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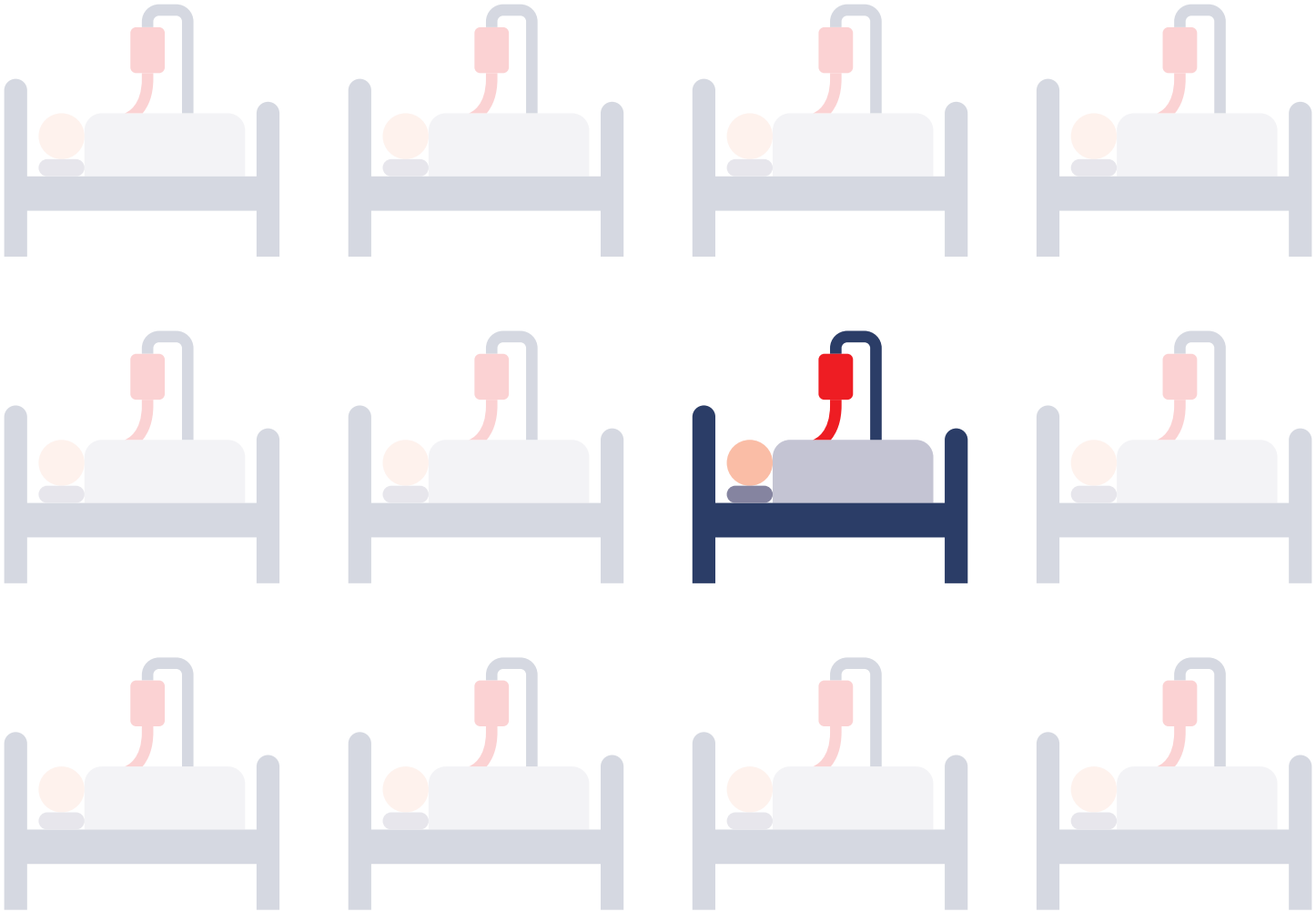
NHS treatment of private patients: the impact on NHS finances and NHS patient care



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The Centre for Health and the Public Interest (CHPI) is an independent think tank committed to health and social care policies based on accountability and the public interest.

