EDITORIAL

Further doubts over the performance of treatment centres in providing elective orthopaedic surgery

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Recent publication of reports showing high revision rates for hip and knee replacements carried out in Independent Sector Treatment Centres (ISTCs) has raised doubts regarding their ability to provide high quality healthcare. The high revision rates also create a financial burden to the NHS. The poor quality of data collected at ISTCs makes their performance difficult to evaluate. Funds may be better spent improving existing NHS facilities rather than establishing parallel ISTCs.

In this issue further concerns have been raised about the results of surgery undertaken in independent Sector Treatment Centres. White, John and Jones\(^1\) report unacceptable revision rates for total hip replacements performed on patients referred from NHS facilities in South Wales.

Since their inception in April 2002, treatment centres have divided opinion regarding their performance in helping the public health sector reduce waiting times for surgery. By February 2006, at the time of a report from the Department of Health’s (DoH) commercial director,\(^2\) 21 Independent Sector Treatment Centres (ISTCs) were admitting patients, with a further 12 centres planned. It was hoped that allowing health care commissioners to purchase services from the independent sector would stimulate capital investment external to revenue obtained from taxation, thereby increasing capacity beyond that which the DoH might otherwise be able to afford. Some consideration was given to the standards of care patients might expect, with strict monitoring of key performance indicators. Surgeons would be required to be registered with the General Medical Council of the United Kingdom and be on the Specialist Register. NHS consultants would not be employed by independent sector centres, necessarily creating a need for an influx of surgeons from other geographical areas.

However, in practice, measuring performance reliably has proved problematic. Of the 28 key performance indicators, only eight are intended to measure clinical performance. The first review of these data was carried out by the National Centre for Health Outcomes Development in 2005, and stated that the data were of such poor quality that “any attempt at commenting on trends and comparisons between schemes and with any external benchmarks was rendered futile”.\(^3\)

Concerns have been raised from the orthopaedic community regarding the true performance of these ISTCs, most recently by the immediate past president of the British Orthopaedic Association.\(^4\) A number of recommendations have been made to ensure proper scrutiny of results in the hope that standards might be rigorously enforced. The poor results achieved for total knee replacement (TKR) published by the NHS Treatment Centre in Weston-Super-Mare\(^5\) highlight the need for standardised outcome measures and thorough patient follow-up.

The publication in this issue of the Journal of Bone and Joint Surgery of results of total hip replacements (THR) performed on patients referred from the Cardiff and Vale NHS Trust waiting list raises further doubts about the quality of surgery being offered in ISTCs.\(^1\) The need for revision surgery has been identified in 20 of 113 THRs (18%) at a mean of 23 months’ follow-up. The authors state poor technique, particularly with respect to cementing the acetabular component, to be the main cause of revision surgery. Figures previously published for cemented hip replacement show the NHS-wide revision rate to be 0.9%\(^6\) at three years.

The economic argument for ISTCs becomes untenable should the results seen in the two aforementioned studies be reproduced in all centres. Initial contracts were awarded at an average premium of 11.2% above the NHS
equivalent price.\textsuperscript{7} A tenfold increase in the revision rate for TKR, together with an 18-fold increase in that for hips, places a huge financial burden on the NHS as a whole, which would not be reflected by ISTC financial performance indicators. All this is without consideration of the loss in human terms.

It may be that the reports of both TKR and THR discussed above highlight individual problems at a single institution with local solutions. However, the lack of data from ISTCs regarding the quality of the care they provide make it difficult to refute the evidence provided by these studies. The unease with which the orthopaedic community has viewed the drafting in of overseas surgeons to carry out procedures appears to be justified. The dissociation between the surgeon and the community he or she serves can only drive standards down, as follow-up becomes impossible and accountability is separated from surgical responsibility.

The simple act of sending patients away to distant centres to receive their elective joint replacement appears to have a negative impact on outcome. Early attempts at reducing waiting lists by sending patients from distant hospitals to NHS hospitals in London for hip replacement in the early 1990s led to unacceptably high complication rates. Ciampolini and Hubble\textsuperscript{7} reported 44% revision rates at a mean of 6.5 years, compared to 4.9% over the same period for surgery performed locally.

In his recent editorial, Cannon\textsuperscript{4} outlined four safeguards aimed at ensuring optimal outcomes. These were that the post-operative radiographs should be peer reviewed; that close communication should exist between surgeon and the rehabilitation teams; that a single surgeon should oversee all phases of treatment; and that surgeons at originating hospitals should be kept informed of progress. With increasing distances between the patient and the operating centre, the last three of these safeguards become more difficult and more costly to implement.

ISTCs do present an opportunity for increasing capacity within the healthcare system. However, this can only be achieved safely by the rigorous enforcement of standards of care, as measured by gathering appropriate clinical data through audit and follow-up. The inability to gather such data places the whole programme in jeopardy, and raises questions about the appropriateness of imposing a free-market economic model on the NHS.

The medical profession is not alone in voicing disquiet over the performance of ISTCs. The House of Commons itself has raised questions over their role, concluding in its 2006 report\textsuperscript{8} that: “We are not, however, convinced that ISTCs provide better value for money than other options, such as more NHS Treatment Centres, greater use of NHS facilities out-of-hours or partnership arrangements. All these options would more readily secure integration and may be cheaper”\textsuperscript{5}.

Herein lies the crux of the matter: if ISTCs provide treatment at greater financial cost and with poorer outcomes than established local NHS alternatives, should healthcare commissioners continue to send patients to them? Would the public purse and patients alike not be better served by switching investment from the ISTC programme to existing providers?

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References