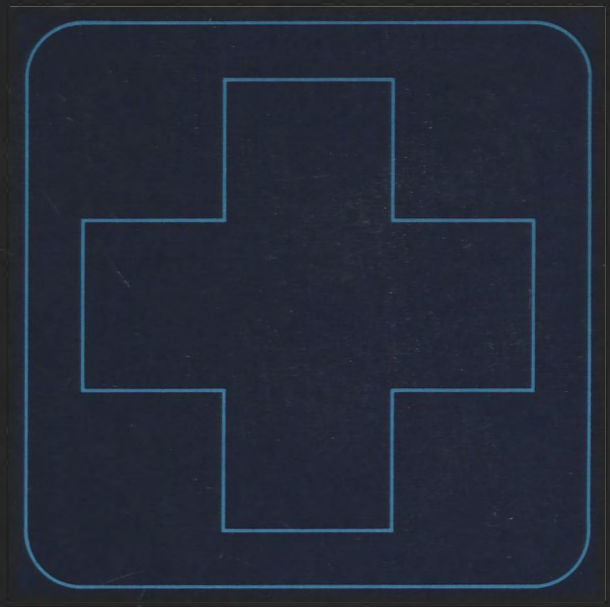
PRIVATE HEALTH CARE



1985

William Laing

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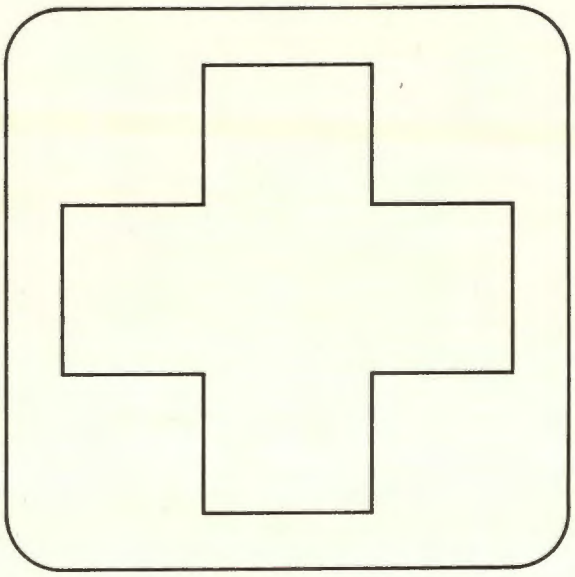

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CONTENTS

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Office of Health Economics

The Office of Health Economics was founded in 1962 by the Association of the British Pharmaceutical Industry. Its terms of reference are:

To undertake research on the economic aspects of medical care.

To investigate other health and social problems.

To collect data from other countries.

To publish results, data and conclusions relevant to the above.

The Office of Health Economics welcomes financial support and discussions on research problems with any persons or bodies interested in its work.

1. INTRODUCTION

This survey covers all major areas of health care in Britain and describes the activity of the private and voluntary sectors in each. The organisation of chapters aims to follow coherent market boundaries. In many cases, these coincide roughly with NHS administrative divisions. The congruence breaks down, however, in the case of long term nursing and residential care of elderly people. Here, the reality of a single market is acknowledged, despite the statutory distinction between 'nursing' and 'personal' care, and between facilities provided and regulated by health and local authorities.

The total value of services supplied by the independent sector, in each of the major markets, is set out in Table 1.1. Overall, independent hospital based services (excluding local authority registered residential care of the elderly) amounted to £827 million in the UK in 1984, or 7 per cent of the total cost of NHS and independent sector hospital based services combined. Employment provides an alternative measure of relative size, giving much the same result. In December 1983 an estimated 25,700 whole-time-equivalent (WTE) nurses were employed in independent hospitals and nursing homes in England, accounting for 7 per cent of all WTE nursing staff employed in the NHS hospital service and the independent sector combined.

Table 1.1 **Estimates of value of independent sector supply of health care: major markets, UK 1984** *£ million*

Acute hospital (excluding approximately £70 million NHS income from pay beds)	475		
Long-term care of the elderly	776		
private/voluntary nursing homes			209
private residential homes			426
voluntary residential homes			141
Other non-psychiatric nursing home care (post operative, convalescent, rehabilitation services in nursing homes without operating theatres)	100		
Acute mental illness	25		
Non-acute mental illness	11		
Mental handicap	7		
Pharmaceutical (1983)	613	(1)	(2)
General practice (1983)	25		
Dentistry (1983)	72	(2)	
Ophthalmics (1983)	250	(2)	
Complementary medicine	220	(3)	

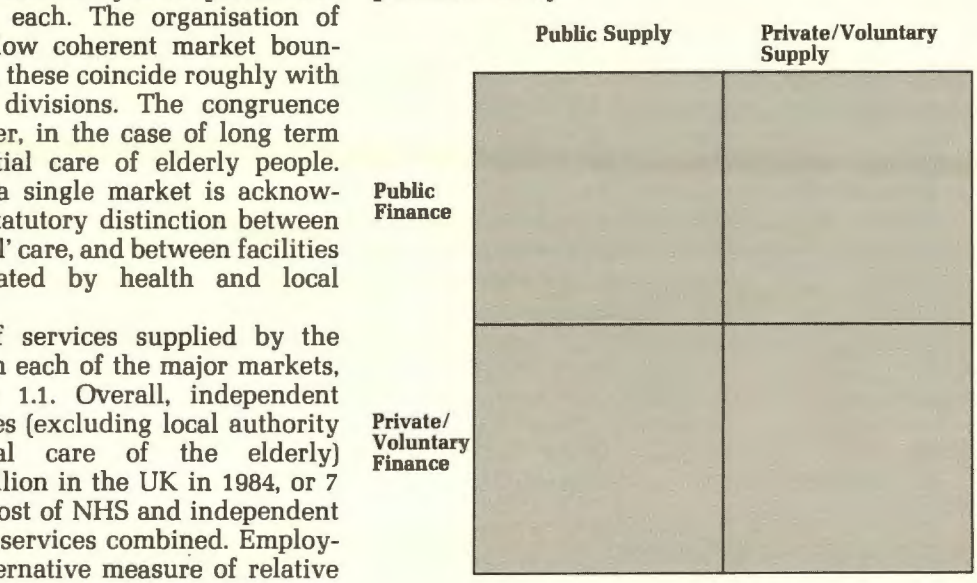
Sources:

1 Includes 'over the counter' non-prescription medicines (£597 million) and private prescriptions (£16 million).

2 Services supplied outside NHS contracts (ie, excludes NHS patient charges).

3 Grant (1985); includes £170 million for trained therapists' consultations (excluding 'healers' and 'creative therapists') and £50 million for remedies and aids; estimates derived from Fulder (1984).

Figure 1.1 **Model for segmentation of public and private activity**



The survey attempts, wherever possible, to take the analysis one stage further by partitioning services into the four possible combinations of private[1] and public finance and supply. In doing so it systematically uses the format illustrated in Figure 1.1. Analysis into these four component parts is crucially important in understanding the private/public mix in health care and avoiding confusion in the debate on 'privatisation'.

To do this, it is necessary to look at individual elements of health care. Since, however, markets do not fit neatly within NHS boundaries, the choice of elements must be selective and a pragmatic approach must be adopted, sometimes using value as the basis of the four way partition and sometimes using volume of activity or level of facilities, according to the data that are available.

Services which are both publicly supplied and publicly financed cover the bulk of the NHS. Services which are publicly supplied but privately financed include, for example, NHS pay beds. They also include, in part, services for which NHS patients pay significant charges, such as prescription medicines. Privately supplied and publicly financed services include contractual bed arrangements and, much more important now, long term care financed by supplementary benefits. Finally, privately supplied and privately financed services include the bulk of treatment in independent hospitals.

Among the different markets there is wide variation in the public/private mix (Table 1.2). Most of the data relate to 1984. Where they do not, earlier years' data remain valid at the date of publication,

1 In this context, 'private' may be understood to mean 'non-public', incorporating for example supply by voluntary as well as commercial organisations. Elsewhere, where the context demands it, 'private sector' may be used in contradistinction to 'voluntary sector' and the term 'independent sector' may be used to cover both.

Table 1.2 **Public/private mix: summary of selected markets**

Market	*Year to which relates*	*Basis of partition*	*Public finance public supply %*	*Public finance private supply %*	*Private finance public supply %*	*Private finance private supply %*
Elective surgery[1]	1981	Cases	86.8	0.3	3.8	9.2
Long-stay care of the elderly (including local authority and private/voluntary residential care)	1984	Cash	55	10	11	24
Acute psychiatric treatment[2]	1984	Beds	96	small	small	4
Non-acute medical care of mentally ill people[3]	1983	Beds	98	small	small	2
Medical care of mentally handicapped people	1983	Beds	97	1.5	small	1.5
Abortions	1984	Cases	49	4	small	47
Maternity	1983	Cases	99	small	small	1
General practice	1983	Consultations	99	0	0	1
Pharmaceuticals	1983	Cash	74	0	6	21
Dentistry	1983	Cash	65	0	25	10
Ophthalmics	1983	Cash	42	0	10	49

Notes:
1 Booked and waiting list cases, excluding termination of pregnancy. Private finance/private supply will be substantially greater in 1984.
2 Based on estimate of 500 occupied acute psychiatric beds in independent sector and NHS norm, in many regions, of 30–35 acute psychiatric beds per 100,000 population.
3 Based on remaining SBH 212 mental illness beds after deducting acute and elderly. Estimate for NHS on the same basis.

with the important exceptions of elective surgery and spectacle supply.

The data source for elective surgery is a major survey carried out in 1981 by the Medical Care Research Unit at the University of Sheffield. But the medically insured population expanded by 18 per cent between 1981 and 1984. Moreover, medical insurance expenditure on benefits has expanded by 40 per cent over the same period (after deflation by the retail price index). Thus the percentage of elective surgery undertaken privately in independent hospitals and NHS paybeds is now certainly substantially greater than the figure of 13 per cent in 1981.

In the case of spectacles, changes implemented in April 1985 limit NHS ophthalmic supply to certain categories of 'poor' clientele and it is envisaged that the NHS supply role will be completely phased out in time.

The extent of private involvement in health care, whether on the supply or demand side, is critically dependent upon four factors:

The limits that the NHS sets to its responsibilities. For example, health authorities and health professionals accept the principle of shared responsibility with local authorities and their private sector counterparts for long term care of elderly, mentally ill and mentally handicapped people. Thus 'free' institutional care is available for only a minority of this clientele. 'Alternative' medicine, for its part, is seen as a fringe activity which except for some homeopathic medicine[1] is not available under the NHS. Nor has the health service adopted a wholehearted commitment to providing abortions or to offering sterilisation as a means of birth control. In some cases a distinction is drawn between what is medically necessary and what is cosmetically desirable and the NHS has, for example, restricted itself to functional but unaesthetic spectacles and hearing aids.

The lack of any tradition in certain modes of health care delivery. Thus the NHS has not developed nursing homes on the private sector model, or along the lines adopted by some other countries' health services. Nearly all its long term geriatric facilities still consist of hospital wards. Nor has the NHS any tradition in specialised hospice type care for terminally ill people. This has been pioneered instead by the voluntary sector which cares for significant numbers of NHS patients.

Medical insurance cover. For example, maternity is not covered by medical insurance and a very small proportion of women have their babies privately.

The marginal cost of care outside the NHS. In the hospital and community health services, as in general medical practice, the marginal cost of opting out of the NHS is equal to the full cost of private care, with no allowance made for any financial contribution to the NHS through taxation. It is this high marginal cost of private medical care which places a limit on its growth.

It is in those areas where the marginal cost of private treatment is relatively low, and where there is a significant supply constraint, that private sector demand and supply has flourished most, as in care of the elderly, abortion and sterilisation and the market for spectacles.

References

Fulder, S (1984). The Handbook of Complementary Medicine. Coronet Books.
Grant, C (1985). Private Health Care in the UK. Economist Intelligence Unit, Report No 207.

1 Five hospitals and some 300 GPs offer homoeopathic treatment under the NHS (Institute for Complementary Medicine, 1984).

2. PRIVATE HEALTH FACILITIES – ACUTE SECTOR

There have always been institutional links between the private sector and the NHS (Lee 1978). They use a common pool of medical manpower and, to a lesser extent, there is a two way exchange of hospital beds with their supporting nursing, technical and ancillary services. There is also a common pool of patients who opt in and out of the public and private sectors. The relationship between the two, however, is contentious and politicised and the development of the private sector has been strongly influenced by the legislative and regulatory environment within which it operates (see Box).

Definitions

Private acute health care is defined in this section as encompassing all services provided from independent 'hospitals', that is, private or voluntary institutions with one or more operating theatres, together with private accommodation and treatment in NHS hospitals. This supply side definition differs from the demand side definition of 'acute private treatment', used in section 3, below, which encompasses all services of the type covered in medicial insurance contracts. Figure 2.1 illustrates the areas where supply and demand side definitions do not overlap. Thus the demand

Regulation of the independent acute sector.

Following the election of a Conservative administration in 1979, the Health Services Act 1980 dissolved the Health Services Board set up by the previous Labour administration in the Health Services Act 1976. The 1980 legislation is explained in HC(80)10.

In addition to halting the closure of NHS pay beds, it modified regulation of private hospital and nursing home developments. For all practical purposes, these are now subject only to local authority planning controls. The Secretary of State must receive and authorise all applications within the scope of the 1980 Act, and District Health Authorities may comment on them. But the Act excludes non-surgical facilities, units under 120 beds (previously 75) and expansions where the new bed numbers would equal less than 20 per cent of the total private bed complement in any health district in any three year period. Thus the scope of this part of the Act is very limited indeed.

A potentially more powerful control exists in section 12 of the 1980 Act which allows any district authority to apply for Designation Status. If granted, this would require the Secretary of State's authorisation for all private hospital developments within the designated area, irrespective of size. No such designation has yet been granted, though the existence of section 12 does provide a mechanism for imposing strict control on new developments by a government less sympathetic to private health care, without the need for legislation.

Registration and inspection of private hospitals and nursing homes is now governed by the Registered Homes Act 1984. This consolidates the Nursing Homes Act 1975 as amended by the Health Services Act 1980 and the 'HASSASSA' Act 1983, together with legislation relating to residential homes. A comprehensive account of the law on registration and inspection is given in HC(1981)8 and changes since then are described in HC(1984)21.

Registration and inspection are functions delegated to district health authorities. The scope of the legislation is comprehensive. It allows districts to demand information and lay down standards of facilities, support services and staffing levels and grades. Chubb *et al* (1982) point out that these powers potentially allow health authorities to exercise significant influence over the operation of the whole range of private hospitals and nursing homes. In practice, however, their principal use has been and is likely to remain maintenance of standards in non-surgical nursing homes catering for elderly and chronically ill patients.

In addition to legislative changes, several initiatives under the Conservative administration have lent support to the development of the independent sector. Ministers have frequently called for greater collaboration between the public and independent sectors. Guidance on contractual arrangements is set out in HC(1981)1. It reminds health authorities that independent facilities form part of the totality of health resources and emphasises the advantages of contracting-out, for example to clear temporary backlogs. The circular also points out that there is no statutory limit on the extent to which a health authority may buy in services from the independent sector. Restrictions on the sale of surplus land have been removed and health authorities have been encouraged to seek purchasers from the independent health sector. The 1981 budget granted tax relief on employer paid health insurance, though this has been restricted to employees earning less than £8,500 per annum.

References

Chubb, P., Haywood, S. and Torrens, P. (1982) Managing the Mixed Economy of Health. Health Services Management Centre, Birmingham.

Health Services Act 1980: Private Medical Practice in Health Service Hospitals and Control of Private Hospital Developments. Amentity beds, HC(80)10, DHSS 1980.

Contractual Arrangements HC(81)1, DHSS 1981.

Registration and Inspection of Private Nursing Homes and Mental Nursing Homes (including Private Hospitals), HC(1984)21, DHSS 1984.

Figure 2.1 **'Demand side' and 'Supply side' definitions of the independent acute sector**

Demand side (areas covered by medical insurance)	Activity	Supply side (hospitals with at least one operating theatre)
Yes	**Acute medical/surgical in-patient and out-patient treatment**	**Most**
Yes	**Acute psychiatric treatment**	**Very little**
No	**Maternity**	**Some**
No	**Abortions**	**Yes**
No	**Executive screening**	**Yes**
No	**Long-stay nursing care**	**Some**

side includes acute mental illness while the supply side does not, and conversely with abortions, executive screening, maternity and long stay care provided in surgical hospitals. Many patients, moreover, are funded by insurance to receive convalescent care or rehabilitation in nursing homes without operating theatres. Despite the differences, however, there is sufficient congruence between the demand and supply side definitions of private acute health care to make precise specification of terms unnecessary in most contexts.