The Centre seeks to frame the policy debate in a way that is evidence-based and open and accessible to citizens.

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Executive Summary

The Health and Social Care Act 2012 allowed NHS hospitals in England to generate up to 49% of their income from private patients. This report, based on official sources, Freedom of Information requests to all 153 acute hospital trusts, and interviews with hospital staff, looks at the impact of this change.

It examines two questions: whether the treatment of private patients generates additional income for NHS hospital trusts, and whether the treatment of private patients risks disadvantaging NHS patients.

It finds the following:

- Since 2012, when the Health and Social Care Act became law, the total amount generated by the NHS from treating private patients has increased from £511m in 2012/13 to £596m in 2015/16 – a 16% increase in nominal terms and 12% increase in real terms (2012/13 prices).
- In general terms, the number of patients who are treated privately in NHS hospitals is a very small percentage of the total number of patients who are treated by NHS hospitals – around 0.5%.
- The NHS has set aside 1,142 beds for private patients, while a further 150 NHS beds are estimated to be occupied by private patients at any one time.
- Ten private patient units – mainly based in London NHS hospitals – account for nearly 60% of the £596m generated by the NHS from the treatment of private patients. For four of these hospitals, private patient income makes up more than 10% of their income.
- There is a lack of proper accounting for the income generated by the NHS from private patients. Of the 41 trusts that provided data in response to FOI requests about expenditure, 9 made a loss on the treatment of private patients in some or all of the years from 2010/11 to 2015/16. Overall four of these 9 hospitals made significant losses between 2010 and 2016, with one making a loss of £18 million over the six-year period.
- NHS hospitals treating private patients have also failed to receive payment for some of the services that they have provided. The total value of bad debts written off for all private patients treated at NHS Foundation Trust hospitals was £1.77m in 2014/15 and £1.81m in 2015/16.
- NHS hospitals trusts also differ widely in the way they set the prices they charge private patients. Some hospitals have no agreed procedure for setting prices, while others negotiate prices with private insurance companies. This leads to wide variations in the prices charged private patients and big differences between these prices and the national tariff paid by NHS commissioners for NHS patients.

NHS treatment of private patients: key facts

1,142	number of NHS hospital beds in England set aside for private patients in in 2015/16
150	approximate number of other NHS hospital beds occupied by private patients at any one time
1%	approximate share of all NHS hospital beds in England set aside for or occupied by private patients
0.5%	finished consultant episodes for private patients as a share of all finished consultant episodes in NHS hospitals in 2015/16
60%	London hospitals' share of all private patient treatments in NHS hospitals
£596m	total earnings from private patients by NHS hospitals in England in 2015/16
12%	real terms increase in NHS trust earnings from private patients between 2012/13 and 2015/16
73	number of hospital trusts responding to a freedom of information request which were unable or unwilling to report their costs in treating private patients
£1.5m	total bad debts owed to NHS hospital trusts by private patients written off in 2015/16

Introduction

1. When the Health and Social Care Act was passed in 2012 the treatment of private patients was expected to become a significant source of NHS hospital trust income. While this has not happened on the scale that some observers foresaw, the continuing squeeze on NHS funding could lead to the treatment of private patients becoming more important, with a potentially significant impact on the availability of care for NHS patients.

2. This report sets out the findings resulting from interviews with 17 hospital staff carried out in 2016,[1] published research findings, official publications, LaingBuisson's market surveys, and Freedom of Information requests to all 153 acute hospital trusts in England.

3. The report describes the scale and distribution of private patient treatment in NHS hospitals. It discusses two issues: whether the treatment of private patients generates additional income for NHS hospital trusts, and whether treating patients privately in NHS hospitals risks disadvantaging NHS patients.

Why do private patients want to be treated at an NHS hospital rather than a private hospital?

4. A primary reason for patients wanting to pay for treatment at an NHS hospital rather than a private hospital is that higher-risk or more complex cases cannot be safely treated in a private hospital if, as is typically the case, it has no on-site specialist teams or intensive care beds. Even patients who are eligible for NHS treatment may elect to be treated as private patients in order to have their choice of consultant, for example, or to be treated more quickly, or to have a private room.

