PRIVATE HOSPITALS AND THE NATIONAL HEALTH SERVICE

Report of a meeting held on 8 April 1981
in the Grand Committee Room, House of Commons, London SW1

Page	*Speaker**	
3		**Preface**
4	Frank Dobson MP, Chairman	**Introduction**
4	Frank Honigsbaum (Historian of British Medicine)	**A perspective on recent developments in the health service**
5	Nick Davidson (Medical Journalist)	**Facts and Figures about the Growth of Private Medicine**
6	Dr Brian Jarman (General Practitioner)	**General Practitioners and Private Medicine**
7	Dr Paul Noone (Consultant Medical Microbiologist)	**In defence of the NHS**
7	Steve Burkeman (Secretary, Central Birmingham CHC)	**What CHCs can do to support and protect the NHS from the damaging effects of private hospitals**
8	Terry Mallinson (Trade Unionist [COHSE] and Area Health Authority Member)	**A Trade Union View**
9	Gwyneth Dunwoody MP (Shadow Minister of Health)	**Summary and the way ahead**

*Each spoke in a private capacity, not as the representative of any particular organisation or group

PREFACE

This meeting at the House of Commons on 8 April 1981 was organised by Frank Dobson, MP for Holborn and St Pancras South, with the assistance of the Secretaries of the South Camden and Islington Community Health Councils. The immediate occasion was the proposal by the Special Trustees of University College Hospital, a teaching hospital with district general hospital responsibilities for the people of South Camden and South Islington, together with Private Patients Plan (Britain's second largest private health insurance company) to build a 112-bed private hospital on NHS property acquired on a long lease at a peppercorn rent, in exchange for eight NHS operating theatres.

Mr Dobson and the two community health councils were well aware of the serious problems posed to the National Health Service by developments of this kind. They were conscious of encouragement being given to private developments and private insurance schemes by the present Conservative government through a series of measures, including the abolition of the Health Services Board, the issuing of new guidance to health authorities about contractual arrangements with private health services, the new hospital consultants' contracts, the review of the planning system, and a strict delineation of the rights of CHCs with regard to private hospitals. The Minister of State, replying to Mr Dobson's adjournment debate in February 1981, had given positive encouragement to the UCH scheme and similar developments.

Speakers were invited who were known to have knowledge and experience of the likely implications of these measures. One hundred and thirty people attended, including NHS workers, CHC and health authority members, MPs, Councillors and other members of the public. The meeting considered that the threatening implications for the NHS called for a national campaign against those who profit from ill health, and about 30 people indicated their willingness to take part in the launch of such a campaign against profit-making health facilities.

As a first step, this report is being circulated throughout the country to community health councils, trades unions, health authorities, members of Parliament, professional and voluntary organisations, and individuals with a known will to support the National Health Service. Follow-up meetings will be arranged in various parts of the country. A register of new and proposed private developments is being compiled, and a Steering Group is being set up, in accordance with the April meeting's wish, to devise a national strategy for shared information and a coordinated approach to the problem.

Information and further copies of the report are available from:

Jacqueline Kelly, Secretary, South Camden Community Health Council
114 Hampstead Road, London NW1 (01-388 6789)

Marcia Saunders, Secretary, Islington Community Health Council
Liverpool Road Hospital, Liverpool Road, London N1 (01-359 5066)

Frank Dobson MP (Chairman)
INTRODUCTION

Frank Dobson opened the meeting by expressing the growing concern in London and elsewhere about the numbers of extensions to private hospitals and proposals for new ones that were in the pipeline. They took assets—physical and staff—from the NHS and made no contribution to training.

