King's Fund

The Regulation of Private and other Independent Healthcare

Memorandum submitted to the Health Select Committee Inquiry by the King's Fund

January 1999

The Regulation of Private and other Independent Healthcare

The King's Fund is an independent charity which aims to improve the health and healthcare of Londoners. We undertake health policy research and analysis, promote good practice in health and social care, support leadership development and offer grants to London projects. King's Fund staff work in organisations throughout the UK and abroad to learn from others and to disseminate best practice in health and social care.

Summary of Arguments

1. This memorandum is submitted as evidence to the inquiry into the regulation of private and other independent healthcare. There are a number of issues that require action, and the Committee can perform a useful service in bringing these issues to the government's attention.

2. Our arguments are based principally on two observations. Firstly, we observe that there is a patchwork of regulation of independent healthcare. Current arrangements in the independent sector mean that some people will have access to complaints procedures if things go wrong, whereas others receiving the same treatment do not. If, for example, people pay for their own hospital treatment, they may have no recourse to complaints procedures if they cannot resolve problems with the hospital itself. Their only options may be to use the legal system or approach the General Medical Council, which are only appropriate if the problems are very serious. This contrasts with the recourse available to those who are insured, or who use NHS services.

3. Secondly, the NHS and independent sectors are already intimately related, and the boundary between them is blurred. NHS consultants can practice privately, NHS patients are routinely treated in private settings, and pay beds are islands of private practice within the NHS. Policies such as the Private Finance Initiative are making public-private relations in healthcare more complex still. These examples are not trivial: almost 20% of healthcare is independently supplied or privately funded[1], and the projected value of PFI hospital contracts is already well over £1 billion. It is therefore sensible to think of our healthcare system as being a mixed economy, albeit with a dominant state funded service at its heart.

4. A focus on independent healthcare is therefore appropriate and timely: but we think that the issues are best addressed in the context of the regulation of the financing and delivery of care in all settings, and by paying close attention to the complex relationships between the NHS and independent sectors[2]. In addition, the boundary between both purchasing and providing health and social care is increasingly mobile, so there should be an integrated approach to the regulation of the financing and provision of healthcare. We believe that the principal objectives of a revised regulatory regime should be to limit the effects of private payment on generating inequalities in access to care, and to provide the same assurances concerning the quality of clinical care and recourse to complaints procedures for treatment, wherever people are treated.

5. Progress towards these objectives will require action in a number of areas. The following sections review, in turn, the regulation of individual professionals, of organisations that provide healthcare, the financing of healthcare and the

[1] Laing and Buisson, Annual Review of Healthcare 1998. This figure includes all independent hospital and residential/nursing home care.
[2] In principle it is possible to interpret the terms of reference to include complementary medicine, over-the-counter medicines, and a number of other topics. The Committee may feel there is merit in considering these issues as part of its inquiry, but for reasons of brevity these wider issues are not discussed in this memorandum.

arrangements for redress. The final section comments on the government's proposals for the regulation of social care, which we think holds potential lessons for the regulation of healthcare.

Regulating The Individual Professional

6. There are two reasons for recommending increased regulation of the individual clinical professional in independent or private healthcare. The first is that NHS patients who are treated in the private setting may not be able to rely on the same system of quality assurance and accountability that underpins care in NHS settings. This inconsistency is inequitable and unfair. The second reason is that patients regardless of whether they are treated in the private or public sectors should expect to receive a similarly assured high quality of care. However, the independent and private sectors are not under the same requirement to ensure that individual professionals whom they employ or contract with are part of a system of professional or organisational regulation and quality assurance.

7. Within the independent and public sectors healthcare is increasingly being provided by the co-ordinated efforts of many different organisations working together. This care is often provided in new settings other than the GP surgery or hospital consultation room. This means that regulatory frameworks that are specific to particular institutions or care settings may become irrelevant to the provision of many healthcare services. The best way to ensure that there is an assurance of quality is to focus on the systems for professional self-regulation of the individual clinical professional regardless of the organisational context or care setting. The government has already called for the modernisation of professional self-regulation in healthcare and we await the results of much self-examination by the professional bodies concerned. However, there are particular issues that need to be addressed when considering how mechanisms of self-regulation impact upon the provision of private and independent healthcare.