5. Another reason, which is particularly relevant to self-paying patients (as opposed to those with private health insurance), is that the price charged for treatment in an NHS hospital's dedicated Private Patient Unit or PPU is reported to be often up to a third less than in a neighbouring private hospital (Scott et al. 2012). Some private patients may also think that the quality of care in an NHS hospital will be higher, thanks to having on-site multispecialty teams of clinicians and offering more assurance of safety, although these advantages have not been widely appreciated in the past (Leys & Toft 2014).

1 Open-ended interviews were conducted with nine junior doctors, six consultants and two nurses, working in hospitals in London (5), Yorkshire and the Humber (6), the North of England (2), East Midlands (2), West Midlands (1) and South East England (1).

What drives the NHS's interest in treating private patients?

6. The Health and Social Care Act 2012 raised the limit on the share of total trust income that NHS hospital trusts may receive from private patients to 49%,[2] and since then NHS hospitals have been encouraged to see private patients as a significant potential source of income. In 2015-16, four years on from the passage of the Act, the total income that the NHS generates from private patients had increased from £511m to £596m – a 16% increase in nominal terms and a 12% increase in real terms (at 2012/13 prices) (Table 1).

7. Despite this increase in the income generated from private patients, the percentage of NHS activity which is dedicated to treating private patients has remained very small. Only 0.5% of all Finished Consultant Episodes in NHS hospitals are for private patients and this percentage has not changed substantially since the Health and Social Care Act became law. In 2013, NHS hospitals' share of the total income earned from the treatment of all private patients in England was little over 8% (LaingBuisson 2014).

8. During interviews, some healthcare professionals suggested that in addition to generating revenue from private patients, NHS hospitals might encourage the treatment of private patients to support consultants who want to treat private patients and sometimes need to treat them in the NHS hospital where they work – whether because a patient is too high-risk or has a condition too complex to be treated at a local private hospital, or because the hospital has facilities that are not otherwise available, or for other reasons. Some clinicians interviewed also thought that treating private patients adds status to a hospital and enables it to attract high-quality staff, in particular consultants.

2 Prior to the Act, NHS Foundation Trusts were limited to generating no more than 2% of their income from private patients.

Table 1. Private patients treated in NHS hospitals in England: number, share of total Finished Consultant Episodes, and income generated (UK data).

Year	Private patient Finished Consultant Episodes in NHS hospitals in England	Total Finished Consultant Episodes in NHS hospitals in England	Private patients as % of all Finished Consultant Episodes in the NHS in England	Income from private patients in UK NHS
2015-16	94,484	19,239,608	0.50%	£596m
2014-15	91,176	18,731,987	0.49%	£561m
2013-14	93,182	18,163,101	0.51%	£534m
2012-13	86,196	17,715,046	0.49%	£511m
2011-12	90,639	17,465,425	0.52%	£487m
2010-11	94,199	17,269,882	0.55%	£452m
2009-10	101,811	16,806,196	0.61%	£433m

Sources: Finished Consultant Episode data from NHS Digital 2011, 2012, 2013, 2014, 2015, 2016; income data for UK from LaingBuisson 2016

9. The amount of income generated from private patients by the NHS varies greatly between NHS hospitals. A small number of NHS hospitals in London earn a significant income from private patients, and many others have invested in private patient beds or dedicated private patient units (PPUs) in an attempt to boost this source of revenue. By June 2016, the number of PPUs had risen from 84 in 2014 to 91, though with a slightly reduced total number of beds – 1,142, down from 1,155 in 2013 (LaingBuisson 2016).