Mr Dobson himself was opposed to private medicine. It was a danger to the NHS, and so long as the rich and influential could opt out, so long would they not be concerned about the general standard. He had become particularly interested at this time by the proposal to give away land next to University College Hospital to a private company so that they could build a 112-bed private hospital. The parasitic nature of such developments was explicit in their own propaganda. Mr Dobson quoted from the feasibility study:

> *'The private sector would gain a high quality new private hospital with the back-up availability of the full resources of a major teaching hospital...'* and *'For the private hospital, the availability of sophisticated supporting services and skilled staff within UCH would provide a range and quality of services which are not generally available in private hospitals and which probably could not be satisfactorily provided by other means.'*

Even they are saying they are parasites!

Mr Dobson drew attention to the Labour Party 1945 Election Manifesto's objective of the best health service for all, with money no passport, and to the Beveridge Report's principle, security from want without a means test. The principle had been seriously eroded over the past 10 years and the current government was directly attacking it.

Mr Dobson referred to the 'horrifying' proposal to build a new private children's hospital financed by United Medical Enterprises Ltd, which was substantially (70 per cent) owned by the National Enterprise Board. Sir Richard Marsh was vice-chairman of another company involved. This proposal meant that in the future in central London no longer would a child's need for treatment dictate whether or not he/she received it—the deciding factor would be, instead, whether the parents could pay.

The meeting tonight had been called to mount a campaign against such hospitals, and to raise our sights to improve our NHS hospitals. It was a campaign simultaneously against the spread of private hospitals and to protect the NHS.

Frank Honigsbaum
A PERSPECTIVE ON RECENT DEVELOPMENTS IN THE HEALTH SERVICE

Frank Honigsbaum began by stating his firm belief that the National Health Service, set up in 1948 because the British people decided health care was too precious a commodity to leave to the whims of the market place, was a sign of the civilised nature of the British community. It also happened to be one of the cheapest health care systems in the industrial world because private practice and insurance made medical care much more expensive, as America had found. Nye Bevan's aim had been for the NHS to be so good that nobody would want an alternative—and this appeared to have happened in Edinburgh, where the 10 private hospitals and nursing homes in the 1960s had fallen to two. When funding was low, however, this ideal would not materialise.

Mr Honigsbaum pointed out how few people had turned to private medicine—only 6 per cent were covered by private insurance but the number was growing, especially in the form of group rather than individual membership, and this included trade unions, despite the TUC's official opposition.

He believed that this growth in private insurance—at a rate of 25 per cent last year—was mainly caused by dissatisfaction with the state of the hospital stock, not with waiting lists, which had recently been reduced. At least £4 billion were needed to modernise Britain's 2,300 hospitals and 4,000 other institutions. Perhaps a portion of the revenues from North Sea oil could be reserved for this? He felt that if this work was not done, the demand for private hospitals would grow, as would demand for a change in the way the NHS was financed. There was pressure from doctors for an insurance system; they seemed to be forgetting the hardships such a system caused before 1948 and would again cause those who would find themselves without a right to health care, or were made bankrupt, as happened so often in America.

Mr Honigsbaum saw the resurrection of insurance funding as a greater threat to the NHS than the growth of private practice. In fact, he thought that the surest way to kill the NHS was to demand the total abolition of private practice, as the Labour Party did last year. He felt that if that view was accepted, energy must be directed to preventing the private sector from getting too big, from draining resources from the public sector and from inflating the costs of health care as a whole.

Mr Honigsbaum was sure that the best way of tackling the problem was to put more money into the NHS, thus improving its facilities and probably drastically reducing the demand for private practice. If money was not forthcoming and the demand for private practice continued its rapid growth, then there might be pressure for still more private beds, with the alternatives of new hospitals or more pay beds in NHS hospitals.

Mr Honigsbaum considered pay beds a more sensible choice, because new hospitals did far more damage – by taking much-needed staff from the Health Service and by having a severe inflationary impact on NHS costs as a whole. In parts of London, NHS hospitals had to employ many much more expensive agency nurses because of the competition from private hospitals. Such a situation would not have arisen if private hospitals had not been built, and the existence of sufficient pay beds could prevent the setting up of private hospitals: in Canterbury a plan for one was scrapped when it became clear that the city's 30 pay beds would be retained. Much of the distaste felt by NHS staff towards pay beds would go if they could be shown that pay beds could prevent the construction of private hospitals, if the charges for pay beds were made more realistic, and if other abuses were curbed by closer regulatory control.