Consultant manpower

Consultants retained from the outset their right to private practice while holding part-time NHS contracts. Though challenged by the Labour administration of 1974–79, the position remained unchanged until 1980 when a new consultants' contract was negotiated. For the first time this allowed full-time NHS consultants to earn up to 10 per cent of their gross income from private practice. At the same time, entry into more substantial private practice was facilitated by allowing consultants giving up NHS payment for one session per week (rather than the previous two) to engage in private practice without restriction, provided they fulfilled their maximum part-time contract commitments to the NHS.

Some indication of the number of consultants who participate significantly in private practive is available from manpower returns (Table 2.1). There is some indication of a recent decline in the number of consultants with part-time contracts, which may be associated with the revised contract of 1980. There is, however, no satisfactory data series on the distribution of private practice between consultants, how much time they spend on it and trends over time. Some generalisations are possible, however. It is known, for example, that the great bulk of private practice is carried out by consultants who also work within the NHS, whether with service or academic appointments. There are few exclusively full-time specialist private practitioners.

It is also known from provident scheme statistics that expenditure on specialists' fees has been growing rapidly in recent years, mirroring the growth of the private sector generally (Figure 2.2). Precise figures are not available because payments other than medical fees are included in benefits classified by provident schemes as out-patient or in-patient physicians' and specialists' fees. Nevertheless, private medical fees from all sources probably exceeded £200 million in the UK in 1984.

Hospital facilities

In many ways it is unsatisfactory to measure hospital facilities in terms of beds. With the trend towards short stay, day care and out-patient treatment, some modern private hospitals may earn only about half of their revenue from in-patient treatment. Screening, moreover, is a significant

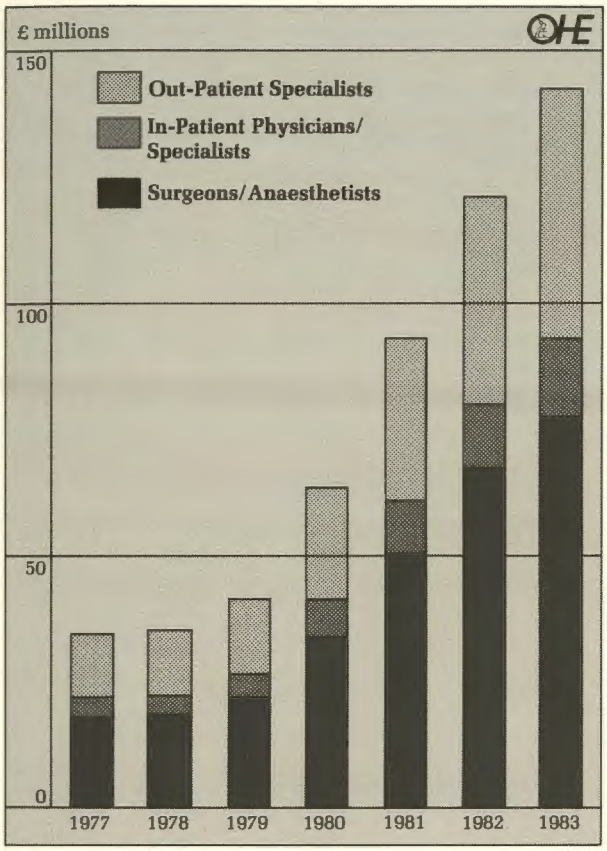
Table 2.1 **Consultant and associate specialist staff by type of contract with NHS, England and Wales**

	1979			*1984*		
	Whole-Time[1]	*Part-Time*	*Honorary*	*Whole-Time*[1]	*Part-Time*	*Honorary*
Hospital medical staff						
Consultants	5,303	5,836	1,392	6,742	5,666	1,534
Associate specialists[2]	634	369	9	607	370	5
Hospital Dental Staff						
Consultants	151	178	168	173	184	182
Associate specialists[3]	43	41	2	53	56	3

Notes:
1 Whole-time includes maximum part-time
2 Termed Medical assistants in 1979
3 Termed Assistant Dental Surgeons in 1979

Sources:
Review Body on Doctors' and Dentists' Remuneration, 10th Report 1980. Cmnd 7903.
DHSS Statistics and Research Division.

Figure 2.2 **Gross value of claims for medical fee reimbursement, BUPA, PPP and WPA**



Source: Provident scheme statistics

growth area. There are no published data on activity levels but by 1985 there were over 40 private screening clinics in Britain, either within independent hospitals or freestanding in city centres.

Nevertheless, bed numbers provide a rough and ready guide to the magnitude of private acute health care and the balance of private activity between the NHS and different parts of the independent sector.

a) NHS pay beds

From the outset, section 5 of the 1946 Act allowed the designation of specific beds for private patients. According to Bevan this was for fear of 'a rash of nursing homes all over the country' (Hansard 1946). Under a minor modification in 1968 the designation of specific beds was replaced by an authorised quota (allowing beds to become physically interchangeable). But it was not until the Labour administration of 1974–79 that the principle was challenged in an attempt physically to separate private practice from the NHS. The Health Services Board was set up in 1976 with the express purpose of phasing out pay beds. The 1976 NHS Act itself contained a schedule revoking authorisation for 1,000 beds, leaving a further 3,444 pay beds in Britian to be withdrawn progressively by the Board (Lee 1978).

In the event, a Conservative administration was elected in 1979 while substantial numbers of pay beds still remained. A new Health Services Act (1980) dissolved the Health Service Board and arrangements were set out in HC(80)10 whereby new pay beds could be authorised, where there was a local demand and subject to the statutory requirement that NHS patients should not significantly be disadvantaged.

Figure 2.3 illustrates trends in pay bed provision from 1965. Other data on regional variations and room charges are given in Figure 2.4 and Tables 2.2 and 2.3. Occupancy has been low throughout, typically around 50 per cent. During the phasing out period, it climbed to a peak of about 60 per cent in 1979, but then fell back to 42 per cent in 1983. Despite the reinstatement of pay beds under the Conservative administration the number of occupied pay beds, and cases treated in them, dropped to all time low levels in 1982 and 1983.

The most plausible interpretation of the data is a long term declining trend in usage of pay beds since the beginning of the seventies, presumably linked to unionisation of the health service, politicisation of private practice and the growth of the independent sector. Interruptions to the steady trend are observed during the pay beds dispute, when throughput significantly dropped, and subsequently in the period of most rapid growth in private demand, when throughput significantly, but temporarily, increased.

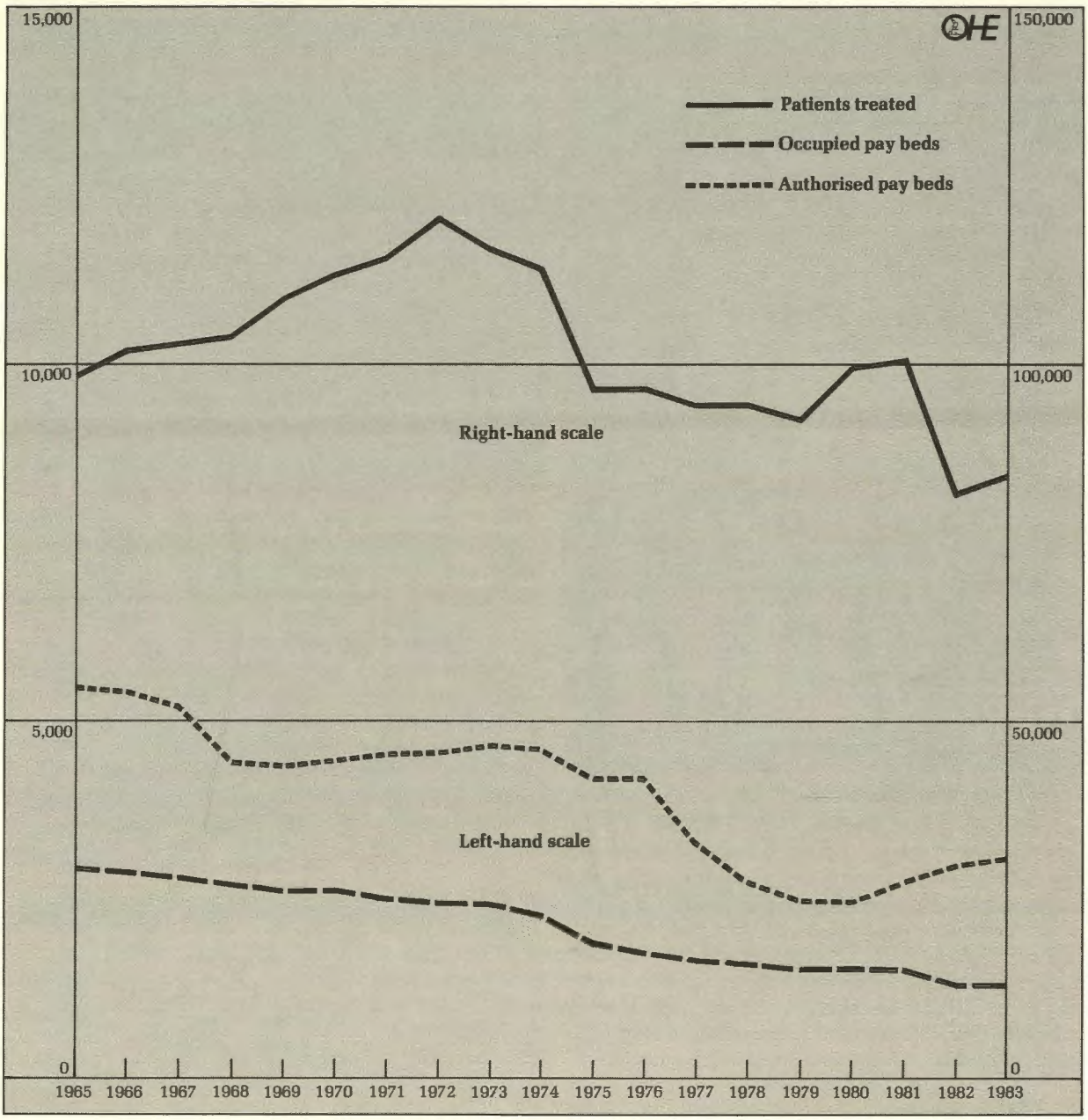
Room charges were substantially increased for the financial year 1985–86 (Figure 2.4) with the intention of including all overheads not previously counted. Income derived by the NHS from pay beds is illustrated in Figure 2.5. It dropped in real terms during the phasing out period but rose significantly again at the beginning of the eighties. During recent years, however, income growth has

Table 2.2 **Pay bed statistics by region. England 1983**

Region	*Authorised pay beds in NHS hospitals*	*Average occupied pay beds in NHS hospitals*	*Discharges and deaths of private patients in NHS hospitals*
Northern	103	28	2,382
Yorkshire	199	76	4,462
Trent	143	52	3,976
East Anglia	106	55	3,617
North West Thames	292	138	8,891
North East Thames	398	186	11,170
South East Thames	332	144	9,090
South West Thames	180	81	5,638
Wessex	120	57	4,395
Oxford	180	81	5,927
South West	104	53	3,038
West Midlands	267	82	6,015
Mersey	123	44	2,651
North West	244	84	5,946
Special Health Authorities and Boards of Governors	183	103	5,740
England	2,987	1,264	82,938

Source: Hansard. Written Answers, 4 February 1985, cols 467–468.

Figure 2.3 **NHS pay beds, England and Wales**



Sources:
1) House of Commons written answers 4 February 1985, Vol 72, Cols 465–7
2) Welsh Office
3) Lee (1978)

fallen off, reflecting declining occupancy and throughput rates illustrated in Figure 2.3. In the year ended March 1984, the latest year for which returns are available, NHS income from pay beds (excluding amenity beds) stood at £58 million in England and Wales. In 1985–86 the government expects something in excess of £60 million.

A few entrepreneurial health authorities have recently aimed to exploit private sector demand as a source of revenue. But consultants have broadly tended to opt out of using NHS pay beds and it is the independent sector which has taken the bulk of new spending on private medical care.

The conclusion depends, of course, on the reliability of pay bed data collected by health authorities. Failure to monitor private treatment and collect payments due might render invalid the data upon which the above analysis is based. Such investigations as have been published, however, though they do confirm widespread failure of such control systems as exist (HMSO 1985, Dobson 1985), indicate that the losses are insufficiently large to affect broad trends. A special investigation of 1983–84 accounts carried out by statutory auditors in 37 health authorities, concentrating on hospitals where there was potential income from private treatment of patients, estimated that uncollected income (in those 13 authorities where estimates proved possible) ranged from 0.1 per cent to 11 per cent of authorities' total income.

Table 2.3 **Daily private resident patient charges 1985–86**

Class of Hospital		Charges for patients not paying consultant(s) separately (1) Single Room £	(2) Other £	Charges for patients paying consultant(s) separately (3) Single Room £	(4) Other £
Class A	Long-stay hospitals	68	62	66	60
Class B	Psychiatric hospitals	54	49	52	47
Class C1	Mainly acute (non-teaching) hospitals	110	100	106	96
Class C2	Acute (non-teaching) hospitals	125	114	120	109
Class D	London teaching (other than A and B)	174	159	166	151
Class E	Provincial teaching (other than A and B)	144	131	137	124
Class F	London postgraduate hospitals managed by Special Health Authorities except the Hospitals for Sick Children and the National Heart and Chest Hospitals	193	176	183	167
Class G	The Hospitals for Sick Children and the National Heart and Chest Hospitals	266	243	253	230

Note: Private patients normally pay the rates in columns 3 and 4. The higher rates in columns 1 and 2 apply only to those patients who are paying the hospital for medical services rather than the doctor.

Source: DHSS

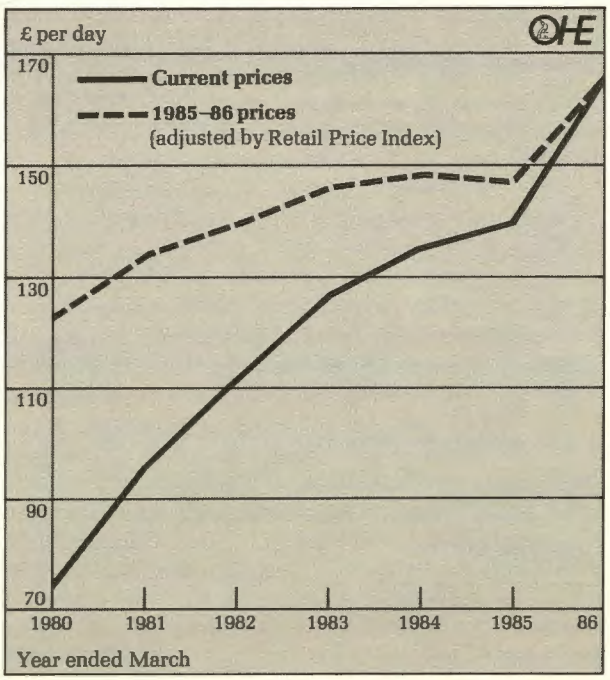
Table 2.4 **Increase in the independent sector 1979–85, acute hospitals**

Year	Change in No of hospitals: new	closed	change	Total No of hospitals	Change in No of beds*	Total No of beds
1979			—	149	—	6,578
1980	+6	−2	+4	153	+364	6,942
1981	+14	−1	+13	166	+832	7,774
1982	+15	−2	+13	179	+792	8,566
1983	+12	−4	+9	187	+679	9,245
1984	+14	−2	+12	199	+762	10,007
1985†	+4	−2	+2	201	+148	10,155
1985–6	+11	?	+11	212	+722	10,876

Notes:
1 Bed numbers include all beds, not just surgical.
2 Figures include all hospitals and homes with operating theatres (including cosmetic surgery and termination of pregnancy homes).
3 Figures refer to UK total.
* Includes new hospital beds, expansions of existing hospitals, and losses.
† To July 1985.

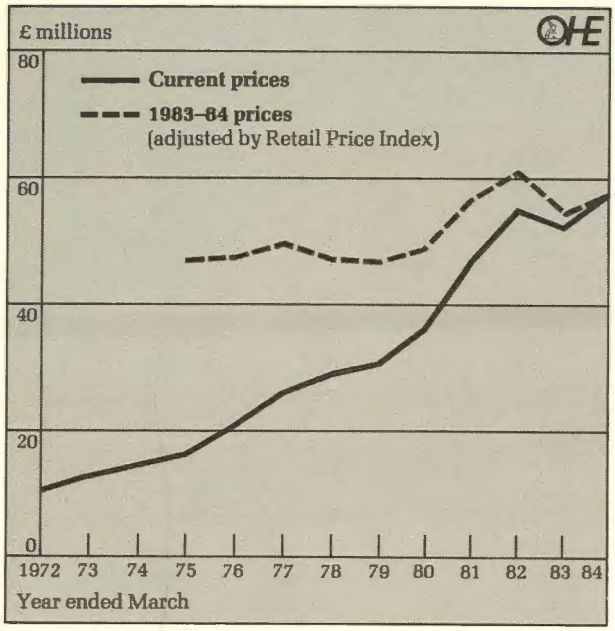
Source: Association of Independent Hospitals.