10. LaingBuisson (2016) estimate that in 2016, besides 1,143 dedicated beds in PPUs, another 1,500 NHS beds in NHS hospitals in England were used to treat private patients about ten percent of the time. Taken together this means that approximately 1% of the NHS's roughly 131,000 beds were set aside for, or used by, private patients at any given time - equivalent to the number of beds in two average-sized NHS hospitals.[3] While small, the number of NHS beds not available for NHS patients should be seen in the context of total NHS bed numbers having fallen significantly over the past 30 years, and being markedly fewer per head of population than in comparable European countries (Ewbank et al. 2018). With overnight bed occupancy rates peaking at 95% (or even more) in the winter months, the loss of capacity for treating NHS-funded patients is potentially a significant issue, as pointed out by the Kings Fund (Ewbank et al. 2018). It should also be seen in the context of the planned further reduction in the number of hospital beds set out in the Sustainability and Transformation Plans due for implementation in 2018 (Kotecha 2017).

11. The distribution of income from private patients is very concentrated. The ten PPUs with the greatest private patient income are all in London, thanks to the concentration of more affluent people in London and southeast England, and because London is the destination of choice for private

3 The average number of beds per NHS hospital is 621 (NHS England **Bed Availability and Occupancy Data – Overnight Quarter 1 2017-18**). https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/

patients from outside the EU. Between them, these ten PPUs account for 58.7% of the total private patient income received by NHS hospitals in 2015/16. Some hospitals in Greater Manchester and Cheshire, however, have also seen some growth in income from private patients in 2015/16 (LaingBuisson 2016).

12. Around a third of NHS hospital trusts reported no income from private patients in 2015/16; excluding these, the median hospital trust income for that year from private patients was only £769,000 (calculated from Foundation Trust Accounts and NHS Trust Accounts). A further third reported private patient income over £1m; thus private patient income in the NHS is highly concentrated amongst a small number of NHS hospitals. Table 2 shows the top ten hospital foundation trusts in terms of the share of total income derived from private patients.

Table 2. Top ten NHS hospital trusts in England by percentage of income received from private patients

NHS Trust/FT name	Operating Income from Private patients	Private patient income as a % of total operating income from patient care activities
The Royal Marsden NHS FT	£83.1m	27.6%
Great Ormond Street Hospital for Children NHS FT	£47.9m	13.7%
Moorfields Eye Hospital NHS FT	£23.0m	12.6%
Royal Brompton and Harefield NHS FT	£39.3m	11.9%
Papworth Hospital NHS FT	£7.5m	5.6%
Imperial College Healthcare NHS Trust	£44.4m	5.3%
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT	£4.8m	5.3%
Royal National Orthopaedic Hospital NHS Trust	£6.4m	5.1%
Liverpool Women's NHS FT	£3.7m	3.9%
Chelsea and Westminster NHS FT	£15.7m	3.5%

Source: NHS Trust and Foundation Trusts accounts.

13. Foundation trusts have seen greater growth in private practice than non-foundation trusts (LaingBuisson 2016). Non-foundation trusts which are struggling to meet NHS financial and other targets are less likely to be able to treat private patients, since Department of Health guidance states that private practice must not adversely affect the ability of a hospital to meet the needs of NHS patients (UK Department of Health 2009). As one consultant at a trust in the south-east of England put it, "*When we are struggling to meet the NHS targets there is no place for private patients…. There is a massive bed crisis, a bad situation, we can't manage. So there are no private patients at all. It is not banned, but there simply is no room.*"

Is the treatment of private patients in NHS hospitals profitable?

14. While income from the treatment of private patients is known with reasonable accuracy, it is only possible to tell whether it represents a net gain to the NHS if the costs of the treatment are also known, and this is frequently not the case. Sally Gainsbury's 2008 study, based on Freedom of Information requests to 182 acute hospital trusts in England, found that some trusts were losing money on some procedures for private patients (Gainsbury, 2009). Many hospitals admitted that they could not calculate the cost of treatment of private patients, and only thirteen provided data. According to that study, out of the 4,142 patients for whom data were provided, thirty percent (1,238) were charged less than the cost of their treatment, and four percent were charged less than the NHS tariff. The total profit made from the treatment of the other 2,904 patients outweighed the losses made, but some trusts probably made losses overall on their treatment of private patients.