8. We wish to highlight three areas of concern. Firstly, clarity over the contractual arrangements that allow individual professionals to work for both the public and private sectors. Secondly, the need for consistency in professional mechanisms for registering different healthcare professions and assuring standards of professional competence. Thirdly, extending the obligation for clinical professionals to participate in the proposed national audit and re-validation systems that are being put in place for the NHS, to those working in the private or independent sector. We will address these issues in turn.

9. We acknowledge that there have been efforts to establish greater clarity in the NHS consultant contract. However, it is still not possible to access information about the extent of private working, or the number of work hours expected for the NHS and the latitude for private or independent sector activity. It isn't possible to identify reliable information from which to assess the impact of clinical professionals working for both the public and private sectors on either quantity or quality of care. **We recommend that standard information is required of all consultants on respective hours and workload conducted in both sectors.**

10. On the issue of self-regulation there are two basic problems. The first is that some healthcare workers do not have a professional body to provide professional accountability, registration and self-regulation. These workers are able to work in the private and independent sector without any mechanism for assuring their professional standing. The second problem is that private and independent organisation may employ healthcare staff without professional registration thus denying patients the assurance of professional standing that such registration represents.

11. **We recommend that healthcare workers without professional representation and associated systems of self-regulation are strongly encouraged to develop**

such systems or be incorporated into already existing ones. These systems should register appropriately competent workers. Registration should represent a protection of title for those healthcare workers. Self-regulation should meet basic criteria for assuring professional competence and include open systems for the fair investigation of any perception of poor performance. If professional performance is found to be below standard and doesn't improve with education and re-training then there should be mechanisms for suspending registration and professional title.

12. **We recommend that the government intervene to limit either the use of professional titles or the particular services or roles that can be performed by those who are not part of an appropriate system of self-regulation.** Given the number of different and emerging professions providing healthcare services we believe that the idea of an overarching body with responsibility for developing professional self-regulation across healthcare merits attention. Such a body would be charged with ensuring consistency in the way that self-regulation is applied across different healthcare professions.

13. Recent proposals for assuring quality in the NHS have included placing obligations upon doctors and other healthcare professionals to participate in comparative national audits of performance co-ordinated by appropriate professional bodies. Similarly, the professional regulatory bodies are also looking at mechanisms for re-validating the professional competence of registered professionals. It is currently uncertain what sanctions will be proposed to counter any reluctance to participate but it may be that employment or registration could be rescinded. **We recommend that the obligation to participate with these systems of national audit be extended to the work that healthcare professionals undertake in the private or independent sector.**

Regulating The Healthcare Organisation

14. We believe that as well as assuring quality through effective mechanisms for professional self-regulation a responsibility for quality of care also arises at the level of the healthcare organisation employing healthcare professionals and providing health services.

15. **We recommend that the same conditions that apply to NHS organisations concerning their employment of healthcare professions be applied to private and independent healthcare organisations.** This would mean that only healthcare workers registered with an appropriate self-regulatory professional body could be employed. Where the individual provider of healthcare is not using professionally recognised skills or the area of healthcare is still emerging and doesn't yet have a body for effective self-regulation then the person in charge of the service must be part of a mechanism for professional accountability.

16. Similarly, **we recommend that the obligation currently being placed on NHS organisations to introduce systems of clinical governance and participate in associated systems of inspection be extended to the private and independent sectors.** This system must enable the organisation to identify and effectively manage poor or dangerous clinical performance through compulsory and evidence-based audit and peer review. It must also include systems to review and change clinical behaviour in line with the latest research evidence for effective and appropriate practice.

17. Given that NHS patients may be treated in private settings it is important that at the very least NHS patients should have the same level of protection wherever they are treated. Therefore **we recommend that the proposed Commission for Health Improvement (CHI) should have a remit that includes the inspection of the independent sector to ensure that they have such quality assurance mechanisms in place.** The Commission should be obliged to publish it's reports

on the systems for quality assurance within the independent as well as the public sector so that this information can be used by the public. The state should also reserve the right to act to close or suspend the working of any independent institution that fails to meet basic benchmarks during this CHI inspection. Clearly this would have financial consequences which we would expect the independent sector to meet.

