New providers in UK health care

Penelope Dash

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What effect will more competition have on the NHS?

St Albans, Hertfordshire AL1 4HH
Penelope Dash
independent advisor in health care
pennydash@aol.com

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Over the past 5-10 years the European airline market has been completely transformed by the introduction of new players. Through a combination of adding capacity and radically changing traditional ways of working, Ryanair and Easyjet have effectively challenged the status quo among the traditional incumbents (British Airways, Alitalia, Air France, etc) and created a whole new approach to air travel across Europe. Can the same transformation happen in health care?

The current UK government hopes so. Since its election to office in 1997, the government has set itself an ambitious strategy to substantially improve health care. The strategy has three key planks—improvement of quality, expansion of capacity, and introduction of new incentives (in particular customer choice[1]) to drive through radical changes (box). This article explores how the expansion of capacity through opening up health care to new providers, combined with increasing consumer choice, will change the way in which health care is provided and used.

New providers to increase capacity

The NHS Plan focused on increasing capacity and put at its heart key targets for the reduction of waiting lists and waiting times for planned elective care.[2] By 2005, no patient will have to wait more than six months for a routine operation, and by 2008, waiting times will be less than three months.

Mechanisms for implementing three key components of NHS strategy

Improving quality
- National service frameworks
- New general practice contract
- Commission for Healthcare Audit and Inspection, other inspectorates, National Institute for Clinical Excellence

Increasing capacity
- NHS Plan
- New providers

Creating incentives for change
- Choice initiative
- Star ratings
- Reforming financial flows
- New staff contracts
- Commissioning role for primary care trusts
- Vouchers?

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Changes in health care could bring substantial benefits to patients

Increased capacity will be achieved partly by expanding existing NHS services but also by purchasing services from non-NHS organisations—so called plurality of provision.[3] The approach is not entirely new; the NHS has been buying in some types of care (terminations of pregnancy, mental health care, magnetic resonance imaging) from non-NHS providers for many years. Nevertheless, the size and scale of this initiative is considerably different.

In September 2003, the government announced the list of preferred providers who will set up and run independent treatment centres (formerly known as diagnostic and treatment centres) across England.[4] To reduce waiting lists, an additional one million cases a year will need to be treated, and the centres will handle up to a quarter of these. Most of the work will be in orthopaedics and ophthalmology—specialties with the longest waiting lists. The table lists the successful bidders

Of note is the absence of traditional private healthcare providers—for example BUPA, Capio, and HCA. This is thought to be because they have a higher cost base than the new providers, partly as a result of the higher fees traditionally paid to British consultants working for these companies.[5]

Potential benefits of new providers

These new organisations will be an important but relatively small component in the drive to reduce waiting lists. Their challenge to traditional working practices may have much greater impact. In particular, new providers are able to deliver improvements in throughput, reductions in costs, and new approaches to patient care.[6]

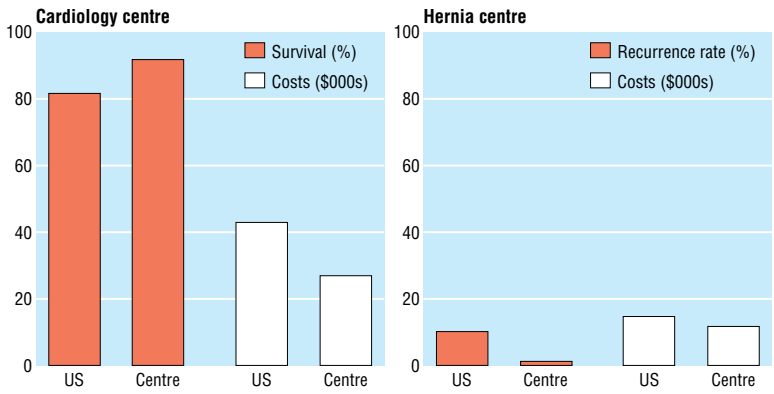
Greater throughput is achieved by focusing organisations or teams of staff on specific diseases or procedures, adopting strict care pathways for each condition, and implementing good operational management.[7] This results in lower costs and, as a bonus, improved clinical outcomes (figure).[8] The capacity to deliver quality care at lower costs led to the new providers winning contracts for treatment centres over the current private sector players.[9]

New providers are also able to adopt new approaches to patient care more rapidly than the NHS, which is often tied down by bureaucracy, traditional employment practices, and long ingrained ways of working. For example, one new provider will be delivering orthopaedic services across a wide geographical area. In order to reduce patients' travelling time, a mobile team will travel around the area to deliver outpatient care, diagnostics services, and surgical interventions in a one-stop approach. The approach is underpinned by good information technology, communication, management support, and common operating principles across the teams.

Implications for existing providers

Existing private providers potentially face a double whammy: the loss of traditional private practice as waiting lists are reduced and the loss of contracts for treatment centres to new providers. They will need to change their working practices to compete successfully.

NHS organisations are similarly reviewing existing ways of working and learning from new providers how to deploy resources more effectively. For example, the flagship treatment centre run by the NHS at the Central Middlesex Hospital has sought to adopt world class practices; as a result it has been able to substantially improve productivity and quality (Central Middlesex Hospital, personal communication). Indeed, a group of NHS treatment centres have recently set up NHS Elect (a not for profit company) to compete with private companies in future bidding rounds for treatment centres.