Figure 2.4 **NHS pay beds daily room charge for London teaching hospital (single room, consultant paid separately)**



Source: DHSS

Figure 2.5 **NHS income from private treatment, England and Wales (excludes amenity beds)**



Source: NHS summarised accounts, various years

b) Independent hospital beds

Prior to 1982, official returns were limited to total numbers of beds in all nursing homes and hospitals registered by health authorities. These are set out in Section 4, below, Table 4.5. It was only with the introduction of the SBH 212 return, self completed by independent sector respondents in England and Wales, that it became possible to extract out acute hospitals from the bulk of mainly small homes accommodating elderly and other long stay patients. The latest data relate to 1983 (DHSS 1985).

More recently, the Association of Independent Hospitals (AIH) has collated up-to-date statistics for the independent acute hospital sector throughout the United Kingdom. Using the 'supply side' definition (all institutions with one or more operating theatre), the AIH survey is continually updated. As well as being more timely than the SBH 212 returns, it is more complete, including certain hospitals incorporated by royal charter which are exempt from completing the government return.

By July 1985 there were 201 hospitals in the UK with a total of 10,155 registered beds (Table 2.4). Since 1979, when the data series starts, there has been a steady growth in bed numbers, averaging 9 per cent per annum. Plans exist for 11 more hospitals and a further 722 beds (including extensions) during 1985–86. These 'pipeline' beds represent

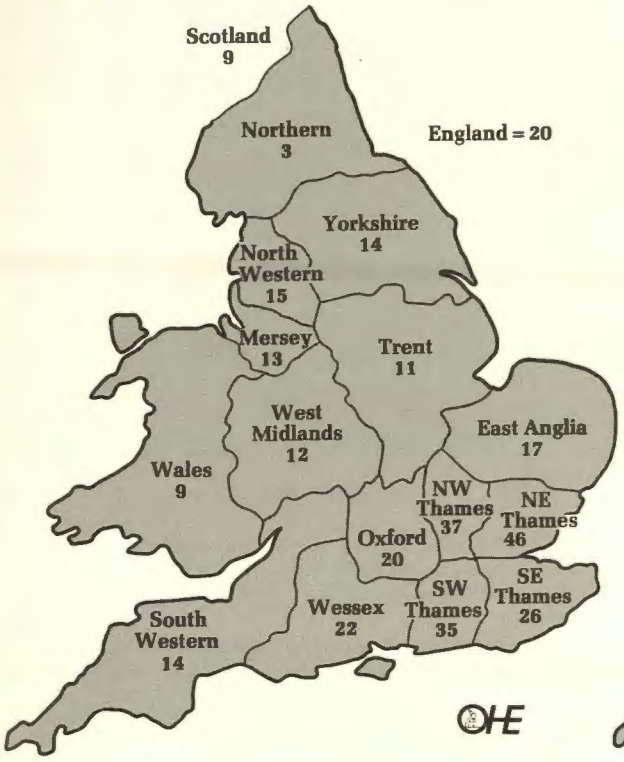
Table 2.5 **Independent acute hospitals by region, July 1985**

Region	*No of hospitals (1985)*	*No of beds (1985)*	*New hospitals since 1979*	*New hospital beds since 1979*	*Proposed new beds 1985–86*
Northern	3	144	2	114	—
Yorkshire	14	535	5	194	35
Trent	14	524	5	238	—
East Anglia	9	332	4	181	20
NW Thames	16	1,225	5	388	7
NE Thames	25	1,704	4	357	160
SE Thames	18	893	6	278	279
SW Thames	16	1,001	4	239	12
Wessex	15	630	8	439	—
Oxford	12	470	5	238	36
South Western	10	425	2	79	53
West Midlands	17	606	5	270	80
Mersey	6	312	2	39	—
North Western	10	616	5	333	71
Total (England)	185	9,416	62	3,387	753
Wales	5	239	1	37	—
Scotland	9	414	2	149	—
Northern Ireland	2	86	—	4	—
Total (UK)	201	10,155	65	3,577	753

Notes:
Acute = hospitals with operating theatres. Beds = all beds, not just surgical beds.
Figures include cosmetic surgery and termination of pregnancy homes, and also hospitals such as Benenden and Manor House which are not generally open to the public.

Source: Association of Independent Hospitals

Figure 2.6 **(A) Number of independent acute hospital beds per 100,000 population, by health region**



Source: Association of Independent Hospitals

Figure 2.6 **(B) Per cent private medical insurance cover by standard region**

Source: General household survey 1982

firm commitments to expand existing hospitals or to complete new hospitals already at an advanced stage of planning or construction.

A regional analysis is set out in Table 2.5. The highest concentrations of acute hospitals are in London, with its national and international clientele, and the South East. The risk of overbedding in London is increasingly recognised and there is some indication that the balance of development activity has switched to the provinces in recent years.

There is evidence of imbalance in the present geographical distribution of independent acute hospital beds. Regional variation in beds per unit population is significantly wider than variation in medical insurance coverage, which is the main indicator of underlying demand. Figure 2.6 illustrates the imbalance, though it cannot be precisely quantified because hospital data are by health region and insurance rates are by standard region.

For most of the post war period independent sector hospitals were primarily owned and operated by religious or charitable institutions. Commercial 'for-profit' organisations began to invest in private health care in Britain in the nineteen-seventies, though expansion was initially constrained by lack of institutional funding in a relatively new sector of private activity. By 1979 the commercial sector, stimulated by the phasing out of pay beds, had established itself with 28 per cent of beds in acute independent hospitals (Table 2.6, Figure 2.7). The trend has continued strongly since and by July 1985 48 per cent were located in commerical hospitals.

Between 1979 and 1985 the charitable hospitals (including the Nuffield chain) increased their bed numbers in absolute terms but their share of bedstock declined from 43 per cent to 35 per cent. Religious institutions, for their part, experienced an absolute decline in bed numbers. This shift from charitable/religious to commercial provision in the UK mirrors a similar trend which emerged in the USA in the nineteen-seventies. The trend is likely to be maintained in Britain since many of the charitable/religious institutions lack the philosophies, incentive structures and marketing skills to be able to compete effectively.

A second pattern, overlapping with the first, is the growth of hospital 'chains' or groups. The first generation of new private hospitals, established in the seventies, were typically independent developments in which local consultants and businessmen frequently took an equity stake. More recently, health care corporations with access to substantial resources and specialised management skills have taken the lead both in new developments and in restructuring the market by acquisition. In 1979 26 per cent of beds in acute, independent hospitals were located within groups (including Nuffield Hospitals). By 1984 this had risen to 47 per cent. There is every indication that this trend is continuing. Non-affiliated hospitals may lack ready access to resources for continuing modernisation of equipment, as well as the management skills to compete effectively.

A 'league table' of independent acute hospital providers, in order of bed numbers, is illustrated in Table 2.7. This remains highly mobile as new

Table 2.6 **Ownership summary, independent acute hospitals, UK**

Category	1979				July 1985			
	No of hospitals	%	No of beds	%	No of hospitals	%	No of beds	%
Charitable								
Religious	33	22	1,879	29	29	14	1,725	17
Charitable	21	14	1,664	25	28	14	2,040	20
Charitable groups	34	23	1,175	18	38	19	1,555	15
Charitable total	88	59	4,718	72	95	47	5,320	52
For-profit								
American groups	3	2	366	6	24	12	1,924	19
British groups	4	3	156	2½	30	15	1,319	13
Independent	54	36	1,378	20	52	26	1,592	16
For-profit total	61	41	1,900	28	106	53	4,835	48
Total	149	100%	6,578	100%	201	100%	10,155	100%

Source: Association of Independent Hospitals.

Table 2.7 **Hospital groups, UK, July 1985**

	Beds		Hospitals	
	1985	(1979)	1985	(1979)
Nuffield Hospitals	1,385	(1,029)	33	(30)
AMI	1,190	(265)	13	(2)
BUPA	562	(62)	10	(1)
HCA United Kingdom	320	(—)	7	(—)
Community Hospitals	293	(—)	7	(—)
Humana	265	(101)	1	(1)
British Pregnancy Advisory Service	170	(146)	5	(4)
GM Health Care	159	(—)	4	(—)
London Nursing Homes	94	(80)	3	(2)
National Medical Enterprises	87	(—)	2	(—)
St Martins	74	(—)	2	(—)
Nu-Med	62	(—)	1	(—)
Health Care Corporation	54	(—)	1	(—)
Health Care Services	30	(—)	1	(—)
Nationwide	20	(—)	1	(—)
Nestor Medical Services	—	(—)	—	(—)
All other hospitals	5,390	(4,895)	110	(109)
Total	10,155	(6,578)	201	(149)

Source: Association of Independent Hospitals

Notes:

Nuffield Hospitals (formerly Nuffield Nursing Homes Trust) was set up in 1957 under the sponsorship of BUPA to fill a perceived need for modern medical and surgical facilities to service the growing demand for private treatment. It is a registered charity.

AMI Healthcare Ltd is the UK subsidiary of United States based American Medical International. Established in Britain in 1969, it is setting up in addition to its acute hospital services, a comprehensive network of health care facilities including services for psychiatry, alcohol abuse, primary care, occupational health, rehabilitation and *in vitro* fertilisation.

BUPA Hospitals Ltd is a subsidiary of BUPA set up to fill a perceived gap in hospital facilities. Its first hospital was opened in 1978. In addition to its own hospitals it undertakes hospital management under contract. It is actively exploring other areas of health care including care of elderly people and occupational medicine. Health screening is provided through BUPA Medical Centre Ltd.

HCA United Kingdom Ltd is the UK subsidiary of Hospital Corporation of America, the largest United States based health care multinational. A London office was opened in 1974 but active development and acquitision of acute hospitals did not start until the early eighties.

Community Hospitals plc is a UK owned, managed and funded private health care organisation which develops and/or manages independent hospitals. It entered the market in 1981.

Humana Hospital Wellington was bought by Humana Inc, a United States health care multinational, in 1976. It is the largest commercial hospital in Britain. Specialisations include open heart surgery.

British Pregnancy Advisory Service is a non-profit charity providing abortions, infertility treatments and investigations, artificial insemination and contraceptive surgery. It entered the hospital sector in 1971.

GM Health Care Ltd is a subsidiary of Grand Metropolitan. In addition to owning and managing acute hospitals it is involved in care of elderly people. It has invested in this area in the United States with the purchase of a major home support chain.

London Nursing Homes Ltd provides general surgery, terminations and contraceptive surgery.

National Medical Enterprises is a United States based healthcare multinational which entered the British market in 1985 with the acquisition of the Alexandra and Elland hospitals.

St Martin's Hospital Group entered the British market in 1982. The group has specialised in urological and kidney disorders. With two further general hospitals in the pipeline it is now moving further into the area of general acute care. St Martin's installed the first lithotripter in Britain.

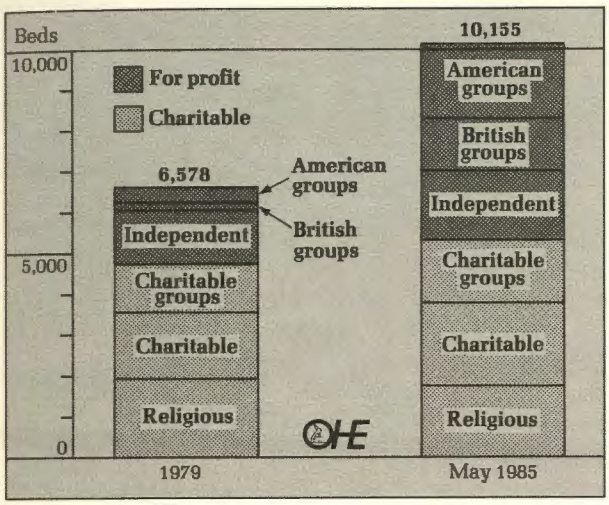
Nu-Med Medical, Inc. is a United States based owner and manager of acute short stay hospitals with full casualty, surgical and support facilities. It entered the British market in 1985.

Health Care Corporation (formerly Hospital Capital Corporation) is a developer and manager of health care facilities including acute hospitals, nursing homes and sheltered housing. It entered the market in 1980.

Health Care Services PLC, previously the London Private Health Group, is a manager and owner of hospitals and nursing and residential homes.

Nestor Medical Services Ltd is a British company ultimately owned by Eagle Star and BAT. Though it owns no acute hospitals, it manages two, New Hall and Winterbourne, in addition to owning and managing a range of psychiatric, rehabilitation and nursing home facilities.

Figure 2.7 **Comparison of bed ownership, 1979 and 1985, independent acute hospitals, UK**



Source: Association of Independent Hospitals

developments come on stream and as acquisitions are made.

A third related trend is the growth of American corporations. AMI was the first to commit itself to the British market. It has established a substantial lead in hospitals and bed numbers and has remained highly active during 1985 in the search for acquisitions. Hospital Corporation of America, which is the largest hospital group worldwide, occupies second position among the American chains in Britain with 7 hospitals. Humana, in third place in Britain among the American chains, has adopted a unique strategy, concentrating exclusively on a single large, high-cost hospital in London, the Wellington. Other American interests continue to investigate the British market. Recent new entrants have included National Medical Enterprises, which has taken over facilities previously owned by the British company United Medical Enterprises, and Nu-Med.

The strength of the American corporations lies in their immense financial and management resources. With high returns from home operations, and the dollar at a historically high level, there has been a strong incentive to invest overseas. Growing demand and an absence of development controls, moreover, makes Britain an attractive location for investment. Smaller British commercial hospital groups on the other hand, such as Community Hospitals, depend on external finance and have opted for consolidation after a period of rapid expansion. Other sources of foreign investment in British private health care have included Middle Eastern interests, but as yet no European based multinationals have entered the British market. With the acquisition of a major home health-care chain in the USA, followed by a retail eye-care chain with outlets in America and Europe, GM Health Care has recently become the first British based company to form the nucleus of a health care multinational operating in the developed world. A number of British companies have been active in construction and management of health care facilities in Arab and third world countries. But to date it is American companies, formed during the sixties and seventies, which have been the sole vehicles of a budding multinational penetration of health care systems in developed countries.

A fourth trend is towards restructuring. Though substantial numbers of new beds remain in the pipeline, the acute sector appears to be entering a period of consolidation as problems of overbedding in the London region are recognised and as development opportunities in the provinces diminish. Some groups, such as GM Health Care and Health Care Corporation, remain actively interested in new developments in the acute sector. But the view of the industry as a whole is typified by BUPA and Nuffield Hospitals who have no further plans for green fields construction. Such growth as is envisaged will be through acquisition and specialisation/expansion on existing sites, or areas of health care outside the acute hospital sector (see section 4). This process of consolidation is likely to lead to further concentration of independent acute hospitals in the hands of a small number of large organisations. It will be aided to the extent that pipeline developments and reductions in the rate of growth of demand combine to create local overcapacity.

To the extent that new development does continue, its pattern will depend on the resolution of the conflicting demands of economies and diseconomies of scale. Many hospital providers have particular philosophies on hospital size. AMI, for example, has chosen to build hospitals of around 100 beds, regardless of location, on the grounds that the quality of care and range of services they wish to offer are uneconomic below a certain size. BUPA Hospitals have also restricted themselves to larger than average units, on similar grounds. Other groups, such as HCA, have varied their hospital size according to the local market. At the other extreme, groups such as Nationwide advocate mini-hospitals of perhaps 20–30 beds serving very local populations.

Trade-offs between small and large hospitals in the independent sector are precisely analagous to those that are increasingly recognised in the public sector as NHS authorities try to restructure their acute services. Quality and supply economies dictate concentration in large centres while access and convenience (whether for doctors or their patients) dictate dispersal in small units.

