The Consequences of the Privatization of Surgeries in England & Scotland

Professor Allyson M Pollock and Graham Kirkwood

Summary

The National Health Service (NHS) is the United Kingdom's public health system. Established in 1948, the NHS is publicly funded through taxes and free at point of use. Equal access for equal need, not ability to pay has been the founding principle of the NHS. However, private payment (out of pocket and private insurance) for private hospital surgeries and diagnostics has existed since its inception. In 1999, health care was devolved giving Scotland and Wales more control over their budgets and policies. Since 2003, the health ministry for England has been using public funds to contract for-profit companies to provide elective hip, knee and cataract surgeries with the stated policy objective of reducing waiting times. There are over 155 private clinics operating in England for hip and knee surgery and 175 clinics for cataract surgery.

In contrast to England, Scotland's health minister decided to increase capacity in the public hospital system and nationalized a large private hospital for that purpose.

These reports show how England's policies are shrinking public provision of surgeries and creating a two-tier system with longer wait times for all patients. The poorest and less healthy patients suffer most with longer waits and less access to care due to reduced capacity in the National Health Service. The private sector use is destabilizing training and other services within the NHS. In contrast, Scotland increased capacity and in-house provision without using private sector contracts and without creating a two-tier system within the NHS.

Private health care services in England v. public hospitals in Scotland

In 2003 in England, the *Independent Sector Diagnosis and Treatment Centres* program (ISTCs – a euphemism for private for-profit clinics) was established. The health minister gave £1.6bn in public funding to for-profit private clinics in 2003, the funding doubled to £3bn by 2005. In 2012, changes to the NHS law made private contracting virtually compulsory for all services.

While England has expanded privatization and reduced public NHS capacity, Scotland chose to do the opposite. In 2003, the Scottish government bought the private for-profit Health Care International hospital in Glasgow and nationalized it for the NHS renaming it the NHS Golden Jubilee National Hospital. A three-year pilot project with a for-profit clinic owned by South African company Netcare, known as the Scottish Regional Treatment Centre, was cancelled in 2010 after showing poor value for money. Scotland more than doubled admissions for hip and knee surgeries and cataracts between 1997/98 and 2018/19 in the public hospital system, without use of private contracts.

The introduction of private providers into the NHS in England is associated with:

- a dramatic reduction in in-house NHS provision
- substitution of public provision by the private sector
- increasing waiting times for all patients
- increasing inequalities

- a two-tier system within the NHS operating in favour of the rich

In comparison, the expansion of public capacity and the Scottish parliament's refusal to expand private for-profit provision has resulted in:

- equal improvements in access to surgeries without using private for-profit clinics
- shorter wait times for all patients for all surgeries
- a smaller increase in inequalities with inequalities in England increasing at two and a half times faster rate than Scotland.

The Privatization of Hip & Knee Replacement Surgeries in England

England's policy has been to direct public funding to private for-profit companies through commercial contracts, transferring a range of services -- including elective surgeries -- out of NHS hospitals. Between 2016 and 2024, for-profit provision of hip and knee replacements increased from 20% to 60% and there are now over 155 private clinics.

Readmissions:

Readmissions due to complications are common. Around 5 – 6% of patients are readmitted to hospitals within 30 days of having had their elective surgery .

- 99.5% of all patients readmitted post-surgery (whether their surgeries were done in public hospitals or for-profit clinics) were readmitted to public hospitals and only 0.5% of readmissions went to private providers between 1997/98 – 2018/19
- readmissions from private for-profit clinics accounted for almost 120,000 "bed days" used or 'lost' in public hospitals
- as many as 60,000 patients on the waiting list for public hospitals may have been displaced by patients treated in private clinics and have to wait for longer.

Wait times:

- between 2003 and 2008 when very few NHS patients were treated in the private sector (7% at its highest) wait times more than halved for both hip and knee replacements
- after 2008/09, following the expansion in the use of for-profit providers, wait times rose for all patients, whether treated privately or in the NHS
- for every 1% increase in publicly funded private sector surgeries, the overall wait time has increased for all patients by 2%

The Privatization of Cataract Surgery in England

Cataract surgery is the most frequently performed surgical procedure undertaken in the National Health Service (NHS) in the UK. It has been the front line of privatization of services as it is a quick and easy operation and can be done as a day case clinic procedure. By 2024 the private sector undertook 1.7 times more operations than it was performing in 2019 and there are now over 172 private clinics in England -

From 2018/19 to 2022/23 the number of cataract operations performed in England increased by 25% to 600,000.

