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DEPARTMENT OF HEALTH AND SOCIAL SECURITY

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From the Secretary of State for Social Services

SECRET

Paul Gray Esq
Private Secretary
10 Downing Street
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3 June 1988

Dear Paul,

NHS REVIEW

I attach a copy of my Secretary of State's Paper on 'A Mixed Economy of Care' for discussion at the NHS Review meeting on Tuesday 7 June.

I am copying this letter and the attachment to the Private Secretaries to the Chancellor and the Chief Secretary and to the Minister for Health, to Sir Roy Griffiths and to Professor Griffiths and Mr O'Sullivan in the No 10 Policy Unit.

Yours sincerely,

Geoffrey Podger

GEOFFREY PODGER
Private Secretary

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A MIXED ECONOMY OF HEALTH CARE

Note by Secretary of State for Social Services

My officials have prepared the attached paper which analyses the private sector involvement in health care and identifies areas for expansion and cooperation.

2. Two points emerge clearly from this paper.

first, we are still some distance away from our aim of a genuine mixed economy of health care, though progress has undoubtedly been made in recent years.

second, we were right in our earlier discussions to focus on fiscal incentives as a significant option in our wish to encourage growth in the private health sector.

3. I believe that the development of a more effective mixed economy will be an important part of our review proposals. But we will need to display proposals for action which will turn our policy aims into reality. I propose therefore that we now ask officials to prepare an action plan for:

* removing or at least reducing the obstacles to better cooperation that have been identified

* developing a better framework for effective trading between the private and public sector, including provision of better information about comparative costs

* encouraging the private sector to work together in developing and presenting the contribution they can make to better health care. Unlike the pension industry, health providers do not have a good record of working together in dealing with Government or the media.

4. We will be considering the role of fiscal incentives when we take the Chancellor's further paper. The clear impression the industry give at present is that they are not planning for a major expansion beyond their current areas of activity. My assessment is that without some fiscal stimulus this situation is unlikely to change.

5. It will be very desirable for fiscal incentives to apply to most sections of the community, either directly to individuals or through employers and not just the elderly. If we conclude that we should not change the present tax exemptions for company scheme benefits, I suggest we look again at the possibility of developing a system of contracting-out limited to cold elective surgery.

6. I invite colleagues to agree that

* officials be asked to prepare an action plan on the lines I have indicated (para 3)

* fiscal incentives will be an important part of our strategy for developing a more effective mixed economy of health care.

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ENCOURAGING PRIVATE SECTOR INVOLVEMENT IN HEALTH CARE

Introduction

1. Paper HC4 compared the main characteristics of the private and public health sectors in the UK. While there are obvious differences in the nature of the businesses and in the relationships with consumers and staff, none of these need be a bar to further growth in private care or to greater co-operation between the two sectors. On the contrary, there is considerable scope for the private sector and the NHS to develop in ways that are complementary to each other. This paper suggests how this development can be encouraged.

Objectives

2. Present policy has two broad objectives:-

- to increase the total amount of health care available to the population by encouraging people to put more of their own money into it;

- to foster cost-effective co-operation between the health service and the private sector to enable more NHS patients to be treated.

3. On the first there has been considerable progress. The number of people covered by private insurance has increased substantially in the 1980s from 2.75 million in 1979 to 5.25 million in 1986. During the same period, the number of private sector hospital beds has increased by over 50 per cent, reaching over 10,000 beds in January 1988. (These are in private hospitals with operating theatre capacity and compare with 130,000 acute beds in the NHS). On the second objective there remains more scope for progress.

Why growth has not been greater

4. There is a rational limit to the size of a private sector given a predominantly free state service - but there is no reason to believe that that ceiling has yet been reached. There are other barriers which have prevented further growth. These include:-

(a) Ideological Some health authority members and NHS staff (management and medical) object to the private sector on political or ideological

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grounds. For these "care" and "profit" are often regarded as irreconcilable (but attitudes are changing as this week's report by the Institute of Health Service Management shows).

(b) Cultural After 40 years the NHS does not think beyond its own borders.

(c) Financial The public and NHS regard the private sector as (prohibitively) expensive. In part this results from the lack of comparative cost data.

