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Outsourcing the NHS

Where ideology outstrips performance

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Outsourcing in the NHS in England has increased substantially over the past 15 years as both Labour and Tory led governments have pursued policies of divesting frontline care and non-medical support services to external suppliers. Department of Health figures show that the proportion of the overall NHS budget spent on private healthcare providers increased from 2.8% in 2006-07 to 6.1% in 2013-14.[1 2] An independent study by Oxford Economics has calculated a growth in the private sector's turnover from outsourced frontline healthcare services from £6.9bn (€9.3bn; $10.6bn) in 2010 to £12.2bn in 2013.[3]

Non-medical services such as finance, contracting, and IT have also been heavily outsourced. In 2010, the NHS Confederation estimated that the total spend on "back office" functions across the NHS in England was £2.8bn.[4] It suggested that a minimum of £600m of this could be released for frontline care if it was divested from the NHS, presenting a big opportunity for the private sector.

Clear direction of travel

It is difficult to quantify how much non-medical work in the NHS has been outsourced to date, but the direction of travel is clear, with the coalition government's Health and Social Care Act 2012 set to prompt the full scale outsourcing of commissioning support services to third party suppliers. Earlier this month, a string of private companies were approved to provide up to £5bn of support services to NHS commissioners. Regional support units subsidised and staffed by the NHS can also bid for this business,[5] but they must become independent of the NHS by 2016 and compete in an open marketplace under the terms of the act.

The widespread outsourcing of NHS medical services in England began under Tony Blair's Labour government. NHS patients were offered the choice of receiving some elective procedures from private providers while still receiving care free at the point of need. This included being treated at the government's new privately run independent sector treatment centres. Ministers said these would increase capacity and reduce NHS waiting

times, but critics argued that the scheme allowed private companies to cherry pick the most profitable services.[6]

In 2009, healthcare think tank the King's Fund concluded that there was "no quantitative evidence" that independent sector treatment centres had reduced NHS waiting times,[7] although research published in *The BMJ* in 2011 suggested the outcomes of elective surgery at these centres were at least as good as in the NHS.[8] But the overall cost effectiveness of the programme was questionable, with estimates suggesting that the private sector was paid almost half a billion pounds for treatment that never took place because of the block contracts awarded by the government.[9]

Prompted by criticism of its block contracting for these treatment centres, Labour introduced the any willing provider policy to allow private companies to provide a range of elective medical procedures on a cost per case basis. This policy was later renamed any qualified provider and accelerated by the Conservative led coalition as it expanded on Labour's existing policies through the Health and Social Care Act.

> This growth comes despite a series of high profile cases that have cast doubt on the outcomes achieved through outsourcing

The act legally enshrined principles of competition into the NHS and arguably swung the balance of power from the public to the private sector as a result. The reforms require NHS clinical commissioning groups to open up more healthcare services to the market (by competitive tender or any qualified provider), creating more opportunities for non-NHS providers to bid for services. Companies can also appeal to sector regulator Monitor if they suspect commissioning groups of engaging in anti-competitive practice, leaving commissioners nervous of litigation.

A recent investigation by *The BMJ* found that the private sector has been awarded a third of the contracts to provide NHS clinical services in England since the Health and Social Care Act came into force in April 2013.[10] Although ministers insist this is still a small part of the overall NHS budget, the growth seems likely to continue in light of current government policies. This growth comes despite a series of high profile cases that have cast doubt on the outcomes achieved through outsourcing.

The private company Serco has entirely stopped providing medical care in the United Kingdom after large financial losses and heavy criticism over the standards of care it provided.[11]

In a separate case involving outsourced eye surgery in Somerset, a confidential report found that patients were left in "severe pain" after procedures carried out by private contractors.[12] Most recently, private firm Circle Health announced its withdrawal from the contract to run Hinchingbrooke Hospital in Cambridgeshire after healthcare regulator the Care Quality Commission uncovered serious failings at England's first privately run NHS hospital.[13]

Both Labour and Tory led governments have argued that the outsourcing policies they have pursued are not privatisation because healthcare remains free at the point of use. But critics point out that the policies used meet the World Health Organization's definition of privatisation in healthcare as "a process in which non-governmental actors become increasingly involved in the financing and/or provision of healthcare services."[14]

Since Labour left office in 2010, its shadow health secretary has said that the party went too far in letting the private sector into the NHS and has pledged that the NHS will be the "preferred provider" if his party returns to power. Regardless of who forms the next government, the current chief executive of NHS England believes that the proportion of NHS care being provided by the private sector is unlikely to increase beyond "the margins" over the next few years.[11]

How far these margins will be stretched is the key question that remains unanswered.

