Item: BMJ-UK; Article ID: Anderson060324;
Article Type: Editorial; TOC Heading: Editorials; DOI: 10.1136/BMJ-2024-079261

Information gaps in England's independent healthcare sector

Private providers should be required to report the same data as NHS providers

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At the beginning of 2024, 7.6 million people were on NHS waiting lists in England.[1] Politicians from both the Conservative and Labour parties have indicated they will continue to procure elective care services from the independent healthcare sector as a strategy to reduce NHS waiting lists.[2 3] Additionally, privately funded admissions have grown steadily over the past two years.[4] The Competition and Markets Authority (CMA) private healthcare investigation order in 2014 has helped improve reporting of activity to the Private Healthcare Information Network.[5 6] However, we still do not have the information on workforce, hospital capacity, outpatient services, and prices required to understand the implications of greater independent healthcare sector activity on the healthcare workforce, demand for services, and healthcare quality.

Aligning workforce data collection between the NHS and the independent healthcare sector would facilitate effective workforce planning, covering aspects such as full time equivalents by specialty and working patterns. This is important because the NHS and the independent healthcare sector largely draw from the same workforce pool.[7] Data collection requirements for nursing and non-clinical staff, in particular, should also be harmonised with datasets from social care to build a more comprehensive understanding of workforce supply across the whole health and care system.[8] Data on income levels would also help investigate

the effects of independent hospitals entering local labour markets. However, a legal framework to collect this information must be established that includes confidentiality commitments—except for key stakeholders exempt from confidentiality such as NHS England and the NHS Pay Review Body.

In addition, we need consistent and transparent data on theatre capacity, critical care capacity, bed numbers, and occupancy in the independent sector. Presently, data sources are patchy and not recent , including ad hoc surveys[5] and Care Quality Commission (CQC) inspections.[9] In contrast, the NHS reports these data monthly.[10] While the independent healthcare sector may see these data as commercially sensitive, they are necessary to model the additional capacity available to clear NHS waiting lists or respond to crises such as covid-19.[11] This information would also facilitate research into differences in access and healthcare quality experienced by patients treated at different types of independent healthcare providers in England. These providers range from small centres specialising in high volume and low complexity procedures, to larger facilities offering more comprehensive specialist services.[12] [13]

Information on services and procedures conducted in outpatient settings is also needed. Currently, the CMA order requires independent providers to collect activity and outcome data only for procedures requiring admission to hospital.[5] Information is therefore incomplete on many consultants' scope of practice and on any adverse events and surgical complications arising from outpatient procedures. Better outpatient data would also allow more comprehensive monitoring of patient pathways, as some patients are initially seen in outpatient clinics in the independent sector then referred to NHS hospitals for further care.

Finally, comprehensive data on the price of all procedures and services in the independent healthcare sector should be freely available to facilitate fair competition between independent hospitals, and to inform patient choice. Currently, the CMA only mandates reporting of hospital consultant fees,[5] rather than the total costs of procedures. Survey data from market analysts LaingBuisson show substantial variations in the prices of procedures—for instance, the price of cataract surgery ranges from £1995 to £3863, and knee replacements from £9445 to £16 795 across England.[12] However, these data come from voluntary submissions and are buried within costly business reports. This lack of transparency leaves patients unable to compare prices between independent healthcare providers.

Harmonisation routes

It is no longer acceptable for data collection requirements to differ so markedly between the NHS and the independent healthcare sector. This divergence continues to hinder comprehensive healthcare workforce and infrastructure planning, fair competition both within the independent sector and with the NHS, and the ability to monitor and provide assurance regarding healthcare quality and safety.[14] The government should take steps to harmonise data collection requirements between the NHS and independent healthcare sectors in the interests of patients safety**.**

The 2022 Health and Care Act granted the secretary of state for health and social care extensive powers to collect information from private healthcare providers if it is considered to be in the interests of the health service in England.[15] This could form the legal basis for improvements in data collection in the independent healthcare sector beyond what is already specified by the CMA, or the government could choose to integrate terms and conditions into future contracts with the independent healthcare sector that meet these critical information needs.

Decisions need to be made regarding which additional data should be reported to the Private Healthcare Information Network or which to NHS England, and how data flows from private and NHS hospitals can be linked together. The ultimate objective should be the creation of integrated databases that take a holistic approach to health and care systems.

We thank Kieran Walshe for his helpful comments and feedback.

Competing interests: *The BMJ* has judged that there are no disqualifying financial ties to commercial companies. The authors declare the following other interests: MA has received consultancy fees from the Private Healthcare Information Network for providing clinical and statistical expertise on clinical coding and outcome measurement. Further details of *The BMJ* policy on financial interests are here: https://www.bmj.com/sites/default/files/attachments/resources/2016/03/16-current-bmj-education-coi-form.pdf.

Provenance and peer review: Not commissioned; externally peer reviewed.

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