Institute for Fiscal Studies

Recent trends in independent sector provision of NHS-funded elective hospital care in England

IFS Briefing Note BN268

George Stoye

Nuffield Foundation

Recent trends in independent sector provision of NHS-funded elective hospital care in England

George Stoye

Copy-edited by Rachel Lumpkin

Published by

The Institute for Fiscal Studies

ISBN 978-1-912805-55-6

Funding for this work from the Nuffield Foundation is gratefully acknowledged. The author thanks NHS Digital for access to the Hospital Episode Statistics under data sharing agreement CON-205762-B8S7B.

Executive summary

Ahead of the upcoming General Election, there has again been extensive discussion about the role that the private sector plays within the National Health Service (NHS). Labour has vowed to 'end and reverse privatisation in the NHS in the next parliament', signalling an ambition to end – or at least significantly reduce – the role played by private providers in treating NHS-funded patients.[1]

This briefing note sets out recent trends in the provision of NHS-funded hospital care by private providers – commonly referred to as independent sector providers (ISPs) – in England. We show that ISPs play a small but growing role in providing pre-planned care to NHS patients, and that this role is much larger for some procedures and in some regions. Policy to reduce this role would require careful planning and a meaningful increase in NHS hospital capacity to prevent falls in some areas of NHS activity.

Key findings

In 2018–19, the NHS purchased £14.0 billion (2019–20 prices) of care from non-NHS providers. This accounted for 11% of the Department of Health and Social Care day-to-day expenditure. Two-thirds of this spending (£9.4 billion) was to purchase a variety of care for NHS patients from ISPs.

ISPs account for a small, but growing, share of NHS inpatient activity. They provided 609,549 NHS-funded elective episodes in 2017–18 (6% of all NHS elective activity) compared with almost none in the mid-2000s.

Wider NHS activity has increased substantially over the last 15 years, with ISPs accounting for one-sixth of this growth. The total number of NHS-funded elective episodes grew by 3.8 million (59%) between 2003–04 and 2017–18, 16% of which were conducted by ISPs.

The NHS is becoming increasingly reliant upon ISPs for some types of elective work. For example, in 2017–18, ISPs conducted 30% of all NHS-funded hip replacements, 27% of inguinal hernia repairs and 20% of cataract procedures. Replacing this capacity within NHS providers would therefore require careful planning.

In some cases, ISPs have provided additional capacity for the NHS, while in others they appear to have been used as an alternative provider of care. 82% of the growth in hip replacements between 2003–04 and 2018–19 was accounted for by ISPs. ISPs carried out 13,478 additional hernia repairs over the period, while NHS volumes fell by 18,267, representing a large shift in activity in this area away from NHS hospitals and towards ISPs instead.

[1] See the Labour Party's 2019 election manifesto, https://labour.org.uk/wp-content/uploads/2019/11/Real-Change-Labour-Manifesto-2019.pdf.

There are large geographical differences in the use of ISPs across England. ISPs conducted over 40% of NHS-funded hip replacements in the East Midlands and the South East. This compares to only 11% in London.

What role does the independent sector play in the provision of NHS hospital care?

The vast majority of healthcare in England is publicly funded and available free at the point of use through the NHS. NHS-funded hospital (or secondary) care has traditionally been provided by large, publicly owned and run hospitals, with a very limited role for private providers restricted to providing additional capacity to the NHS on an ad hoc basis when required. This is in contrast to primary care, where privately owned general practitioners (GPs) contract with the NHS to provide publicly funded primary care to NHS patients.

In 2018–19, the Department of Health and Social Care (DHSC) spent a total £14.0 billion on non-NHS providers of care (2019–20 prices).[2] £9.4 billion (66.8%) of this was spent on purchasing healthcare from ISPs, while the rest was spent on care provided by local authorities (£3.0 billion, 21.1%), the not-for-profit sector (£1.7 billion, 11.8%) and the Devolved Administrations (£50 million, 0.4%).

One area in which ISPs are active within the NHS is in the provision of elective (pre-planned) secondary care. From the mid-2000s, a set of reforms formalised and expanded the use of the private sector in providing elective NHS-funded secondary care, with the aims of boosting NHS capacity, reducing waiting times and stimulating improvements in care through greater patient choice.[3] Emergency care remains almost exclusively provided by public hospitals.