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The healthcare system is organised to deal with single conditions and to separate mental and physical healthcare, complicating attempts to provide integrated care

Designing care for people with mixed mental and physical multimorbidity

Integrate and collaborate to help improve depression symptoms

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Most people with long term health problems have more than one condition, and, for many, multiple conditions are the norm.[1] In stark contrast, the healthcare system is organised to deal with single conditions[2] and to separate mental and physical healthcare, complicating attempts to provide integrated care.

In a linked article, Coventry and colleagues report findings from a cluster randomised controlled trial of integrated collaborative care for adults with diabetes or heart disease and comorbid depression.[3] Collaborative care models generally use non-medical case managers working with a patient's designated doctor or nurse, often with additional input from a mental health professional. The intervention was associated with moderate improvements in depressive symptoms, self management, and satisfaction compared with usual care. There were no significant differences between groups in physical health, quality of life, or functional outcomes.

After four months, patients managed with collaborative care had depression scores that were 0.23 points lower than control patients on the symptom checklist depression subscale (SCL-D13). The difference was significant, equating to an effect size of 0.3. The effect on depression symptoms was modest, but comparable with effects found in other trials of collaborative care for depression[4 5] and of a magnitude likely to be clinically meaningful.[6]

Common, debilitating, and complicated

Multimorbidity presents a major challenge to healthcare systems.[1] There is perhaps no greater challenge than delivering effective healthcare for mixed mental and physical multimorbidity, which is common, debilitating, and complicated by social and economic disadvantage.[7] The linked study, conducted in 36 general practices (8% of those invited) in the north west of England, used practice based disease registers to identify 14 843 potentially eligible patients with diabetes or coronary heart disease to take part in the trial. The authors report that 1602 (10.8%) agreed to be screened for depression, and, of these, 387

The challenge

(24.2% of those "agreeing" and 2.6% of those offered screening) entered the trial. As expected, participants reported high levels of multimorbidity and disadvantage.

The new trial reported similar improvements in mental health to a randomised controlled trial of collaborative care for patients with depression and chronic illness conducted in the United States, but it failed to achieve the parallel improvements in physical health and quality of life.[8] The difference in findings can probably be attributed to differences in context, methods, and design of the intervention.

Firstly, the US researchers recruited a less deprived and less depressed cohort, which could explain the better uptake of and adherence to their intervention. Secondly, Katon and colleagues used individual rather than cluster randomisation, a stronger research design for determining a treatment effect, despite the potential for contamination between the two treatment groups.[8] Thirdly, their patients had poorly controlled physical illnesses, giving more scope for improvement. And, finally, they used a different approach to integrate physical and mental healthcare. The same practitioner (a diabetes nurse) closely monitored and treated both physical and mental health conditions, so care was integrated at the level of the practitioner.

In contrast, Coventry and colleagues used a psychological wellbeing practitioner to deliver the psychological intervention and a consultation liaison model to integrate physical care via the practice nurse.[3] Interestingly, both approaches were associated with similar improvements in mental health, even though Katon and colleagues reported better uptake of both screening and clinic visits.[8]

Important questions remain about how to engage patients more in collaborative care models. Less than 11% of eligible patients took up the offer of screening in the new study, despite three attempts, suggesting that a different approach is needed to "sell" this model of care, especially to patients with social and economic disadvantage. Adhering to eight treatment sessions was obviously hard work—just under half the participants received a potentially therapeutic "dose" of the intervention and a third either withdrew after referral or did not attend any sessions. We clearly need to find out more about patients' experiences of such care, involve them fully in the design of interventions, and explore the potential of different delivery options.

We now have evidence that internet based treatments can be just as effective as treatments given face to face.[9] Mixed modes of delivery of psychological therapies might well have a place in future models of collaborative care, but they must be implemented in collaboration with patients and in a way that doesn't increase health inequalities. If these efforts were supported by incorporating patients' preferences and better tailoring of care to match patients' needs the cost effectiveness of collaborative care might improve.

The high levels of social and economic disadvantage among participants (75% were not working) suggest that models of collaborative care that include a social care element are worth testing. The most appropriate outcome measures for trials of interventions aimed at improving multimorbidity and the need to include the patient's perspective and to move beyond disease specific measures alone should also be discussed.[10]

The linked study shows that collaborative and integrated care can deliver a modest reduction in depressive symptoms for those with concurrent physical health problems. Questions remain as to whether such models are cost effective and how best to incorporate them into routine practice.

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Antidepressants and risk of suicide

Reported differences among drugs are important to know, but hard to interpret

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Suicide is recognised as one of the most urgent public health concerns of our time, with approximately 60% of such deaths attributed to mood disorders.[1] Ideally, well designed randomised controlled trials would guide doctors toward the best antidepressant for reducing the risk of suicide (and away from those likely to increase it).

