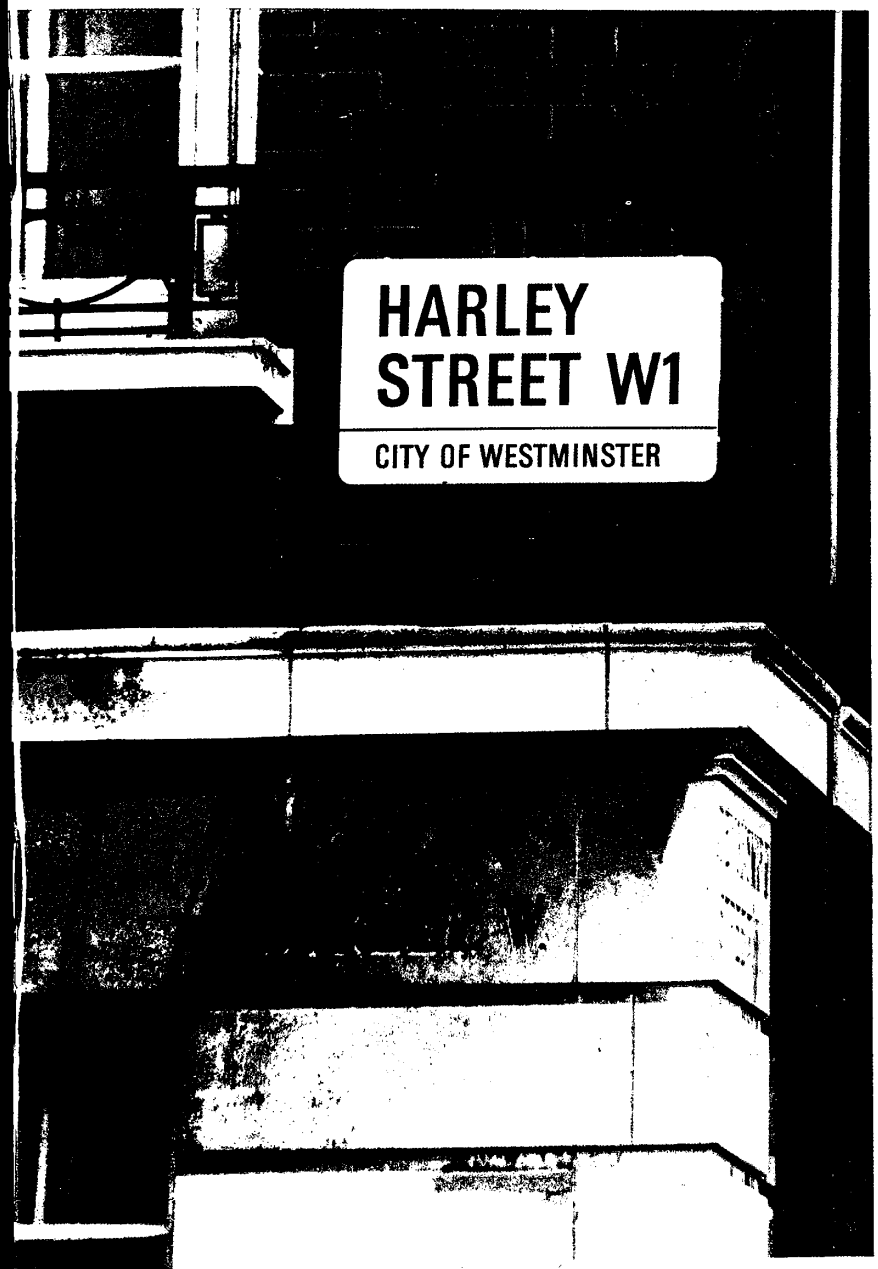
# GOING PRIVATE




## Independent health care in London

**Going Private**
Independent health care in London

# Going Private

## *Independent health care in London*

**William Laing**

for the King's Fund Commission
on the Future of Acute Services in London

ISBN 0 9518892 5 7

Published by the
King's Fund London Initiative
2 Palace Court
London W2 4HS
(telephone 071-727 0581)

Cover photograph by
Martyn Partridge

Design and print by Intertype

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# Executive summary

*Going Private: Independent health care in London* deals with the "acute sector" – that is, the range of medical and surgical outpatient and inpatient treatment normally covered by private medical insurance and the "long-term care sector" – that is, care provided in nursing and residential homes for elderly and chronically sick people, with no medical supervision.

## History of independent health care

### Acute sector

From the inception of the NHS to the 1970s, there was a steady increase in private medical insurance (PMI) and spending on private health care. In the early 1970s, oil wealth caused an influx of Arab patients, mainly to central London private hospitals. In the late 1970s, the Labour government's attempt to phase pay beds out of the NHS stimulated a massive programme of development of private, for-profit hospitals in London and throughout the UK.

In 1979, the Conservative administration introduced a new consultant contract which removed all practical constraints on the supply of consultant labour to service the private sector. Coincidentally, there was an unprecedented boom in PMI subscriptions from 1979 to 1981, followed by a period of more modest but sustained growth throughout the 1980s. By 1990, it is estimated that 16.9 per cent of London's population was covered by PMI, compared with 11.7 per cent for the UK as a whole.

### Long-term care sector

Expansion of independent nursing and residential homes for elderly people has been less rapid in London than elsewhere in the UK since the early 1980s, when supplementary benefits (now income support) funding first became available.

## Current scale of London's private health care

### Acute sector

In 1986, 25 per cent of elective surgery procedures, excluding termination of pregnancy, carried out on British residents in the four Thames regions took place in the "private" sector – that is, in independent hospitals or NHS pay beds. The proportion probably reached one-third by 1990. There are currently 42 independent

medical/surgical hospitals with 3054 beds registered within the old GLC boundaries. This compares with 30,770 acute non-psychiatric beds in London. The independent sector therefore provides 9 per cent of acute non-psychiatric beds in the capital. If the 673 authorised NHS pay beds are included, the proportion of overall private provision in London rises to 11 per cent.

The combined revenue of the 42 independent medical/surgical hospitals within the old GLC boundaries is estimated at £295 million in 1990. NHS private patient revenue adds a further £50 million to this total. In comparison, an estimated £1710 million in revenue was spent on NHS acute non-psychiatric hospitals within the GLC area. The independent sector, therefore, absorbs fifteen per cent of the total revenue spent on London's acute non-psychiatric hospitals, with 9 per cent of the beds.