ISPs include both Independent Sector Treatment Centres (ISTCs) – purpose-built facilities treating only NHS patients but run by private providers – and pre-existing private hospitals that treat NHS patients as well as private-pay patients. In both cases, patients receive free care (as they do with all other NHS hospital care) but this treatment is carried out by a non-NHS healthcare provider, which is paid the same price as an NHS hospital for treating patients for a specific condition.

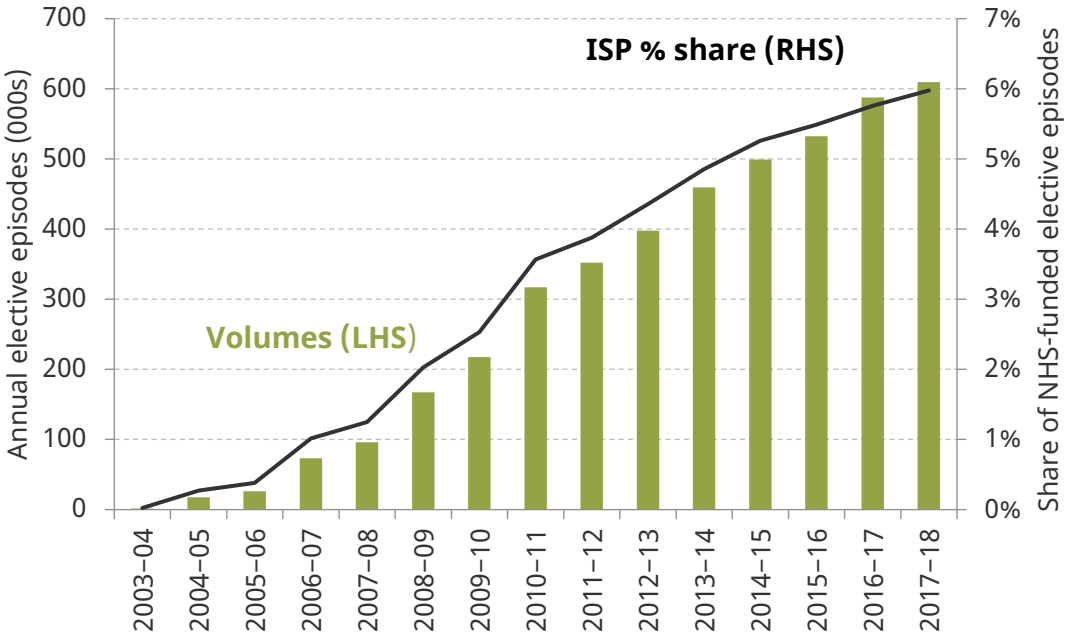
[2] See Table 37, Department of Health and Social Care Annual Reports and Accounts 2018–19, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832765/dhsc-annual-report-and-accounts-2018-to-2019.pdf. 2019–20 prices are calculated using the GDP deflator from the Office for Budget Responsibility Public Finances Databank (accessed November 2019).

[3] Naylor, C. and S. Gregory (2009), 'Briefing: Independent sector treatment centres', London: King's Fund, https://www.kingsfund.org.uk/sites/default/files/Briefing-Independent-sector-treatment-centres-ISTC-Chris-Naylor-Sarah-Gregory-Kings-Fund-October-2009.pdf.

ISPs provide a small but growing share of NHS-funded elective activity

Figure 1 shows the number of NHS-funded elective episodes of inpatient care at ISPs in each financial year between 2003–04 and 2017–18.[4] The figure (green bars) shows that inpatient activity at ISPs has increased substantially over time. In 2003–04, the year in which the first ISPs were announced, just 1,510 elective episodes of care took place in ISPs. Elective volumes at ISPs increased considerably from the mid-2000s, growing particularly strongly after 2006–07. In 2017–18, ISPs accounted for 609,549 elective episodes, or 6.0% of total NHS-funded activity (as shown by the black line and the right-hand side axis).

Figure 1. Annual volume of NHS-funded elective episodes at ISPs, 2003–04 to 2017–18



Note: Activity defined at the episode level. An elective episode is defined as a pre-planned period of care under the responsibility of a hospital consultant. ISPs are providers with provider codes beginning with 'N' or 'A'.