15. Given the importance attached by NHS England to the treatment of private patients, echoed on many NHS hospital trust websites, it seemed important to try to find out how far the situation reported by Gainsbury in 2009 had changed – how far the £596m revenue that NHS hospitals in England earned from treating private patients in 2015/16 represents a net gain for the NHS. One hundred and fourteen out of 153 trusts responded to an FOI request to provide figures for the annual number of finished consultant episodes for private patients, and the income and expenditure relating to them.

16. Most of the 114 trusts that responded reported earning some income from treating private patients, but 73 of these were unable to report their expenditure on doing so, in most cases due to not measuring or not recording it.

17. The figures provided by 9 trusts, however, indicate that each of them made a loss on the treatment of private patients in some or all of the years from 2010/11 to 2015/16. Overall 4 of these 9 hospital trusts made significant losses between 2010 and 2016, with one, Frimley Health NHS Foundation Trust, making a loss of £18m over the six-year period.

Table 3. Profits and Losses (in pounds sterling) made by some NHS hospitals from treating private patients (losses shown in red)

Trust	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Aintree University Hospital NHS Foundation Trust	n.a.	n.a.	n.a.	n.a.	(1,424,360)	(1,165,096)
Burton Hospitals NHS Foundation Trust	198,679	35,823	(166,598)	(586,510)	(510,044)	(724,188)
Croydon Health Services NHS Trust	83,000	262,023	212,073	(715,743)	182,486	39,033
Frimley Health NHS Foundation Trust	(3,174,751)	(2,968,518)	(2,724,801)	(3,023,980)	(3,479,218)	(2,630,411)
Isle Of Wight NHS Trust	n.a.	n.a.	(235,848)	209,154	226,365	227,193
Leeds Teaching Hospitals NHS Trust	0	(64)	0	(165,089)	273,999	44,469
London North West Healthcare NHS Trust	759,000	231,000	36,000	458,000	(36,000)	170,000
University Hospitals Coventry and Warwickshire NHS Trust*	(219)	0	(920,351)	(797,964)	(808,953)	(775,704)
Wrightington, Wigan and Leigh NHS Foundation Trust	349,026	90,009	261,997	(135,230)	(8,807)	179,846

n.a. = not available

*This trust stated that they did not hold data on expenditure on private patients and therefore used the values submitted in annual reference costs.

18. The reasons why trusts do not measure or record costs are numerous, but interviews with hospital doctors made it clear that recording the procedures performed for private patients separately is burdensome and seldom done systematically, even when hospitals have guidance in place for clinicians on the requirement to do it. Some trusts were only able to give the combined cost of patients from overseas whose care is paid for by their home country's healthcare systems, through reciprocal arrangements with the UK, and those who pay for their own treatment or are covered by insurance.

19. Some of the money due from private patients is never received. Table 4, drawn from Foundation Trust accounts, shows the scale of debts written off for the ten NHS Foundation Trusts with the largest bad debts, ranging from Guy's Hospital, which wrote off £407,000 in 2015/16, to Aintree which lost £53,000. This represents on average 3% of the income received from private patients for these ten hospital trusts with bad debts. According to the accounts of Foundation Trusts the total value of bad debts written off for all private patients treated at NHS Foundation Trust hospitals was £1.77m in 2014/15 and £1.81m in 2015/16.[4]

4 In 2016 Great Ormond Street Hospital for Children was owed £30m for past work for international patients. It called this debt "doubtful" but said it was considered "recoverable" because "the vast majority... relates to cases of sponsorship by a government or other international organisation" (Clover, B, 2017). No data have been found for the scale of debts written off by this hospital, although its work for international private patients alone accounted for 12% of its income in 2016.

