NHS pay beds "not to make profit"

Private leeches feed off NHS

Cartoon:

MARK BURGESS, the 10-year old whose 13 month wait for a hole-in-the-heart operation embarrassed Margaret Thatcher during the Election campaign, eventually got his life-saving operation: at the private London Bridge Hospital.

After Guy's Hospital had five times cancelled his admission for lack of beds, Mark's grandparents stepped in and raised an appeal for the cash for the operation in the new private hospital just over the road.

Both the surgeon and anaesthetist waived their usual £3,000 fees; but the bill for Mark's 10-day stay was still £5,000. Cheeky hospital bosses promised to hand some of their profits from the deal as a donation to Guy's cardiac unit.

Mark's grandmother, Mrs Joan Burgess, had earlier explained that she was a firm believer in the NHS, but had felt forced by the repeated cancellations into making a public appeal to help raise the money in order to save his life. This proved rather more effective than Margaret Thatcher's promise to act on Mark's behalf when questioned by reporters prior to the election.

A NEW 24-hour private "casualty service" in Croydon is little more than a first-aid post — charging a hefty £30 a visit.

The accident service consultant at the nearby Mayday Hospital, Kambiz Hashemi, was warned that the new Shirley Oaks private clinic could not cope with any serious accident or medical emergency:

"There is no way that the hospital could cope with a road accident, heart attacks or head injuries, and valuable time may be lost if patients ask to be taken to the private unit," he told the Health Service Journal.

For the £30 initial fee, patients with bruises, cuts, dislocations and minor fractures could sign up for a quick X-ray, stitches and bandages.

This limited service seems likely to ensure that Shirley Oaks — owned by private US corporation UHS International — will be mostly empty, compared to the busy Mayday A&E unit, which handles a massive 92,000 cases a year.

DHSS policy on NHS pay-beds is quite specific: they are not allowed to make a profit.

Even if everything works out perfectly, with sufficient beds occupied and every private patient paying the full amount they owe, strict government guidelines lay down that the whole exercise would simply cover its costs.

While any profit to benefit NHS patients is categorically excluded, any slippage at all — through bad debts, fiddles, rising costs or falling occupancy of private beds — must mean that the NHS stands actually to *lose* money rather than gain from running private beds.

The latest ministry directive, issued in February to all health authorities (HC(87)5) spells out these points beyond any shadow of doubt.

Point 6 makes it clear that scales of charges once adopted on April 1 of each year are binding on the health authority for the next 12 months, regardless of rising costs or other circumstances:

"Authorities must before 1 April each year determine charges which apply from 1 April throughout the following 12 months. *The charges set cannot be added to or amended in any way during the year in which they apply.*"

This stands in stark contrast to the government talk of "business methods", and the involvement of top bosses from Sainsbury, Marks and Spencer and IBM in NHS management: how many big firms would voluntarily impose an unconditional 12-month price freeze on everything they sell?

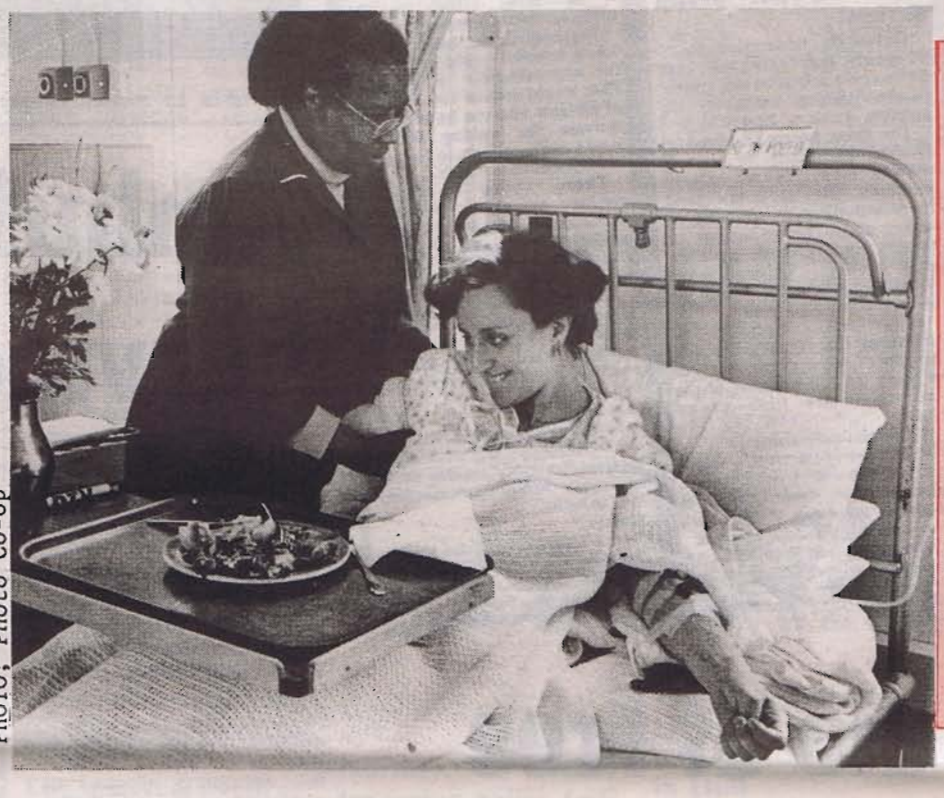
Even less businesslike is the next astounding stipulation from the ministry.