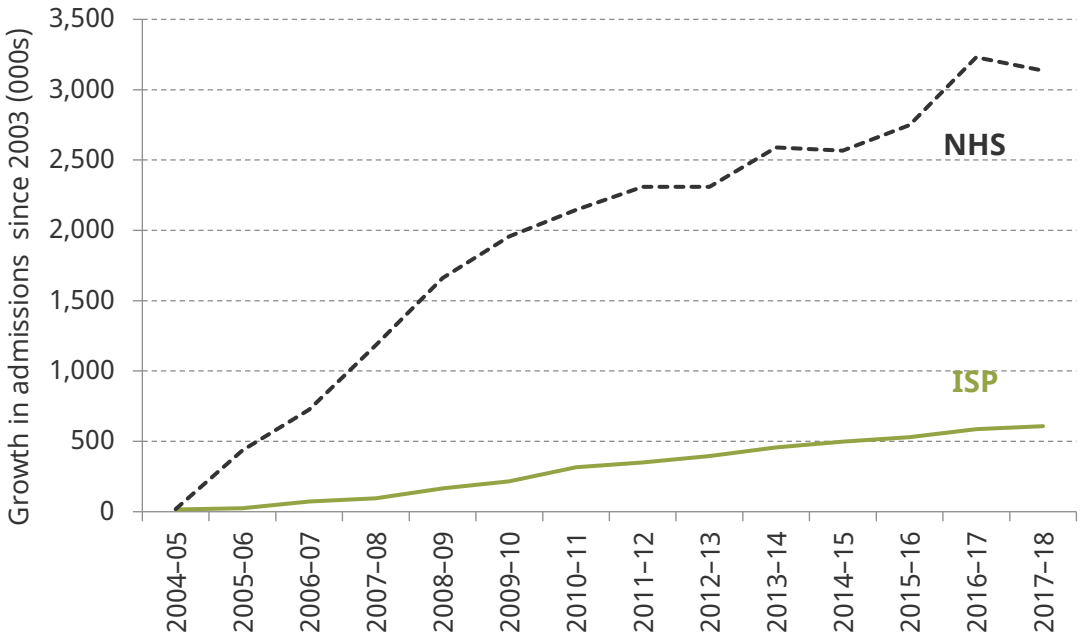
Source: Author's calculations using Hospital Episode Statistics Admitted Patient Care data.

ISPs have therefore played an increasingly important role in providing inpatient care since the mid-2000s. However, it is important to note that while volumes have increased at ISPs, this increase still only represents a small part of the growth in NHS activity over this period, with the vast majority of additional procedures taking place at NHS hospitals. Figure 2 shows the change in elective inpatient episodes at ISPs (green solid line) and all other NHS providers (black dotted line) between 2003–04 and 2017–18. Over this period, NHS-funded elective episodes at NHS hospitals increased from 6.4 million to 9.6 million, an increase of 48.8%. Combined, total NHS-funded elective episodes increased by 3.8 million, or 58.8%. This means that one-sixth (16.1%) of the additional NHS-funded elective

[4] An episode of care is defined as a period of care under the responsibility of a single hospital consultant. Patients may undergo multiple episodes of care within the same hospital spell.

episodes over this period were provided by ISPs, with the remaining five-sixths of additional care being carried out by NHS providers, predominantly NHS acute trusts.

Figure 2. Growth in annual NHS-funded elective admissions, by provider type, 2003–04 to 2017–18