It is estimated that NHS districts within the old GLC boundaries, together with the London non-psychiatric special health authorities, spent £153 million on medical consultants in 1989–90. In comparison, it is estimated that London generated £175 million in private practice fee revenue for these consultants. Private practice in London, therefore, accounts for over 50 per cent of medical consultants' revenue. Exactly how consultants have managed to increase their private activity without compromising their NHS service is a conundrum which has not yet been satisfactorily answered.

The independent sector's contribution to medical training in London is minimal and the growth of private health care has led to some depletion of the proportion of elective surgery material available for medical students. The independent sector makes some contribution to nurse training in London and elsewhere, but this is constrained by difficulties in obtaining English National Board accreditation which is based on NHS facilities and procedures.

However, the independent sector does not as yet pose a significant threat to the availability of nursing staff to the NHS.

### Long-term care sector

In mid-1991, the independent sector supplied an estimated 46 per cent of London's long-term nursing care bed capacity for elderly people and 49 per cent of social care capacity in residential homes. The remaining 54 per cent of nursing care bed capacity in London was supplied by the NHS in long-stay geriatric and psychogeriatric wards.

The independent sector's share of supply is lower in London than elsewhere. In the UK as a whole the independent sector provides 66 per cent of nursing care bed capacity, and 61 per cent of social care bed capacity.

## Patient flows

### Acute sector

There is a small (5 per cent) net inflow of private patients into the Thames regions from other regions of England and Wales. Net inflow into the greater London area is unquantified.

### Long-term care sector

Many elderly Londoners seek nursing home care in the southern Home Counties. Partly this is because fees are high and there are few places available for people wholly reliant on state benefits. Partly it is because of supply constraints, particularly in the inner London area where property prices in many areas make care home operation prohibitive.

Inner London's per capita private and voluntary nursing home provision is 25 per cent that of the UK. The level of provision of all forms of institutional care for elderly people combined is also significantly lower for London than for the adjoining southern Home Counties.

## Future development

### Acute sector

Privately paid acute health care looks set to expand further in the 1990s. The seeds of two potentially far-reaching changes to private acute health care are present at the beginning of the 1990s.

One possible direction of change is towards a resurgence of NHS pay beds, or public/private partnership developments, as major suppliers of private treatment. However, this can only be justified if pay beds contribute a surplus after charging full capital and overhead costs.

The other potentially far-reaching change relates to the way in which private specialist services are bought. No one has yet seriously challenged the private fee structure for specialists though there is an increasing awareness among private medical insurers that substantial savings could be made for private patients if hospitals were to employ their own specialists to undertake operations on a sessional basis.

### Long-term care sector

The long-term care sector is approaching what will probably be a time of great turbulence after April 1993, when public money now spent on income support benefits for people entering care homes is transferred to local authorities which will become the principal budget holders for publicly funded long-term care.

From the NHS planning perspective, a key issue is what degree of responsibility health authorities should assume for long-term nursing care of elderly people. Total withdrawal from long-term care is not a real option for London health authorities, because of the shortage of local independent sector provision, but the implementation of the government's community care reforms is likely to force a review of strategy.

Another key issue is the formula for redistributing the income support money presently spent on independent care homes. If money is distributed according to population served as opposed to current location of care home this is likely to trigger a substantial transfer of spending from the Home Counties to London and from outer to inner London.

# INTRODUCTION AND DEFINITIONS

This report deals with the two major areas of independent health care activity:

## 1 Acute sector

In the independent health care context, this broadly refers to the range of medical and surgical outpatient and inpatient treatment normally covered by private medical insurance (PMI). The great bulk of acute independent health care consists of elective surgery, where going private enables patients to avoid National Health Service (NHS) waiting lists and to receive treatment at the time of their choice. Medical specialties – including psychiatry and geriatrics – account for a relatively small proportion of overall spending on independent health care.

## 2 Long-term care sector

This refers to care provided in nursing and residential homes for elderly and chronically sick people, with no medical supervision.

## Definitions

In the context of the *supply* of health care services, the word "private" is used to refer to for-profit activity. "Voluntary" refers to not-for-profit activity. The word "independent" relates to private and voluntary activity combined (excluding NHS pay beds).

In the context of *demand* for health care services, the word "private" relates to services which are funded privately, whether through PMI or out of patients' own pockets, and provided in the independent sector or by the NHS.

London, unless otherwise stated, refers to the inner and outer London boroughs, i.e. the area within the boundaries of the old Greater London Council (GLC).

CHAPTER 1

# History of independent health care

## Acute sector

The mid-1970s is generally viewed as a watershed in the development of private health care in Britain. Up to then, there had been a steady increase in uptake of PMI although the supply of independent health care services remained, as in the 1950s, dominated by charitable hospitals and NHS pay beds. Private practice was still an occasional activity for senior consultants.

Two things happened in the mid-1970s to change this; one was almost exclusively a London phenomenon. Oil wealth caused an influx of Arab patients and a massive, though short-lived, increase in private practice for overseas patients, centred around Harley Street. The second led to much more far reaching and permanent change, and affected private health care throughout the UK. This was the attempt by the 1974–79 Labour administration, under Barbara Castle as Secretary of State for Health & Social Security, to phase pay beds out of the NHS.

The 1979 general election took place before phasing out could be completed. However, the effect of the policy had been to stimulate a massive programme of development of private, for-profit hospitals in London and throughout the UK. Though the new Conservative administration reversed the phasing out policy and allowed the authorisation of new pay beds once again, the momentum of the private building programme was irreversible. Independent hospital capacity in London in 1991 was almost twice what it was in 1977 (see Table 1.1).