Despite 1.5% of the world's population dying from suicide,[2] these deaths occur throughout the lifespan so risk remains low during any brief period under study. This makes research uniquely challenging. For example, one large meta-analysis of 372 antidepressant trials and nearly 100 000 patients reported a total of just eight suicide deaths.[3] Given this, large population based studies are needed to understand better the true impact of antidepressants on patients.

In a linked paper Coupland and colleagues conducted a cohort study using a large UK primary care database to quantify associations between different antidepressants and suicide as well as deliberate self harm (including suicide attempts) during the first five years of follow-up for adults with a diagnosis of depression.[4] Using citalopram as a reference the authors found no differences in the risks of suicide associated with individual selective serotonin reuptake inhibitors (SSRIs) or between SSRIs and tricyclic antidepressants (TCAs). However, the hazard ratio for suicide was increased significantly during treatment with the "other" antidepressants venlafaxine and mirtazapine compared with SSRIs (2.6, 95% confidence interval 1.7 to 4.0).

Similar results were found for self harm. Odds of self harm were also increased with trazodone, and reduced with amitriptyline. Across all antidepressants, hazard ratios for self harm and suicide were increased during the first 28 days of treatment and, for suicide death only, during the 28 days after stopping treatment.

Readers should pay careful attention to drug doses when interpreting the results in tables 2 and 3. A defined daily dose (DDD) of 1 corresponds to the generally accepted minimum effective doses of antidepressants (for example, 20 mg for citalopram and fluoxetine, 75 mg for amitriptyline). Most of the exposure to SSRIs in Coupland and colleagues' study occurred at doses >0.5 DDD or >10 mg of citalopram, for example, and the same was true for the "other" antidepressants. However, 64% of person years exposure to TCAs occurred at doses ≤0.5 DDD, corresponding to ≤37.5 mg of amitriptyline. Some of this difference may be explained by the fact that TCAs are often titrated more slowly than other antidepressants. Doctors may also be conservative in their dosing as reflected, for example, in the National Institute for Health and Care Excellence guidelines, which suggest that low doses of TCAs may be maintained if clinical response is achieved.[5] However, low dose TCAs can be used for a variety of other indications such as insomnia or headaches, so hazard ratios for the TCAs in Coupland and colleagues' study may be underestimated as a result of indication bias.

> An escalation—especially in suicidal ideation and self harm—is a signal that requires prompt evaluation

As the authors do well to emphasise, the study's results may be vulnerable to indication bias, residual confounding and, despite large cohorts, lack of power. One major question the study cannot answer is how individual patients will respond to particular antidepressants. Multiple studies have identified a small potential signal that venlafaxine and mirtazapine are associated with a greater risk of suicide and self harm at a population level.[4 6 7]

Doctors should already exercise caution when prescribing these drugs in patients at high risk for suicide given published evidence that they are the most lethal non-TCA antidepressants when taken in overdose.[8] Nevertheless, clinical trials—subject to their own sources of bias—indicate that venlafaxine and mirtazapine are at least as effective as SSRIs in alleviating symptoms of depression.[9 10] What doctors urgently need in the face of this mixed evidence are tools to help them predict how individual patients will respond to particular antidepressants.[11] For now clinicians must exercise caution when prescribing all antidepressants and carefully weigh up the potential risks and benefits on a case by case basis before treatment.

Just as the mechanism behind the association between the "other" antidepressants and increased suicidal behaviour is unclear, so is the mechanism behind the increased suicidality associated with starting and stopping treatment. Coupland and colleagues' study cannot tell us whether the physiological effects of starting antidepressants or withdrawing from them confers risk, or rather, as is likely, that these events are usually timed during periods of heightened risk.

When to increase surveillance

Regardless, doctors should convey their optimism that depression will improve when an antidepressant is started but also share with patients that the decision to start treatment is an indicator of a period of increased overall risk. Patients should be monitored carefully during this time; warned to look out for worsening symptoms, including suicidal ideation and self harm; and told to view any escalation—especially in suicidal ideation and self harm—as a signal that they need prompt evaluation and treatment. Likewise, doctors should counsel patients that stopping antidepressants may also trigger a period of higher risk that justifies intensified surveillance for at least four weeks.

All medical treatments carry some risk, and antidepressants are no exception. It is worth emphasising that depression itself is often the major driving force behind self harm and suicide. Doctors must be prudent, exercising vigilance at times of high risk and, possibly, with higher risk drugs, but they should also be careful not to deny patients potentially effective drugs on the basis of observational associations alone.