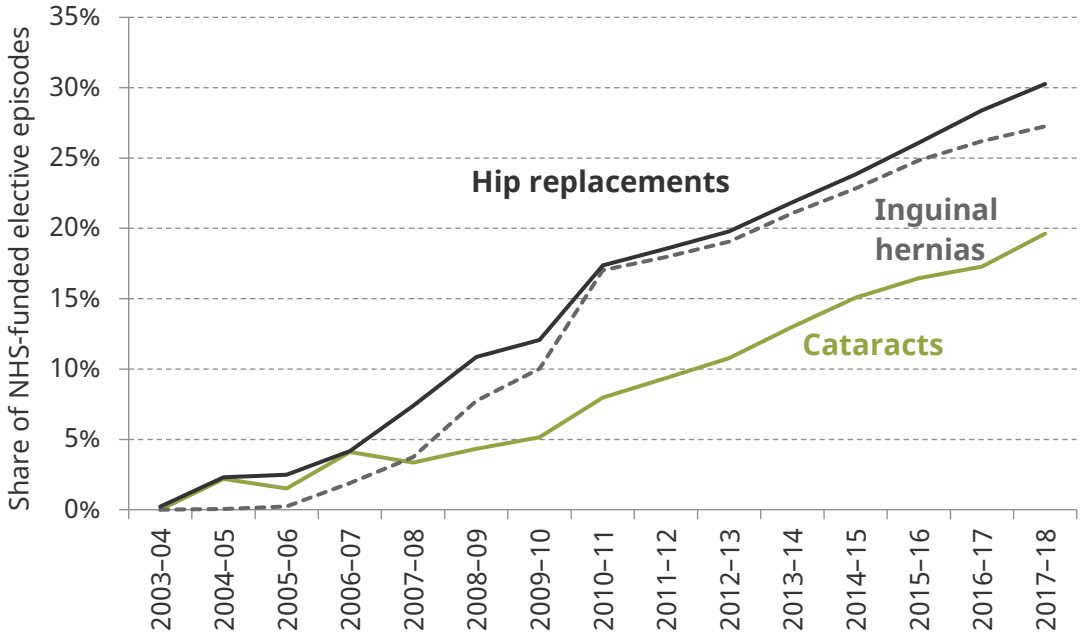
Source: Data underlying Figure 1.

ISPs account for a much higher share of some routine procedures

ISPs have become particularly important in providing certain types of NHS-funded care. Figure 3 shows how the share of NHS-funded procedures conducted by ISPs has changed for three procedures: cataract removal, primary inguinal hernia repair and hip replacement. All three are examples of common procedures that are funded by the NHS, and for which ISPs have developed a significant role over the past 15 years. In 2003–04, there was essentially no NHS-funded activity undertaken by ISPs. By 2017–18, ISPs accounted for 19.6% of all NHS-funded cataract surgeries, 27.3% of inguinal hernia primary repairs and 30.3% of hip replacements. This suggests that while the overall role played by ISPs in providing NHS hospital care remains quite small, they play an important role for particular conditions. Replacing capacity in these areas would therefore be difficult without significant increases in capacity within NHS hospitals.

Indeed, while the NHS remains the dominant provider of publicly funded care in each of these areas, the more recent increases in capacity in these procedures have been driven by ISPs. Figure 4 shows the number of NHS-funded hip replacements by provider type between 2003–04 and 2017–18. Over this period, the annual number of surgeries within NHS hospitals increased by 5,101. This increase compares to the 23,354 (82.0% of the total increase) additional procedures taking place at ISPs over this period. ISPs therefore accounted for more than four-fifths of the total increase in NHS-funded hip replacements.

Figure 3. Share of NHS-funded elective episodes conducted by ISPs, by procedure type