*Table 1.1*

Growth in independent medical/surgical* hospital capacity, 1977–91

| | London | | UK | |
|---|---|---|---|---|
| | **Hospitals** | **Beds** | **Hospitals** | **Beds** |
| 1977 | 25 | 1,605 | 154 ** | 7,035 ** |
| 1991 | 42 | 3,054 | 216 | 10,911 |

*excluding independent psychiatric hospitals and NHS pay beds

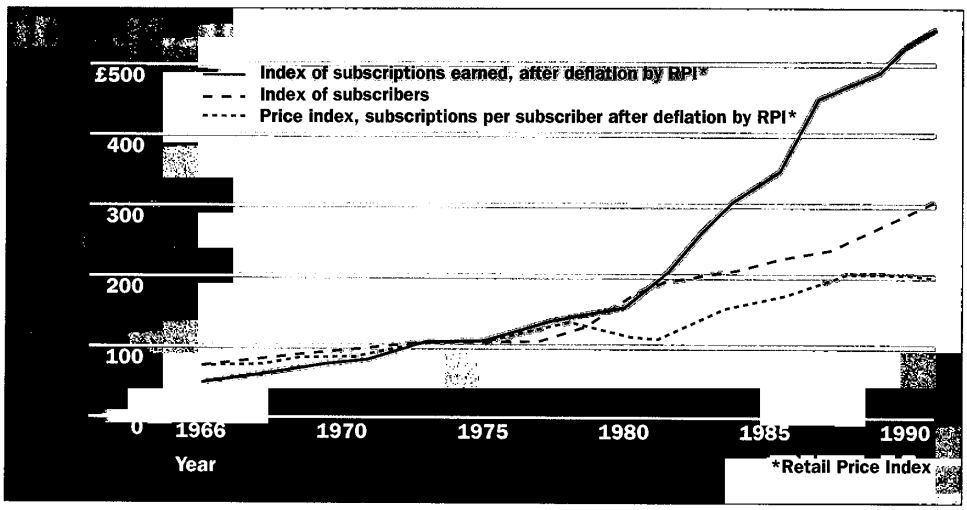
**relates to 1980

*Source:* 1991 and 1980, Independent Healthcare Association; 1977, BUPA Summary of Private Hospital Facilities

At the same time, the Conservative administration brought in a new consultant contract which, for the first time, allowed full-time NHS consultants to practise privately, up to a limit (in practice unverifiable)

*Figure 1.1*

Medical insurance trends at constant prices, after deflation by the Retail Price Index, all insurers, 1966–90 (Index 1975 = 100)




of 10 per cent of their NHS salary. There was no restriction on private practice for consultants with part-time NHS contracts. The effect of the new contract was to remove all practical constraints on the supply of consultant labour to service the once more rapidly growing private sector.

Labour's phasing out policy had coincided with a levelling off of PMI uptake, partly (presumably) because of loss of confidence in insurers' ability to deliver the private health care they promised, but probably mainly because of the coincidental rise in the real price of PMI as medical insurers sought to increase their reserves. The election of the Conservative administration witnessed a massive rebound in demand, with a surge in PMI uptake caused partly (presumably) by a return of confidence but probably mainly because insurers cut the price of PMI substantially in an effort to stimulate the market (see Figure 1.1).

Though the unprecedented boom in PMI subscriptions lasted only from 1979 to 1981, the last decade has witnessed sustained growth in numbers of persons insured and in spending on private health care. As a result of these changes, the current private health care scene differs from that of the early seventies in several important respects:

- NHS pay beds' share of private spending on hospital treatment has dropped from approximately 50 per cent in the early 1970s to 12 per cent nationally in 1989 (14 per cent in London) (see Table 1.2).
- The balance of independent hospital provision has shifted away from charitable and religious hospitals and towards private, for-profit hospitals (see Table 1.3).
- Private practice now accounts for approximately one-half of London consultants' gross income – see below.
- A significant proportion of elective surgery is now privately funded – see below. It is no longer possible to dismiss the independent sector, as the Royal Commission on the NHS did in 1979, as being peripheral to mainstream health care provision.

*Table 1.2*

Independent hospital and pay bed revenue in the UK, 1972–90

| | Independent acute medical/surgical hospital revenue £m | Pay bed revenue £m |
|---|---|---|
| 1972 | 15 | 14 |
| 1975 | 30 | 22 |
| 1980 | 97 | 48 |
| 1985 | 402 | 67 |
| 1990 | 847 | 113 |

*Source:* Laing and Buisson, 1992

*Table 1.3*

Independent acute medical/surgical hospital capacity by ownership type, 1991

| | United Kingdom | | London | |
|---|---|---|---|---|
| | Beds | % | Beds | % |
| For profit | | | | |
| British groups | 3,573 | 33 | 522 | 17 |
| European groups | 1,685 | 15 | 763 | 25 |
| US groups | 257 | 2 | 267 | 9 |
| Independent | 1,053 | 10 | 426 | 14 |
| Total for profit | 6,568 | 60 | 1,978 | 65 |
| Not for profit | | | | |
| Charitable groups | 1,622 | 15 | 197 | 6 |
| Charitable independent | 1,580 | 14 | 685 | 22 |
| Religious | 1,141 | 10 | 194 | 6 |
| Total not for profit | 4,343 | 40 | 1,076 | 35 |
| Grand total | 10,911 | 100 | 3,054 | 100 |

*Sources:* (UK) Independent Healthcare Association, *Survey of acute hospitals in the independent sector*, 1991; (London) Laing and Buisson database

### Private medical insurance

PMI has been the main engine of private health care growth in the UK since World War II. It is estimated (Laing & Buisson, 1992) that approximately 71 per cent of spending on private health care is PMI funded. In London, the corresponding figure is estimated to be around 60–65 per cent, because of the concentration of overseas private patients in the capital. Market research clearly shows that the main reason why people buy PMI is to avoid NHS waiting lists and to be able to choose the time of treatment for elective surgery (non-emergency), should it become necessary.

There were no separate figures for PMI coverage in the London area until the 1980s, when questions on PMI were introduced into the *General Household Survey* and regional breakdowns of results were

*Table 1.4*

PMI penetration in UK and London, 1955–90

| Region | Per cent of population covered by PMI | |
|---|---|---|
| | UK % | London % |
| 1955 | 1.2 | |
| 1960 | 1.9 | |
| 1965 | 2.7 | |
| 1970 | 3.6 | |
| 1975 | 4.1 | |
| 1985 | 8.6 | |
| 1986 | 8.7 | 12.5 |
| 1987 | 9.3 | 13.4 |
| 1988 | 10.4 | |
| 1989 | 11.0 | |
| 1990 | 11.7 | 16.9 (est.) |

published (e.g. OPCS, 1988). The series was discontinued, however, from 1987. On the assumption that PMI has grown, since 1987, by the same proportion in London as in the UK as a whole, it is estimated (see Table 1.4) that 16.9 per cent of London's population was covered by PMI in 1990, compared with 11.7 per cent for the UK as a whole.