Financial Regulation

18. Almost six and a half million people are covered by private medical insurance, and this is the main source of financing of privately provided treatment. We are entering a period of product innovation, with some insurers offering cover for primary healthcare and dental care, apparently in competition with health cash plans. Some six million people currently have health cash plans (HSA Healthcare alone has 3 million members), which provide payments when people use dental, optical and other health services. These services may be provided privately, be NHS services which are charged for, or may be services provided by the NHS. And, increasing numbers of people now pay for their own treatment: there has been a steady rise in self-payment, and some 10% of private in-patient procedures are paid for by individuals from their own pockets[3].

19. The main focus of financial regulation in the independent healthcare sector is on insurance and other financial instruments. There is external regulation of the ability of insurance *firms* to conduct business by the Insurance Directorate, and of many health cash providers by the Friendly Societies Commission and the Association of Friendly Societies: all three are now part of the Financial Services Authority (FSA). The *selling* of private medical insurance products is subject to self-regulation, embodied in Codes of Conduct developed by the Association of British Insurers. Firms selling private medical insurance have internal complaints procedures, and if complaints can not be resolved locally then cases

can be referred to an external body: most firms belong to either the Personal Insurance Arbitration Service or the Insurance Ombudsman Bureau schemes. However, not all organisations that sell health cash plans are members of complaints schemes. **We recommend that all financing organisations are required to join appropriate complaints schemes.**

20. We note the proposal that the FSA should extend its powers to non-life insurance, including private medical insurance, and the possibility that the personal investment, insurance and banking ombudsman schemes will be merged. These may well provide more satisfactory redress for consumers. The recent Office of Fair Trading report on private medical insurance and other health-related products, similarly, seems likely to lead to changes which will provide greater protection for consumers.

21. These developments are welcome, but we think that two specific points merit the Committee's attention. There will still be gaps in regulation in the private healthcare sector, and regulation may be concerned principally with the processes of underwriting and selling products, and not with their appropriateness *per se*.

22. **We recommend that all methods of payment should be included in a review of the financing of private healthcare.** It is important to recognise the variety of means already used to pay for healthcare privately, and the anomalies this creates. The most obvious gap at present is for people who pay for their treatment out of their own pockets. If they experience problems they have few options if they cannot resolve problems with their consultant or hospital: they can only use the legal system or approach the GMC, but these are only appropriate in the most serious cases. People who have health cash plans are also poorly protected, since regulation focusses on the financial status of the

[3] Laing and Buisson, Annual Review of Healthcare 1998

organisations which offer them. We think it is necessary to devise regulations on the basis that there will be a number of different sources of financing of private healthcare in the future, and so the different types of financing should be considered in the round.

23. **We recommend that reform of regulation should include the powers to examine the appropriateness of products.** We can see a situation emerging where the process of selling is well regulated, but people still buy inappropriate products, because they lack information about their value for money. The government and the FSA should therefore be encouraged to review this point in any forthcoming changes in the FSA's powers.

Pursuing Complaints

24. Regulation is a fundamental part of providing necessary protection for users by ensuring good quality services; but if "No regulatory system can absolutely guarantee consistently good standards everywhere"[4], then it is essential, when things have gone wrong, that the interests of users are safeguarded through an adequate complaints system. In the interests of consistency and equity, such a system should cover quality issues for all health and social care services and treatments delivered in all settings, whether provided by the public, private or voluntary sectors, and irrespective of whether the purchaser is a statutory body, an insurance company or an individual.

25. Such a system should also be able to consider financial issues, particularly where complaints about quality of treatments or services are intertwined with concerns about their cost. The key point here is that extending the role of a single body, such as the NHS Ombudsman, to the private sector is unlikely to provide solutions for many people who do not currently have access to an appropriate, low cost mechanism for seeking redress because – in this example - the NHS

Ombudsman lacks the powers to consider financial matters. Two examples, health cash plans and residents in residential and nursing homes, illustrate the problem. If people who have health cash plans feel that they have been poorly served, then they may have no recourse to complaint to an external body: few health cash providers are members of an independent complaints handling body such as the Personal Investment Arbitration Service or the Insurance Ombudsman Bureau. The sums of money involved are relatively small – though may be important to people on lower incomes - so that it is unlikely that the legal system will be appropriate, as legal costs may be far greater than the sums at stake.