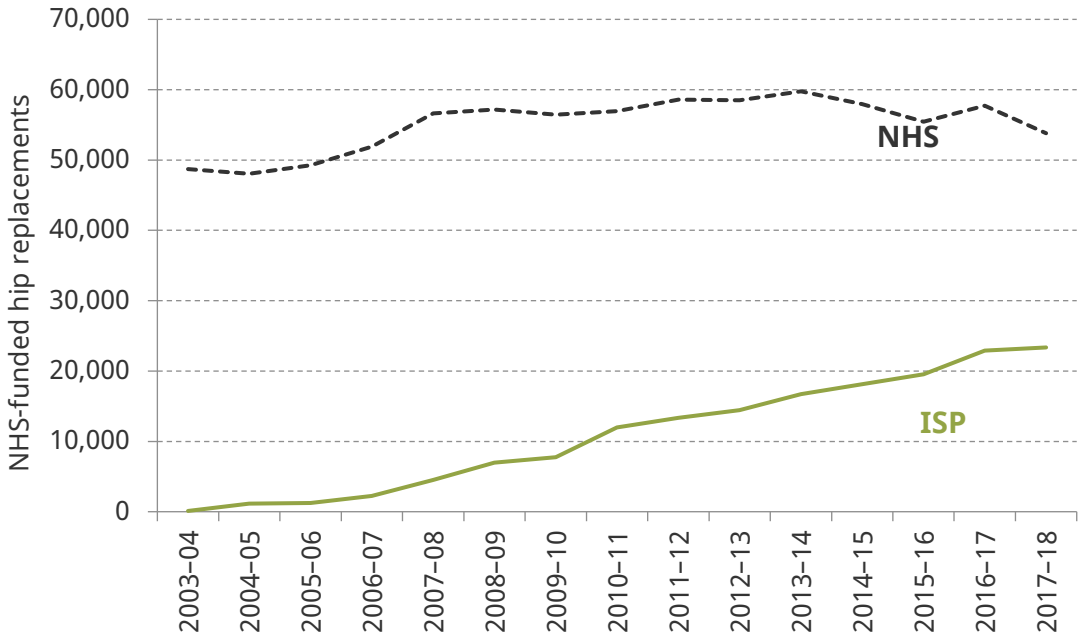


Note: Patients are classified as having a procedure if any of their primary or secondary procedure codes include appropriate OPCS Classification of Interventions and Procedures version 4 (OPCS-4) codes. Cataract procedures are defined by codes C71, C72, C74 and C75.1. Primary repair of an inguinal hernia is defined by code T20 for patients with a primary diagnosis (ICD-10 code) of K403 or K409. Hip replacements and knee replacements are defined in line with National Joint Registry definitions of primary and revision procedures (OPCS codes are available at http://www.njrcentre.org.uk/njrcentre/Portals/0/Documents/OPCS4%20Procedure%20Codes%20used%20in%20NJR%20Annual%20Report.pdf?ver=2012-02-15-165150-000. ISP and elective definitions are the same as set out in the notes to Figure 1.

Source: Author's calculations using Hospital Episode Statistics Admitted Patient Care data.

This pattern is even starker in the case of hernia repairs. Figure 5 shows that while ISPs carried out 13,478 additional procedures over the period, NHS volumes fell by 18,267 (and therefore the total number of NHS-funded procedures fell). This represents a large shift in activity away from NHS hospitals and towards ISPs instead.

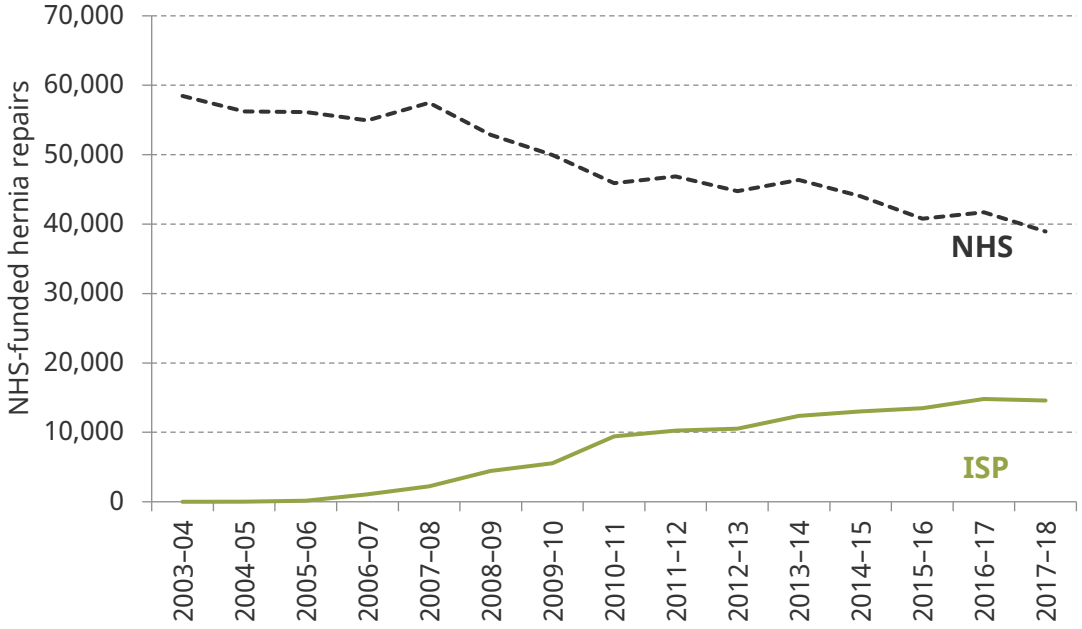
Figure 4. Volume of NHS-funded hip replacements by provider type, 2003–04 to 2017–18



Note: Patients having hip replacements are defined as in Figure 3.