Point 8 insists that:

"Authorities should aim to recover the full costs of treating private patients *but not to make a profit*."

So while private insurance schemes cash in on low-cost NHS pay-beds, the NHS itself is ordered to do no more than break even. When will we see this policy in Sainsbury's?

Point 10 underlines the same policy. It declares that "four principles" should be taken into account in calculating private charges:



PHOTO; Photo Co-op

"● Overall, the full cost of treatment should be recovered;
● Charges should be equitable, that is reasonably closely related to the cost of individual treatments;
● Administration costs should be kept to a minimum;
● The interests of NHS patients should not be jeopardised."

The second of these four "principles" again rules out making a profit — or even charging a higher fee for certain types of treatment in order to subsidise others or reduce NHS costs.

The objective of minimising administrative costs could also mean that more of this burden is shouldered unpaid by existing NHS clerical staff. Alternatively it could compound the already notorious problems of monitoring the treatment received by private patients and chasing up full payment from them afterwards.

With all of these restrictions on a serious system of charges, it is hard to see how the fourth principle — protecting the interests of NHS patients — can be more than a fig-leaf. The strong probability from the preceding stipulations is that not only will NHS patients be passed by in the queue by the wealthy, but that NHS financial and other resources will actually be milked in order to sustain private services.

Point 13 refers to this issue, and provides a more detailed "get out" clause designed to duck governmental responsibility in cases where this charging structure is exposed as a disaster:

"Authorities are reminded of Section 62 of the (NHS 1977) Act, whose effect is that pay beds or private out-patient facilities *should be withdrawn where their use becomes detrimental to NHS patients for whatever reasons...*

"(...) if private patients costs should unexpectedly rise well above their anticipated level, *charges cannot be increased until next April*, and some alternative remedy must be found. In the first instance, the Authority should attempt to reduce its losses (!) by altering its private patients case mix, but if this fails there is no choice but to invoke Section 62."

This would appear to be quite categoric: but Section 62 seems not to have been used by health authorities, despite some losing vast amounts on certain types of private operations for which they were charging, on the official scales, far below the actual cost of treatment.

Few DHA members, campaigners or trade unionists are aware even of the existence of Section 62.

Last year, the House of Comons Public Accounts Committee heard that Blackpool DHA had been losing £30,000 a year on private hip replacements, while Lewisham & N. Southwark DHA had lost a massive £376,000 in 1984 alone on private coronary by-pass surgery. Yet NHS chiefs could not tell the MPs of a single instance of Section 62 actually being invoked to close down such loss-making private treatment.

The loss-making is still going on, even while several London DHAs head the pack in seeking to expand the number of pay-beds and even build new private blocks. Bloomsbury DHA — boasting the longest NHS waiting list in Britain — decided last December to invest £800,000 of special trust fund cash in refurbishing pay beds at University College Hospital, after being told that this would then generate a "surplus" that would benefit the District. This followed a £25,000 feasibility study by management consultants.

Yet a mere five months later, Bloomsbury's Finance Director Chris Savoury admitted to the DHA:

"We are not recovering our costs at the moment."