Mr Honigsbaum's answer to the challenge of private hospitals was to raise more money for the NHS, but, if that was not possible, to allow more pay beds. The NHS was under greater threat from a demand to change the way it was funded, especially to an insurance system, than from private practice. It had to be remembered that it was more important to preserve the NHS than to destroy private practice, and to act otherwise was to risk destroying the institution we wanted to preserve.

Nick Davidson

FACTS AND FIGURES ABOUT THE GROWTH OF PRIVATE MEDICINE

Nick Davidson began by pointing out the importance of seeing any new proposals for the development of private medicine in the context of a growth in medical insurance, a growth in private facilities and a government attempt to try to integrate the private and public sectors.

Insurance

Insurance was crucial as it was the only way private medicine could grow, because of the costs involved. A day in a London teaching hospital pay bed now cost £118.10, and a week in a private hospital could range from £600 to £1,600, not including consultant and operating theatre time. To encourage the growth of insurance cover, the latest Budget had introduced tax concessions from next April for employers offering insurance to employees.

What was more worrying was that the government would be publishing a consultative paper in the summer proposing to alter radically the financial basis of the NHS from taxation to an insurance-based system. It was unlikely that the government would opt for a US-type system with all health care financed from private insurance contributions, because that was too radical and had proved not to work – the whole system was too expensive and many people still had to be paid for by the state. Mr Davidson anticipated that the government would probably propose a system similar to the West German one: a two-tier system by which the state ensures the basic cover, with people free to opt out into a private scheme.

If this happened we could expect a boom in private insurance. At the moment about 3.5 million people – 6.4 per cent of the population – were covered by private insurance and growth was still averaging about 20 per cent per annum. A significant proportion of these new subscribers was made up of individuals, and a significant number of them were working class. Continued growth would depend on three factors – what the government decided to do about medical insurance, the state of the NHS and the state of the economy.

Private hospitals

Mr Davidson said that the existence of NHS waiting lists was what attracted many people to private hospitals, but that there were now waiting lists for some of these too. There were about 2,500 pay beds and 6,000 private hospital beds today – it was the private hospitals which were now the motor of private practice in Britain. Current expansion suggested that there would soon be 150 private hospitals with 10,000 mainly acute beds (including pay beds).

The developers were 50 per cent American, 50 per cent British. The main American companies were American Medical International, Humana (which owned the Wellington Private Hospital Ltd) and Hospital Affiliates International, as well as various other concerns which were moving from selling fried chicken and doughnuts to selling health care. The major British companies were Nuffield Nursing Homes Trust, BUPA and Allied Medical Group, while various companies such as British Caledonian, Grand Metropolitan Hotels and Cunard were considering entering the market. Some observers, however, thought there might soon be too many private beds as demand in some hospitals was dropping, particularly from Middle Eastern customers.

Integration

Mr Davidson explained how, in an attempt to enlarge the size of the private sector and give it a legitimate role in health care in Britain, the government had in the last six months issued many circulars encouraging the NHS to establish better links with the private sector, from contracting out work to joint training and planning between the NHS and the private sector. Yet even the BMA had warned of the dangers:

> *'An NHS hardpressed financially must be tempted to economise most drastically in those sectors in which private practice is expanding most rapidly, so that in many parts of the country the private medical sector might eventually be the main provider of, say... some forms of surgery. Dental care is already scarcely available through the NHS in some parts of London.'*

Mr Davidson stressed that the government had, however, shown no sign of changing direction.