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More cynically, it could be suggested that because the disease mainly affects people born outside the UK and indigent people there has been little public or political desire to do better

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Collaborative tuberculosis strategy for England

The future of tuberculosis control need not be one of continuously failing to learn from the past

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Public Health England and NHS England have just launched their collaborative five year tuberculosis strategy for England.[1] The consistent decline reported by most western Europe countries over the past decade in tuberculosis incidence has not been seen in England, where in 2013 there were 7290 cases of active tuberculosis.[2] Although this is peanuts in comparison with the number in Africa and Asia, cases in England may exceed those in the United States within the next few years on current trajectories.[1] Indicators of the incidence and treatment outcomes in tuberculosis have already been included in the NHS public health outcomes framework,[3] so why a strategy now?

One reason may be a convergence of political will and external pressure. The World Health Organization's End Tuberculosis strategy calls for a 50% reduction in tuberculosis incidence between now and 2025.[4] That will be a tall order as incidence fell by 2% between 2003 and 2013, according to Public Health England data.

More cynically, it could be suggested that because the disease mainly affects people born outside the UK and indigent people (over two thirds of cases occur among those in the two most socially deprived quintiles in England) there has been little public or political desire to do better.[5]

Using a combination of measures (box) the strategy aims to achieve an (undefined) year on year decrease in the incidence of tuberculosis plus a reduction in the associated social gradient. The ultimate goal is eliminating tuberculosis as a public health problem across England.

The strategy will be administered by nine tuberculosis control boards, each covering both metropolitan and rural areas. The exception is London, which has around 3000 cases annually—an incidence higher than any western European capital other than Lisbon. Tuberculosis control boards will be led by a director, and include clinicians, public health experts, members of local authorities and clinical commissioning group, patient advocates, and third sector representatives.

Strategy's recommended actions

- Improve access and earlier diagnosis
- Provide universal high quality diagnostics
- Improve treatment and care services
- Ensure comprehensive contact tracing
- Improve BCG vaccination uptake
- Reduce drug resistant TB
- Tackle TB in underserved populations
- Implement new entrant latent TB screening
- Strengthen surveillance and monitoring
- Ensure an appropriate workforce

This model may assuage genuine fears of a fragmented service unable to take responsibility for public health as well as clinical concerns—especially if local commissioning arrangements support rather than hinder innovation and joined-up working. Much is made of governance and accountability to achieve positive outcomes; however, it remains unclear whether the boards will have the power to ensure that change occurs if key objectives are not met.

Return of the Edinburgh method

The overall approach is not new to England or the United Kingdom. Indeed, it was first undertaken in the 1950s in cities such as Edinburgh, where it was appreciated that tuberculosis could not be managed by the healthcare model at the time.[6] The Edinburgh method was adopted with much success in other parts of the world,[7] so there is an irony that the disease has returned to the United Kingdom almost 60 years later.

Any national strategy should have at its centre those affected or at risk and their families, carers, and communities. The strategy acknowledges this and encourages improved access to health and social care, using the example of extended clinic opening. This is a good idea, although the problem is not only about staffing the clinic because key associated services such as radiology, pharmacy, and pathology must also be available. Thus the real workforce that contributes to a tuberculosis service is in fact larger and more diverse than outlined in the strategy. Engagement with these other stakeholders needs to start as soon as possible.

The strategy relies on a monitoring framework to ensure accountability. There are 19 indicators that will assess process and outcome at national, control board, and local levels. Some of these—such as the overall tuberculosis incidence in England, tuberculosis incidence in people who are non-UK born and children (generally regarded as an indicator of *Mycobacterium tuberculosis* transmission between individuals), and the offer of HIV testing to patients with active tuberculosis—have improved over the past couple of years.

Does this mean that the strategy is too late and a waste of time, effort, and money? We believe not and suggest that its value is because, in part, some of its content is being used already by tuberculosis service providers locally. For example, tuberculosis cohort review (the systematic audit of clinical cases, their outcome, and contacts requiring assessment) was introduced in 2012[8] and may have affected subsequent national tuberculosis rates. Thus, the strategy can ensure country-wide best practice, often at minimal cost.

The strategy has identified three specific areas that need new funding because there is no systematic commissioning or service provision. These are setting up the tuberculosis control boards (supported by Public Health England at a cost of £1.5m (€2m; $2.3m) a year); testing and treatment for latent tuberculosis infection, particularly among new entrants to the population; and enhanced outreach work (both funded by NHS England). The total of £11.5m is an annual cost, and it is concerning that there is little mention of a mechanism to ensure that funds will be available for at least the next five years (which, the strategy estimates is the minimum time before it becomes cost neutral). As the Public Health England and NHS commissioning rounds for 2016-17 start in March 2015, we hope that this has been incorporated into future plans.

Are the strategy's aims achievable? Yes—partly because they are suitably vague. This is politically astute but should not deflect from the importance of ensuring that the future for tuberculosis in England is not one of continuously failing to learn from the past.

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