Indeed Bloomsbury's financial statement in April showed an "overspend" (i.e. a loss) of £216,000 on private patients in UCH by February, with a projected year-end loss of £215,000.

Worse, the expensively-hired management consultants appeared to have overlooked the impending government policy guidelines: the new general manager recruited to take charge of the pay beds insisted to the DHA that he had the "clear understanding that we are definitely not allowed to make a profit."

There is certainly little danger of profit-making in Bloomsbury, which last year wrote off almost £500,000 in bad debts from fly-by-night private patients, despite having spent as much as £250,000 in fees to financial consultants Deloitte Haskins and Sells to pursue unpaid bills totalling over £1m.

The damage done to NHS patients is underlined by the fact that Ward M at the Royal Ear Hospital was closed to finance

LAST year private pay-bed and outpatient fees paid to the NHS totalled only £61m nationally compared to an NHS budget of £18 billion.

But private hospital bosses angrily claim that this is only around half of the real cost of treatment.

The Independent Hospitals Association, struggling to compete for the same limited pool of private patients, argues that NHS hospitals are charging artificially low rates, which effectively subsidised private customers to the tune of some £50m last year.

ACCIDENTS, heart attacks, chronic ailments, mental illness and the afflictions of old age are all left out of private health care provisions.

If you get run down in the street, need cancer or transplant surgery, other urgent or long-stay treatment the private firms and insurance schemes will hand you back to the NHS.

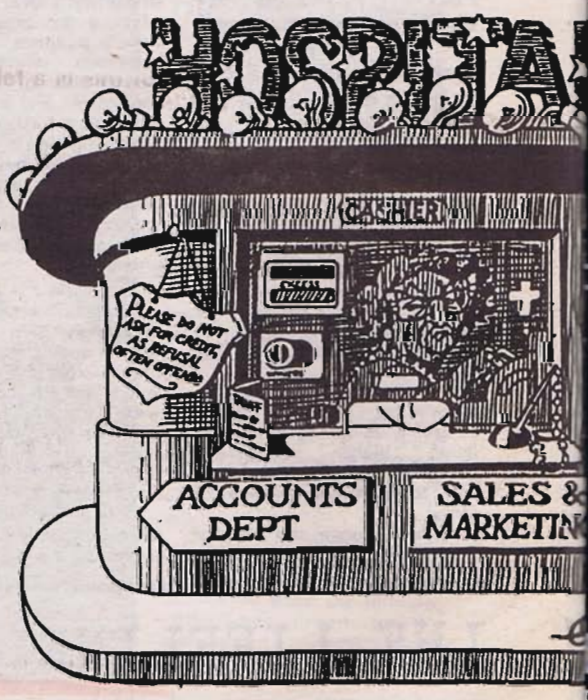
If you sign up for private insurance with an existing ailment, they will not pay to treat it. And private medical cover offered as a "perk" by employers almost always ends upon retirement — which is precisely the time of life when most people have most need of health care, and private premium fees are much higher.

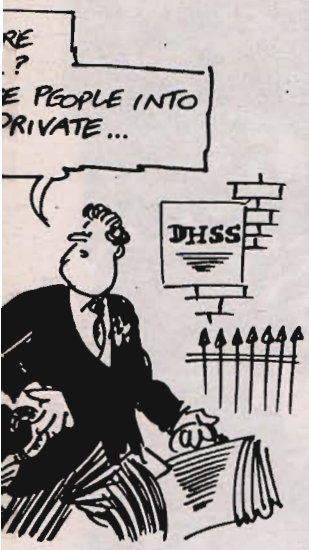
Unfair to DHAs

AMONG the sceptics unconvinced by the current DHSS model charges and policies on pay beds are the hard-line government supporters on *Merton & Sutton* health authority, which noted "the constraints imposed by the (DHSS) circular which required Authorities to recover their full costs but prohibiting them from making a profit." The minutes record that:

"Members considered that the regulations worked to the disadvantage of Health Authorities, and that the charges did not reflect the fact that most NHS hospitals provided a much wider range of diagnostic equipment than private hospitals.

"It was felt that the centrally determined charges should be more in line with private hospital fees and it was AGREED that this should be taken up with the DHSS."





alth Service Journal

the opening of a ward in the Private Patients Wing at UCH. Despite assurances that this would enable NHS accident and emergency cases to use private wing beds when necessary, this arrangement has come to an end within three months: but Ward M remained closed.