26. For residents in residential and nursing homes, the Office of Fair Trading says that all should have clear, comprehensive, written contracts for their care[5]. This is to be welcomed, but explicit contracts may not always exist for other types of care, or for treatments. Such contracts, where they do exist, may give some users a potential legal route for financial redress but, in the absence of any compulsion on the form and content of contracts, on its own a contract may prove insufficient protection for many users and patients.

27. As we have argued above, it is crucial to identify all groups of people who do not currently have adequate protections, and design new redress procedures to take account of all of them. If the NHS Ombudsman system is extended to include complaints about the quality of independent sector healthcare regardless of type of purchaser, then this should be developed hand in hand with mechanisms for working with the financial ombudsman schemes. **We recommend that, where complaints involve both the quality of treatments or services and their cost, there is a clear mechanism for the NHS Ombudsman and the relevant financial ombudsman scheme to agree which body is to take the lead in**

[4] *Modernising Social Services*, Cm 4169, para. 4.3
[5] *Older people as consumers in care homes*, Office of Fair Trading, 1998

investigating the complaint. Whilst both bodies should work closely to investigate their relevant elements of the complaint, the lead body would be responsible for reporting on the complaint in its entirety, taking advice on the particulars from the other body. At the moment, the plans for merging the different financial ombudsman schemes, and other developments noted above, risk leaving gaps in the private healthcare sector.

Lessons From the Regulation of Social Care

28. In order to illustrate the importance of the points we are making about private healthcare, we include here a brief discussion of the government's plans for health and social care services for vulnerable people. These show that the government has already acted to create cross-boundary bodies to regulate an important area of public policy – so our proposals would, we think, be in line with current thinking. They also highlight the potential pitfalls of failing to create regulatory regimes which cover all of the people and organisations that can deliver care in domiciliary settings.

29. The Government has set out its intention, in Modernising Social Services, to create a new regulatory body, the Commission for Care Standards (CCS). Once established, the CCS will be responsible for the regulation of services such as:

- Residential homes (local authority, private and voluntary sector)
- Nursing homes (private and voluntary sector)
- Domiciliary personal social care providers (local authority, private and voluntary sector)

30. However, the proposals omit a range of services including independent sector home healthcare services delivered to people living in their own home, with relatives or friends, or in sheltered housing. This means that there will be inconsistencies in the treatment of similar services provided by social care

agencies and independent home healthcare agencies. For example, both types of agency may administer and supervise an individual's medication; and both may provide catheter and pressure sore care. For one service provider to be regulated where another is not clearly leaves anomalies of the sort the Government appears to wish to see removed. An individual would receive regulated nursing care in a residential or nursing home but unregulated nursing care at their own home, even if the nursing tasks being carried out were identical in both settings. Further, whilst local authorities will be required to only contract with regulated domiciliary social care providers on behalf of users, the NHS will be free to contract with unregulated independent sector home healthcare providers, quite likely on behalf of the same vulnerable users.

31. A key question remains as to whether the NHS should be included in these regulatory proposals. Whilst this appears to be outside the immediate remit of the Committee's Inquiry, nonetheless it is an important issue. Firstly, not to do so will perpetuate further inconsistencies in the regulation system. For example, the increased use by the NHS of contracted independent sector nursing home places for those meeting NHS continuing inpatient criteria means that some vulnerable people will continue to receive care in regulated homes, whilst others do so in unregulated NHS nursing homes or other NHS long-stay provision. This would be in direct contrast with local authority arrangements where all places in residential or nursing homes, whether provided through a contract with the independent sector or direct provision in a 'Part III' local authority residential home, would be regulated.