### Overseas patients

Newly oil rich Arab patients came to London in the mid-1970s in the absence of hospitals in their own countries. However, as hospitals came "on stream" in the gulf states from the late 1970s, this source of private practice in London started to decline.

Current industry estimates suggest that approximately 15–20 per cent of London independent hospital treatment by value is now accounted for by overseas patients. In addition to patients from Arab states, who come to London for all types of treatment, Germany, Greece, Norway, and Nigeria are the main sources of overseas demand – in particular for heart surgery.

### Self-pay patients

Most of the remaining 15–20 per cent of London independent sector revenue comes from British residents paying for treatment out of their own pockets. In the absence of any regular and reliable source of data, this figure, like the figure for overseas patients, is no more than an educated guess, based in this case on estimates of self-pay for the UK as a whole. Moreover, self-pay business, like overseas business, is volatile. Personal communications from a number of hospital groups indicate that the economic recession has led to a significant decline in self-pay business in 1990 and 1991.

### NHS funding of independent hospitals

In 1987–88 the NHS spent approximately £50 million on contractual arrangements with independent hospitals in the UK, mainly through long-established contracts with charitable hospitals and mainly for care in non-acute specialties (HMSO, 1989). It is estimated (Laing & Buisson, 1991a) that contractual spending on acute medical care accounted for approximately £20 million, or around 3 per cent of total independent hospital revenue at the time. Neither the waiting list initiative nor the implementation of the NHS and Community Care Act 1990 has led to any significant increase in contracting with independent hospitals for acute services. NHS contracts remain a small element of independent sector revenue, and an insignificant element for private hospitals in particular.

## Long-term care sector

The independent sector's contribution to long-term care, in London as in the remainder of the UK, is almost wholly concentrated on the supply of nursing and residential homes. Such independent community care (or "home care") services as exist are believed to be concentrated in the "informal" (i.e. unpaid) sector and in the "grey economy" where cash payments of unknown magnitude pass between individual recipients and providers of services (Lewis, 1991).

By far the largest segment of the independent care homes market is care for elderly, chronically ill, and physically disabled people. In 1991 in the UK, there were 353,000 independent nursing and residential home places for this client group (Laing & Buisson, 1991b). In comparison, there were 16,300 registered places in independent care homes for "recovering" mentally ill people and 23,700 for people with learning disabilities, nearly all of them in residential rather than nursing homes. This report focuses exclusively on the elderly care market, which is the only segment where the independent sector provides a significant element of professional nursing care.

In the UK as a whole, independent nursing and residential homes for elderly people started to grow in numbers as local authority investment in local authority old people's homes ground to a halt in the mid-1970s, and as supplementary benefits (now income support) became readily available in the 1980s for people without resources of their own to enter nursing or residential homes. Regional data on care home bed numbers are available from 1987 onwards from Laing and Buisson's database. Prior to 1987, trend data are available at national level only (see Table 1.5).

It is striking that the explosion in independent nursing and residential home capacity in the UK has not been mirrored in London. Independent nursing home bed numbers increased by 147 per cent in the UK between 1987 and 1991, but by only 50 per cent in London. There was a 30 per cent increase in independent residential home capacity across the UK in the same period, but only an 18 per cent increase in London. This is despite London's relatively low level of

*Table 1.5*

Growth in independent nursing and residential home provision, 1970–91

| | London | | United Kingdom | |
|---|---|---|---|---|
| | **Private and voluntary nursing home beds** | **Private and voluntary residential home beds** | **Private and voluntary nursing home beds** | **Private and voluntary residential home beds** |
| 1970 | | | 20,300 | 63,800 |
| 1975 | | | 24,000 | 66,800 |
| 1980 | | | 26,900 | 80,000 |
| 1985 | | | 38,000 | 130,400 |
| mid-1987 | 4,200 | 11,200 | 60,300 | 156,600 |
| mid-1988 | 4,700 | 11,400 | 78,300 | 170,900 |
| mid-1989 | 4,900 | 11,900 | 99,000 | 183,100 |
| mid-1990 | 5,500 | 12,300 | 123,100 | 195,600 |
| mid-1991 | 6,300 | 13,200 | 149,000 | 204,000 |

*Source:* Laing and Buisson database

independent care home provision per unit population compared with the UK – see below.

### Funding of independent long-term care

Funding of independent long-term care is wholly different from funding of acute independent health care services, and insurance as yet plays no part. Long-term care insurance has been identified as a major potential growth area by the insurance industry, but the first funding products were launched only in 1991.

It is estimated (Laing and Buisson, 1991b) that, nationally, forty per cent of independent nursing and residential home residents pay their fees entirely privately; around 3 per cent are funded by local or health authorities and the remaining 57 per cent are paid wholly or partly through income support. It is probable, though there are no supporting data, that the majority of income supported fees are topped-up from family or charitable sources. No corresponding figures are available for London.

CHAPTER 2

# Scale of London private health care versus NHS

## Acute Sector

### Activity

Data on independent hospital activity are not collected routinely, either by the Department of Health or by any independent sector body. The Independent Healthcare Association has tried to collect activity data from its members but response rates have been inadequate.

The most reliable data by far have been published by Brian Williams and his colleagues (Nicholl *et al.*, 1989a and 1989b) at the University of Sheffield Medical School. They conducted two surveys of independent sector activity in 1981 and 1986, obtaining virtually 100 per cent responses.

In 1986, 25 per cent of elective surgery procedures (excluding termination of pregnancy) carried out on British residents in the four Thames regions (London was not separately identified) took place in the "private" sector, i.e. in independent hospitals or NHS pay beds (see Table 2.1).