Dr Brian Jarman

GENERAL PRACTITIONERS AND PRIVATE MEDICINE

Dr Brian Jarman began by reminding the meeting that there was not a great deal of private practice in the field of primary health care. Research carried out by Dr Ann Cartwright in 1966 and 1977 suggested that only two per cent of the population in this country preferred purely private general practitioner services, whilst only a further two per cent opted for a mix of NHS and private GP services.

General practitioners did receive a portion of their income from non-NHS work such as insurance forms, but because it was up to 10 times more expensive to organise GP services privately it was unlikely that there would be a substantial growth in this area of private medicine in the near future.

The most significant recent development in private GP care was the emergence of 'Medicover'. Started just over one year ago in north London, the scheme enabled a family to obtain all its GP services for £120 a year. However, the indications were that take-up by the general public had not been very great. The British Medical Association was totally against the scheme for ethical reasons.

Another scheme now being proposed by 'Air Call' was a commercial venture to introduce the first-ever private general practice with big company backing. The proposal involves building two private health centres in London, somewhere along the North Circular Road and South Circular Road. Apparently this scheme had the support of the BMA.

The way GPs were allowed to work permitted the doctor to have up to 10 per cent of his patients registered as private patients. If a GP had more than 10 per cent, his basic practice allowance was docked by the appropriate amount. It was in the Kensington, Chelsea and Westminster area where the greatest reductions in basic practice allowances had been made and where presumably the highest private practice existed.

Dr Jarman explained why there were more incentives to take on private patients in London – certainly the overheads were higher here.

He declared himself to be a passionate believer in the NHS and would not want to see private medicine develop in the same way as private education had developed.

As a GP he emphasised that the greatest problem in the NHS was the fact that insufficient resources had been switched to the area of primary care and prevention, and the present government's current emphasis on developing cooperation between the NHS and the private sector in relation to acute services was doing little to convince people of the importance of primary care.

Dr Paul Noone
IN DEFENCE OF THE NHS

Dr Paul Noone said he wanted to make four points:

1. *What's good about the NHS.* We actually provided the 'Cinderella' service rather well in comparison with many other countries (eg primary care, geriatrics, A&E, psychiatry and mentally handicapped). However, it could be argued that the apparent low cost of the NHS was in part a reflection of the low wages paid to nurses, ancillary workers and others. There was provision of medical service in all parts of the country of uniform good standard, unlike America, for example. The NHS was GP-based. GPs dealt with 90 per cent of medical interventions and prevented the over-use of specialist and high technology services, as found in the USA. A whole range of acute services, including intensive care units, was well distributed around the country. Patients were more likely to be treated as whole people rather than a series of malfunctioning parts. The NHS had come in for a lot of negative propaganda. It was fashionable to 'knock' and this was doing a disservice to health care in this country.

2. *What were the needs of the people.* The Black Report had defined the needy (unskilled and semi-skilled workers and their families) and the measures needed to be taken: better nutrition, housing, maternity care, etc; not more high technology, but the basic relief of poverty, better provision of primary care and better preventive practice.

3. *Development of the medical-industrial complex.* In the USA a huge new industry providing health care services for profit had grown up (proprietary hospitals, nursing homes, diagnostic laboratories, health-care and emergency-room service, haemodialysis and other technological services). The gross income of this industry was 35-40 billion dollars last year. Doctors were heavily involved with insurance companies and other interests in running this sickness business. It created problems of over-use and duplication of services; over-emphasis on technology and curative (as opposed to preventive) medical care; and it exerted a powerful influence on national health policy. The development of private practice in this country would generate the same kinds of problems here too.

