

## Role of private sector in United Kingdom healthcare system

Yvonne Doyle, Adrian Bull

Since 1948 the private sector has viewed itself as complementary to the NHS. Before the NHS was set up in 1948 health care was provided by charities and voluntary hospitals, private medical clubs, occupational medical services and works clubs, fee for service insurance, friendly societies, public medical services (which were funded by subscription), and medical fees paid on an ad hoc basis. The structured health insurance sector initially developed between 1940 and 1947 with the instigation of the London based Hospital Services Plan (now PPP Healthcare) and the amalgamation of several regional schemes into British United Provident Association (BUPA).

### Structure of UK private healthcare sector

In 1997, over 12 million people were covered for medical expenses by insurers, friendly societies, and cash plan companies. Seven million people (12% of the population) were covered by private medical insurance. Care for this group, however, represents only 75% of acute medical and psychiatric inpatient and outpatient hospital treatment in the private sector. Some private care is self financed, and the NHS also contracts out to private providers—notably in the psychiatric services, care of elderly people, termination of pregnancy, and through waiting list initiatives.

Private medical insurance is more common among older people and those in social classes I-III, with coverage ranging from 22% for social class I to 2% for social class IV. The proportion of the population with private medical insurance also varies by geographical distribution; 20% of the population in the outer London metropolitan area are covered but only 4% in the north of England.<sup>1</sup> About two thirds of private medical insurance policies are paid for by employers, and one third are paid by individuals.

### Contribution of private health care to health economy

The aggregate value of services supplied in the private sector in 1996 was £13.7bn. Most of the money is spent on care of elderly and physically disabled people (46%), on pharmaceutical products and devices (22%), and in the acute hospitals sector (17%). Sixty four per cent of inpatient psychiatric care in 1996 was financed publicly but provided privately, as was 57% of long term residential home care of people with learning

### Summary points

Over 12 million people in the United Kingdom are covered for private health care

The private sector already provides many services for the NHS, such as psychiatric care and long term residential care for people with learning disabilities

The NHS provides many private beds

Collaboration between the NHS and private sector would provide a better health service than continued isolation

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disabilities and 34% of long term residential care for elderly people. However, fewer than 1% of patients having elective surgery in the private sector had their operation financed from public funds.<sup>1</sup>

Nevertheless, the NHS is a substantial supplier of private beds. There were an estimated 1400 dedicated pay beds in NHS private units in 1997, of which 39% were in London. In 1989, the Health and Medicines Act freed NHS authorities to charge market prices for such services.

### Changing case mix and increased demand

The case mix in private health care has shifted from simple elective surgery to include complex surgery such as coronary artery bypass grafts, acute and subacute care, intensive care, and cancer (including bone marrow transplantation and radiotherapy).<sup>2</sup> The demand for health care by insured people is high. Since the mid-1950s, apart from a few exceptional years, the overall claims in the United Kingdom have been £80-£89 for every £100 of premium paid.<sup>1</sup> Insurers manage demand by, for example, concurrent utilisation review (a system for continuing monitoring of use of a service) and case management (allocation of an experienced manager to oversee progress of a healthcare episode).

The use of new medical technologies is common in private practice. Usage may differ widely in the absence

of clinical consensus about which intervention is best. Medical departments of insurance companies gather evidence on the effectiveness of new technology to determine whether it is eligible for funding; private medical insurance generally excludes treatments for which the evidence of effectiveness is poor, as does the NHS. Isolation of private sector purchasers from main-line policy development on cost effectiveness would constitute a serious lack of support for their efforts.

### Innovations and controlling costs

In the 1990s insurers began to think more laterally about the health of their insured populations. Among the more successful plans introduced are employee assistance programmes to promote psychological well-being in the workforce, "back to work" initiatives linking cover to a range of common physical conditions affecting productivity at work, and 24 hour telephone helplines to advise, inform, and counsel customers. The NHS has recently set up its own helpline, NHS Direct.

Specialists practising privately are reimbursed on a fee for service basis, so there is a strong financial incentive to investigate and treat patients. Some insurers have made important moves to open dialogue with medical consultants about the nature and quality of care offered to insured patients, and this is made easier through the preferred provider mechanism.<sup>3</sup> Preferred providers are those who enter into an explicit relationship with the payer so that, for example, access, cost, and quality standards are agreed by the provider in advance in return for guaranteed levels of business from the payer.

The move to evidence based medicine has affected practice in the private sector as well as the NHS. The large insurance companies have noticed a fall in procedures such as insertion of grommets for glue ear and dilatation and curettage in younger women. Guidelines issued by bodies such as the royal colleges are increasingly being taken into account when assessing claims.

### Regulation of private sector

Common minimum standards should operate across both public and private sectors. Important areas in

which regulation could benefit patients include the organisational standards of hospitals, clinical governance of practice, better information for patients about costs and fees, and a national complaints procedure for the private sector. A recent government white paper is taking such regulation forward.<sup>4</sup>

### What is the optimal relation with the NHS?

Consumer expectation of health is changing, and people are making heavier demands on health services.<sup>5</sup> Some of these demands the public systems may not even attempt to meet—for example, removing anxiety over unresolved symptoms, treatment for conditions mainly affecting the quality of life, and the achievement of personal life aims such as fertility.