From 2019 – 2024, the proportion of cataract surgeries in England provided by for-profit clinics increased from 15% to 59%.

Admissions:

- admission rates more than doubled in England between 1997 and 2019 with a concomitant fall in waiting times

Wait times:

- wait times were around two thirds longer in England than in Scotland in 1997/98 which may have been due to England having more private practice

- the dramatic fall in waiting times after 2003 in England may have been due to changes in clinical practice and NHS doctors being able to supplement their NHS income with extra-contractual work within the NHS

- wait lists and wait times for other more complex eye procedures have increased

Higher costs in England:

- expenditure on cataracts approximately doubled from 2018/19 to 2022/23, from >£268m to >£522m and accounts for a higher share of the total eye budget.
- expenditure on private for-profit cataracts in this period more than quadrupled from >£59m to >£282m, accounting for most of the increase in expenditure.
- the NHS pays the for-profit clinics at higher rate than NHS hospitals,
- senior doctors have been reducing their NHS sessions in favour of undertaking lucrative cataract surgery in the private sector and some are setting up their own private clinics.

Less money for public hospitals due to private clinics:

- affects the training of junior doctors and all staff
- affects the availability of eye care for other serious conditions e.g. eye cancers, macular degeneration and diabetic eye disease.
- affects care of patients who have other chronic long-term eye diseases including glaucoma and medical retina conditions- many patients who need cataract surgery have chronic eye diseases.

Scotland achieved better results through its public system

In comparison to England, Scotland built capacity in its public system and achieved superior results without resorting to privatization:

- Scotland increased admissions at a similar rate to England without using the private sector, thereby maintaining its egalitarian character. In England, inequality in admissions increased at two and a half times the rate of Scotland.

- Overall wait-times were shorter in Scotland than in England by the final period of the study.

- Unlike England, Scotland continued to invest in training its health care professionals and thereby maintaining expertise in the public system.

- Scotland has also protected other eye services by ensuring a comprehensive eye service.

The Privatization of Hospital Surgeries: Lessons for Ontario from the United Kingdom

There has been a sharp escalation in the contracting of health services to private for-profit clinics and other private facilities to do elective surgeries in the UK. Virtually all of those surgeries were formerly conducted in the U.K.'s National Health Service hospitals which are the equivalent to Ontario's public hospitals.

In Ontario, under the Ford government, there has been a dramatic redirection of elective surgeries from public hospitals to private for-profit clinics. The privatization in Ontario has been slower than the government intended and remains not as radical as the English experience. However, the most recent $155 million funding increase for private for-profit clinics announced by Premier Ford this summer would double their current budgets and speed Ontario more perilously down the same road.

While privatization steamrolled through the English public hospital system, Scotland started down the path of surgical privatization then reversed course, nationalizing a large private hospital, cancelling a major private contract that did not show value for money, and increasing surgical volumes in public hospitals rather than private clinics.

The choice to take two separate tracks provides an important real-world comparison of outcomes. How did the country that expanded public hospitals rate next to the country that privatized the surgeries? Compared to England, wait times for all patients are lower and surgical services have expanded more equitably in Scotland. Costs are also considerably lower in public hospitals compared to the private clinics.

The reports released today reveal lessons from the experiences with surgical privatization in England and Scotland that should serve as a warning to Ontario's patients, health professionals and policy makers alike.

Parallels & Lessons from England and Scotland: Privatization of Cataract Surgeries