Market value – private acute health care

There is no supply side data source which can be used to estimate the value of the private acute sector. Using the demand side definition, however, (see above) private expenditure on acute health care is estimated at £535 million in 1984 (Table 2.8). The estimate is derived by mutliplying gross benefits paid out by all medical insurers (including medical/surgical fees, room charges and miscellaneous items such as pathology and operating theatre charges) by a factor of 100/70 to include expenditure by uninsured individuals (see footnote to

Table 2.8 **Private expenditure on acute medical care, UK**

	£ million* (current prices)	£ million (1984 prices)†
1984	535	535
1983	457	479
1982	383	420
1981	293	349
1980	192	256
1979	126	199
1978	102	183
1977	98	190
1976	79	177
1975	69	179

Notes:
* Estimated by multiplying gross benefits claimed from medical insurers (room charges, surgical and medical fees and miscellaneous services such as pathology and operating theatres) by a factor of 10/7. The multiplying factor can be justified by reference to two sources: a) the Royal Commission on the National Health Service (HMSO 1979) estimated that about a third or more of all private in-patients were not covered by health insurance. b) General Household data from 1982 indicate that 44 per cent of insured persons' in-patient episodes are located in the private sector and 2 per cent of non-insured persons'. Applying these percentages to the known proportions of medically insured and uninsured people gives a comparable ratio of total to insured private in-patients of about 3:2. The factor of 10/7 follows from adjusting for charges, which are somewhat lower in NHS pay beds than in independent hospitals.

† Adjusted by retail price index excluding food.

Table 2.8). Though crude, this provides acceptable order of magnitude estimates.

Growth of the private acute sector, so defined, has averaged 25 per cent per annum since 1975 in cash terms and 13 per cent at constant prices, after adjusting by the retail price index. Growth in volume of services will have been rather less, because of relatively high rates of price inflation in health care.

Activity of the private acute sector

Elective surgery

Very little was known about the activity of the private acute sector (for example, how many operations were performed in independent hospitals, and of what sort) until an important survey carried out by the Medical Care Research Unit at the University of Sheffield in 1981. Though now 4 years old the data still provide the best available snapshot view of the sector (Williams *et al* (1984), Nichol *et al* (1984)). Their study was based on samples of hospital records in 148 out of the 153 independent hospitals with operating theatres in England and Wales at the time. Of the remainder, 2 refused to co-operate and 3 had closed down before they could be approached.

Termination of pregnancy was the most frequently performed operation in the independent sector, accounting for 28 per cent of the total, though most of these were concentrated in specialised abortion clinics. Terminations apart, the case-mix was typically elective surgery, of the type frequently found on NHS waiting lists. Few were major or complex and relatively few were cosmetic (Table 2.9).

Table 2.9 **Distribution of certain operations in independent hospitals, residents of England and Wales, 1981.**

Operation or procedure	Estimated number	%
Lens operation	3,846	1.3
Other eye operation	3,684	1.3
Tonsillectomies and adenoidectomies	8,967	3.1
Other ear, nose, and throat	11,000	3.8
Dental extraction	7,186	2.5
Coronary artery bypass	363	0.1
Heart valves, septum	82	<0.1
Abdominal hernia repair	9,173	3.2
Major intra-abdominal	5,965	2.1
Haemorrhoidectomy and other anal, perianal	5,524	1.9
Appendicectomy	1,644	0.6
Prostatectomy	2,720	0.9
Vasectomy	7,956	2.8
Circumcision	2,591	0.9
Dilation and curettage	10,573	3.7
Hysterectomy	8,939	3.1
Division/ligation/occlusion oviducts	3,982	1.4
Termination of pregnancy	64,293	22.4
Other gynaecological	7,683	2.7
Arthroplasty	6,141	2.1
Other orthopaedic	16,687	5.8
Ligation/stripping varicose veins	7,237	2.5
Plastic	5,857	2.0
Other skin, subcutaneous	15,482	5.4
All endoscopic examinations	12,031	4.2
All other operations or procedures	37,630	13.1
No operation	16,893	5.9
Not known	2,886	1.0
All operations or procedures	287,015	100.0

Source: Williams *et al* (1984).

As to the patients, the independent sector primarily serves the domestic British population. Sixty-nine per cent of abortions and 90 per cent of all other operations were on UK residents. As compared with the NHS, young and middle-aged adults were over-represented in independent hospital populations and children and elderly people under-represented.

After adding in NHS pay beds, the Sheffield team found that 13.2 per cent of all elective surgery (excluding abortions and operations on foreign citizens) were undertaken privately in 1981, 9.5 per cent in the independent sector and 3.8 per cent in NHS pay beds (Table 2.10). Proportions were much higher for some operations. Thus more than a quarter of all domestic elective total hip replacement was undertaken privately in 1981. These numbers were much higher than commentators had previously given credence to and contradict the NHS Royal Commission's assertion in 1979 that the impact of the private sector was, even at that time, at most marginal and local.

Table 2.10 **Operations by sector of treatment England and Wales**

Operation (OPCS code)	Private sector: Independent hospitals 1981 No	Private sector: NHS pay-beds 1980 No	NHS 1980 No	Proportion treated in private† sector (%)
Tonsillectomy and adenoidectomy (233)	4,376	2,445	40,020	14.5
Repair of inguinal hernia (411)	6,969	2,811	60,160	14.0
Haemorrhoidectomy (493)	2,755	477	10,390	23.7
Cholecystectomy (522)	2,593	1,150	30,380	11.0
Hysterectomy (696)	7,131	1,308	31,940	20.9
Total hip replacement (810)	3,890	2,310	17,460	26.2
Excision, internal structure of knee (820)	2,431	831	11,050	22.8
Varicose veins, ligation and stripping (893/4)	7,618	1,662	31,020	23.0
All other operations	124,325	44,476	1,208,450	12.3
All elective surgery excluding abortion	162,088	57,470	1,440,870	13.2

Note: *England and Wales residents, booked or waiting-list in-patients only.
†Independent hospitals and NHS pay beds combined.

Source: Nicholl *et al* (1984)

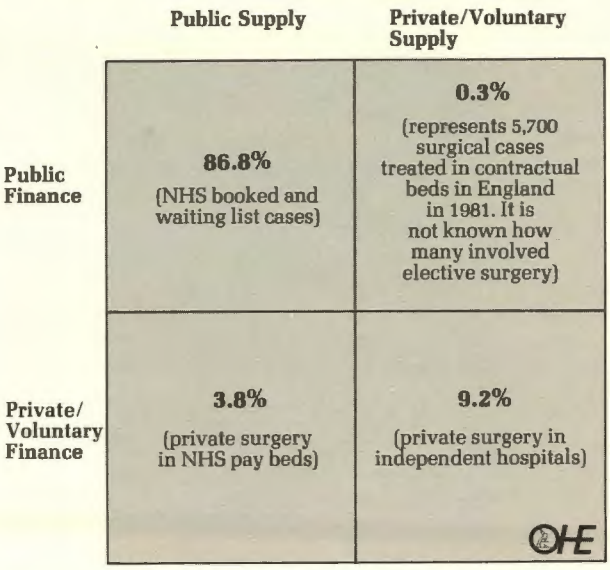
Table 2.11 **Estimated regional variation in the contribution of the private sector* to the total domestic inpatient elective surgical† caseload,§ England and Wales**

Region of residence	Caseload treated in private sector* %
Northern	5.2
Yorkshire	10.8
Trent	10.2
East Anglia	12.3
North West Thames	21.8
North East Thames	12.8
South East Thames	13.6
South West Thanes	21.7
Wessex	14.6
Oxford	18.5
South Western	13.6
West Midlands	13.1
Mersey	13.3
North Western	9.3
Wales	10.3
All regions	13.2

Notes:
*Independent hospitals and NHS authorised pay-beds.
†OPCS classification of surgical operations. Termination of pregnancy (742/741.1) excluded.
§Based on 1980 HIPE data and 1981 independent hospitals data.

Source: Nicholl *et al* (1984).

Figure 2.8 **Segmentation of public and private activity: elective surgery (excluding termination of pregnancy), England and Wales 1981**



Sources:
Nichol *et al* (1984)
DHSS, for contractual beds

Regional variations were broadly as expected, with larger proportions of private treatment in the London region (Table 2.11). Twenty-two per cent of elective caseload in the affluent North-West and South-West Thames Regions was treated privately, compared with 5 per cent in the Northern region.

Variations in median length of stay for some common operations are illustrated in Table 2.12. Whereas median lengths of stay in independent and NHS hospitals were similar, those in pay beds were conspicuously shorter. The authors concluded that part of the apparent relative inefficiency of the independent sector (in comparison with pay beds) may be due to geographical separation of independent hospitals, and consequent delays in decisions on procedures and discharge.

The four way partition between private and public demand and supply for elective surgery is set out in Figure 2.8, using 1981 figures from the Sheffield study. Private sector activity has risen faster than NHS activity since that time and it is likely that the proportion of elective surgery undertaken in independent hospitals or NHS pay beds will now be substantially greater than the 13 per cent recorded then.

Maternity

About 99 per cent of hospital births take place in NHS hospitals, reflecting exclusion from private medical insurance. There were only 277 maternity beds recorded in 1983 in SBH 212 statistics for England. The partition between the sectors is illustrated in Figure 2.9.

Abortions

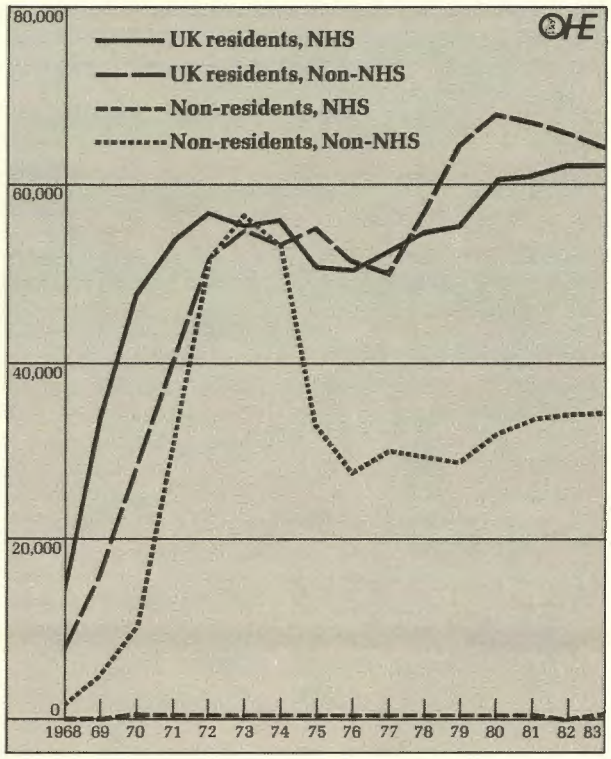
There are some areas of health care where the NHS has never provided a fully comprehensive

Figure 2.9 **Segmentation of public and private activity: maternity beds, England 1983**

	Public Supply	Private/Voluntary Supply
Public Finance	**99%** (NHS Maternity beds occupied by NHS patients)	**0.1%** (NHS patients in contractual beds)
Private/ Voluntary Finance	NA	**1%** (Private patients in independent hospitals and nursing homes)

Sources:
SBH 212 returns, for independent sector DHSS

Figure 2.10 **Abortions, England and Wales**



Source: Office of Population, Censuses and Surveys

service. In the case of termination of pregnancy, the NHS responded quite rapidly in most areas to the demand created by the 1967 Act. But gaps were clearly evident in some areas and these were rapidly filled by both voluntary groups such as the British Pregnancy Advisory Service, which is the largest single provider, and commercial clinics. The commercial clinics, however, tend to concentrate on the non-UK residents.

Trends since 1968 are illustrated in Figure 2.10 and the four way division between private and public demand and supply is set out in Figure 2.11, for UK residents only.

Sterilisation is another area where the NHS has not provided a comprehensive service. Privately

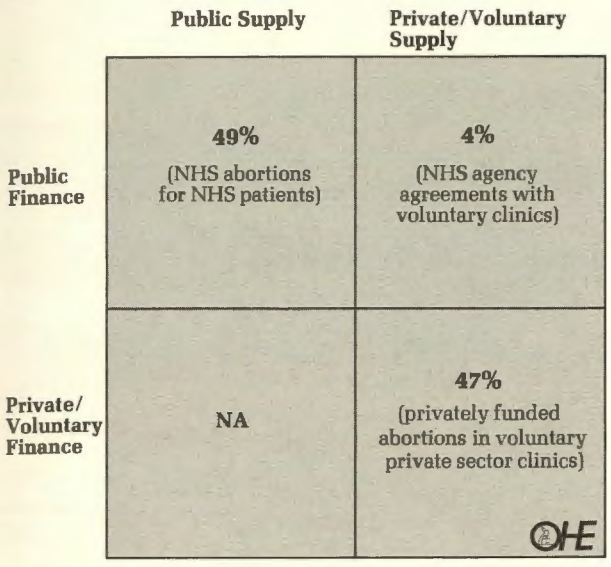
Table 2.12 **Estimated median duration of stay (days) for selected operations, according to sector of treatment*, England and Wales**

	Pre-operative stay			*Post-operative stay*			*Total stay (95% confidence interval)*		
Operation (OPCS code)	*Independent hospitals*	*NHS pay-beds*	*NHS*	*Independent hospitals*	*NHS pay-beds*	*NHS*	*Independent hospitals*	*NHS pay-beds*	*NHS*
Tonsillectomy and adenoidectomy (233)	1.2	0.8	1.5	1.9	1.5	2.1	3.1 (2.8–3.3)	2.3 (1.8–2.6)	3.6 (3.6–3.7)
Repair of inguinal hernia (411)	1.4	1.2	1.5	4.5	3.0	4.0	5.9 (5.6–6.5)	4.2 (3.8–4.6)	5.5 (5.3–5.6)
Haemorrhoidectomy (493)	1.4	1.1	1.6	6.0	3.9	5.8	7.4 (6.8–8.1)	5.0 (4.3–6.7)	7.4 (7.1–7.6)
Cholecystectomy (522)	1.4	1.4	1.7	8.6	8.4	9.0	10.0 (9.3–10.7)	9.8 (8.9–10.8)	10.7 (10.5–10.8)
Hysterectomy* (696)	1.4	1.4	1.9	9.4	8.4	9.3	10.8 (10.4–11.3)	9.8 (9.1–10.4)	11.2 (11.0–11.4)
Total hip replacement (810)	1.7	1.5	2.5	13.2	9.3	17.3	14.9 (14.0–16.2)	10.8 (9.1–12.5)	19.8 (19.4–20.2)
Excision of internal structure knee (820)	1.2	1.2	1.6	4.3	3.7	5.2	5.5 (5.0–6.1)	4.9 (4.2–6.1)	6.8 (6.5–7.1)
Varicose veins, ligation and stripping (893/4)	1.1	1.0	1.5	2.9	2.3	2.7	4.0 (3.7–4.4)	3.3 (2.9–3.7)	4.2 (4.0–4.3)

Note: *Not elsewhere classified.

Source: Williams, BT *et al* (1985)

Figure 2.11 **Segmentation of public and private activity: abortions 1983, UK residents only**



Source: Office of Population, Censuses and Surveys

funded male and female sterilisations account for a substantial proportion of the total, though data sources are insufficiently reliable to permit quantification. Uniquely within the NHS, funds exists in some districts to pay item of service fees to NHS hospital surgeons performing sterilisations on NHS patients. The finance available, however, has never been sufficient to fund more than a part of potential demand.

References

Dobson, F. (1985) Monitoring consultant's commitment to the NHS: A report of two surveys. Press Statement from the Shadow Health Minister.

DHSS (1985) Independent Sector Hospitals, Nursing Homes and Clinics in England.

Hansard (1946) House of Commons Debates 30 April 1946, Col 57, Item 1.

HMSO (1979) Royal Commission on the National Health Service, Report. Cmnd 7615 London.

HMSO (1985) NHS Summarised Accounts 1983–84 (in continuation of House of Commons Paper No 399 of 1983–84).

Lee, M. (1978) Private and National Health Services. London: Policy Studies Institute.

Nicholl, J. P., Thomas, K. J., Williams, B. T. and Knowelden, J. (1984) Contribution of the Private Sector to Elective Surgery in England and Wales. *Lancet* 14 July, pp 89–92.

Williams, B. T., Nicholl, J. P., Thomas, K. J. and Knowelden, J. (1984) Analysis of the work of Independent Acute Hospitals in England and Wales, 1981. *BMJ* 289, 446–448.

Williams, B. T., Nicholl, J. P., Thomas, K. J. and Knowelden, J. (1985) *BMJ* 290, 978–980.

3. MEDICAL INSURANCE

About 70 per cent of acute, hospital based private medical care is believed to be insurance funded (see note to Table 2.8, above). Thus the level of medical insurance provides a fairly good proxy indicator of underlying demand in this sector.

Before the war insurance existed in two forms, the contributory associations with their roots in the nineteenth century, through which free hospital care was provided for low income groups, and the provident societies which developed in the 1930s to meet partial costs of hospital care for the middle and upper classes. When the NHS was instituted in 1946 many of the contributory societies went out of existence while others turned to providing cash sickness benefits to their members. The provident societies, however, recognised a continuing demand for insurance against private medical costs among upper income groups. A number amalgamated to form in 1947 the British United Provident Association (BUPA), which has dominated the health insurance market since.