*Table 2.1*

Inpatient elective surgery* carried out on residents of England and Wales

*excluding termination of pregnancy

| | **Elective surgery inpatients treated in the "private sector" (i.e. independent hospitals or NHS pay beds) 1986** | **Proportion (%) of patients treated in the "private sector"** | |
|---|---|---|---|
| | | 1986 | 1981 |
| North West Thames | 28,600 | 31.2 | 21.8 |
| North East Thames | 47,470 | 22.0 | 12.8 |
| South East Thames | 32,750 | 19.0 | 13.6 |
| South West Thames | 26,480 | 30.8 | 21.7 |
| Combined Thames regions plus London postgraduate hospitals | 136,190 | 25.1 | - |
| England & Wales | 322,400 | 16.7** | 13.2 |

**286,700 inpatient elective surgery operations (14.8 per cent of combined private and NHS total) took place in independent hospitals and 35,700 (1.9 per cent of the combined private and NHS total) took place in NHS pay beds

*Source:* Nichol *et al.*, 1989a and 1989b

A key question is how this has changed since. Though subsequent activity data are not available, there is no doubt that the percentage of elective surgery carried out in the "private" sector has grown significantly since 1986. This can be inferred from increases in medical insurance coverage (see Table 1.4) together with evidence from the major medical insurers' returns to the Department of Trade and Industry (see Table 2.2) which confirm the consensus view within the medical insurance sector that claims rates (mainly for elective surgery) have been increasing in recent years – and have continued to do so in 1991.

*Table 2.2*

Claims per subscriber, average claim cost, and claims cost per subscriber, BUPA/PPP/WPA, 1981–90 (Index 1981 = 100)

| | **Claims per subscriber** Index | **Average cost per claim after deflation by RPI** Index | **Cost of claims per subscriber after deflation by RPI** Index |
|---|---|---|---|
| 1981 | 100 | 100 | 100 |
| 1982 | 109 | 106 | 115 |
| 1983 | 112 | 113 | 126 |
| 1984 | 118 | 117 | 137 |
| 1985 | 126 | 116 | 146 |
| 1986 | 131 | 121 | 159 |
| 1987 | 132 | 127 | 167 |
| 1988 | 134 | 128 | 172 |
| 1989 | 142 | 124 | 176 |
| 1990 | 144 | 126 | 181 |

*Source:* DTI Returns and Retail Price Index

With a 35 per cent increase in PMI cover between 1986 and 1990, and a 10 per cent increase in claims rates, it is probable that by 1990 as much as one-third of all elective surgery in the London area was being carried out in independent hospitals or NHS pay beds.

### Hospital capacity

There are currently (1991) 42 independent medical/surgical hospitals with 3054 (see Table 2.3) beds registered within the old GLC boundaries. This compares with 30,770 acute non-psychiatric NHS beds.

*Table 2.3*

London acute hospital capacity – bed numbers – 1991

| | **Bed numbers** | **%** |
|---|---|---|
| Independent medical/surgical hospitals | 3,054 | 9 |
| NHS acute non-psychiatric hospital beds | 30,770 | 91 |
| (of which, NHS pay beds) | (673) | (2) |
| (of which, located in dedicated NHS pay bed units) | (321) | (1) |
| All acute non-psychiatric beds | 33,824 | 100 |

*Sources:* Independent hospitals and dedicated pay bed units, Laing and Buisson database; Acute NHS hospitals and other pay beds, *Hospitals and Health Services Yearbook*

These two figures are as near comparable as possible. Independent hospitals were counted if they have an operating theatre, and then *all* beds were counted whether acute or not. Similarly, NHS hospitals were counted if they are classed as acute, mainly acute or partly acute. The independent sector, by this measure, accounts for 9 per cent of total acute non-psychiatric capacity in London. If the 673 authorised NHS pay beds are included, the proportion rises to 11 per cent.

### Hospital revenue

The combined revenue of the 42 independent medical/surgical hospitals within the old GLC boundaries, with a total of 3054 beds, is estimated at £295 million in 1990 (see Table 2.4). NHS private patient revenue (mainly from inpatients using the 673 pay beds) was an estimated £50 million in 1990. In comparison, an estimated £1710 million was spent on the revenue account on NHS acute non-psychiatric hospitals within the GLC area. The independent sector, therefore, (with 9 per cent of the beds) absorbs 15 per cent of revenue spent on London's acute non-psychiatric hospitals. The difference reflects a number of factors, including case mix and capital servicing. It is not, however, a consequence of higher occupancy rates in independent hospitals. Though occupancy figures are commercially sensitive and tend not to be published, it is widely recognised that the decline in overseas business and the more recent downturn in self-pay demand has meant that many independent hospitals in London are operating at well below target. In the independent sector, as in the NHS, London has an overcapacity problem.

*Table 2.4*

Revenue spending on London's acute non-psychiatric hospitals, 1990

| | £m | % |
|---|---|---|
| Independent medical/surgical hospitals | 295* | 15 |
| NHS acute non-psychiatric hospital beds | 1,710** | 85 |
| (of which, NHS private patient income) | (50)*** | (2.5) |
| All acute non-psychiatric beds | 2,005 | 100 |

*Sources:*

*The estimate for independent hospitals is based on their most recent actual revenues given in annual accounts for those hospitals reporting separately, as collated by Health Care Information Services, 1991. These revenues are adjusted to a 1990 calendar year basis, with non-reporting hospitals' revenues estimated at an equivalent revenue per bed.

**The NHS estimate is based on total revenue expenditure per bed for inpatients, outpatients, day patients, day cases and other hospital patients in the four Thames regions, as reported in the most recent (1986–87) Health Service Costing Returns, adjusted for inflation to calendar 1990 and applied to the 30770 acute, mainly acute or partly acute NHS beds within the GLC boundaries.

***The estimate of NHS private patient income is based on the latest available accounting returns (1989–90) from the four Thames regions (excluding districts outside the GLC area) and the London special health authorities – adjusted for inflation to calendar year 1990.

### Consultants' revenue

Independent hospital revenue figures do not include medical fees. Privately practising consultants are nearly always paid separately, whether by insurance companies or by patients themselves. NHS

*Table 2.5*

Consultants' gross earnings from NHS employment and private practice, 1989

| | NHS employment | Private practice | Private practice as per cent NHS + private practice |
|---|---|---|---|
| | £m | £m | % |
| London (GLC area) | 153 | 175 | 54 |
| UK | 640 | 404 | 39 |

*Sources:*

**Private practice** Gross private practice fees for consultants and anaesthetists are taken from Laing and Buisson, 1991a. The UK total of £404 million in 1989 is derived from private medical insurers' figures on the breakdown of benefit payments, grossed up for overseas and UK resident self-pay fees. London estimates have been derived by assuming a constant ratio of private practice earnings to independent hospital and pay bed revenue.

