Perspectives in NHS Management

Private practice: answer or irrelevance?

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Since the creation of the National Health Service in 1948 private practice has been a source of controversy. Depending on the ideological stance of the protagonists, private practice is seen to be either the answer to health care problems or an irrelevance. Such simplistic conclusions cannot be sustained after careful analysis of the available evidence. Private practice is neither an answer nor an irrelevance. Certainly, the compromise agreed between the Labour government and the medical profession, which allowed private practice within the National Health Service, has meant that private medicine could not be ignored by NHS management.¹ The industrial unrest and the medico-political disputes in the NHS in the late 1970s owed something to the political differences about the place of private medicine in the health service.^{2 3}

About 96% of the private health care insurance market is in the hands of three non-profit making provident associations: British United Provident Association, Private Patients Plan, and the Western Provident Association. The largest of these, British United Provident Association, controls 70% of the market. The remaining 4% of the total market is in the hands of the non-profit making hospital contributory funds and the fast growing (for profit) commercial companies such as Mutual of Omaha and Crusader.⁴

The subscription income of the big three provident associations was £274 million in 1982, and benefit outlays amounted to £233 million—that is, equal to about four or five NHS districts. These companies had 1.9 million subscribers covering nearly 4½ million members.^{5 6} A substantial minority of subscribers are in company schemes—that is, nearly 49% of subscribers have their contributions paid for them by their employers. It is this type of scheme, together with employee schemes that cover employed groups with subscriptions paid by the members, that has grown most rapidly recently. Only 28% of subscribers purchased insurance cover individually.

The coverage given by subscriptions generates benefits that reimburse full costs in most cases. Generally, copayments or part payments by patients are absent if the depth of insurance coverage is adequate. The main element financed by these outlays are room charges (about 45% of payments), with £70 million or just over 26% of benefit payments financing surgeons' and anaesthetists' fees, and just under 5% of expenditure financing inpatient physicians' and specialists' fees.

In addition to these insurance incomes, which finance private care, some patients pay for care out of their own pocket. About 30% of inpatient episodes are financed in this fashion. So, in 1982, an estimate of the total flow of finance into private health care would be of the order of £347 million—£233 million from BUPA, PPP, and WPA, £10 million from other insurance institutions, and about £104 million of self finance.

Who provides what private care?

The range of activity in the private sector is narrow. The non-profit making insurance associations finance largely cold, elective surgery: perhaps more than 60% of their outlays go on about 30 routine procedures, such as abortions, hernias, haemorrhoids, varicose veins, dilatations and curettages, etc. Very little general practice, dentistry, and accident and emergency care is covered by these insurers.

In 1983 the number of acute beds in registered nursing homes in Great Britain was more than 6700, with most (93.8%) being in England.^{7 8} Considerable expansions in this stock seem to be in the pipeline (perhaps an additional 1500 beds) with non-profit making organisations (charitable and religious) being the least active in this growth. The distribution of these beds in England is unequal with 54% in the four Thames regions. Just under a half of the private sector acute beds are owned by commercial for profit organisations (American and non-American), and it is these bodies that are adding and planning to add to private acute bed stock at the most vigorous rate.

There were more than 3250 NHS pay beds in 1983. Most (over 90%) of these beds are in England and these are concentrated in the four Thames regions. The NHS pay bed stock was 2677 in 1981—that is, between 1981 and 1983 it grew by 17% as entrepreneurial district health authorities sought to increase their revenue in difficult times. Thus, in total, there are just under 10 000 private acute beds (including NHS pay beds) in Great Britain. Although this stock continues to grow, it remains small in relation to the NHS bed stock.

Problems in finance and provision

The rate of growth of the market served by the big three insurers has fluctuated greatly in the past five years, averaging nearly 13% a year. The rapid growth of the late 1970s and early 1980s, however, has evaporated, with the market growing by only 3% in 1982. What is the explanation of the growth rate declining to this level in 1982 from 25.9% in 1980?

The reasons are many and complex. Firstly, premiums tend to reflect costs with the tax offset rules being modest (only those earning less than £8500 a year may set off their premiums against tax) and offer little public subsidisation (the tax offset rule reduced income tax revenue by £4 million in 1982-3). Costs have risen rapidly in the 1980s because of increased patient utilisation, perhaps associated with the coverage of blue collar workers, encouraged by the new NHS consultant contract, which encourages private work, and higher private sector fee scales.

These factors caused large increases in expenditure by the provident associations, and to balance their books they were obliged to raise their premiums. Thus one company raised all its rates for its main insurance package by 25% in 1981, by 22% in 1982, and by 14-18% in 1983. These sharp increases in premiums had two effects. Firstly, the rate of lapses of existing subscribers

grew substantially to over a quarter of a million in 1982 and, secondly, the higher premiums made it less easy to expand the coverage of private health insurance. These cost pressures seem to have moderated, and the industry believes that it is now in a period of relatively modest growth in premiums (perhaps 5-8% in the next year) and slow but steady growth in coverage (perhaps 3-5%).