Table 3.1 sets out the main indicators of activity for the three major provident schemes combined, BUPA, Private Patients Plan (PPP) and Western Provident Association (WPA). Figure 3.1 shows trends in subscribers and persons covered since 1950, with estimates for all insurers for later years, including the smaller provident schemes and commercial medical insurers. Nationally, a long term growth trend is clearly evident, punctuated by a plateau in the mid and late seventies, followed by a period of very rapid growth from 1979 to 1981, falling off again in the last few years. The questions posed by these data are, why the long term growth, why the plateau, why the surge in growth at the end of the seventies and why the recent slowdown in growth? Undoubtedly, many complex variables have a bearing, but a plausible explanation can be offered by reference to a few key factors.

Teeling Smith (1984) has pointed out that in the early post-war years expectations of the British

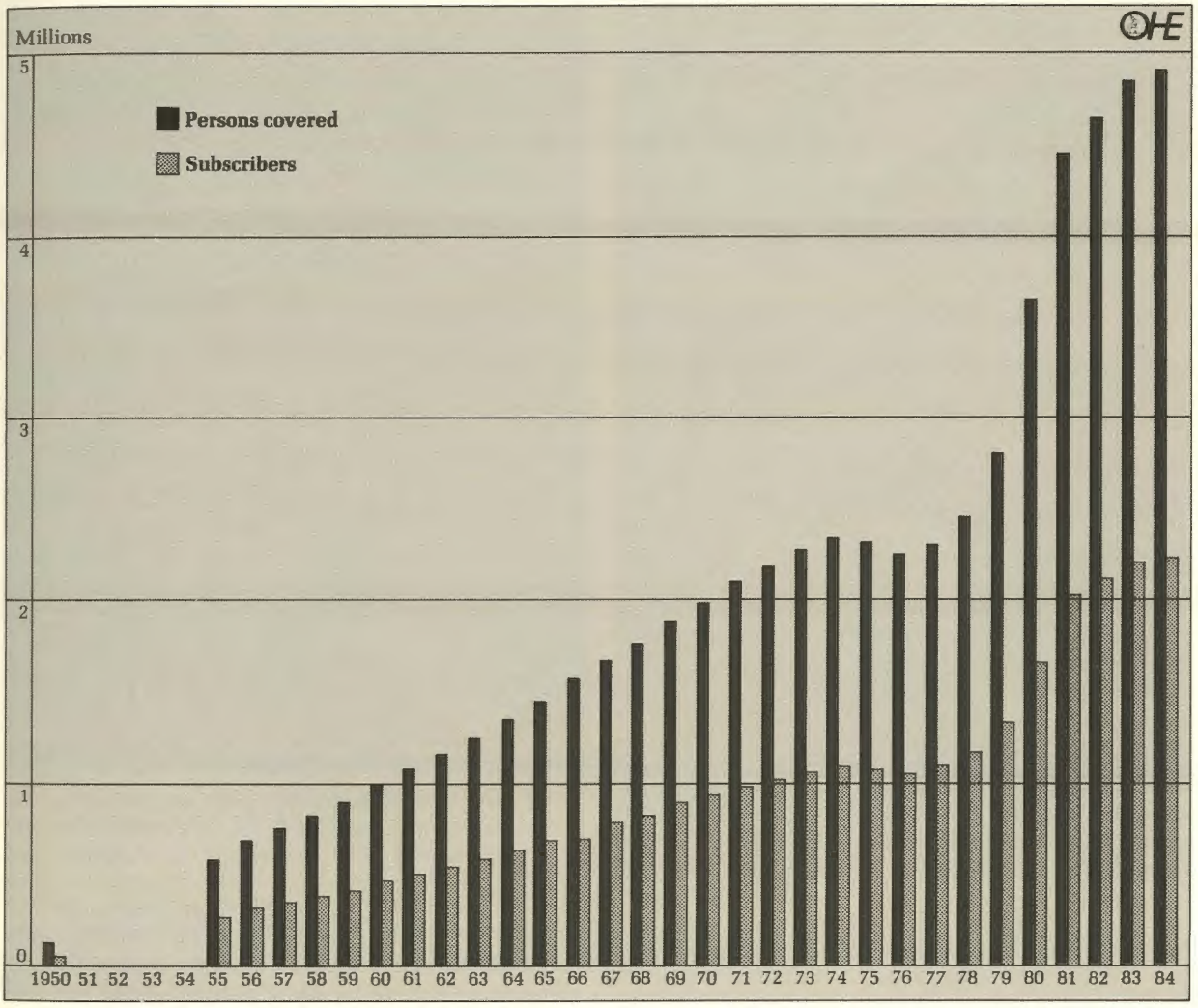
Table 3.1 **Number of people insured and payments for private health care – BUPA, PPP and WPA**

					Persons insured	
	Subscribers at 31 December 000s	*Persons insured at 31 December 000s*	*Subscriptions paid £m*	*Benefits paid £m*	*per 1,000 UK population*	*Benefits paid as % of subscriptions*
1955	274	585	1.8	1.5	11.5	84
1956	318	680	2.3	1.9	13.3	85
1957	354	755	2.8	2.3	14.7	84
1958	387	825	3.3	2.8	16.0	84
1959	419	895	3.9	3.2	17.2	84
1960	467	995	4.5	3.8	19.0	84
1961	504	1,070	5.2	4.4	20.3	84
1962	546	1,165	6.0	5.2	21.9	87
1963	587	1,250	7.0	6.2	23.3	89
1964	632	1,345	8.0	7.1	25.0	89
1965	680	1,445	9.1	8.0	26.7	88
1966	735	1,565	10.7	9.4	28.7	88
1967	784	1,670	12.5	10.9	30.5	87
1968	831	1,770	14.5	12.2	32.2	85
1969	886	1,887	17.3	14.9	34.1	86
1970	930	1,982	20.4	16.9	35.8	83
1971	986	2,102	23.8	19.7	37.8	83
1972	1,021	2,176	28.9	24.5	39.0	85
1973	1,064	2,265	36.2	29.2	40.5	81
1974	1,096	2,334	45.2	36.2	41.7	80
1975	1,087	2,315	54.9	45.6	41.4	83
1976	1,057	2,251	70.6	53.2	40.3	75
1977	1,057	2,254	90.7	64.7	40.4	71
1978	1,118	2,388	105.1	67.7	42.8	64
1979	1,292	2,765	122.1	84.0	49.5	69
1980	1,647	3,577	154.3	127.6	63.9	83
1981	1,863	4,063	204.5	195.1	72.5	95
1982	1,917	4,182	285.9	244.9	74.7	86
1983	1,954	4,254	355.4	291.4	75.6	82
1984	2,010	4,367	413.4	341.0	77.6	82

Notes: All figures relate to aggregates of BUPA, PPP and WPA. *For total private health spending, see Figure 2.12.

Sources: BUPA, PPP, WPA. Lee Donaldson Associates.

Figure 3.1 **Numbers medically insured, UK. All insurers (estimates) 1977–84, BUPA, PPP and WPA only 1950–76**



Sources: Provident Scheme Statistics, BUPA, PPP and WPA from 1977; Lee Donaldson Associates for previous years. Estimates for insurers other than BUPA, PPP and WPA.

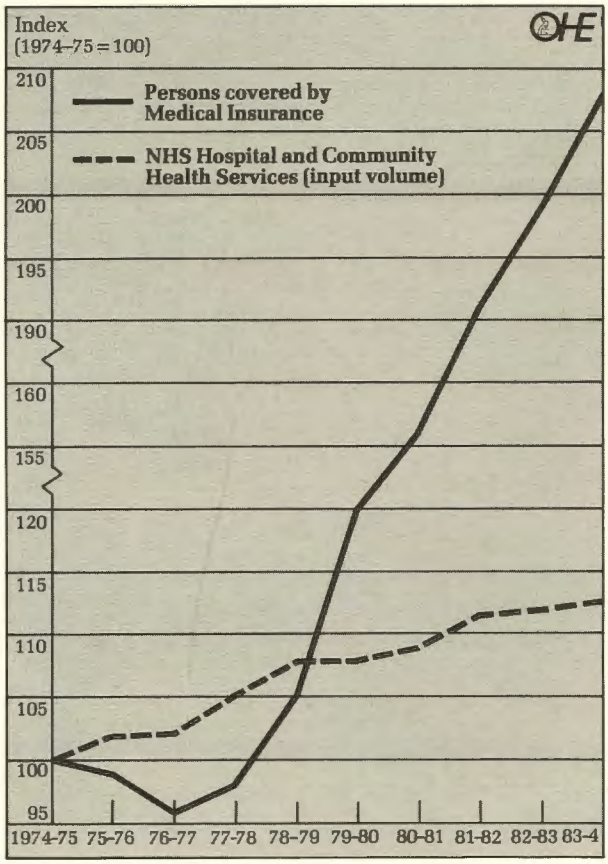
public were relatively modest. But with increasing affluence, holidays abroad and access to a much wider range of goods and services, expectations have risen faster than standards of amenity and service in NHS hospitals. In particular, queues developed for routine surgery and few NHS patients were offered the convenience of rapid access to treatment at the time of their choice. It is this which provides a rationale for the apparently paradoxical phenomenon of private sector growth against the background of a free and comprehensive NHS.

The interruption, in the mid-seventies, of the secular growth trend cannot be explained by adverse movements in the cost of insurance. Indeed, this was a time of unusual stability in insurance costs associated with a price war between medical insurers (Figure 3.3). Broader economic problems of rapid inflation and falling real income in the period following the first oil price shock may have had some effect (Lee 1978). But the most likely explanation is that the uncertainties engendered by the pay beds dispute of 1975, and the attempt by the Labour government to phase private treatment out of NHS hospitals under the Health Services Act of 1976, was directly responsible for arresting the growth of private medical insurance.

The upward trend began to reassert itself in 1978 and 1979 and in the 'boom' year of 1980 net growth in subscribers reached 26 per cent. In part, this very rapid growth may have represented 'catching up' after a period of depressed market activity. Another explanatory factor may have been price stability in the immediately preceding period. Perhaps more important was the impact of new private facilities which were coming on stream, independent of the NHS. These had been stimulated by the phasing out of NHS pay beds and provided visible evidence that the private treatment promised in insurance brochures could actually be delivered. It is likely that supply of new facilities and demand for medical insurance were mutually reinforcing in this period.

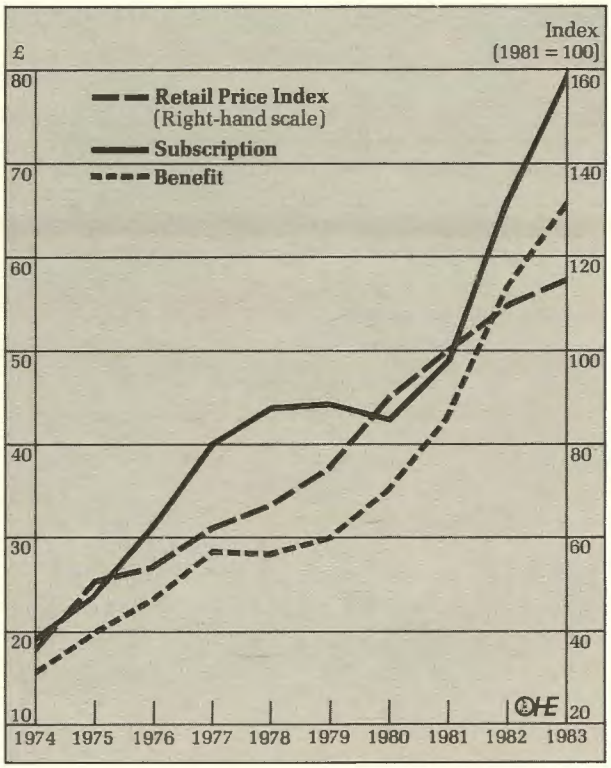
The election of a Conservative government in 1979 undoubtedly had a powerful influence on

Figure 3.2 **Volume expenditure on NHS hospital and community services and persons covered by private medical insurance, Indices, 1974–75 = 100**



Sources:
Public expenditure on the Social Services, Sixth Report from the Social Services Committee, Session 1984–85, HMSO, Figure 1, Page 9.
Provident Scheme Statistics (BUPA, PPP, WPA only).

Figure 3.3 **Medical insurance: average benefits and subscriptions per person covered (all insurers)**



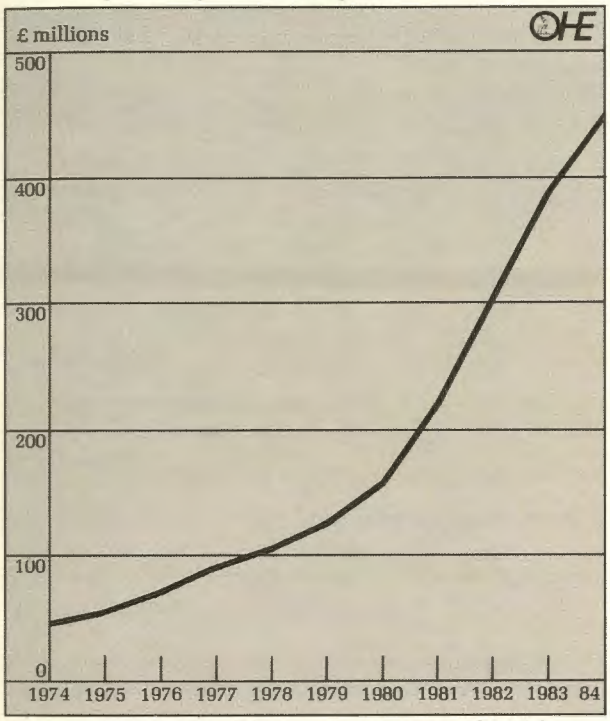
Source: BUPA estimates November 1984

confidence within the industry, and presumably on purchasers of medical insurance as well. It may seem anomalous that rapid growth in the market coincided with rising unemployment and continuing recession in the economy as a whole. But purchase of medical insurance remains concentrated among employed persons in higher socio-economic groups. For them, the period since 1979 has been one of significant income growth.

Clearly the broad level and standard of service in the NHS must be a prime long-term determinant of the demand for medical insurance and decisions to opt for private treatment. However, what evidence there is is equivocal regarding the impact of marginal and short-term changes in the NHS. The boom in private medical insurance may have been encouraged by widespread industrial unrest during the 'winter of discontent' in 1979. But no similar stimulus to private insurance was apparent following the consultants' 'work to contract' in 1975, which probably had a much greater direct impact on the availability of routine hospital treatment. Nor was the NHS strike of 1982 followed by any surge in new subscribers. As regards funding of the NHS, there is no evidence of any inverse relationship between growth in NHS Hospital and Community Health Services and expansion of insurance coverage during the mid seventies and early eighties (Figure 3.2). Nor did waiting times for elective surgery change significantly, though perceptions of longer waiting times, and of NHS shortcomings generally, may have been fostered by frequently inaccurate media reports.