4. *Consultant contract.* There had been pressure from the BMA for a change of contract for some years, to eliminate the financial incentive for whole-time practice. The Conservative government changed the contract as soon as it came to office. Originally whole-time consultants did not gain personally from private medicine. Maximum part-time consultants were expected to carry out the same obligations and duties as whole-time consultants but received 9/11ths of the whole-time salary and were allowed to do as much private practice as they wished otherwise. More than one half of Britain's consultants were whole-time before the change (this included academics who had honorary whole-time contracts). The new contract immediately gave maximum part-time consultants a 10 per cent increase in NHS salary for no extra work and they now received 10/11ths of the whole-time salary and could do as much private practice as they wished. Whole-time consultants were now allowed to earn up to 10 per cent of their NHS salary as private practice fees. If they earned more than this amount for two years running, then they would be asked to go part-time. The new contract obviously encouraged consultants to do private practice and would have a negative influence on the recruitment of consultants to those areas and specialties where there was little private practice and also into academic posts. medical posts.

Dr Noone did not agree with the speaker who indicated that it may have been wiser to leave private medicine within the confines of private wings of NHS hospitals alone as the attack on this seemed to have precipitated the present expansion in private medicine. He believed that private medicine was fundamentally wrong and that it should be phased out completely both inside and outside the NHS.

Steve Burkeman
WHAT CHCs CAN DO TO SUPPORT AND PROTECT THE NHS FROM THE DAMAGING EFFECTS OF PRIVATE HOSPITALS

Steve Burkeman emphasised that the problems posed by private hospitals were not unique to London. He would first give the background to where he worked in Birmingham and then outline what he saw as an action programme for community health councils. Although he was speaking in a private capacity, he felt that most of his members would agree with most of what he said.

Central Birmingham was characterised by extremes of poverty and affluence. Forty per cent of the population

lived in what had been designated a Partnership area, for the usual reasons: poor housing, low employment and all the factors which called for highly developed primary care services to deal with them.

The health district had very good hospitals which served all of the West Midlands, an area the size of Denmark. Most of Birmingham's 73 pay beds were within this district and, since the imposition of cash limits, the district was dependent on income from these pay beds. Mr Burkeman believed that up to £150,000 had been lost because of competition from the private sector.

The district's community health services were declining, partly because few people were being recruited. Six out of every 10 children were not receiving all the screening and immunisation which they were meant to have. There also seemed to be little awareness of the community services among some people in the medical establishment. There had never been a District Community Physician in Central Birmingham; the community nursing establishment had remained the same since 1974. Because of all these factors, the acute secondary services were in a very powerful position.

In such a situation the expansion of the private sector was an insult. Nuffield and AMI were planning private hospitals. It had been unfortunate that of 13 CHCs who had replied to AMI's proposals for a 110-bedded hospital only two had opposed them, including Central Birmingham. Central Birmingham's opposition had not been on ideological grounds but because of the effects on the NHS, especially in terms of staffing. The local authority had refused planning permission and the matter now rested with the Department of the Environment.

Mr Burkeman stressed that a strategy for CHCs had to be based on facts and would not succeed by being divisive.

- CHCs had first to find out the facts: what the use of NHS facilities by the private sector was, for example. Even the administrators didn't know this but they could seek out the information if CHCs asked for it.
- CHCs had to expose the true cost to the NHS.
- CHCs had to establish how hard NHS consultants were working for the NHS.
- The cost of tax subsidies for private medicine in each district had to be worked out.
- CHCs had to pressurise administrators to ensure that there were common waiting lists within the NHS.

Publicity was all-important and CHCs were good at it. They should, for example, publish waiting list information and distribute leaflets on the effects of tax subsidies.

With all this information and all that routinely kept by CHCs, they could question any private developments. There was still consultation on pay beds. Where relevant, CHCs should take up the question of planning permission. They should insist on visiting the private sector's institutions and, if permission were refused, should publicise that. They should watch what happened to consultants' contracts and CHC observers should ask questions about the consultants, two years off retirement, who changed to full-time NHS work. They should ask for changes in the law so that disclosures about financial involvement in the private sector had to be made.

