Editorial

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Nuclear medicine in the transition to private clinical care

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Government policy is to use part of the NHS budget to create a new private health-care sector capable of competing with NHS providers [1]. The consequence is that NHS patients, services and staff will move from the NHS into the private sector. Nuclear medicine is now being included in this privatization programme.

The privatization programme is being spearheaded by contracts with new Independent Sector Treatment Centres (ISTCs). The first wave of these began work in October 2003, with an emphasis on elective surgery, plus a substantial element, only recently made public, [2] of diagnostic procedures. (In evidence given to the House of Commons Health Committee in 2006, the Department of Health made no mention of the diagnostics element in these contracts.) The second phase, which begins this year, covers a much wider range of elective procedures. It also includes the creation of a variety of privately run centres known as Clinical Assessment and Treatment Services, or CATS, charged with vetting general practitioner referrals with a view to reducing the scale of hospital-based specialist treatment; plus a large expansion of the private diagnostic sector, including a PET/CT scan project covering the whole of England, shared between two private companies (Table 1).

The 23 first-wave ISTC schemes have contracts for a total of 912 000 diagnostic procedures over 5 years (an average of 182 000 per year). The second wave involves contracts for nearly 7.5 million diagnostic procedures over 5 years (an average of just over 1.5 million a year) [3]. The first and second wave of contracts will run concurrently, making a total of about 1.67 million diagnostic procedures a year to be provided by private companies. Diagnostic procedures are also included in three of the Phase 2 elective schemes, to a total of 350 000 a year [3].

The most striking aspect of the private schemes so far is the shortfall in the number of procedures actually undertaken. Wave 1 ISTCs are contracted to perform just under 880 000 elective procedures within a 5 year period; by the end of 2006 (more than 3 years from the start of the programme) they had undertaken a total of 114 000 [2]. Similarly, out of the 912 000 diagnostic procedures contracted for in the first wave, in the first 3 years just 60 000 had been undertaken [2].

Four main possible reasons for this may be identified. First, delays in getting facilities in place; second, reluctance on the part of some doctors to refer patients to ISTCs, or reluctance on the part of patients to be referred to them; third, difficulties in recruiting qualified clinical staff under the restrictions of the 'additionality' rule: ISTCs were supposed to add to the capacity of the NHS, and so could not employ anyone who had worked for the NHS in the previous 6 months; and fourth, the 'take or pay' element in the 'first wave' ISTC contracts, which means that the private providers have no short-term financial incentive to deliver, since they are paid for all the contracted procedures even if they are not performed (the NHS assumes the whole 'demand risk') [4].

Although doctors were recruited from overseas, and their UK registration was 'fast tracked', the private sector had difficulty in recruiting qualified staff from outside the NHS. The Department of Health made a number of concessions. The additionality rule could be waived on a 'case by case' basis [5]. This was subsequently formalized into a system known as 'structural secondments' so that, on average, just under 25% of Wave 1 ISTC clinical staff have been seconded from the NHS [6].

Now the Department of Health has signed contracts which increase the number of elective procedures to be done by private companies more than seven-fold (from about 170 000 to about 1 280 000 a year), and the number of diagnostic procedures more than nine-fold (from about 180 000 to about 1 680 000 a year). The question is how the staff needed to achieve these numbers are to be found.

One way is by recruiting NHS staff who want to work for ISTCs. For Phase 2 contracts the 'additionality rule' has been effectively abandoned. The only remaining ban is on recruiting NHS staff in 'shortage professions', but there is no agreed definition of 'shortage professions' [7], and the private companies can employ NHS staff even in shortage

Table 1 Phase 2 diagnostics contracts (services commencing in 2007) [3]

Scheme	Company	No. of procedures* per year	No. of staff
London	Inhealth Netcare	290 000	228
East	Inhealth Netcare	200 000	256
South West	Atos Origin	240 000	212
North East	AMC Diagnostics (Alliance Medical and Care UK)	154 000	240
North West	Atos Origin	230 000	220
South East	BUPA	100 000	176
West Midlands	Mercury Healthcare	188 500	231
England (north) PET/CT	Alliance Medical	48 000	37
England (south) PET/CT	Molecular Imaging Solutions (In Health Group)	43 000	19
Totals		1 493 5001	649