England:	Ontario:
The proportion of cataract surgeries done by private clinics in England increased from 15% to 59% between 2019 – 2024. Expenditure on cataract surgeries (both in public hospitals and private clinics) almost doubled between 2018/19 and 2022/23 with cataracts accounting for an increasing proportion of the total eye budget leaving less money for other eye services. Expenditure for private cataract surgeries quadrupled in this period. In England, while expenditure for cataract surgeries went up by nearly 95% the number of operations only increased 25%. Budgets are under pressure because of the high costs of paying private providers. The annual cost to the NHS of cataract surgery is estimated at around £600m. It has been estimated that just five companies alone extracted £90m in one year in interest payments and dividends from their NHS-funded cataract surgery.[1][4] This is money that could have been reinvested in the NHS, helping to ensure a sustainable service with better training and facilities. In England, the most affluent people benefitted from privatization at the expense of the most deprived sections of the population. By 2018/19, almost twice as many people were admitted from	Of 935,729 cataract surgeries done in Ontario between January 2017 and March 2022: 761,393 (81.4%) were done in public hospitals and 174,336 (18.6%) were done in for-profit clinics. (Link) After remaining stable until 2019, funding for private clinics increased by 30.8% between 2020/21 and 2023/24. In the same period, operational funding for public hospitals increased by 5.4%, less than the rate of inflation. Ontario is also paying more at private clinics. The Ford government is paying a premium of 20% from OHIP billings alone (not including extra user fees charged to patients) for each cataract surgery done at private clinics: they are funding public hospitals approximately $500 per surgery and private clinics are getting $605 per surgery and the for-profit hospital (the Don Mills Surgical Unit) is getting $1,264 for the same surgery.[2] In Ontario, public funding for eye surgeries in private clinics increased by 16.4% yet the number of operations done in private clinics only increased by 7.1% from 2017/18 to 2021/22. (Link.) A 2024 study published in the Canadian Medical Association Journal by Dr. Robert J. Campbell et al found that the expansion of private for-profit surgical centres in Ontario was correlated with increasing inequity in access to care. The highest

[1] *The Lowdown* mentions five companies: SpaMedica, CHEC, Newmedica, Optegra, and ACES.[11]

[2] The proponents of private clinics have tried to claim such comparisons are not fair because they do not account for hospital overhead costs. This is false. The pricing per procedure methodology in Ontario, euphemistically called "Quality Based Procedures" calculates both the direct and indirect costs per procedure as follows, "Funding is allocated to hospitals for specific procedures based on a 'price x volume' basis, which is then adjusted for patient complexity. This approach aims to reimburse hospitals for both the types and quantities of patients treated…. [The calculation] included both direct (e.g. salaries, supplies) and indirect (e.g. education, administrative and support services, research) costs. This ensured that hospitals were held accountable for efficiencies in both direct and indirect expenses." See: https://www.oha.com/Documents/3B.QBP_Carve_Out_and_Pricing_2017.pdf . In fact, private clinics only take the uncomplicated cases and do not provide teaching. The facility fee paid to private clinics is at least equivalent to the QBP price for hospitals. In fact, given that private clinics do not have the same complexity, readmissions, and teaching obligations, the comparison is likely weighted in favour of the private clinics. Regardless, there is no inaccuracy in the claim that they are paid more per procedure.

the most affluent areas for hip replacements, and one and a half times for knee surgeries.	income earners gained better access to care while the lowest suffered worse access to care. Within private for-profit surgical centres, the rate of cataract surgeries rose 22.0% during the funding change period for patients in the highest socioeconomic status quintile, whereas, for patients in the lowest socioeconomic status quintile, the rate fell 8.5%. (Link)
Scotland: In contrast, in Scotland, where the decision was made in 2003 to limit private suppliers and boost in-house operations, only 2% of publicly funded cataract procedures were carried out in the private sector in 2022/23. Wait times fell in both countries but were still longer in England than in Scotland by the end of the study period. England experienced a higher growth in inequality than Scotland. Scotland achieved equal improvements in volumes for cataract surgery over the entire period without any real contribution from the private sector.	

Lessons from England and Scotland: Privatization of Hip & Knee Surgeries

Virtually all of Ontario's hip and knee replacement surgeries are done in public hospitals, though the Ford government has repeatedly announced plans to expand privatization. In England, for two decades the government has been using public health care funds to contract private for-profit clinics for elective hip and knee surgeries and this experience yields key lessons. Between 2016 and 2024, for-profit provision of hip and knee replacements increased from 20% to 60% with more than 155 private clinics offering these procedures.

As mentioned above, England's privatization is associated with increased inequality in access to care, longer wait- times, and shrinking capacity in the public system. In contrast, Scotland's continued investment in the public system has yielded superior results: increased capacity without recourse to the private sector, maintenance of an egalitarian public system. In contrast, inequality in terms of admissions increased in England at two and a half times the rate of Scotland.