(d) Commercial practice The private sector have been poor at marketing their services. There has been no united attempt to show NHS managers and the public what could be provided. When approached private hospitals tend to offer full cost individual treatment rather than volume contracts at marginal costs.

(e) Commercial judgement The private sector has consciously limited its insurance coverage to the soft end of the market - predominantly white collar workers covered for elective surgery.

(f) Medical profession The prime reason for high private sector charges is the element for the consultants' medical fee. Consultants operate a closed shop with nationally negotiated rates. All work is done by consultants many of whom would not perform the same operations in the NHS. This makes private practice very lucrative and attractive for consultants but severely limits the ability of the private sector to compete.

Progress is being made in overcoming most of these barriers. Yet there is still considerable scope for further development.

Scope for development

5. The private sector takes decisions on a commercial basis taking account of its perceptions of market opportunities. The Government can do more to stimulate the development of the market opportunity and then encourage and assist the

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private sector to move into it. There is a role for fiscal incentives. The following paragraphs look at other action possible to overcome each of the barriers described above.

Co-operation between public and private sectors

6. Cultural habit and ideological animosity can be overcome by demonstrably effective co-operation. To date co-operation between the two sectors has been patchy. There are now signs that attitudes are beginning to change. The Health and Medicines Bill will, for the first time, allow health authorities to operate in a commercial framework. The waiting list initiative, emphasis on income generation and the present policy of fostering co-operation have borne fruit and led to a number of imaginative schemes. There is considerable scope for building on and expanding these initiatives, many of which lend themselves to the kind of contractual arrangement which underpinned the self-governing hospital model. Specific examples include:-

(i) NHS buying more treatments from the private sector The private sector has much spare capacity which ought to allow it to sell packages of treatment to the NHS at marginal rates. These projects could assist with waiting lists or form the basis of longer term contractual agreements following competitive tendering.

(ii) NHS selling clinical services to the private sector A number of NHS hospitals already generate income by selling support services - such as pathology and X-ray services - to private hospitals. This can be extended to include clinical services such as the provision of breast screening, infertility clinics, and physiotherapy services, particularly where existing NHS facilities are under utilised.

(iii) Expansion of NHS private sector facilities Currently there are some 3,000 pay beds in the NHS. The Health and Medicines Bill will allow for commercial charging. The competition could lead to pressure on the private sector to reduce costs to maintain market share.

(iv) Joint use of resources Expensive equipment or minor capital developments can be shared. Current examples include the installation of a Magnetic Resonance Image Scanner, joint ventures to build day surgery units

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and a proposal by a private company to build a private hospital on NHS land adjacent to a new NHS hospital in return for a substantial contribution to capital costs.

(v) Private sector involvement in education and training The private sector could be encouraged to co-operate with the Royal Colleges to play a greater role in health service medical training in its acute hospitals. Similarly, the DHSS is already discussing with the private sector scope for increasing its contribution to nurse training.

(vi) Staffing interchange Greater exchange of staff between the NHS and the private sector, on a secondment basis, would allow the NHS to develop a greater sense of what the private sector can offer. It would also serve to educate the private sector about the needs and limitations of the NHS.

(vii) Private sector management of NHS hospitals One approach towards independent hospitals may be to introduce private sector management or managers on a pilot basis. The Group may want to return to this issue as part of a wider "programme of change".

Better marketing

7. The private sector has not been astute or united in selling its services to the NHS. It is diverse and needs to be encouraged to develop a more effective representative role. The perception remains that it is expensive. There is a lack of reliable data comparing costs between the two sectors. What data does exist tends to confirm the NHS view that the private sector is more expensive for comparable services (annex A). Yet there is scope for the private sector to make better use of its existing capacity.

8. The rapid growth of the private sector in the early 1980s was concentrated geographically in the south east and was highly dependent on the short term profit from overseas patients. There is still over capacity of some 3,500 beds which is only slowly being rationalised. The private sector will only grow in total size when existing capacity is better utilised. It should, however, enable the private sector to offer packages of treatment to the public sector at marginal costs. NHS waiting lists offer the opportunity of guaranteed volume at

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times of otherwise low occupancy. The private sector can be encouraged to make more of this marketing opportunity, and the NHS to respond.