*With the exception of the all-England PET/CT scan scheme the range of procedures varies somewhat from contract to contract: they include echocardiography (screening), ECG, BP monitoring, endoscopy, phlebotomy testing, CT, MR, X Ray, DEXA and ultrasound imaging, audiology, nephrology, spirometry, flexible sigmoidoscopy and neurophysiology.

professions in their 'non-contracted hours'. In other words Phase 2 private contractors may employ NHS staff who are not in shortage professions, plus the non-contracted hours of those who are in shortage professions, plus seconded staff, and their operations can still be (and are) described as involving '100% additionality' [8]. For example, for the PET/CT scans scheme the Department states that 'Both schemes (northern and southern) are 100% additional activity and are not currently expected to involve NHS staff secondments. The additionality policy has been amended for this contract to allow contracted hours to be used by the provider'.

But it seems doubtful that the mix of fast-tracked foreign surgeons, voluntary NHS secondments and part-time work by NHS staff which has prevailed up to now will be sufficient to do the much larger volume of private sector work now contracted for, especially when one considers that this mix has succeeded in delivering only a fraction of the procedures contracted for in Wave 1. It seems more likely that a growing number of medical professionals will be forced to join the private sector as a result of medical unemployment resulting from the service closures and redundancies caused by NHS deficits, aggravated by the destabilizing effects of diverting patients from NHS trusts to ISTCs. The Department of Health forecast, for example, that there will be 10 000 unemployed junior hospital doctors later this year, and potentially 3200 surplus consultants by 2010–2011 [9].

A significant number of the Phase 2 contracts explicitly involve the planned transfer of NHS staff [10]. The Avon, Gloucestershire and Wiltshire scheme may need to have 20 NHS ward and theatre nurses seconded; the London North and South elective schemes both involve 'activity transfer' and 'minimal levels' or 'small numbers' of staff secondments; in two other cases investigations were said to be taking place into the 'potential effect' on NHS staff; in Lymington the work will be '100% transferred activity' and 'there will be opportunities for NHS staff who wish to, to work in the ISTCs'. And in the renal dialysis contract for a large area in the north of England a number of existing NHS units and their staff are to be taken over by Fresenius, the German contractor.

Thus, the Department of Health now acknowledges that the creation of a new private health-care sector means that NHS staff, or newly trained staff who would otherwise have worked in the NHS, will in future be employed by private, for-profit providers. As the chairman of the CBI's health-care panel noted 18 months ago, the scale of Phase 2 of the ISTC programme means that it is 'no longer about additionality; it is about transfer of services' [11], which, in practice, means transfer of staff.

None of this should come as a surprise. The ISTC contracts are simply fulfilling the Department of Health's intention, announced in June 2002, of creating 'a new sector in health-care provision in England', which is to be 'radically different from the traditional usage of the private sector, not least in that the NHS will be the core business of units in this sector; and ... managed and operated as independent sector units' [1]. The ISTC programme, focussing on relatively standardized and low-risk procedures, presented itself as an effective way of initiating this; and it is, in fact, following fairly closely the recommendations of a report on 'market sustainability', presented to ministers in July 2004, which said that a sustainable private health-care sector capable of creating 'a whole new pluralistic market', offering 'real competition to the NHS monopoly', would require a total of at least 700 000 procedures a year to be purchased from it [12].

The call by BMA leaders and others for 'integration' between NHS trusts and the ISTCs is misleading for both patients and staff. The reality is going to be that a growing share of medical employment will in future be on terms and conditions offered by corporations focussed on the bottom line. While NHS staff seconded to ISTCs in the short run may be able to remain on NHS terms (this seems currently uncertain), in the longer run profitability will depend on ISTCs being able to employ

less-expensive staff by changing the skill mix, terms of employment, and professional standards. It should be noted in this connection that the General Counsel of the Department of Health was emphatic in telling the House of Commons Health Committee that the private firms involved in these procurements are not bound to offer NHS terms of employment [13].

So far, NHS professionals have put up little resistance to these changes, or asked what they imply for professional standards, quality of care and patient access, as well as for national terms and conditions of service. But the process is accelerating, and the Prime Minister (Tony Blair) and Secretary of State for Health (Patricia Hewitt) have both recently declared that there is no upper limit to the share of the NHS budget that may be spent on private providers [14]. The time has come to challenge a process which has the explicit aim of subjecting the NHS to the pressures of competition and profitability in place of its founding value of universal care for all.

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