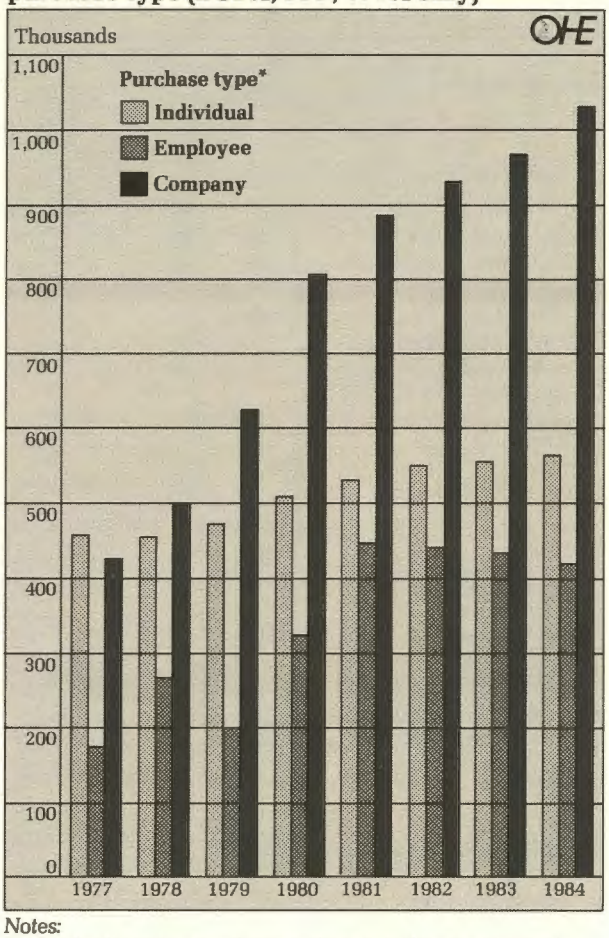
The pace of growth between 1979 and 1981 was sufficient to fuel speculations of perhaps 10 million medically insured people by the mid eighties. In the event, however, growth levelled off in 1982. This has universally been attributed to escalation of insurance costs. Analysis of price movements is problematical because of complexity of terms and conditions of different insurance contracts. But the broad picture of premium inflation is illustrated in Figure 3.3. Between 1981 and 1983, when the retail price index rose by 14 per cent, the average subscription cost per person covered rose by some 61 per cent. Two elements contributed, increased volume of claims and increased costs of medical treatment, though claims volumes are not published and it is not possible to separate the impact of the two components. Increases in medical care costs cannot be regarded solely as price inflation. In large part they reflected new, better equipped and more expensive facilities coming on stream. As regards claims volume, it is widely reported that new subscribers attracted during the boom years, particularly from 'blue-collar' unions,

Figure 3.4 **Medical insurance subscription income growth (all insurers) UK**



Source: Estimates for all insurers based on Provident Scheme Statistics

Figure 3.5 **Medical insurance subscribers by purchase type (BUPA, PPP, WPA only)**



Notes:
*Individual purchases: all subscribers enrolling by personal application and through 'groups' arranged by professional or trade associations.
Employee Purchase: All subscribers enrolling through a scheme organised by the subscriber's employer but where the employee pays his or her own subscription, whether direct to the Association or via the subscriber's employer.
Company Purchase: All subscribers enrolling through a scheme organised by the subscriber's employer, where the employee's (but not necessarily the dependants') subscription is paid by the employer.
Source: Provident Scheme Statistics, BUPA, PPP, WPA

proved to have relatively high levels of morbidity and propensities to claim. In addition the new consultant contract for the first time allowed full-time NHS consultants to earn up to 10 per cent of their gross income on private practice. This is believed to have encouraged higher utilisation rates in the privately insured population generally.

Unexpected cost escalation was such that operating margins were tightly squeezed. The effect is illustrated in Figure 3.3 and Table 3.1. Benefits paid reached 95 per cent of subscriptions earned in 1981 for the three major provident schemes combined. The response of BUPA and other insurers was substantially to increase premium levels. This in turn has had the effect of arresting the rapid volume growth of the boom years. Maynard (1984) points out that the lesson of the early eighties is that the market works: the period of rapid growth from 1979–1981 was strangled by cost and premium escalation. This in turn explains the industry's present concern with cost containment.

Pressure on insurers' margins in the early eighties found particularly symbolic expression in the announcement of an underwriting loss by BUPA, the market leader. The extent of the insurers' problems, however, and by association the problems of the private sector as a whole, were grossly exaggerated in some media reports. Table 3.1 and Figure 3.3 illustrate how adequate margins were in fact re-established in 1982 and 1983. Significant volume growth remained, moreover, even during a period of substantial price inflation.

Premium income growth is illustrated in Figure 3.4. Because of cost inflation, rates of growth between 1982 and 1984 remained high in value terms.

The industry believes it has now entered a period of steady but relatively modest growth. Subscribers are estimated to have increased by about 3 per cent in 1984 to give something in excess of 5 million persons covered by private medical insurance in the UK at the end of that year, paying a total of some £450 million in premiums.

The figure of 5 million, however, based on aggregation of cover reported by all insurers, may overestimate the true figure by about 10 per cent. The General Household Survey (GHS) is a methodologically superior alternative data source for medical insurance cover. If more timely, it would be the data series of choice. It indicated 7 per cent coverage of the population in 1982, equivalent to about 4 million for the UK as a whole. This compares with the provident schemes' figure of 4.5 million in 1982 when estimates for the smaller, commercial insurers are added in. The inconsistency may be caused by the multiplying factor used by provident schemes, who frequently do not know how many dependants are covered through

Table 3.2 **Private medical insurance cover by sex, age and socio-economic group: percentage of persons who were: a) policy holders, b) covered by private medical insurance**
Persons aged 16 and over *Great Britain: 1982*

Socio-economic group*	Males				Females				Total			
	16–44	45–64	65 and over	Total	16–44	45–64	65 and over	Total	16–44	45–64	65 and over	Total
a) Percentage who were policy holders												
Professional	18	31	[13]	23	4	2	[1]	3	11	18	[14]	14
Employers and managers	19	23	8	19	3	5	5	4	11	15	7	11
Intermediate and junior non-manual	10	12	2	9	3	5	4	4	6	8	3	6
Skilled manual and own account non-professional	3	3	nil	2	1	1	1	1	2	2	Ø	2
Semi-skilled manual and personal service	1	1	Ø	1	1	1	Ø	1	1	1	Ø	1
Unskilled manual	Ø	1	1	1	nil	1	nil	Ø	Ø	1	Ø	1
All persons	6	9	3	6	2	3	2	2	4	6	2	4
b) Percentage who were covered by private medical insurance												
Professional	20	32	[13]	24	20	27	[8]	22	20	30	[21]	23
Employers and managers	19	24	8	19	20	22	10	19	19	23	9	19
Intermediate and junior non-manual	11	13	3	10	9	11	5	9	10	12	4	9
Skilled manual and own account non-professional	4	3	Ø	3	3	3	1	3	3	3	Ø	3
Semi-skilled manual and personal service	2	2	Ø	2	3	1	Ø	2	2	2	Ø	2
Unskilled manual	4	1	1	3	2	2	nil	1	3	2	Ø	2
All persons	8	10	3	7	8	8	3	7	8	9	3	7

Source: General Household Survey 1982. *Note:* Percentages in square brackets are based on small numbers.

a particular policy. Though absolute provident schemes' figures may be overestimates, trends remain unaltered.

Much of the growth in recent years has been generated by 'company' or 'employee' purchase (Figure 3.5). Private medical insurance is in this sense linked with employment and many commentators see it primarily as a fringe benefit over which consumers do not exercise direct control, or as an occupational health phenomenon, the main perceived purpose of which is to return key employees to work as soon as possible. Closer analysis, however, does not support these views.

Though 'company purchase' is typically an employer decision, the insured person himself frequently has to pay for cover to be extended to his family. Individual consumer decisions are also at the root of 'employee purchase', where the employer merely provides the administrative umbrella while the employee pays. GHS data from 1982 indicate that only about 30 per cent of all medical insurance policies are wholly paid for by an employer and about a further 15 per cent are partly employer paid. Most medical insurance, therefore, is paid for directly by consumers. The phenomenon of opting out of the NHS is primarily consumer led. The thesis of rapid rehabilitation of key employees, as a rationale for health insurance, certainly has some merit. But only a relatively small proportion of insurance funded private treatment is carried out on the archetypal business executive while Horne (1984) found that only 36 per cent of his sample of private patients said they were the main earner of the family. Health care in the private sector, as in the public sector, must be seen primarily as a consumption good, not as investment in human capital.

Future market trends are inevitably speculative. The high growth of the recent past is unlikely to be re-established without an extension of tax relief on insurance premiums. At present, company subscribers to health insurance benefit from relief on fringe benefits where their salary does not exceed £8,500 per annum. The possibility of extension has, for the present, been discounted as politically impracticable by the industry.

Data from the General Household Survey (GHS) suggest there remains substantial untapped demand for private medical insurance in the provinces of Britain, (Tables 3.2 to 3.4). They illustrate how private medical insurance cover is at its highest among middle-aged professional people in the South East of England. Most striking is the social class gradient in insurance cover. Twenty-three per cent of all 'professional' persons were covered in 1982, rising to 30 per cent for those aged 45–64. In contrast, only 2 per cent to 3 per cent of persons classified as 'skilled, semi-skilled or unskilled manual' had medical insurance.

Of particular interest is an analysis of variation in cover by region and socio-economic group which was carried out on the 1982 GHS data (Table 3.4). This calculated the ratio of observed to expected medical insurance rates in each of the standard regions of Britain. The 'expected' rate for each region was 'that which would occur if the percentage insured in each socio-economic group were the same in the region as in Great Britain as a

Table 3.3 **Private medical insurance cover by sex and region: percentage of persons who were: a) policy holders, b) covered by private medical insurance**

Persons aged 16 and over

Standard region	*a) Percentage who were policy holders*			*b) Percentage who were covered by private medical insurance*		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*
England						
North	3	1	2	3	3	3
Yorkshire and Humberside	6	2	4	7	7	7
North West	6	2	4	7	7	7
East Midlands	5	1	3	6	5	5
West Midlands	6	2	4	8	6	7
East Anglia	6	2	4	6	6	6
Greater London	10	4	7	10	9	10
Outer Metropolitan Area	12	4	8	14	12	13
Outer South East	8	3	5	8	9	9
South West	7	3	5	8	8	8
Wales	3	1	2	3	2	3
Scotland	3	1	2	3	3	3
Great Britain	7	2	4	7	7	7

Source: General Household Survey 1982.

Table 3.4 **Private medical insurance cover by region: observed rates as a percentage of expected rates***

Persons aged 16 and over — *Great Britain: 1982*

Standard Region	$\frac{\%\ observed}{\%\ expected} \times 100$
England	
North	50
Yorkshire and Humberside	103
North West	106
East Midlands	83
West Midlands	101
East Anglia	94
Greater London	125
Outer Metropolitan Area	156
Outer South East	118
South West	109
Wales	43
Scotland	43
Great Britain	100

Note:

*The expected rate for each region is that which would occur if the percentage insured in each socio-economic group were the same in the region as in Great Britain as a whole.

Source: General Household Survey 1982.

whole'. The results show much lower than 'expected' insurance cover outside London and the South East, in particular in the North, the Midlands, Wales and Scotland. It is this which suggests untapped potential demand in the provinces. Experience elsewhere indicates that the creation of new private medical facilities induces demand for medical insurance. Thus recent hospital development activity in provincial locations may bring increased medical insurance cover in its wake.

Under the present Conservative administration, with its sympathetic approach to private medicine, the legislative and regulatory environment is likely to remain favourable for private medical insurance. If there is a threat to traditional medical insurance it is innovation within the marketplace itself. Thus private primary care or private health maintenance organisations on the United States model would circumvent ordinary insurance funding mechanisms. Should such provider organisations become established in significant numbers, drawing on the presumably limited pool of consumer funding available for health care, they could present a real threat to insurers' markets in Britain in the long-term future, as they have in the United States in the recent past.

Moreover, expansion of the medical insurance market in Britain has begun to generate some significant structural changes and variations in insurance packages. Until very recently, private medical insurance could be virtually identified with the activities of the three major provident associations, BUPA, PPP and WPA. BUPA dominated the group, not only in market share, but also by acting as market leader in the terms and conditions of insurance contracts. More recently, the monopoly of the big three has been challenged by commercial insurers. Some are small specialist insurers. Others are major institutions for which medical insurance represents a small but potentially lucrative new area of activity. At the end of 1983 the non-profit provident associations were estimated to control 93.5 per cent of the market, with the remaining 6.5 per cent in the commercial sector (Table 3.5).

Whereas the smaller provident associations have generally been content to follow BUPA's lead in contract terms and conditions (the fine print sometimes being identical) the commercial insurers have been more aggressive, experimenting with new approaches and packages. A wide variety of competitive devices are available to them. Co-payments and excesses can be used to deter claims

Table 3.5 **Medical insurance market shares, UK 1983**

Non-profit	*Benefits paid £000*	*% of Total*
British United Provident Assoc	191,261	59.9
Private Patients Plan	79,637	25.0
Western Provident Assoc	20,495	6.4
Bristol Contributory Welfare Assoc	4,618	1.4
Exeter Hospital Aid Society	604	0.2
Civil Service Medical Aid Assoc	1,489	0.5
Provincial Hospital Services Assoc	270	0.1
Private Patients Anglia	25	—
Total Non-profit	298,399	93.5
Commercial		
Allied Medical Insurance	2,000	0.6
Crusader	7,700	2.4
Mutual of Omaha	3,400	1.1
Iron Trades	2,600	0.8
Crown	6	—
Orion, MT Medex	5,100	1.6
Total Commercial	20,806	6.5
Total Non-profit/Commercial	319,205	100.0

Source: BUPA estimates.

and reduce premiums, extensiveness of cover can be tailored by excluding marginal risks such as psychiatric care and low risk clientele may be selected. These are seen by commercial insurers both as a means of 'creaming' market share from the larger provident associations and of creating new business in an increasingly cost conscious environment. Among the provident associations, PPP has introduced selectivity into one of its plans which restricts reimbursement to admissions where a 6 week NHS waiting time exists. BUPA, as the market leader, has been reluctant to experiment in this way, preferring to retain as unified a structure of subscriptions and benefits as possible and focusing its cost containment strategies not on controlling consumer demand but on influencing the behaviour of suppliers of private medical care. In part at least its position as market leader dictates philosophies and strategies which are different from those of the smaller insurers.

The challenge posed to the providents' present dominance lies partly in commercial insurers' flexibility, their willingness to unbundle and tailor insurance packages to consumers' and suppliers' specifically defined needs. It also lies, according to some commentators, in the capacity of commercial insurers and other interested parties, such as employee benefit consultants, to engage in more vigorous cost containment activities than the provident associations have been willing or able to undertake.

One option which has been the subject of much recent attention is 'self insurance' for substantial company or group clients. Money that would have been paid in ordinary insurance premiums is instead placed with a trust fund, with or without reinsurance to avoid catastrophic loss. This is in principle no different from 'cost plus' schemes run by the providents, but administration charges can be substantially lower. Self-insurance, however, is unlikely to become established without clarification of the tax position. Under existing rules the Inland Revenue reviews each case individually and there remains the possibility that any benefits received by an individual from a self-insurance scheme (which could run into many thousands of pounds) may be deemed to be taxable.

The benefits of self-insurance alone are, in any case, restricted to the relatively small administrative element of insurance premiums. Much more substantial potential savings may be realised by rigorous monitoring and control systems. These may take the form of comprehensive claims management on behalf of a company or group client, including monitoring of claims, counselling claimants (perhaps suggesting day treatment, or NHS treatment where readily available) and negotiating with doctors and hospitals. Some advocates maintain that this is a job best undertaken by third parties since insurers are reluctant to adopt vigorous control measures and client companies do not themselves have the expertise.

Cost containment is a fairly recent issue in medical insurance and experience will show whether there is a significant demand for such measures. It is certainly true that the provident associations have not favoured such an active role in claims management. Their approach to cost containment remains low key. However, should the market require it, BUPA and the other providents have the data bases, monitoring systems and market strength to compete effectively in this area.

Probably, the continued dominance of BUPA and the other provident associations will depend most critically on broad policy decisions by the major commercial insurers which have been testing the market in recent years. Should they decide to target medical insurance for a major expansion they would undoubtedly be capable of substantial penetration. On the other hand, they may decide that the special character and ethos of medical insurance dictates only a marginal involvement by themselves.

References

Horne, D. (1984) A Survey of Patients in the Private Sector. Hospitals and Health Service Review, March 1984.

Lee, M. (1978) .Private and National Health Services. London: Policy Studies Institute.

Teeling Smith (1984) A New NHS Act for 1986. Office of Health Economics, London.

4. CARE OF THE ELDERLY

Care of the elderly is now recognised as one of society's major challenges, as the tide of demographic change flows inexorably for the remainder of the century and beyond. Recent years have seen substantial shifts from public to private provision and further major shifts are in prospect.

Most elderly people needing some sort of continuing health and social care receive it while living in their own homes, in line with current professional philosophies and declared government policy objectives.

This review does not, however, offer any systematic description or quantification of public, private and voluntary 'community care'. To do so would be to raise difficult conceptual problems, such as how to treat informal, non-marketed care from volunteers, friends and family. Besides, few data are available.[1]

Nor does this review deal with acute, assessment and fast stream rehabilitation services specifically for elderly people, of the type provided by NHS departments of geriatric medicine. Independent hospitals offer little of this type of care.

The focus of attention for this section, therefore, is exclusively on long-term residential or nursing care in one sort of institution or another. It is recognised that this is only one element of a fluid range of services which runs through to sheltered housing and home support. But it is an expensive mode of care, demand for which, it is argued below, is very unlikely to be reduced by any shift to home based services.