London Health Emergency has called publicly for the closure of Bloomsbury's loss-making private beds under section 62, on the basis that the longer they remain open, the more NHS funds will be drained from vital services. District General Manager Alastair Liddell has yet to reply.

The myth of "profits" from pay-beds however remains a stubborn one to dislodge. In controversial plans to market clinical services at Barts Hospital (see back page) Hackney's District General manager Ken Grant has claimed that:

"Broadly speaking, one private bed will fund two NHS beds."

And in nearby Hampstead, management has been doggedly defending private beds in the cash-strapped Royal Free Hospital, even while temporary and long-term closures of 270 acute beds this summer have reduced the hospital to "yellow alert" status — admitting urgent cases only.

112 acute beds at the Free were lost by the closure of New End Hospital; another 161 acute beds — 20% of the remainder are closed for nine weeks over the summer while maintenance work is carried out. However management are adamant that they will release only 7 of the Free's 29 private beds during this crisis period: they claim that up to £200,000 income could be lost if the beds are handed over to the NHS.

As a result the only non-urgent cases admitted to the Royal Free this summer will be private patients. Despite a 5,000-strong petition from local campaigners, a motion at the June DHA to release 14 pay-beds for NHS use was voted down with only two Camden councillors, Julia Devote and Phil Turner, in favour.

A suitable case for Section 62?

Towards a 2-tier NHS

By JOHN LISTER

MORE and more efforts are being made by health authorities to improve conditions for their private patients — in order to compete with private hospitals and other DHAs for the available business.

Hampstead's efforts have included the commissioning of a report by management consultants Price Waterhouse on how to attract the wealthy punters. Among the suggestions were:

- Appointing a specific official — at a salary of £17,000 — to look after private patients;
- Improving standards of food and accommodation for paying customers;
- Improving staff attitude towards the wealthy queue-jumpers.

Plans included a substantial upgrading of Gloucester and Victoria wards and Clinic 7, at an estimated cost of £300,000.

Price Waterhouse were also in on the act — with very similar proposals — in **Riverside's** efforts to flog more pay beds. Their report last July — at a cost of £27,000 — amounted to a catalogue of the problems of an under-funded, poorly-maintained and crumbling National Health Service. The Price Waterhouse suggestions were aimed at creating small islands of affluence for the wealthy minority within the general framework of decline.

Among their main conclusions:

- Poor decor and furniture, low standards of catering and hygeine are "a major problem" in attracting private patients (though we know NHS patients love Riverside hospitals just the way they are).
- Pay-bed customers do not like sharing wards with ordinary NHS patients.
- Administration of private patient admissions is not as quick and efficient as these important people would like.
- There is a need for "a more service orientated approach", including "that extra element of personal service which is expected and is provided in private hospitals." NHS staff need to be trained in the "client service ethic".
- Private patients are put out when because of NHS emergency admissions their reserved pay-bed is cancelled.
- "There is no arrangement to meet private patients and welcome them on entering the hospital..."

Alongside these demands for more deference, grovelling and crawling on behalf of NHS staff, Price Waterhouse repeatedly point out that the present mix of private and NHS patients makes it impossible to quantify the exact cost of the services pay-bed customers are getting.

Meanwhile Guy's Hospital decided in May to go the whole hog, and consolidated a two-tier health service by handing over the management of their loss-making private wing, Nuffield House, to the US Hospital Capital Corporation.

The firm will spend £4m to refurbish the block, and then run it as a profit-making hospital, buying services such as pathology, catering, pharmacy and X-ray from Guy's at low NHS prices. Guy's will receive a guaranteed £200,000a year. Until recently they had been running Nuffield House at an estimated £600,000 annual loss.

NUMBERS of NHS paybeds have increased by at least 23% — from 2,405 in 1979 to 2,967 in 1985. Yet 20,000 fewer patients a year are making use of these increased facilities — dropping from 91,128 in 1979 to only 70,782 in 1985: this is a fall of 22%

The decline in use of more beds is part of a general pattern in the private sector, in which typical bed occupancy figures hover around the 40-50% mark.