Table 4. Largest bad debts and claims abandoned in relation to private patients

Foundation Trust name	Bad debts and claims abandoned in relation to Private Patients			
	2015/16		2014/15	
	Total number of cases[5]	Total value of cases	Total number of cases	Total value of cases
Guy's & St Thomas' Hospital NHS Foundation Trust	300	£407,000	184	£130,00
Chelsea and Westminster NHS Foundation Trust	647	£251,000	102	£79,000
University College London Hospitals NHS Foundation Trust	145	£183,000	–	–
Birmingham Children's Hospital NHS Foundation Trust	1	£175,000	–	–
Blackpool Teaching Hospitals NHS Foundation Trust	321	£124,000	–	–
Oxford University Hospitals NHS Foundation Trust	147	£94,000	–	–
University Hospital Southampton NHS Foundation Trust	179	£86,000	202	£148,000
The Royal Marsden NHS Foundation Trust	655	£76,000	472	£151,000
Royal Brompton and Harefield NHS Foundation Trust	25	£68,000	91	£309,000
Aintree University Hospitals NHS Foundation Trust	13	£53,000	–	–
Total		**£1,517,000**		**£687,000**

Source: NHS Foundation Trust Consolidation data set.

How do NHS Trusts determine how much to charge private patients?

20. Failure to set prices for treating private patients which reflect the cost of delivering the care may also explain why some hospitals were making a loss from their private patients. Despite the substantial income which is generated by treating private patients, there is no standard price-setting approach across the NHS.

21. Of the 114 NHS acute hospital trusts that responded to an FOI request, 78 provided information about their methodologies for setting the prices charged to private patients. As Table 5 shows, 22% of the responding trusts did not have a standard procedure for setting private patient charges, and of trusts that did have a standard procedure, most based their prices on either (a) a calculation of the costs of the treatment, (b) NHS tariffs, (c) insurance company or market prices, or (d) a combination of these. Six trusts stated that

5 A case is defined as an individual debtor (as opposed to an individual invoice).

they add a mark-up to the national tariff (the price per procedure, such as a hip operation, which is set centrally by Monitor and NHS England). Of these, four disclosed their percentage mark-up, which varied from 20% to 50%.

Table 5. Approaches to price setting

Approach used	Number of trusts which responded	Percentage of trusts which responded
Agree a tariff with insurance company	8	10%
Set prices based on market rates	2	3%
Calculate costs of providing the treatment	23	29%
Set prices based on the NHS national tariff	23	29%
Use more than one of the above approaches	5	6%
No standard procedure	17	22%
Total	**78**	**100%**

22. Table 6 shows the resulting variation in the prices set for a range of procedures by four hospitals, reflecting these differences of approach. The variations are strikingly wide, although this may be partly accounted for by different ways in which interventions are coded or bundled together (for example, some trusts charge a separate price for the contrast injection that is given before some MRI scans). It is also notable that for two interventions the price charged to private patients is below the NHS tariff. As noted above, some prices may be set low, and even below the cost of the intervention, in order to compete in the local private healthcare market, or to attract or retain consultants. To the extent that this approach plays a significant role in price-setting, however, the treatment of private patients seems unlikely to add to a trust's net revenues.

Table 6: Examples of prices charged for private patient treatments (in £s) in four NHS hospitals (differences from the national tariff shown in brackets)

	National tariff 2016/17	Barking	Blackpool (self-pay)	North Cumbria	Whittington (self-pay and insured charged equally)
Chest x-ray	25[6]	40 (+60%)		104 (+316%)	70 (+180%)
MRI – one body part	124	325 (+162%)		600 (+384%)	405 (+227%)
MRI – two body parts	158	650 (+311%)		833 (+427%)	475 (+201%)
First consultation haematology	288	150 (-48%)			
Angiogram day case			1066		810
Coronary artery bypass graft	6,860[7]		9028 (+32%)		

Source: NHS England, 2016. Annex A: 2016/17 national prices and national tariff workbook

6 Guide price given by NHS England for a plain x-ray. X-rays for NHS patients are always bundled together with other procedures for which a composite tariff is set.

7 Ordinary elective tariff.

23. Setting tariffs in such a way as to attract private patients while also making a profit is obviously a commercial skill which NHS hospitals have not historically needed. A study published in the *Health Service Journal* in 2012 found that many PPUs charged 50% less than private hospitals for comparable services (Scott et al. 2012).

24. To conclude, it is not possible to say whether the NHS benefits financially from devoting resources to the treatment of private patients. Given that these resources are significant and that NHS hospitals are running large deficits and are under pressure to make risky economies (Dunhill, 2017), this is an issue that needs urgent clarification. When NHS income from private patients is predicted to grow by 6% a year till 2020 it is important to determine whether this would represent a net financial gain (Clover, 2017a).