Overlapping clientele: a composite market for hospital, residential and nursing care

In a health service context it may seem natural to confine attention to nursing homes, which continue to be registered with health authorities under the Registered Homes Act of 1984 (see Box). But to do so would be to ignore the very substantial overlap in clientele between local authority Part III accommodation, private and voluntary homes registered by local authorities, nursing homes, geriatric wards and psychogeriatric wards in mental hospitals. Admission into one rather than another is frequently a matter of chance (eg Wade, Sawyer and Bell 1981). The divide between residential and nursing care is breaking down, in practice if not in theory, as Part III accommodation (and its private/voluntary counterpart) has taken on a greatly extended role in care of demented people (Batchelor (1984), Centre for Policy on Ageing (1982)). In reality each type of institution can be considered as part of a single composite 'market', which accommodated some 279,000 people over 65 in England and Wales at the end of 1984, representing 3.7 per cent of the elderly population (Table 4.1].[2]

Table 4.1 **Estimated long-stay residents aged 65+ by institution, December 1984**

		England	*Wales*	*England and Wales*
Local authority homes	(1)	102,000	7,200	109,200
Private residential homes	(1)	63,000	3,800	92,800
Voluntary residential homes	(1)	26,000		
NHS, non-psychiatric hospitals (1983)	(2)	31,700	2,500	34,200
Private/voluntary nursing homes	(3)	21,800	1,000	22,800
NHS, psychiatric hospitals	(4)	19,000	900	19,900
Total		263,500	15,400	278,900

Notes and Source:

1 Derived from Residential Accommodation Statistics, DHSS and Welsh Office. Adjusted for non-reporting by local authorities. Extrapolated to December 1984 on the basis of reported private sector registrations and on the assumption of no change over March 1984 for local authority and voluntary homes. See Table 4.2 for independent verification from census data.

2 Aggregate of in-patients in the speciality of Geriatrics in non-psychiatric hospitals NOT classified as acute, mainly acute and partly acute, following methodology used by the DHSS (DHSS 1981). See Table 4.2 for independent verification from census data.

3 Derived, on the assumption of 85 per cent occupancy, from SBH 212 returns for 1982 and 1983 published by the DHSS in 'Independent Sector Hospitals, Nursing Homes and Clinics in England (Tables 4.5 and 4.6), extrapolated to December 1984 on the basis of health authority registrations. About 15 per cent lower than corresponding census data suggest (Table 4.2).

4 Estimated from the 1971 census of patients in psychiatric hospitals, which found 15,442 in-patients diagnosed as Elderly Severely Mentally Infirm, on the assumption of constant age specific occupancy rates. The estimate is not inconsistent with corresponding census data (Table 4.2).

1 The Equal Opportunites Commission estimated in 1983 that there were one and a quarter million informal carers in Britain, most of them women and most of them looking after elderly relatives. There are also known to be some 435 nursing agencies in England and Wales, from an enquiry carried out by the Medical Care Research Unit at the University of Sheffield, preliminary to a major study on the movement of nurses and nursing skills between the public and private sectors. A major part of their business is meeting the demand for privately funded home nursing services. But the size of the private home nursing market in Britain is unknown. Equally, some private and voluntary homes offer the private equivalent of hospital or local authority day care, but the magnitude of activity is unknown. There are examples of contracting out public community care services to the voluntary and private sectors, especially in the social service sector where the government strongly advocates a strategic and facilitating role for local authorities in place of their traditional provider role. Here again, however, there is no reliable information on its extent.

2 'Very sheltered housing' also overlaps functionally with nursing/residential home care. No reliable data are available in this growing area of provision, though numbers remain small compared with the totality of nursing/residential home places.

Legislation and Regulation

On 1st April 1985 the Registered Homes Act of 1984 came into force. It now governs the operation of both residential and nursing homes, superseding the 1980 Residential Homes Act and the 1975 Nursing Homes Act. Nursing homes are registered and inspected by health authorities and residential homes by local authorities.

The new legislation aims to eradicate abuses among a minority of disreputable home owners, to enhance standards generally and to fund regulation from fees payable by proprietors. The principal changes embodied in the Act are:

- residential homes offering board and personal care to 4 or more persons must register with the local authority; all homes offering nursing care must register with the health authority; the maximum fine for operating an unregistered home is raised to £2,000.
- dual registration is for the first time allowed for homes offering both residential and nursing care
- fees for both residential and nursing homes are increased to £100 on initial registration and an annual fee of £10 per registered place
- where a residential home is owned by a corporate body both the owner and the manager should be registered; for a nursing home either the corporate body or the manager, but not both, may be registered
- appeals against refusal of registration or deregistration, formerly heard by magistrates courts, are to be heard by newly established 'registered homes tribunals' (it is believed that the new tribunals will be more likely than magistrates' courts to rule against home owners or managers)
- prolonged absence by the person in charge must be notified to the regulating authority.

The legislation goes to some lengths to maintain a distinction between residential and nursing homes and to debar the former from purporting to offer or actually offering nursing care. Residential homes are defined as those providing board and 'personal care' (ie, assistance with bodily functions). The National Association of Health Authorities' handbook (see below) offers guidance on what is or is not 'nursing'.

The Act recognises that there is a group of residents who can quite easily cross the ill-defined boundary between residential and nursing care, and for whom continuity of care is the paramount objective. Dual registration is intended to be one means of enabling such clients to avoid a potentially traumatic move.

The notion of a joint regulatory agency to cover all types of home was widely canvassed before the Act. Though rejected, it is likely to remain a live issue for future debate.

Accompanying the new legislation, a pair of codes of practice, one for residential homes and one for nursing homes, have been published. Though non-governmental in origin, the Secretaries of State have commended them to local and health authorities. The contents of these documents can, therefore, be regarded as quasi-statutory.

Registration and Inspection of Nursing Homes: A Handbook For Health Authorities is published by the National Association of Health Authorities. It makes no recommendations on single room occupancy and leaves staffing norms largely to the discretion of health authorities. Such minimum staffing levels as it does recommend (at least one 1st level nurse on day duty and one 2nd level nurse on night duty, with on-call night-time back up from a 1st level nurse) are actually lower than in the corresponding code for residential homes, if taken at face value.

Thus registration and inspection of nursing homes, though more expensive and possibly more rigorous than before, breaks little new ground.

Home Life: A Code of Practice for Residential Care is a much more radical document.

Produced by a working party sponsored by the DHSS and convened by the Centre for Policy on Ageing under the chairmanship of Lady Avebury, its recommendations on staffing levels and multi-occupancy of rooms could have profound short and long term effects on the economics of the private home industry.

In the short term, the asset value and even operational viability of some existing homes are threatened. In the longer term, the new regulatory environment may help to shift the competitive balance in favour of larger homes and away from the small proprietor-managed enterprises which presently dominate supply.

The pace of change will depend on how the code is implemented in practice. Local authorities will probably proceed with caution and at a variable pace. No clear pattern has yet emerged.

References

Home Life: a code of practice for residential care. Centre for Policy on Ageing (1984).

Registration and Inspection of Nursing Homes: a handbook for health authorities. National Association of Health Authorities (1985).

Table 4.2 **Persons aged 65+ resident* in non-private households, census returns, England, June 1981**

	65–74		75+		Total 65+	
	No	*% pop*	*No*	*% pop*	*No*	*% pop*
Homes for the old and disabled (1)	25,231	0.58	136,016	4.93	161,247	2.26
NHS hospitals and homes						
Non-psychiatric (2)	5,849	0.13	25,248	0.91	31,097	0.44
Psychiatric (3)	16,540	0.38	20,137	0.73	36,677	0.51
Non-NHS hospitals and homes						
Non-psychiatric (4)	1,443	0.03	10,135	0.37	11,578	0.16
Psychiatric (5)	1,066	0.02	1,189	0.04	2,255	0.03
Other non-private households (6)	8,456	0.19	8,539	0.31	16,995	0.24
Total	58,585	1.34	201,264	7.29	259,849	3.64

Source: Census 1981 Unpublished Tables DT1596U and DT1602U.

Notes: *'Resident' means a person living at the Institution.

1 Includes local authority, private and voluntary homes. The corresponding DHSS figure (Table 3.1) for March 1981 is 158,952, (65+) excluding short stay residents.

2 Approximates to long-stay geriatric patients (independently estimated at 32,468 (65+) in 1981 by the method of Table 3.1).

3 Includes resident patients in both mental illness and mental handicap hospitals. (In-patient statistics from the Mental Health Enquiry for England 1981 estimate all patients over 65 – resident or not – at 39,700 and 6,400 respectively.) The literature (eg, Health Advisory Service 1982) suggests that about half of patients over 65 in mental hospitals (ie, about 19,800) can be classified as 'old long-stay'.

4 Approximates to long-term elderly patients in private and voluntary nursing homes. These are independently estimated for 1981, by extrapolation of SBH 212 data in Table 3.1, at about 13,600 in non-psychiatric hospitals and nursing homes and 400 in psychiatric ones.

5 Includes local authority homes and hostels for mentally ill and mentally handicapped people, as well as private and voluntary mental hospitals and nursing homes. On the basis of SBH 212 returns the latter accommodate about 400 long-stay elderly.

6 This small residual category includes hotels, hostels and other miscellaneous non-private households.

Table 4.3 **Available NHS beds in speciality of geriatrics, England and Wales**

	England		*Wales*	
	*Acute**	*Non-acute***	*Acute**	*Non-acute***
1972	15,581	41,074		
1973	16,580	39,606	784	2,873
1974	16,846	38,566	812	2,871
1975	17,150	38,408	876	2,992
1976	18,044	37,704	947	2,993
1977	18,881	37,048	1,231	2,788
1978	19,652	36,335	1,256	2,818
1979	19,887	35,252	1,358	2,733
1980	19,662	35,334	1,506	2,602
1981	20,066	35,016	1,603	2,565
1982	20,376	35,270	1,607	2,491
1983	21,178	34,623	1,514	2,625

Note:

*'Acute' geriatric beds are defined as those located in hospital types 1, 2 and 3 (acute, mainly acute and partly acute).

**'Non-acute' geriatric beds are those located in all hospital types other than 1, 2 and 3.

This precise estimate raises the question of the identity of the client group, and whether a consistent definition can be sustained in each sector such as to permit valid comparison of private, voluntary and public sector activity. The major difficulty is with the NHS, which does not separate long-term from acute geriatric care in routine statistics. Nor does it maintain statistics on bed occupancy by people with mental disorders of old age in mental hospitals. Superficially crude proxy measures have to be used instead. These are described in the notes to Table 4.1. Remarkably, however, they can be verified independently from unpublished census data (Table 4.2).

Public/private mix: recent trends

The market is partitioned into its private and public elements in Figure 3.1, illustrating the plurality of service provision and the extensive overlap between the private and public sectors. Out of an estimated value of £2,012 million in England and Wales in 1984, about one third was supplied by the private and voluntary sector to self paying individuals, supplementary benefit claimants and residents funded by local and health authorities. Similarly, about one third of all long-term care was privately financed, either in payment for private/voluntary sector accommodation or in the form of local authority charges. No charges are made for NHS care. At the core of public sector activity, 55 per cent of the market value was both publicly financed and supplied.

Figure 4.1 **Segmentation of public and private activity: estimated expenditure on long term care of elderly people (65+) in hospitals, nursing homes and residential homes, England and Wales. Annual expenditure at December 1984**

	Public Supply	Private/Voluntary Supply
Public Finance	**55%** £ million Local Authority Net Revenue and Capital Expenditure 409 NHS (Revenue) Expenditure a) Non-Psychiatric Hospitals 449 b) Psychiatric Hospitals* 250 Total 1,108	**10%** £ million Local Authority Supported Residents (net expenditure) a) Voluntary homes 26 b) Private homes 9 NHS Contractual Beds 10 Supplementary Benefits to Meet Charges in Private and Voluntary Nursing Homes and Residential Homes (excluding mental illness, mental handicap and younger physically disabled) 163 Total 208
Private/ Voluntary Finance	**11%** £223 million Local Authority Income from Charges to Residents	**24%** £ million Charges Paid by Private Residents 462 Charges Paid by Residents Supported by Local Authorities 11 Total 473

*Elderly severely mentally ill only: ie excludes long stay psychotic patients.

Sources:
1) Table 3.1.
2) Personal Social Services Statistics, 1983–84 actuals, 1984–85 estimates, CIPFA.
3) Health Service Costing Returns 1983–84.
4) HMSO (1985) Cmnd 9466, Page 6, for Supplementary Benefit funding (all client groups).
5) OHE Survey of residential and nursing homes.

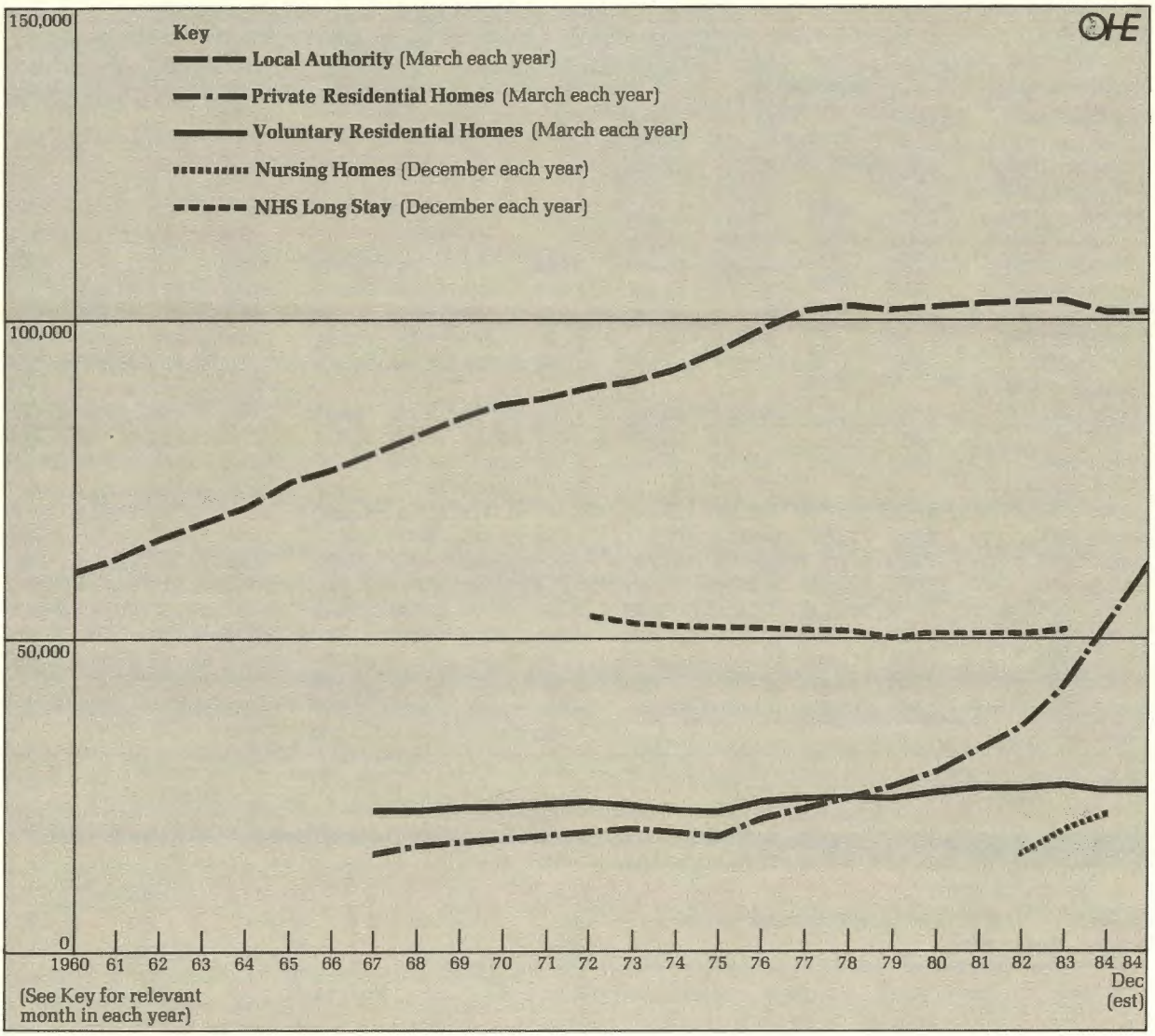
Recent trends in numbers of clientele are illustrated in Figure 4.2. It is clear that public sector provision has either been static or falling since the mid seventies. Net voluntary sector provision of residential care for the elderly has also been static, though this conceals significant growth among some organisations, such as Abbeyfield, and decline among others, particularly homes run by religious orders. Though NHS trend data are unreliable, there is some evidence that long-stay geriatric bed provision has been falling in absolute numbers in England and Wales (Table 4.3), while accommodation in psychiatric hospitals for age related mental illness may have been increasing.

The dynamically growing elements have been private residential homes for the elderly (Table 4.4) and, to a lesser extent, nursing homes (Table 4.5). By the end of 1984 they accommodated 31 per cent of all elderly people in long-term residential or nursing care in England. Inclusion of voluntary residential homes brings the non-statutory share to 43 per cent of the total.