Finally, people involved in this needed what Americans called 'sticktoitiveness'. Past experience had shown that the opposition could be beaten on brainpower, and if the recent *Litmus Papers* was an example of the quality of thought among those who supported private medicine this was the case now.

Terry Mallinson

A TRADE UNION VIEW

Terry Mallinson reaffirmed the aims of the NHS when it was first set up in 1948, to make health service free at the point of delivery. Opponents of the NHS claimed (without any evidence) that private medicine relieved the burden on the NHS by shortening waiting lists for outpatient appointments and inpatient admissions, the implication being that the NHS would not be able to function properly without the private sector. In this way patients, staff and NHS facilities were being bought off.

He told the meeting that he was personally opposed to NHS pay beds, both inside and outside the NHS. Pay beds actually cost the NHS a great deal of money. In 1974, for instance, NHS pay beds earned £14.3 million but cost the NHS £21.5 million in revenue. In other words, the NHS subsidised private doctors and patients to the tune of £7 million. It was also worth remembering that the private sector was also unable to earn enough money to offset the capital costs it incurred to the NHS.

Mr Mallinson went on to question the view that private medicine was necessary in order to prevent our medical consultants from emigrating. In practice, it was not the consultants but the senior registrars, the 'cream' of the

NHS who covered the work of the consultants most of the time, who were actually attracted to the idea of leaving the country to practise medicine abroad. He informed the meeting that the over-provision of medically trained staff throughout Europe had now halted this net exodus of trained doctors. We should therefore not be fooled by such idle threats.

On the question of private health insurance, it was necessary to bear in mind who it was that these private companies were interested in selling health insurance schemes to. They were not interested in the old or the poor; they were interested in those patients who required 'clean' medicine and elective surgery, where it was possible to make a quick profit. If the present government had its way the NHS would be left to care for the old, the poor and the chronic sick.

He called for more resolutions to be presented to TUC Congress and Labour Conference about the dangers that private medicine posed to the NHS, and concluded by suggesting that he would be pleased to see as many private hospitals built in the next few years as was possible, because when the Labour government came into power it should nationalise private hospitals and in this way the NHS could substantially improve its capital stock of hospital facilities.

Gwyneth Dunwoody MP
SUMMARY AND THE WAY AHEAD

Gwyneth Dunwoody made it clear that she was very concerned about the current increased interest in private medical insurance and agreed with previous speakers who had indicated that they saw this as the crux of the problem. She mentioned with dismay the reference to the possibility of a state insurance scheme in a recent press release from the Minister of Health.

People attracted to private medicine by easier insurance schemes should be aware of the dangers in entering a hospital where, although they might be attended to by a top consultant, they did not have the constant attention of trained junior staff should an emergency arise. Presumably all those junior doctors in NHS hospitals weren't there for nothing!

Mrs Dunwoody believed that the government was afraid to tackle the NHS head on but was nevertheless determined to wear it down by attrition. She referred to the Rayner Report and the iniquity of the government's suggestion that NHS patients should make use of private hospitals with public funds footing the bill. This would take from the NHS those patients with simple, clean operations which did not cost a prohibitive amount and leave the NHS with the expensive, difficult and chronic patients—meanwhile increasing the cash flow in the private sector.

Mrs Dunwoody was at pains to make it clear that private practice would be abolished entirely under the next Labour government. She felt that the enthusiasm of the private insurance companies was grossly misplaced as a Labour government would not take kindly to their activities.

She went on to point out that private hospitals were unlikely to be built where hospital beds might be most needed, but were only going up in areas like London and the home counties where the private companies could be sure of making sufficient profit.

Mrs Dunwoody pledged the next Labour government to abolition of private medicine from the beginning of that government, and concluded her rousing speech with a declaration that no one should have to think about money when they were sick.

Published by
Islington Community Health Council   Liverpool Road Hospital   Liverpool Road   London N1
and
South Camden Community Health Council   114 Hampstead Road   London NW1

May 1981