**NHS employment** Actual expenditure on medical consultants in 1989–90 was obtained for districts within the old GLC boundaries from three of the four Thames regional health authorities' accounts. Spending for the fourth region, for which actual figures were not available, was estimated on a per acute bed basis. It was not possible to obtain expenditure on consultants directly from the six non-psychiatric special health authorities in London, and their expenditure was estimated at the same per acute bed rate as those London teaching hospitals for which data were available.

revenue spending figures, on the other hand, *do* include consultants' salaries. It is estimated that NHS districts within the old GLC boundaries, together with the London non-psychiatric special health authorities, spent £153 million on medical (i.e. non dental) consultants in 1989–90. In comparison, it is estimated that London generated £175 million in private practice fee revenue for consultants. These figures are of necessity approximations – see notes to Table 2.5 – but it is believed they are sufficiently accurate as order of magnitude estimates of the relative contibutions of NHS pay and private practice fee income to consultants' gross revenue.

It has not been possible to estimate consultants' income from other sources, such as university funding not included in health authority returns, but it may be said that London consultants as a body earn approximately as much in gross income from private practice as they do from NHS and quasi-NHS employment.

The great bulk of private practice is believed to be carried out by NHS consultants with a part-time contract. According to BUPA, some 12,000 out of the 16,900 consultants in the UK (71 per cent) engage to some extent in private practice. There is no corresponding figure available for London alone, though the percentage is likely to be higher because of the concentration of private practice in the capital.

The extent of private practice for individual consultants can range from very small to very large. Recently, new information derived from medical insurance statistics has been reported on private practice earnings at the upper end of the range. This indicates that the highest earning 20 per cent of consultants in the UK grossed an average of £95,000 per annum from private practice in 1990 (Laing and Buisson, 1991c). The response of the British Medical Association (BMA) to media questions which followed was that the average is weighted by a small number of consultants with exceptionally high earnings in central London. At an anecdotal level, this view appears to be widely accepted within the private health care sector, but no further "hard" information is available on the spread of private practice earnings. The range of full-time consultants' NHS earnings is much narrower, from £29,700 for a newly appointed consultant to £78,680 for a consultant on the full A+ award in 1989–90.

In their commentary of their 1986 private sector survey results, Brian Williams' team pointed out (Nicholl *et al.*, 1989a) that only 5 per cent of acute specialty surgeons' standard eleven-session working week

was not contracted to the NHS. However, in that non-contracted time, plus their own spare time, they managed to carry out 16.7 per cent of elective inpatient surgery. The authors concluded:

> *It is difficult to see how in the short-term private sector activity could continue to increase further without consultants doing more work outside the normal working week, which may have consequences for the costs of treatment, or without many full time consultants switching to part time work, thereby reducing their NHS workload.*

Nevertheless, private sector activity has continued to increase, as has NHS activity (though at a slower rate). Exactly how consultants manage to increase their private activity without compromising their NHS service is a conundrum which has not yet been satisfactorily answered.

### Nurse staffing

In 1989, independent hospitals in England employed 8965 whole time equivalent nursing staff, compared with the 199,400 whole time equivalent nursing staff employed by the NHS in all types of hospital (including psychiatric). Figures are not readily available, but it may be assumed that, when NHS psychiatric and non-acute hospital staffing is taken out, acute independent sector nurse employment in London is in line with their share of bed capacity, i.e. 9 per cent.

In 1985 the Medical Care Research Unit at the University of Sheffield was commissioned to investigate the movement of nursing staff between the NHS and the independent sector. Their results, which were published in 1988 (Thomas, Nicholl and Williams, 1988), remain the most recent source of reliable data, though they relate to England as a whole and no separate analysis was done for London. The study showed that the NHS experienced a gross loss to the independent sector (independent hospitals and nursing homes combined) of around 1800 qualified nurses in 1985. The net loss was approximately 1100 or 0.4 per cent of their total qualified nursing workforce. These figures are small compared with overall staff turnover in the NHS. However, further analysis showed that private hospitals do selectively attract recruits from specific groups within the NHS workforce, in particular nurses under 30 years of age with specialist skills such as theatre nursing, renal nursing, intensive care, and oncology. In the case of theatre nurses, the survey results suggested future growth of private hospitals might quite substantially deplete the pool of qualified staff available to the NHS.

### Training

In London, as elsewhere in the UK, little formal medical and nursing training is undertaken in the independent sector. In the case of medical training, this reflects the relatively small size of independent hospitals (only one in London has more than 200 beds and most have fewer than 100 beds), their fairly limited case mix (mainly elective surgery), and the fluidity of private practice (consultants generally do not wish to tie their private practice to particular independent hospitals). A number of practical barriers, therefore, would have to be surmounted for a

significantly greater proportion of medical training to be undertaken in independent sector hospitals.

The growth of private health care has certainly depleted the proportion of elective surgery material available for the training of medical students. However, two-thirds of elective surgery is still conducted under the NHS in the London area, and the absolute numbers of NHS elective surgery operations have continued to increase despite the rapid growth of private elective surgery.

In the case of nurse training, a survey by the Independent Healthcare Association (Davenhall, 1989) suggests that the problem is not so much lack of enthusiasm among independent hospitals for becoming involved in training, but the difficulties in obtaining English National Board accreditation using criteria based on NHS facilities and procedures – despite the fact that since 1989 it has been possible for private hospitals to become accredited. To date, no independent hospital in London has set up its own post-registration nurse training scheme, though placements in independent hospitals are commonplace. Project 2000 nurses now regularly spend placement time in acute private hospitals in London.

## Long-term care sector

### Capacity

In mid-1991, the independent sector supplied an estimated 46 per cent of London's long-term nursing care bed capacity for elderly people (and 49 per cent of social care capacity, i.e. in residential homes) (see Table 2.6). The bulk of the independent sector's nursing care bed capacity is provided by private (for-profit) nursing homes. The remaining 54 per cent of nursing care bed capacity in London was supplied by the NHS in long-stay geriatric and psychogeriatric wards. The independent sector's share of supply is lower in London than in other areas of the UK. In the UK as a whole, the independent sector provides 66 per cent of nursing care bed capacity (and 61 per cent of social care bed capacity).

### Revenue

Independent sector care home prices are substantially higher in the London area than in other parts of the country. Laing and Buisson's annual survey carried out in mid-1991 found that private nursing home charges averaged £424 per week for a single room compared with £305 per week for the UK as a whole. Fees charged by London private nursing homes are on average about the same as revenue spending per bed on NHS long-stay geriatric hospitals (though the latter contain no element of capital servicing). The proportion of institutional nursing care spending absorbed by independent sector nursing homes, therefore, is about the same as their share of bed capacity (i.e. 46 per cent in London).