The main problem facing the industry is cost containment. Costs can be contained by two methods: controlling demand or controlling supply. The industry favours the latter approach and adopts a gentle approach using moral suasion to curb the excesses of the medical profession. If this genteel approach fails the industry can either evaluate, monitor, and control the behaviour of private practitioners more rigorously or it can control patient demand by introducing copayments—that is, part payment of the cost by patients may control costs by reducing demand for fear of its financial consequences.

The problems facing the insurers are making these pay masters more cost conscious. While the attempts to curb cost inflation eases the problems of the insurers, it worsens the problems of the providers, doctors, and hospital owners. If hospital use is curtailed beds may lie empty and consultants may become anxious about business. The paradox is that the insurers' problem is the providers' income, and effective control of providers' income enables the insurers to control costs, moderate premium increases, and generate market growth. The lesson of the 1980s is that the market works: the period of rapid growth in the 1979-81 period has been strangled by cost and premium escalation. Only if the insurers can moderate private sector costs—that is, the incomes of private practice doctors and the owners of private hospital beds—can they achieve substantial growth in their markets.

The only way in which the insurers can break this circle that limits their market growth is increased public subsidisation of their activities. To get this they lobby the Chancellor of the Exchequer each year in the hope that he may increase the limit below which subscribers can reduce their tax bills by offsetting their premium payments against their income, in the same manner that mortgage interest is offset against tax.

Any government that yielded to this pressure would be subject to several criticisms. Firstly, such subsidies would benefit income tax payers—that is, they would represent redistribution of income to the relatively affluent. Another criticism of such subsidies is that no right thinking market oriented libertarian, such as Milton Friedman, would support the provision of public subsidies to the private sector.⁹ The libertarian believes that if private enterprise cannot generate a demand for its services, it should go out of business. As is well known, the Prime Minister, Mrs Thatcher, is no enthusiast for supporting lame ducks. If the private sector is to grow it must set its house in order by efficient management of its activities, and this means that it must control the costs, quantity, and quality of the private health care that it finances, or, to put it another way, the managers in the private health insurance industry must regulate the costs, quantities, and quality of care—that is, control the incomes of doctors and hospital owners.

Evolving responses to the problems of the private sector

The problems of cost containment and the debate about its resolution in the United States is relevant for the development of the United Kingdom's private health care sector—and of more than passing interest to NHS managers. In the United States the evolving trend has been the growth of the for profit movement and the relative decline of the non-profit sector (Blue Cross and Blue Shield on the insurance side and local non-profit hospitals on the provision side).

The for profit insurers have managed to carve out increased markets for themselves by creaming the market: they have identi-

fied groups who are good risks and offered them highly competitive premiums. The non-profit making companies have lost their good risks to their cheaper competitors, being left with high cost relatively bad risks. The non-profit companies have had to respond to this by changing their premiums setting policies, but creaming continues, with market forces tending to generate market segmentation of risks between the profit and non-profit making insurance companies.

The for profit hospitals generally operate in groups and have good collateral (their premises) for loans to develop and modernise their facilities. The non-profit hospitals in the United States tend to be local, individual institutions with poor collateral and substantial financial obstacles to modernisation. These factors have led to the relative decline of the non-profit hospitals or the "corporatisation" of American health care.

Thus the United States market is producing a response to the private sector's problems that means the slow relative decline of the non-profit making movement in insurance and provision. The incentive structure of the for profits movement is powerful; managers and shareholders get a share of any increased profits that they can create by greater revenue generation. In non-profit making firms, as in the NHS, managers and shareholders do not get the fruits of increased efficiency generally and as a result may strive less vigorously to cut costs and increase revenue.

While the profit motive induces for profit managers to generate increased revenue, however, it may not increase efficiency. The successful firm may have high costs: some American evidence indicates that (for profit) investor owned hospitals had higher costs and charges than not for profit hospitals.¹⁰ Thus the profit incentive may generate higher costs and more severe cost containment problems.

The market trends in the United States, the rise of the for profit insurers and providers, can be seen in the United Kingdom. Nearly half of private acute beds are owned by for profit hospitals, and the three giant non-profit insurers are being challenged by as yet small but rapidly growing for profit insurers—for example, Mutual of Omaha. These trends will generate higher costs, higher premiums, increased pressure for subsidisation by the state, and increased questioning, as is happening in the United States, of whether higher costs give better quality health care or merely more luxury and profit for investor owned institutions.

The response of the optimistic promarket libertarians is that profits will generate competition for new producers and that the profit motive will, via competition, control costs and maximise efficiency. The history of health care throughout the Western world, however, has been that competition has never and probably will never exist. President Reagan's initial love of competition in the health care market in 1980 was killed off by the opposition of insurers, professionals, and hospital owners who feared for their incomes and employment. As Adam Smith wrote in 1776: "People of the same trade seldom meet together, even for merriment and diversion, but the conversations end in a conspiracy against the public or in some contrivance to raise prices."¹¹

As Smith recognised, capitalists are the enemies of capitalism. The health care market is highly monopolised, and these sellers—hospital owners and doctors—are interested in maximising their incomes. The challenge to insurers is to control these propensities to maximise revenues and incomes and achieve efficiency in the use of scarce economic resources.

