How the private sector benefitted from a £2bn NHS covid contract

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When health services are stretched, the conversation invariably turns to capacity. How do we create more capacity in the system (doi:10.1136/bmj.p335)?

Another 5000 hospital beds and 800 new ambulances should do it. We can do it now—or, at the latest, tomorrow. We will even throw money at it, millions or billions. Perhaps we can utilise the private sector?

But the capacity conversation generally misses two central, and seemingly obvious, points. Firstly, who will staff those extra beds and ambulances? Even the private sector relies on the public sector for its staffing. Extra capacity in a workforce crisis is an oxymoron (doi:10.1136/bmj.p314, doi:10.1136/bmj.p317, doi:10.1136/bmj.p345). And, secondly, isn't it better that public health, primary care, and social care services work well enough to keep people out of hospital?

In an acute crisis, such simple realism is easy to overlook, and the covid-19 pandemic is a case in point. The UK’s pandemic response, among many a misstep, was marked by two white elephants of capacity building. The more highly publicised was the “Nightingale” hospitals, seven of which were built at a cost of over £500m (https://www.kingsfund.org.uk/blog/2021/04/nhs-nightingale-hospitals-worth-money). Many other countries, from Argentina to China, did the same. But the UK ones, at least, served little purpose other than to show that they could be built and to furnish government ministers with positive messaging.

The lesser known but more expensive initiative is examined in an investigation by The BMJ (doi:10.1136/bmj.p329, doi:10.1136/bmj.p348). In March 2020, the NHS paid around £2bn for the entire capacity of England’s 200 private hospitals, and associated staff and equipment, to help with waiting lists and urgent care, including for covid-19. The contracts were not activity based.

The data for this investigation have been obtained through a long and exhaustive process, involving freedom of information requests and persistence, to break through a governmental wall of secrecy around levels of activity in private hospitals during the pandemic. When public money has been spent to the tune of billions on a national contract, transparency and accountability are non-negotiable, yet neither is much in evidence.

Essentially, the private hospital sector had its costs covered by the NHS in exchange for “capacity,” but it was allowed to continue with private work on the basis that it retained between 15 and 40% of “net revenue,” with the balance returned to the NHS. This proved to be a perverse incentive.

The leading private providers, responsible for 143 hospitals, gave over only 51% of their episodes of inpatient care to the NHS in the pandemic’s first year.

Patients with covid-19, just as with Nightingale hospitals, received little care in private facilities. The London Clinic, for example, delivered somewhere between 800 and 1500 inpatient, day case, and outpatient NHS activities, depending on how the data are counted, between 29 March and 13 September 2020, while delivering over 16 000 private inpatient episodes of care in the first year of the pandemic.

The private providers say that their services were available, but the NHS chose not to use them fully and that the figures don’t count the use of private facilities for NHS work done by NHS staff. The NHS says that the extra capacity bought from private hospitals was vital to care for NHS patients, especially in the early phase of the pandemic.

Critics, however, argue that the level of NHS activity in some private hospitals was remarkably low. Extra staff and equipment were not available to make use of the extra beds. And in some areas the private sector was not able to manage anything other than diagnostics or routine, less complex cases. Despite the buck passing and the excuses, the data do not lie. The pattern of benefitting from an imbalanced and lucrative NHS contract is clear across private providers.

The private sector, the NHS, and the government—which ultimately controls the NHS—share responsibility for failing to ensure value for money to taxpayers. They must be held to account.

1 Oliver D. David Oliver: Can NHS England’s recovery plan for urgent and acute care deliver? BMJ 2023;380:. doi: 10.1136/bmj.p335 pmid: 36792120
2 Mahase E. Waiting lists are unlikely to fall before mid-2024, analysis finds. BMJ 2023;380:. doi: 10.1136/bmj.p314 pmid: 36754438
7 Ryan S. “A gift to the sector”: why did the NHS’s contract with independent hospitals allow private patients to be treated when the NHS was overwhelmed? BMJ 2023;380:. doi: 10.1136/bmj.p348 pmid: 36792134