### Nurse staffing

In 1989, 29,000 whole time equivalent nurses were employed in independent nursing homes in England. This represents 12 per cent of

*Table 2.6*

Independent and public sector care home capacity for elderly, chronically ill, and physically disabled people, mid-1991

| | London | | UK | |
|---|---|---|---|---|
| | **Beds** | **%** | **Beds** | **%** |
| Independent nursing homes | 6,300 | 46 | 149,300 | 66 |
| of which: | | | | |
| Private nursing homes | (4,600) | (34) | (137,000) | (61) |
| Voluntary nursing homes | (1,400) | (10) | (10,200) | (5) |
| Religious nursing homes | (300) | (2) | (2,100) | (1) |
| NHS geriatric/EMI long stay* | 7,300 | 54 | 76,000 | 34 |
| Total nursing care sector | 13,600 | 100 | 225,300 | 100 |
| Independent residential homes | 13,200 | 49 | 204,000 | 61 |
| of which: | | | | |
| Private residential homes | (7,100) | (26) | (161,700) | (48) |
| Voluntary residential homes | (5,600) | (21) | (39,100) | (12) |
| Religious residential homes | (500) | (2) | (3,200) | (1) |
| Local authority residential homes | 13,900 | 51 | 130,500 | 39 |
| Total social care sector | 27,100 | 100 | 334,500 | 100 |

*estimated from RHA data on long-stay beds provided by the Department of Health

*Source:* Laing and Buisson, 1991b

the NHS and independent sector nursing workforce combined. Any qualified nurse can run or work in a nursing home. They need not be – and are not – confined to the specialty of geriatrics.

No separate figures are available for London, though the proportion of the nursing workforce absorbed by the independent long-term care sector is certainly substantially lower than England as a whole, because independent nursing home bed capacity in London is only 36 per cent of the national level of independent nursing home provision per unit population (see Table 2.7).

*Table 2.7*

Whole-time equivalent registered and enrolled nursing and midwifery staff by sector, England, 31 March 1989

| | |
|---|---|
| NHS hospitals | 199,400* |
| Independent sector | |
| independent hospitals** | 8,965 |
| nursing homes*** | 29,065 |
| Nursing agencies | 8,000 (est.) |

*At December 1988
**Establishments with operating theatres
***Establishments without operating theatres

*Source:* DHSS, KO36 returns and estimate of qualified nursing agency staff

CHAPTER 3

# Patient flows in and out of London

## Acute sector

The 1986 survey of the independent sector by the University of Sheffield Medical School (Nicholl *et al.*, 1989a) shows a 5 per cent net inflow of "private" patients into the Thames regions from other regions of England and Wales (see Table 3.1). Inter-Thames region net patient flow is much greater, where the authors note that many residents of North West and South West Thames were treated in North East and South East Thames independent hospitals and pay beds. But there are no data indicating the flow of patients into and out of the GLC boundaries of London.

*Table 3.1*

Private sector* elective surgery for residents of England and Wales, by region of treatment and residence, 1986

| | Number treated in region | Number of residents treated anywhere |
|---|---|---|
| North West Thames | 28,600 | 35,730 |
| North East Thames | 47,470 | 31,910 |
| South East Thames | 32,750 | 27,150 |
| South West Thames | 26,480 | 34,830 |
| Thames regions combined** | 136,190 | 129,620 |

**Including London postgraduate hospitals not included in the individual Thames regions figures

*Private sector includes independent medical/surgical hospitals and NHS pay beds

*Source:* Nichol *et al.*, 1989a

Nicholl *et al.* (1989a) found that private sector case mix for British residents was dominated in 1986 by non-complex operations such as hernia, hysterectomy, and hip replacement, where the catchment radius for patients is usually around 10 miles or less. More complex procedures in independent hospitals and NHS pay beds are likely to have a larger component of demand from overseas patients.

## Long-term care sector

There are no available data on cross-boundary flows of elderly people into independent sector care homes. At an anecdotal level, it is widely recognised that many elderly Londoners have in the past sought nursing home places, and to a lesser extent residential home places, in the southern home counties and the south coast, and continue to do so

now. The putative flow of elderly long-term care patients out of London is explained by some commentators as a replication of traditional patterns of holiday migration. A similar phenomenon can be observed in other areas of Britain, for example in the North West where nursing homes in Blackpool accommodate large numbers of people previously living in Manchester. It can also be explained in terms of the shortage of affordable care homes in the GLC area, where in mid-1991 only an estimated 20 per cent of shared rooms in nursing homes were priced at or below the Greater London income support of £288 for individuals without sufficient resources of their own. Supply constraints are also particularly important in the inner London area, where property prices in many areas make care home operation prohibitive.

Of the 217 nursing homes registered within the GLC boundaries in 1991, only 58 were located in inner London boroughs. In total, there were only 1935 registered independent nursing home beds in inner London, representing 25 per cent of the national level of provision for an equivalent population.

The level of provision of all forms of institutional care for elderly people combined is significantly lower for London than for the adjoining southern home counties (see Table 3.2). This is consistent with (though it does not, of course, prove) a net outflow of long-term care patients from London to the South.

The implications of an outflow of elderly nursing care patients for the NHS in London and elsewhere are not clear. On the one hand, the presence of private nursing homes, and the availability of income support funding to pay for people of limited means, reduces the

*Table 3.2*

Index of supply* of institutional care in London and neighbouring areas, mid-1991

| | Index of places (UK = 100) | | |
|---|---|---|---|
| | **London** | **Southern Home counties** | **Northern Home counties** |
| Independent nursing homes | 36 | 103 | 62 |
| NHS Geriatic/EMI long stay | 81 | 79 | 79 |
| All nursing care | 51 | 95 | 67 |
| Independent residential homes | 55 | 151 | 77 |
| Local authority homes | 93 | 69 | 93 |
| All social care | 69 | 120 | 83 |
| Total nursing and social care | 62 | 110 | 77 |

*100 times the ratio of observed to expected places, the latter being the number of places that would have been observed in the given region if national rates of provision had been applied to the population of the region

*Source:* Laing and Buisson, 1991b

pressure on health authorities to provide long-stay geriatric beds. In addition, the shortage of affordable independent nursing home places in London must be a factor in maintaining NHS provision at a higher level than it might otherwise be.