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If she was a sincere libertarian Mrs Thatcher might regard private practice as an answer but would advocate, following Milton Friedman, the deregulation of the health care market

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Effects of cuts on research and patient care

In 1982 the BMA and the British Dental Association set up a monitoring body on the effects of university cuts on medical and dental faculties. This body includes representatives from the Joint Consultants Committee, the University Hospitals Association, the Federation of Associations of Clinical Professors, the Standing Conference of Royal Colleges and Faculties of the United Kingdom, and the Association of University Teachers. Observers are invited from the University Grants Committee and the Committee of Vice chancellors and Principals.

The monitoring body believes that it is important to give early warnings of developing trends and on the basis of reports received, from surveys undertaken by the University Hospitals Association and the National Association of Health Authorities and by the BMA, and the interim data available, several problems of importance to university medicine and the NHS were identified and quantified.

The monitoring body was concerned that because of reductions in numbers medical staff in medical schools and university hospitals had less time to devote to research and teaching because they had to spend more time caring for National Health Service patients. The greatest reduction in staff has been in the age group 30 to 34 where future academic leaders could be expected to emerge. Evidence showed that losses caused by the cuts have bitten more deeply in medical departments than in non-medical university disciplines. The group believed that it was undesirable that the numbers of consultants in university hospitals

should be reduced pro rata with reductions in the numbers of hospital beds.

The chairman of the monitoring body, Professor J P Quilliam, has written to the chairman of the University Grants Committee expressing his colleagues' concern.

NHS consultants' private practice: CCHMS advice on statutory audit

The Central Committee for Hospital Medical Services has issued the following advice to NHS consultants who carry out private practice in NHS hospitals in the United Kingdom.

"The CCHMS is concerned to ensure that the principles outlined for the conduct of private practice are strictly followed. The committee has, however, recently had drawn to its attention certain activities of the NHS statutory auditors who are investigating private practice in various health authorities throughout the country. The involvement of these auditors was a decision of the Secretary of State. The NHS (Audit of Accounts of Health Authorities) Regulations 1982 state that an auditor has the right of access to, and may require production of, documents of an authority in connection with its accounts. In addition, they state that any officer of an authority, for example a consultant, may be required to produce documents of an authority in connection with its accounts. Whereas it is reasonable for all consultants to cooperate with the auditors, the committee has been advised that the auditors' powers under the above regulations do not extend to access to private diaries normally retained in the possession of the consultant. The only way in which private diaries could be made available is by the agreement of the consultant, or by an individual court order taken out at the behest of the auditors."

Treasury rebuffs BMA claim to represent Civil Service medical officers

The claim for recognition of the BMA and the British Dental Association as the negotiating bodies for medical officer and dental officer classes in the Civil Service was the main item at the first meeting of the newly elected civil service medical officers committee, held at BMA House on 31 May. Dr C J Bolt (DHSS) was elected chairman for the next two years and Dr Basil Slater (Scottish Office) was elected deputy chairman.

A letter had been received from the Treasury indicating that on the current membership figures provided by the BMA, the British Dental Association, and the Institution of the Professional Civil Servants there was no justification in changing the existing arrangements under which the institution was the recognised negotiating body for doctors and dentists in the Civil Service. The committee regretted the Treasury's decision and decided to make a further attempt to achieve better representation of the interests of medical and dental officers in cooperation with the Institution of the Professional Civil Servants. It was agreed that discussions should be re-opened with the institution with a view to reconstituting the joint BMA/IPCS committee with more clearly defined terms of reference.

The committee also approved the report of the Central Committee for Hospital Medical Services working party on the integration of the artificial limb and appliance service within the NHS. After a discussion on retirement policy for Civil Service doctors members concluded that, in principle, the retiring age should be 60, but, subject to the continuance of good health and efficiency and an annual review, doctors should be permitted to remain in employment until the age of 65.

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and the abolition of the monopoly power (or the capacity of professionals to arrange their patients' lives) of doctors, pharmaceutical companies, and other powerful groups who would otherwise rig the market to their own advantage.⁹

If he was a sincere socialist Mr Kinnock might regard the private sector as a burdensome irrelevance that diverted scarce resources into activities inimical to the achievement of the objectives of the NHS. He would, therefore, advocate the abolition of private practice so that all available health care resources were mobilised to achieve the objectives of the NHS.

Politically, Mrs Thatcher does not have the strength to challenge the health monopolists and make the market work. Politically, Mr Kinnock does not have the strength to challenge the health monopolists by abolishing private practice and cutting their income and the choice of voters. Private practice can never be an answer or an irrelevance. It will continue to frustrate socialists and liberals alike. The former would like its abolition and the latter its triumph, but such ideals are unattainable and the reality is that the problems facing the managers of the private sector are remarkably like those facing the managers of the NHS—cost containment, value for money—that is, efficiency in the use of society's scarce resources.¹²

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This is the eighth in a series of articles on NHS administration and management, which started on 28 April.