTCs provide better value for money than other options such as more NHS Treatment Centres, greater use of NHS facilities out-of-hours…. All these options would more readily secure integration and may be cheaper'.

The ISTC programme proved to be especially important as a Trojan horse to three of the large private healthcare providers operating in the UK today: Spire, Care UK (now known as the Practice Plus Group) and Ramsay Healthcare, whose initial growth can be traced back to the ownership of ISTCs in the early 2000s.

Conclusions

Under the Blair government, Labour showed an ideological commitment to the private health care sector. Policies were not well supported by evidence and promised benefits failed to materialise, while there were adverse consequences for NHS services. Labour's current approach is not a re-run of ISTCs, but the Government is committed to making use of the private sector to tackle the NHS waiting list, alongside a refusal to commit to more funding. Is this good use of limited resources? There is little evidence to support claims that the private sector provides better or cheaper care. Experience during the covid pandemic shows that money can be thrown at the private sector with very little return in value (e.g. Nightingale hospitals; Personal Protective Equipment; Test and Trace; block booking of beds).

According to the King's Fund, multi-year funding increases were crucial to bringing about the major improvements in NHS performance between 2000 and 2010. The dramatic deterioration in performance since 2010 is a result of much lower funding increases, limited funds for capital investment, and neglect of workforce planning.

If Labour is serious about rebuilding the NHS anew, it needs to examine the evidence from its own previous practice and reach the appropriate conclusions about what does and what does not work – time to show leadership and courage!