Examples of improved quality and lower cost from US cardiology centre and Canadian hernia centre compared with US average performance. Data on survival for cardiology are average of one year for whole of United States and of five years for cardiology centre. Source: McKinsey and Co, unpublished data

Potential issues to be overcome

These new approaches to providing health care raise several issues that will need to be considered—in particular, training needs. Even though the current volumes of work being transferred from the NHS to the private sector are small, they represent an opportunity for staff to train in new organisations and benefit from exposure to different approaches.

Robust preoperative assessment of patients will be needed to ensure that only appropriate cases are managed in separate facilities. Quality of care will have to be measured in more sophisticated ways to ensure that the different case mixes being cared for in different centres are taken into account. And information about quality will need to be made more available to users to enable them to make appropriate decisions about when and where to access care.

Increased competition inevitably means increased capacity, as more players enter the market and all are driven to maximise efficient use of resources. This may result in an overcapacity of beds, operating theatres, diagnostic facilities, and even staff. This will be a novel experience for the United Kingdom, and new financial

Successful bidders to run private treatment centres

Company	Type of treatment centre	Details/background
Anglo-Canadian	London chain for orthopaedics and general surgery	Consortium including Calgary Health Region, University of Calgary Medical Group, Surgical Centres Inc, and others
Nations Healthcare	2 general centres	US company specialising in commissioning and providing day case surgery
New York Presbyterian	2 general centres	US hospital partnered with WS Atkins (UK buildings and services provider)
Mercury Health	Chain for orthopaedic and general surgery across the United Kingdom	New company formed by Tribal (conglomerate of healthcare consulting companies based in UK) with Ascent Health (part of Johnson and Johnson USA)
	1 general centre	
Care UK Afrox	2 general centres	Partnership between Care UK (residential and nursing home provider), Alliance Medical, and Afrox Healthcare (largest provider of independent health care outside United States)
	1 orthopaedic and general surgery centre	
Netcare	Ophthalmic chain across the United Kingdom	Largest South African provider of integrated healthcare services
	1 general centre	
Birkdale clinic	1 general centre	UK based group

systems[10] will have a key role in ensuring it doesn't result in less efficient working practices—for example, longer lengths of stay.

The impact on existing NHS facilities also needs to be considered. Some NHS providers may have a higher proportion of emergency cases than other providers. This will need to be better managed, with an increased ability to predict likely variations in demand and match resources to manage it more effectively. NHS providers are also more likely to deal with the more complex cases, which has implications for resource requirements. And they may be required to manage complications arising from non-NHS providers—clear processes and protocols will need to be in place to underpin this.

Integrating new providers with existing NHS organisations more generally will be important. The interface between primary care and intermediate care, for example, will need to be carefully managed to ensure that improved care pathways can be realised.

Finally, the implications for staffing will be important. Initially, the new providers will be largely staffed by overseas clinicians. Over time, however, UK trained staff may apply for posts in these organisations. The NHS will have to become a "better employer" to compete for staff as well as for patients.

Where next?

If this limited outsourcing of elective care to the private sector proves successful, where might the government look to next? Diagnostics could be the next area of focus. Both major political parties have already aired the concept of vouchers, and diagnostics would be ideal for a pilot. Potentially any patient needing one of a shopping list of diagnostic procedures or an annual health check could be given a voucher to redeem where they chose. This could be with existing providers of diagnostic services, such as Alliance Medical, or new providers, such as supermarkets, gyms, or high street pharmacists.[11]

Primary care could also be opened up to new players. Some entrepreneurs are already spotting an opportunity and developing new private primary care services. Examples include Primecare, U-First-Healthcare, and Doctors Direct.

But perhaps most interest will come from new approaches in the management of chronic disease.[12] Encouraged by research suggesting that better integrated care can reduce costs,[13] the government has funded two US companies (Kaiser Permanente and United Healthcare) to work with primary care trusts across England to explore the potential to deliver care in new ways. The next step could be for primary care trusts to contract directly with organisations to provide care for groups of patients with chronic diseases such as asthma, diabetes, or heart disease.

Conclusions

The government's recent attempts to open up the UK healthcare market to new providers look set to continue. This could result in a dramatically different healthcare system—one in which the NHS is a commissioner or purchaser of healthcare services provided by a range of organisations, all competing to drive up quality and efficiency to ensure they attract more patients. Will it work?

Summary points

- Several new private providers have recently been awarded contracts to provide healthcare services for the NHS
- In future, NHS organisations will compete with private providers to attract patients
- New providers are introducing new ways of working, resulting in faster throughput and lower costs than traditional private providers
- Existing providers (NHS and private) are having to re-examine how they provide care
- The initiative may expand to include diagnostics, primary care, and chronic disease management services

Only time will tell. But if the airline business is anything to go by, things will certainly be different, and the cosy duopoly of the NHS and mainstream private providers will be a thing of the past.

Competing interests: PD works as a paid advisor to a range of organisations including the NHS, think tanks, charitable organisations, pharmaceutical companies, McKinsey & Co, and private sector healthcare providers.

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Endpiece

Expelling patients 1778

Such patients are to be expelled from the infirmary: (1) Who at their admission falsified their disease, or intentionally concealed any material part of it. (2) Who refuse the food, drink, medicines, or operations prescribed, or take any medicines, drink, or food, not ordered by the physicians or surgeons.

The History and Statutes of the Royal Infirmary of Edinburgh. Edinburgh: E Balfour and Smellie, 1778:76-7

Jeremy Hugh Baron, honorary professorial lecturer, Mount Sinai School of Medicine, New York