Does the treatment of private patients adversely affect NHS patients?

25. The NHS Code of Practice for Private Patients states that "provision of services for private patients should not prejudice the interests of NHS patients or disrupt NHS services", and "NHS commitments should take precedence over private work" (UK Department of Health; 2004, p.1). In theory, therefore, private patient care should not impact on the availability of beds or other resources for the treatment of NHS patients.

26. This principle appears to be compromised in practice in various ways. For example, junior doctors who were interviewed said that "clerking" (taking notes on) private patients admitted without adequate notes tended to take time away from attending to NHS patients. Others said that private patients – and NHS patients who had previously been private patients of the admitting consultant, and so were already known to them – tended to get more attention from the consultant, and therefore also from the junior doctors in the consultant's team, than NHS patients. Two nurses who were interviewed, however, said that when private patients were admitted to the NHS wards they worked on, nurses often did not know which patients were private and therefore did not treat them differently.

27. It seems unlikely that NHS patients are significantly disadvantaged in terms of receiving consultations and care from health professionals, so long as the number of private patients relative to NHS patients is small and the pressure of work permits all patients to receive appropriate attention from all the staff. If NHS funding per patient continues to fall, however, and the ratio of private to NHS patients increases, a pattern of different levels of treatment could potentially emerge in some hospitals.

28. A more measurable disadvantage may flow from the treatment of private patients making NHS patients wait longer. A major reason why patients choose private treatment over NHS treatment is to be treated speedily. If they are treated in an NHS hospital, and especially if the treatment requires theatre time, treating them quickly is only possible if NHS patients wait longer, as several consultants who were interviewed acknowledged.

29. It appears that to give proper effect to the Code of Practice for Private Patients a rule is needed to the effect that faster treatment cannot be obtained by being a private patient in an NHS hospital unless the hospital can demonstrate that it provides additional facilities, staff and beds, over and above those needed to treat NHS patients and corresponding to the number of private patients who will be receiving such faster treatment.

30. A particularly invidious challenge to the principle of priority for NHS patients is that that a patient may "jump the queue" by paying for the first part of their care and receiving an earlier diagnosis and/or initiation of treatment, and then transfer to NHS funding (BMA 2009). Regulations state that patients moving from private to NHS funding should face the same waiting times, access to medications and standard of care as any other NHS patient (NHS Commissioning Board 2013; UK Department of Health 2004, p.4); and NHS guidelines state that "patients referred for an NHS service following a private consultation or private treatment should join any NHS waiting list at the same point as if the consultation or treatment were an NHS service. Their priority on the waiting list should be determined by the same criteria applied to other NHS patients" (UK Department of Health 2004).

31. This means that if a patient chooses to transfer from private care to NHS care before receiving treatment there should be an assessment of the patient's clinical priority. The interpretation of this rule in practice may leave room for queue-jumping, however. For example, while one trust's guidelines state that the assessment should be carried out by the clinical director of the department, another trust says the assessment should be done by the consultant looking after the patient's care, and that he or she should only "consider discharging" the patient and putting them on the appropriate NHS waiting list. The latter guidance does not explicitly bar the consultant from placing their formerly private patient on the waiting list ahead of other NHS patients with similar or even higher clinical needs. To avoid this, all trust guidelines should require the assessment to be made by the clinical director of the department or an alternative independent consultant.

Conclusion

32. Information provided by NHS acute hospital trusts, published reports and health professionals working in the NHS suggests that increasing the provision of private healthcare within the NHS may pose risks to the use of NHS funds and the care of NHS patients. Procedures for acceptance, treatment and charging of private patients are not standardised and frequently not transparent, with some trusts stating that commercial confidentiality prevents them from providing such information. To ensure adherence to the values of the NHS, including equity of access and quality of care, and to ensure financial sustainability, NHS hospital trusts should be required to measure, record and report the costs of, and income from, the treatment of private patients.

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