The averge daily occupancy of NHS paybeds fell by 30% between 1979-1985 — the fall for the Thames regions covering London is 32%, with NW Thames paybeds dropping a massive 50%.

Nowhere in the country are NHS paybeds averaging more than 50% occupancy.

"Put it this way — if you don't expire soon, our life savings will."

Floating off?

COULD Sid soon be helping to tip investors the wink about shares in a new privatised NHS Corporation?

There is along way yet to go in softening up public opinion and creating a prospect of profitable investment from health services. But more and more signs are pointing in this direction, the latest of which is the public suggestion by the former chair of the NHS Management Board, Victor Paige, that the NHS be made into a self-contained Corporation, functioning outside of direct government control.

The working model is already there in the pre-privatisation Telecom and Gas corporations, which sold services on a commercial basis to the government as well as to private consumers. To make Paige's suggestion a reality, all that would be needed would be to translate existing NHS services into a scale of charges for which the bill would initially be picked up by the government.

Of course once the cash factor — together with the concept of a "modest" profit margin for the new Corporation — had been firmly established at the centre of health provision, there would then be scope to introduce means testing — or possibly a "voucher system" — in gradual moves to shift an ever-greater burden of payment onto the patient: this has already happened with prescription charge, dental and opticians' services.

So far the official government response to Victor Paige's idea has been less than enthusiastic: he appears to have jumped the gun. But the issue has been under active discussion since at least 1983, and now seems more of a real possiblity than ever before.

Hived off!

REDBRIDGE health authority, which brought us the Barking Hospital strike over privatisation, has now "privatised" 20 of its elderly patients.

Some 20 patients have been discharged from long stay beds at Dagenham Hospital — and sent to the private Rowallan Court Nursing Home, where fees range from £295 to £330 per week.

While the health authority reduces its financial responsibility for these patients, the DHSS has been called upon to pay out £187 per week in social security towards the fees to those with savings of less than £3,000. The remainder of their fees will be paid by the health authority — producing an estimated "saving" of £20,000 per annum.

The biggest "savings" come from discharging patients with savings of *over* £3,000, who are responsible for paying all their own fees — until their assets fall below £3,000.

MANY private hospitals itemise treatment and services received by each patient, charging for every pill, bandage, X-ray, test and by the minute for physiotherapy.

Even where a similar breakdown is attempted using current NHS guideline figures, each of the charges laid down is significantly lower than the equivalent in a private hospital. Some (physiotherapy, occupational therapy and operating theatre charges) are quite ludcriously cheap.

At £9 for each attendance it can be cheaper to get private physiotherapy than to take a dog to the vet. Model charges for NHS operating theatres reach a maximum of £81 for anything over 30 minutes — a staggering bargain compared to much higher and more detailed price lists in private hospitals.

THE private sector has been profiting from a share of the £50m government hand-outs to relieve waiting list figures. Among the examples that have come to light:

City & Hackney has spent £30,000 on facilities at the private Princess Grace Hospital;

Hounslow health authority is spending £150,000 sending over 250 patients from the crisis-hit West Middlesex Hospital for private operations at the Royal Masonic Hospital;

Scunthorpe DHA is spending £30,000 on 70 private ENT operations.

Last year the NHS sent some 14,000 patients for private operations.

PADDINGTON & N. Kensington Health Authority last month agreed to write off almost £71,000 in bad debts owing from private patients.

Nearly £57,000 had been owing to the authority for over 12 months. Management argues that "the accounts to be written off amount to less than 2% of annual income." But the cuts necessary to make good such losses come from NHS spending, not from pay bed provision.

The big firms

IN 1980 the private health market in Britain was growing at 30% annually — from a very small base. But by 1986 there were still only 5 million people covered by private insurance (9% of the poulation), and growth had slowed to 3-5% per year.

Benefits paid out have also sharply increased, producing a rapid rise in premium payments. In 1981 benefits took 95% of subscriptions paid in: they have risen at up to 20% per year.

The market has also changed with the arrival of more blatant profit-making US firms such as American Medical International to challenge the hold of traditional provident funds like BUPA, PPP and WPA.

One new profit-making scheme, Health First, backed by the US Mutual of Omaha, offers a policy which quite openly rests on the NHS: it provides up to£5,000 for private treatment — but only when local NHS waiting lists are longer than 6 weeks.