On the other hand, the putative flow of elderly patients into private nursing and residential homes in the southern home counties may lead to a higher demand for acute health services (depending on the propensity of frail elderly people to use acute health services) and for community health services (to the extent that health authorities feel obliged to provide district nursing support – particularly for residential homes – and supplies, for example incontinence pads).

There does not appear to be any work that has measured how the presence or absence of independent care homes impact on various district services. The South East Thames Regional Health Authority has recently (October 1991) commissioned a study on the implications of non-NHS provision for their sub-regional resource allocation formula, and the remit may incorporate investigation of some of these issues.

CHAPTER 4

# Possible futures

## Acute sector

Privately paid acute health care looks set to expand further in the 1990s. There is no indication that PMI, which is the principal engine of independent sector growth, is close to saturation level. In the recession year of 1990, subscriber numbers increased by 7 per cent. There may be little or no increase in 1991, as the recession has deepened and as insurers have raised prices to cover increasing claims rates, but with new insurers entering the PMI sector and new distribution channels opening up, it is likely that expansion will continue throughout the 1990s, unless the NHS reforms can deliver real reductions in waiting times for elective surgery. Laing and Buisson (1991c) have projected growth in PMI coverage from 11.7 per cent of the population in 1990 to 18 per cent in the year 2000. The seeds of two potentially far reaching changes to private acute health care are present at the beginning of the 1990s. The discussion that follows is speculative, but the scenarios described are nevertheless plausible.

One possible direction of change is towards a resurgence of NHS pay beds, or public/private partnership developments, as major suppliers of private treatment. The Health and Medicines Act of 1989 freed health authorities to make a profit from pay beds and to deal in land. This stimulated development of some new dedicated pay bed units and refurbishment of others. Trust status will give a further impetus to pay bed development.

Many medical insurers are keen to see NHS pay beds develop, in order to increase competition among suppliers. Though few London NHS pay bed units have yet demonstrated their capacity to compete on equal terms with independent sector hospitals, their potential to gain market share is considerable. However, the key to future development must be profitability rather than marketing success. It is unfortunate in this context that information on the financial performance of NHS pay bed units is likely to remain outside the public domain.

The other potentially far reaching change relates to the way in which private specialist services are bought. So far, privately practising consultants have managed to wield their market power very effectively. Whereas in other areas of the economy, volume increases usually bring unit price reductions, consultants' private fees per procedure have risen in line with inflation. London consultants have thus reached the extraordinary position in which about half their collective income is derived from private practice on which they spend, collectively, a fraction of their time.

No one has yet seriously challenged the private fee structure for specialists though there is an increasing awareness among private medical insurers that substantial savings could be made for private patients if, say, hospitals were to employ their own specialists to undertake operations on a sessional basis. This would involve a major change in the traditional route of patient referral, which is through consultants who then choose the hospital, and it would clearly meet with strong resistance from privately practising consultants. However, the establishment of NHS hospital trusts, with their ability to negotiate terms of service directly with consultants, may be the catalyst which destabilises the present structure.

It is not inconceivable that a new sort of arrangement might emerge, possibly in association with an innovative insurance company seeking a preferred provider relationship, whereby the hospital itself would become the key focus of the referral chain and the full-time consultants working for the NHS hospital trust would be compensated sufficiently to exchange that for the traditional pattern of private practice. Once the traditional pattern had been breached, it is then not hard to see how forces of competition might lead to a radical restructuring of the private acute health care sector in Britain.

## Long-term care sector

The long-term care sector is approaching what will probably be a time of great turbulence, after April 1993, when public money now spent on income support benefits for people entering care homes is transferred to local authorities which will become the principal budget holders for publicly funded long-term care.

Though 1993 may witness a temporary downturn in publicly funded demand for independent care homes, the independent sector is likely to increase its share of long-term care provision in the 1990s as:

- local authorities are financially penalised for using their own in-house residential care (though this would presumably be reversed under a Labour government);
- the NHS seeks to concentrate its resources on acute health care services;
- demographic change increases demand for long-term care.

From the NHS planning perspective, the key issue is the degree of responsibility which health authorities should assume for long term-care of elderly people.

There are now some areas of the country (e.g. Weston-Super-Mare) where the NHS has no in-house geriatric long-stay provision at all. These areas rely entirely on independent sector provision, whether funded by income support or (to a much smaller extent) through direct contracts with the health authority.

Total withdrawal from long-term care is not a real option for London health authorities, because of the shortage of local independent

sector provision, but the implementation of the government's community care reforms is likely to force a review of strategy.

Much will depend on how much money the government distributes to local authorities to replace income support funding. Some local authorities have already raised the question of what financial contribution health authorities will make to continuing care. Sir Roy Griffiths' report on community care funding envisaged that both residential *and* nursing care would be paid for by local authorities. However, it is recognised there is a grey area where social care meets health care and many health authorities appear to recognise that, if they withdraw further from continuing care provision, they will have to make some contribution to the increased cost burden which will fall on local authorities.

Another key issue is the formula for redistributing the income support money (presently spent on independent care homes) in grants to local authorities. Should the grants go to the local authorities within whose boundaries the care homes are presently located? Or should they go to the local authorities of provenance of care home residents? The logic of current health care funding principles would suggest the latter. If so, should substantial sums be spent on developing *local* nursing care services, even though, with high property and labour prices in London, this could only be done at the cost of limiting access to services to fewer people?

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# King's Fund London Initiative

## Working Paper No. 4

**Going Private: Independent health care in London** was prepared to inform the work of the King's Fund Commission on the Future of Acute Services in London. It is being published in advance of the Commission's strategy for London in order to inform debate about the future of health care in the capital. This paper should not, however, be interpreted as in any way anticipating the recommendations of the Commission's final report.

**The King's Fund Commission on the Future of London's Acute Health Services'** terms of reference require it to "develop a broad vision of the pattern of acute services that would make sense for London in the coming decade and the early years of the next century". With this in mind, the Fund's London Acute Services Initiative has undertaken a wide-ranging programme of research and information gathering on the Commission's behalf, of which this working paper represents one part.

£7.00
ISBN 0 9518892 5 7