Expanding the market

9. The commercial judgement of the private sector about the scope for expanding the market has been notably cautious. The market can be expanded in two ways:-

- increasing the pool of people who would benefit from private care;

- expanding into new areas of care.

The private sector has tended to concentrate on the insured population, yet there is also opportunity to promote the cash purchase of care. There is more scope for including elderly and middle income groups through excess or limited coverage insurance schemes. While these are commercial judgements there are already signs of expansion. Closer co-operation with the public sector should help to break down the psychological barriers that deter some patients from using the private sector.

10. The rapid growth of the private health sector has been concentrated in two areas: elective acute surgery and nursing homes for the elderly. The latter reflects the private sector's response to the market created by the availability of social security board and lodging payments.

11. There is also scope for expansion into other major areas of hospital care including private sector psychiatric and mental handicap care. Few people will want to insure themselves against these but they could be developed further and marketed at competitive rates to health authorities. The scope for expansion of private primary care is probably more limited. There is little consumer pressure for an alternative to public sector general practice and the White Paper on Primary Care already includes proposals for making general practitioner services more consumer orientated.

The involvement of the medical profession

12. In many cases the customer for the private sector hospital is not the patient but the subscribing consultant who can often choose which private

hospital to use. This necessarily limits the scope for reductions in medical fees to enhance competitiveness. When looking further at the medical profession, the Group will want to consider the scope for reducing this restrictive practice and for increasing the potential supply of clinicians through action on consultant contracts.

I.

Annex A

PUBLIC/PRIVATE SECTOR COST COMPARISONS

1. Comparisons of efficiency and unit costs between the two health care sectors need to take account of variations in unit costs; quality of hotel care; and accounting practices. There is also likely to be some discrepancy between private patient charges and the actual cost per case as overall cost recovery from insurers does not require precise allocation of costs to patients.

2. There is little objective research available. A controlled DHSS study (1982) of three common surgical procedures in six NHS hospitals and three private non-profit hospitals suggested that the average cost per case was considerably higher in private hospitals. This was mostly due to doctors' fees per case in the private sector (where most medical care is provided by consultants) being nearly four times higher than salary cost per case in the NHS. Excluding medical costs, the NHS was 10 per cent cheaper for two of the conditions, though differences in the quality of hotel services may account for this.

3. A recent BUPA survey (see table below) has confirmed this picture. It indicates faster growth in charge per case in independent hospitals than in cost per case in smaller NHS acute hospitals, due mainly to increased medical fees and salaries in the private sector. The charge per case in the private sector is shown to be considerably higher than cost per case in NHS hospitals, again due mainly to differences in medical costs.

4. The evidence suggests that the NHS is cheaper and has a better record of cost containment. However, this does not take account of variations in case mix: the NHS tends to treat older people and those with more complicated conditions. Nor does it reflect the absence from NHS costs of capital cost recovery. However, this would not invalidate the argument that the NHS is currently cheaper. In addition, it is not clear to what extent variations in charges in the private sector reflect variations in true costs as the latter are often "loaded" on to items which meet with least customer resistence so as to maximise income and circumvent insurers' measures to reduce costs.

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5. An comparison of the costs of NHS and private sector provision of renal dialysis units also indicates that NHS costs are comparable or lower, taking account of capital costs and NHS support to some private units. The more activity within a given capacity, the lower the unit costs tend to be. A comparison of relative efficiency is complicated by the unknown profit element in the private sector. The NHS has so far been unable to match competitive deals offered by the private sector, but the evidence suggests that profits have been kept low to obtain NHS business and this is unlikely to be sustainable in the long-term. It is unlikely that the NHS can obtain substantial savings from greater private sector involvement.

6. A different picture emerges from a study of the costs of private nursing home care compared to NHS geriatric care. This suggests that good quality care costs as little as two thirds that of equivalent care in a NHS geriatric hospital. American research supports this finding.

Table: Cost comparison between the public and private sector

	Charge/case in independent acute hospitals*			Revenue cost/case in NHS acute hospitals (300 beds)		
	1980	1985	% change	1980/81	1985/86	% change
	£	£		£	£	
Medical fees and salaries	179	270	51	65	84	29
Other	357	690	93	551	643	17
Total	536	960	79	616	727	18

* Source: BUPA