Source: Author's calculations using Hospital Episode Statistics Admitted Patient Care data.

Figure 5. Volume of NHS-funded inguinal hernia primary repairs by provider type, 2003–04 to 2017–18



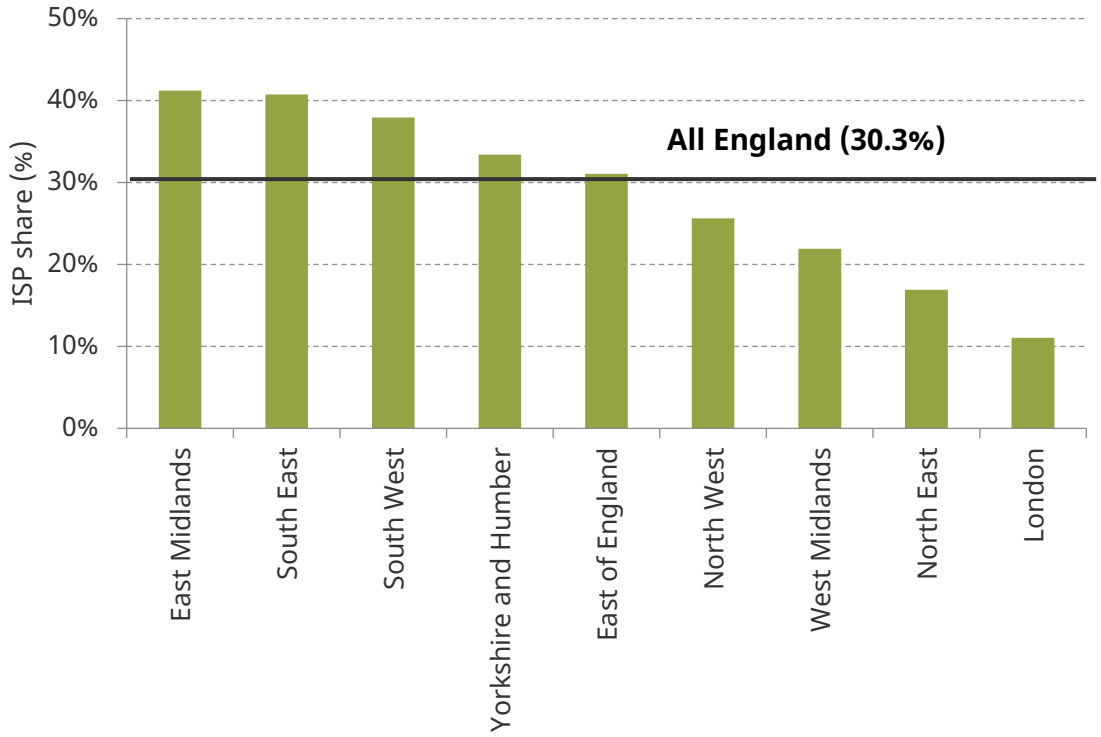
Note: Patients having primary repair of an inguinal hernia are defined as in Figure 3.

Source: Author's calculations using Hospital Episode Statistics Admitted Patient Care data.

Use of ISPs varies considerably across the country, with the lowest use in London

There is considerable geographical variation in the use of ISPs across the country, even for procedures where ISPs are playing a prominent role in providing NHS-funded care. Figure 6 shows the percentage of NHS-funded hip replacements conducted by ISPs in 2017–18 in each region, compared to the national ISP share of 30.3%.

Figure 6. Share of NHS-funded hip replacements conducted by ISPs in 2017–18, by region



Note: Hip replacements are defined as in Figure 3.

Source: Author's calculations using Hospital Episode Statistics Admitted Patient Care data.

In 2017–18, more than 40% of hip replacements in the East Midlands and the South East took place at an ISP. This contrasts with only 11.1% in London, which has a much smaller ISP share than each of the other regions. These differences in the use of the ISPs – albeit for one single procedure – could reflect differences in the availability of NHS and non-NHS hospital resources, variation in demand increases, different decisions taken by local commissioners, or a combination of all three. Policies to reduce the role of the independent sector in providing NHS-funded elective care could therefore have different consequences for different regions of the country, with a greater need to find alternative NHS capacity in areas where ISPs account for a larger share of elective procedures.