32. Secondly, it is important not to dismiss the NHS from consideration of the regulatory system, since it may become subject to regulation in the future in certain circumstances. For example, should NHS Trusts or Primary Care Trusts provide social care services as the integrated providers envisaged in the Green

Paper Partnership in Action, these NHS-provided social care services would be subject to the proposed regulatory scheme[6].

33. Failure to include independent sector home healthcare services, NHS home healthcare services, and NHS nursing homes and other long-stay provision within a regulatory system, will potentially leave many vulnerable users without the protection which the Government believes is necessary to secure for social care services. In the case of independent sector home healthcare services, this is of particular concern because there is currently no statutory complaints system, should things go wrong. However, the Government's plans for an Ombudsman service for complaints against a regional CCS exercise of its duties may not be sufficient, since this does not necessarily imply that complaints about standards of care in regulated services – as opposed to complaints about the CCS - will be investigated. It is also an example of the creation of a new ombudsman, which goes against the trends noted elsewhere, and against the integration which we argue is crucial to a successful system. **We therefore recommend that lessons from the government's proposals for the regulation of social care are taken into account in the design of a regulatory regime for healthcare.**

Final Comment

34. We believe that it is possible to act on a number of these issues without resort to primary legislation. The Secretary of State for Health has powers enshrined in statutes that allow him to act in a number of areas. To give an example relating to organisations, the Health Services Board was set up by the last Labour government to regulate pay beds and the size of the private sector[7]. The Board was abolished in the Health Services Act 1980 (Chapter 53, Section 9), but the powers of the Board were transferred to the Secretary of State, who is therefore

[6] *Partnership in Action*, par. 4.40
[7] Under the Health Services Act 1976 (Chapter 83, Part II) and the National Health Service Act 1977 (Chapter 49, Sections 72-86)

able to control the numbers of pay beds and of private hospitals if he or she wishes.

35. There is also an opportunity to influence forthcoming legislation. The current government has indicated that the NHS Modernisation Bill will include paragraphs that will modify the terms of reference of the GMC, currently defined under the Medical Act 1983, and introduce new arrangements for clinical governance. There is an opportunity here to influence legislation, and shape it to take account of the need to reform the regulation of private and independent healthcare.

If the Committee wishes to discuss this memorandum, or seeks further information, then in the first instance inquiries should be addressed to Dr Angela Coulter, Director of Policy and Development, King's Fund, 11-13 Cavendish Square, London W1M 0AN. (Tel: 0171 307 2693, Fax: 0171 307 2810, email: acoulter@kehf.org.uk).

SUMMARY OF RECOMMENDATIONS

Concerning Professionals

- **Create greater clarity within NHS consultant contracts about the rights and responsibilities of a commitment to the public sector.**
- **Establish a standard requirement for information on the size of professionals' public and private clinical workload.**
- **Ensure comprehensive coverage of healthcare professions within a consistent system of professional registration and self-regulation.**
- **Promote government intervention to limit either the use of professional titles or the practices and roles that can be performed by unregistered healthcare professionals.**
- **Give consideration to an overarching body responsible for the registration and self-regulation of all healthcare professionals.**
- **Place an obligation on professionals working in the private or independent sector to participate in national audit or re-validation systems.**

Concerning Organisations

- **Limit the employment of healthcare professionals within the private sector to those with professional registration.**
- **Extend the obligation for systems of clinical governance to private and independent healthcare organisations.**
- **Extend the inspection of healthcare by the Commission for Health Improvement to the private and independent sector.**

Concerning Financial Regulation and the Pursuit of Complaints

- **All insurance and other financing organisations should be required to join an approved independent complaints scheme.**
- **The role of financial regulators should be extended to cover the appropriateness of products.**

- **These products should include all means of paying for healthcare, including health cash plans and the new payment schemes operated by some hospital groups for private individuals paying for treatment.**
- **Where complaints involve both the quality of treatments or services and their cost, there should be a clear mechanism for the NHS Ombudsman and the relevant financial ombudsman scheme to agree which body is to take the lead in investigating the complaint.**

Learning Lessons from Social Care

- **Lessons from the government's proposals for the regulation of social care should be taken into account in the design of a regulatory regime for healthcare.**