The NHS addresses the social ethic of pursuing the maximum gains within a limited budget.<sup>6</sup> Voters appreciate the policy in the abstract, but it does not always work for the individual. When people require health care they become aware that their needs are competing with the needs of many others and that the degree to which their need is met can be quite arbitrary.

Furthermore, the NHS has not resolved the dilemma of simultaneously attempting to provide elective services to reduce waiting times and acute and emergency care, usually from the same facilities. These two competing arms of the service are driving the system in different directions. Bed occupancy rates are now so high that they frustrate efficient throughput of emergency cases and completely negate optimal use of resources for elective work. Good use has been made of day surgery, but the NHS still has a pressing need for elective facilities for more complex work while the private sector has an abundance of underused facilities.

The private sector should be encouraged to support the NHS in taking on a proportion of the elective workload. This could be particularly effective as hospitals are centralising services in larger centres that cover wider populations, with fewer smaller hospitals. To fund NHS elective surgery in the private sector, consideration should be given to the limited introduction of a mixed economy in health care. Certain parts of the population, according to income, would be expected to pay more for guaranteed access, and those who could not afford to pay would have similar access funded by the state. However, the current public and private sectors cannot simply be grafted on to each other; we need to consider how cooperation can best service the public health.

The primary concern in discussions about mechanisms for financing health care ought to be the health policy objectives of the total system.<sup>7</sup> Other European countries do not have separate private and public healthcare systems. Currently the United Kingdom has no overall strategic view about the best deployment of total available resources to achieve national public health and healthcare aims. Consequently there are lost opportunities for cooperation in training and development, technology and costing expertise, and the coordination of screening programmes and research and development; incentives are confused for people who work in both sectors.



No single system will dominate provision of health care in future, nor can any one model accommodate the huge pressure of technological development and patient demand.<sup>8</sup> Collaboration between public and private healthcare sectors, where it is sensible to do so, would serve the country better than continued isolation.

Competing interests: YD was director of medical policy for PPP Healthcare from June 1996 to March 1998.

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## Commentary: Cooperation should be based on what the public wants and needs from its healthcare system

Justin Keen

Doyle and Bull argue that we need to devise new policies for managing the relation between the public and private healthcare sectors in the United Kingdom. The likelihood of such policies being developed seems to have been increased by the government's commitment to use private health care in certain circumstances.<sup>1</sup> This is not a simple matter as large increases in resources for the NHS might affect the demand for private hospital care, and the impact of one sector on the other will have to be considered.

Doyle and Bull do not set out a framework for thinking about the relation between the NHS and private health care, but they point to three issues that are critical in deciding how to frame policies. Firstly, should we be comfortable with the present arrangements whereby people using private services (and particularly hospital based services) can access them more quickly than NHS patients? The authors suggest that some people should make supplementary contributions but that these people and state funded patients would have similar access to care. Would this be preferable?

Secondly, the authors argue that private hospitals should take on a greater share of elective surgery. This raises many questions, but a central one concerns the supply of doctors and other clinical staff to do the work. The numbers of surgeons in orthopaedics and other specialties are closely controlled, and these surgeons already do substantial volumes of private work. It is difficult to see how more private surgery could be provided without affecting access to NHS elective and emergency services<sup>2 3</sup> unless the number of surgeons is increased. The argument here, therefore, is that both the private and the public systems should be larger. Do we as a society want this?

Thirdly, what are the objectives of a healthcare system? One answer is that health care should be available to all regardless of income or where we live—this is the equity principle that underpins the NHS. Doyle and Bull do not say what they think the objectives should be, but the article implies that one important objective is to promote consumer choice and hence, presumably,

a mixed economy. One role of the NHS would therefore be to provide a safety net for people unable to take out insurance.

It is not necessary to agree with the authors about the way that policies should develop. For example, alternative arguments can be used to show that a tax financed NHS is sustainable for the foreseeable future.<sup>4</sup> Doyle and Bull do, however, point to the need for a serious debate about what people in the United Kingdom need from their healthcare system. The government is beginning to combine the NHS and private sectors in its thinking, and the Care Standards Bill is a start.<sup>5</sup> Now we all need to think about these three issues as we move forward in this most difficult of policy arenas.

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### Corrections and clarifications

*Decision making, evidence, audit, and education: case study of antibiotic prescribing in general practice*  
Some data were wrong in this paper by Toby Lipman and Dawn Price (22 April, pp 1114-8). In table 3, under the heading "Organism" the correct number (percentage) for the 7 day treatment for "No growth" should have been 16/43 (37) [not 16/74 (22)] and that for "Trimethoprim sensitive" should have been 25/43 (58) [not 25/74 (34)].

*Risk of acquiring Creutzfeldt-Jakob disease from blood transfusions: systematic review of case-control studies*  
In this paper by Kumanan Wilson and colleagues (1 July, pp 17-9) we inadvertently deleted, just before going to press, a note drawing readers' attention to the fact that further information about the methods is available on the *BMJ's* website.