Regional variations

Trends observed in Wales (Table 4.6) are similar to those in England. For Scotland, however, the pattern is very different (Table 4.7). Long-stay NHS provision per unit population is about twice as high as in England and Wales and has continued to grow into the early eighties. Residential accommodation levels are correspondingly lower and,

Figure 4.2 **Residents aged 65+ by type of institution, England 1960–1984**



Sources:
DHSS Residential Accommodation Statistics for local authority provided and registered residential accommodation, with estimates for December 1984 based on local authority registrations.
SBH 212 returns for nursing homes, adjusted for bed occupancy and estimated for 1984 on the basis of health authority registrations.
Sources and methods for NHS residents described in Table 4.1.

though there has always been a significant private/voluntary sector for residential accommodation in Scotland, it has not experienced the rapid growth observed throughout England and Wales. A similarly anomalous pattern is seen in Northern Ireland (Table 4.8) where there is substantial (though static) NHS non-acute geriatric bed provision, relatively low levels of residential accommodation and a significant, but static, voluntary and private sector.

Within England and Wales, the percentage of residential home residents accommodated by private sector homes in 1984 varied between 14 per cent in Greater London and 48 per cent in the South West (Table 4.9). (Greater London is a special case. High property prices have virtually excluded private homes from the inner London area.) Private sector growth is not confined to a few traditional retirement areas. In every region of England (except the Southern Home Counties and the South West, which started from a much higher base) the percentage of residential home activity accounted for by the private sector more than doubled between 1975 and 1984. Similarly, nursing home growth is not a phenomenon confined to the more affluent southern and south-western retirement areas. Between 1982 and 1983, the first years for which data are available on nursing home provision for elderly people, some of the largest proportionate increases were recorded outside the traditional nursing home regions.

Table 4.4 **Residential accommodation for the elderly and physically handicapped, England**

	Local Authority Homes				*Private Residential Homes*				*Voluntary Residential Homes*			
	Homes	*Places*	*Residents 65+*	*Residents all ages*	*Homes*	*Places*	*Residents 65+*	*Residents all ages*	*Homes*	*Places*	*Residents 65+*	*Residents all ages*
December 1960	1,238		60,993	67,948								
December 1961	1,304		62,569	69,362								
December 1962	1,372		65,557	72,408								
December 1963	1,438		68,192	74,905								
December 1964	1,530		70,512	77,065								
December 1965	1,643		74,495	80,574								
December 1966	1,755		76,262	83,095	1,542			16,301	945			27,296
December 1967	1,850		79,082	85,670	1,628	19,624	15,763	16,423	942	29,934	22,266	26,404
December 1968	1,947		81,843	88,242	1,672	21,000	16,618	17,359	960	30,439	22,568	26,495
December 1969	2,026		84,719	90,831	1,706	21,741	17,369	18,021	992	31,582	23,239	27,301
December 1970	2,136		86,857	92,880	1,748	22,492	18,090	18,744	1,020	32,425	23,262	27,818
December 1971												
March 1972	2,230		89,574	95,792	1,808	23,623	18,820	19,557	1,047	33,149	23,887	29,038
March 1973	2,317		90,758	96,848	1,779	24,166	19,750	20,543	1,086	32,717	23,418	28,046
March 1974	2,382		92,462	98,449	1,765	23,955	18,926	19,842	1,055	31,986	22,708	27,304
March 1975	2,459		95,113	100,953	1,770	24,606	18,759	19,652	1,091	33,319	22,454	27,030
March 1976	2,561	110,746	99,027	105,107	1,769	26,412	21,320	22,285	1,025	32,789	23,788	28,580
March 1977	2,601	112,631	101,681	107,511	1,869	28,126	22,921	23,956	1,030	33,022	24,284	29,128
March 1978	2,614	113,574	102,804	108,711	1,946	30,073	24,657	25,806	1,040	33,292	24,526	29,707
March 1979	2,624	113,592	102,086	107,645	2,052	31,998	26,095	27,530	1,060	33,912	24,716	29,920
March 1980	2,638	114,103	102,890	107,852	2,278	35,764	28,854	30,495	1,107	34,957	25,449	30,665
March 1981	2,658	114,921	103,090	108,308	2,519	39,253	31,838	33,691	1,120	36,881	26,037	31,960
March 1982	2,662	115,493	103,668	108,637	2,830	44,346	35,839	37,791	1,119	36,743	26,116	31,867
March 1983	2,669	115,913	103,598	108,569	3,375	51,771	42,142	44,435	1,135	37,613	26,468	32,543
March 1984 (Prov)	2,663	116,282	101,996	106,917	4,041	61,520	52,675	53,963	1,135	38,066	26,005	31,867
December 1984e*					5,100	76,300	62,900	65,500				

Source: Residential Accommodation Statistics, DHSS.

Note: *Extrapolated from March to December 1984 on the basis of reported private sector registrations at the end of the year. These estimated figures are adjusted to take account of non-reporting of certain local authorities' recent data (eg, Kent) in DHSS returns. This adjustment would add 1,200 residents to the England total in March 1984.

Table 4.5 **Registered hospitals and nursing homes, England**

	No of homes and hospitals	*Total registered beds*	*Registered beds for* elderly*
December			
1969	1,001	23,021	
1970	1,004	23,346	
1971	1,061	24,445	
1972	1,065	24,778	
1973	1,073	25,509	
1974	1,091	26,965	
1975	1,127	29,616	
1976	1,097	29,819	
1977	1,103	30,101	
1978	1,111	30,847	
1979	NA	NA	
1980	1,135	31,875	
1981	1,132	32,380	
1982	1,214	34,786	18,197
1983	1,316	38,054	22,554
1984e**	1,490		25,700

Source: DHSS.

Notes:

*Separate data on beds for elderly people became available in 1982 with the new SBH 212 return. In the notes to the return proprietors are asked to include only beds intended for people over 65 requiring long-stay (ie, 3 months and over) nursing care.

**Estimated from registrations with a sample of 89 health authorities at the end of 1984.

Table 4.9 also sets out, in index form, regional variations in levels of long-stay care. There is some evidence that low occupancy rates in one sector are offset by high rates in another, and vice versa. It is also striking that the highest overall occupancy levels are observed in those regions (the Southern Home Counties and the South West) with the highest proportions of private sector provision. It is not known to what extent these high levels of demand are related to ability to pay, social isolation or migration from the metropolitan area into areas of plentiful supply and relatively low prices.

Table 4.6 **Long-term care of elderly people in Wales**

	Residential accommodation for the elderly, physically handicapped and blind Residents, all ages in:		*Nursing Homes (voluntary and private)*	
	Local authority homes (31 March)	*Voluntary and private homes (31 March)*	*Available beds intended for use by elderly*[2] *(31 December)*	*NHS 'non-acute'*[1] *geriatric beds Occupied beds (31 December)*
1976	7,111	1,516		2,836
1977	7,302	1,597		2,641
1978				2,643
1979	7,381	1,686		2,540
1980	7,388	2,135		2,444
1981	7,509	2,226		2,412
1982	7,619	2,344	816	2,337
1983	7,573	2,675	947	2,456
1984	7,569	3,491	1,170 est[3]	

Source: Welsh Office.

Notes:

1 'Non-acute' geriatric beds defined as those located in hospital types OTHER THAN 1, 2 and 3, acute, mainly acute and partly acute.

2 From SBH 212 returns. Respondents were asked to include only beds devoted to long-term nursing care of the elderly (ie, 3 months +).

3 Estimated from registrations among a sample of health authorities at the end of 1984.

Table 4.7 **Residents in homes for the elderly and occupied hospital beds in long-stay geriatrics and psycho-geriatrics, Scotland 1976–1983**

	Homes for the elderly				*Occupied beds in NHS hospitals*	
	Local authority homes (31 March)		*Private and voluntary homes (31 March)*		*Geriatric long-stay (30 September)*	*Psycho-geriatric (30 September)*
	Homes	*Residents*	*Homes*	*Residents*	*Occ beds*	*Occ beds*
1976	239	8,433	178	4,496	6,289	1,767
1977	247	8,712	173	4,552	6,464	1,818
1978	247	8,780	173	4,668	6,710	1,890
1979	244	8,745	176	4,681	6,993	2,231
1980	247	8,790	175	4,635	6,963	2,623
1981	249	8,845	177	4,680	7,329	2,767
1982	249	8,660	178	4,661		
1983	247	8,717	184	4,672		

Sources: Scottish Health Statistics, Common Services Agency. Residential accommodation for the elderly and certain other adults. Statistical Bulletin RI/1985. Scottish Education Department, Social Work Services Group.

Notes:

No data are available on elderly residents in private and voluntary nursing homes. However, in February 1985 there were 99 private and voluntary hospitals and nursing homes in Scotland with 3,109 registered beds. 2,330 of the beds were in nursing homes without surgical facilities. (*Hansard*, vol 74, cols 398–399, 5 March 1985). It is likely that most patients in these nursing homes are elderly, long-term residents.

Table 4.8 **Residents in old people's homes and occupied geriatric beds in hospitals, Northern Ireland**

	Residents in old people's homes		*Occupied beds in non-acute hospitals in geriatric medicine Health and Social Service Boards*
	Run by Health and Social Service Boards	*Voluntary and private*	
December			
1974			1,090
1975			1,084
1976	957	1,059	1,091
1977	1,032	1,035	1,063
1978	1,043	1,054	1,065
1979	1,056	982	1,074
1980	1,200	1,038	1,076
1981	1,263	1,047	1,051
1982	1,357	1,082	1,078
1983	1,351	1,168	1,085

Source:
Department of Health and Social Services, Northern Ireland.

Notes:
No data are available on elderly residents in private and voluntary nursing homes. However, in 1983 there were 15 private and voluntary hospitals and nursing homes in Northern Ireland with 402 registered beds for both acute and non-acute care. In 1974 there were 7 hospitals or nursing homes with 219 beds.

No data are available on in-patients in psychiatric hospitals with mental illness associated with old age.

The sources of private sector growth: local authority resource contraints, supplementary benefit funding and demographic change

The current spate of private sector growth dates from the mid seventies and Anthony Crosland's 'The Party's Over' speech to local authorities. Prior to that, in the heyday of the welfare state, local authority 'Part III' accommodation had become virtually synonymous with residential accommodation for the elderly. From the mid seventies, however, Part III provision plateaued and from that time on the private sector has satisfied the demand for extra places generated by demographic change. The relatively painless shift that took place was facilitated by a requirement, then as now, for local authorities to charge residents according to their ability to pay. This meant that when local authorities started to restrict admissions more rigorously, many of those who would previously have gone into Part III accommodation were able to enter a private sector home without financial disadvantage.

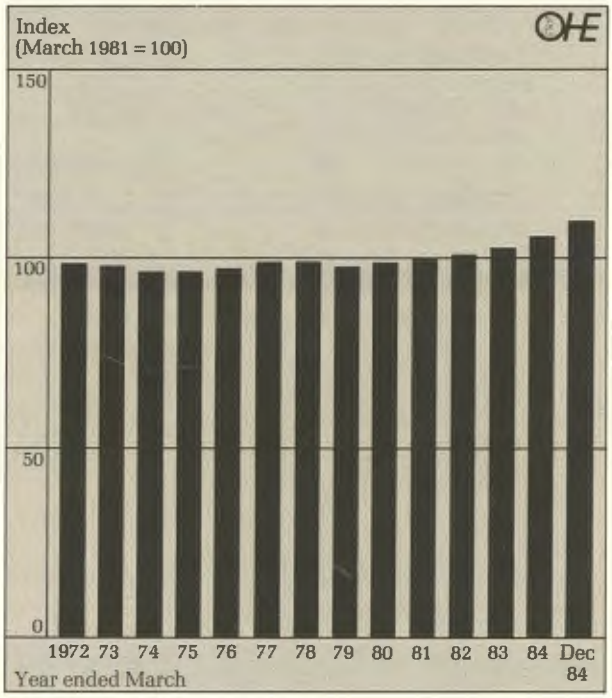
As local authority budgets were increasingly constrained by the recession and the Conservative government's economic policies, substantial pressure built up for other sources of funding, most powerfully articulated by voluntary homes whose local authority agency work had been eroded. Sixty per cent of their residents aged 65+ had been funded by local authorities in England in 1974. By 1983 the proportion had dropped to 34 per cent.

Table 4.9 **Regional variations in long term residential/nursing care of elderly people**

Region	*Ratio of observed to expected* residents (estimated December 1984) index, England = 100*		*Residents in private and voluntary residential accommodation as percentage of all residential accommodation (estimated December 1984)*		
	All institutions providing long-stay residential and nursing care Index	*Local authority and private/voluntary residential accommodation only Index*	*Private %*	*Voluntary %*	*Private and voluntary %*
Northern	.98	.97	16	7	23
Yorkshire/Humberside	.94	.96	22	9	31
North West	1.02	1.01	23	16	39
West Midlands	.91	.90	20	12	32
East Midlands	.90	.87	21	14	35
Greater London	.83	.83	14	26	40
East Anglia	1.02	1.03	32	13	45
Southern Home Counties	1.21	1.21	46	21	67
Northern Home Counties	.88	.88	22	24	46
South West	1.22	1.27	48	14	62
England	1.00	1.00	28	16	44
Wales	.94	.93	NA	NA	31
Scotland	1.07	.69	NA	NA	35

Note: *On application of England age-specific occupancy rates to region's population.

Figure 4.3 **Standardised residency ratios*, England. Local authority, private and voluntary residential homes combined. Index: England, March 1981 = 100**



*Ratio of observed to expected home occupants, the latter being the number that would have been observed in a given year if England 1981 specific rates are applied to the population in that year.

Sources:
1) Residential Accommodation Statistics, DHSS.
2) Local Authority registrations, December 1984.

New funding sources began to materialise in the early eighties in the form of supplementary benefit (SB) support for people with capital resources below £3,000.

In November 1983, changes in SB rules introduced a new and substantially more generous system of local limits for residential and nursing home provision. There seems little doubt that this induced a surge of demand and an increase in the underlying level of demand.

An age-adjusted measure of provision: 'SRR'

Trends in underlying provision, standardised for demographic change over the last decade, are illustrated in Figure 4.3. They relate to local authority, private and voluntary residential accommodation combined, accounting for three-quarters of all long-term care of the elderly. The data are set out in the form of 'Standardised Residency Ratios' (SRRs) representing the ratio of observed to expected residents, the latter calculated by applying age specific residency rates from a base year (1981).

Between March 1981 and March 1984 the 'SRR' for England rose by 5 per cent. By the end of 1984, using estimates based on local authority home registrations, the SRR for England as a whole had risen by a further 6 percentage points. The end 1984 estimate may be subject to error, but confirmation of an exceptional surge in demand in 1984 is available both from published DHSS estimates of the growth in supplementary benefit funding (Table 4.10) and from a survey of 158 nursing and residential homes carried out by OHE at the end of 1984.

According to DHSS estimates, the number of residential and nursing home residents in Britain supported by supplementary benefits rose from 25,800 in 1983 to an annual rate of 42,500 at December 1984, equivalent to 31 per cent of all residents in private and voluntary residential and nursing homes in Great Britain. Even this may underestimate the number of claimants. In the OHE survey, 39 per cent of residents were reported to be in receipt of supplementary benefits, implying a total of 53,000 claimants in Britain at the end of 1984.

It is likely that some of the growth in private residential and nursing accommodation represented a shift from NHS provision, though the magnitude of the increase is too large to be explained by this factor alone. NHS time series are too crude for any precise quantification.

Future trends: continuing private sector growth

Analysis of past trends and present public sector policies provides a sound basis for future projection. Two sets of projections are offered (Figure 4.4). One is based on current (end 1984) age-specific residency rates and the other is based on residency rates ruling in 1981 (and throughout most of the seventies) before the recent surge in provision.

Up to 1990, numbers of elderly people in long-term residential and nursing care are expected to rise by 6,000–7,000 a year in England and Wales. The rate of growth will start to diminish thereafter, though expansion will continue up to the end of the century and beyond. At the same time, the shift away from the public sector, and towards private residential and nursing homes can be expected to continue. On 1984 residency rates, and assuming no net change in public sector provision, the private and voluntary sectors combined will reach 50 per cent of the total in 1991 (or in 1998 on 1981 residency rates).

This pattern, overall growth and a shift to private provision, can be projected with considerable confidence. It is based, on two premises, continued public sector resource constraints and continued pressure of underlying demand for residential or nursing care.

Static public sector provision

Growth in public sector capacity is highly unlikely for both financial and professional reasons. Few if any local authorities plan to increase spending on residential care. Many plan to reduce it. In the health service, though there is a commitment at DHSS and Regional level to transferring resources to the priority services, including the elderly, this does not mean long stay nursing care. Rather, it means upgrading acute, assessment and rehabilitation facilities in the speciality of

Table 4.10 **Claimants in private and voluntary residential and nursing homes**

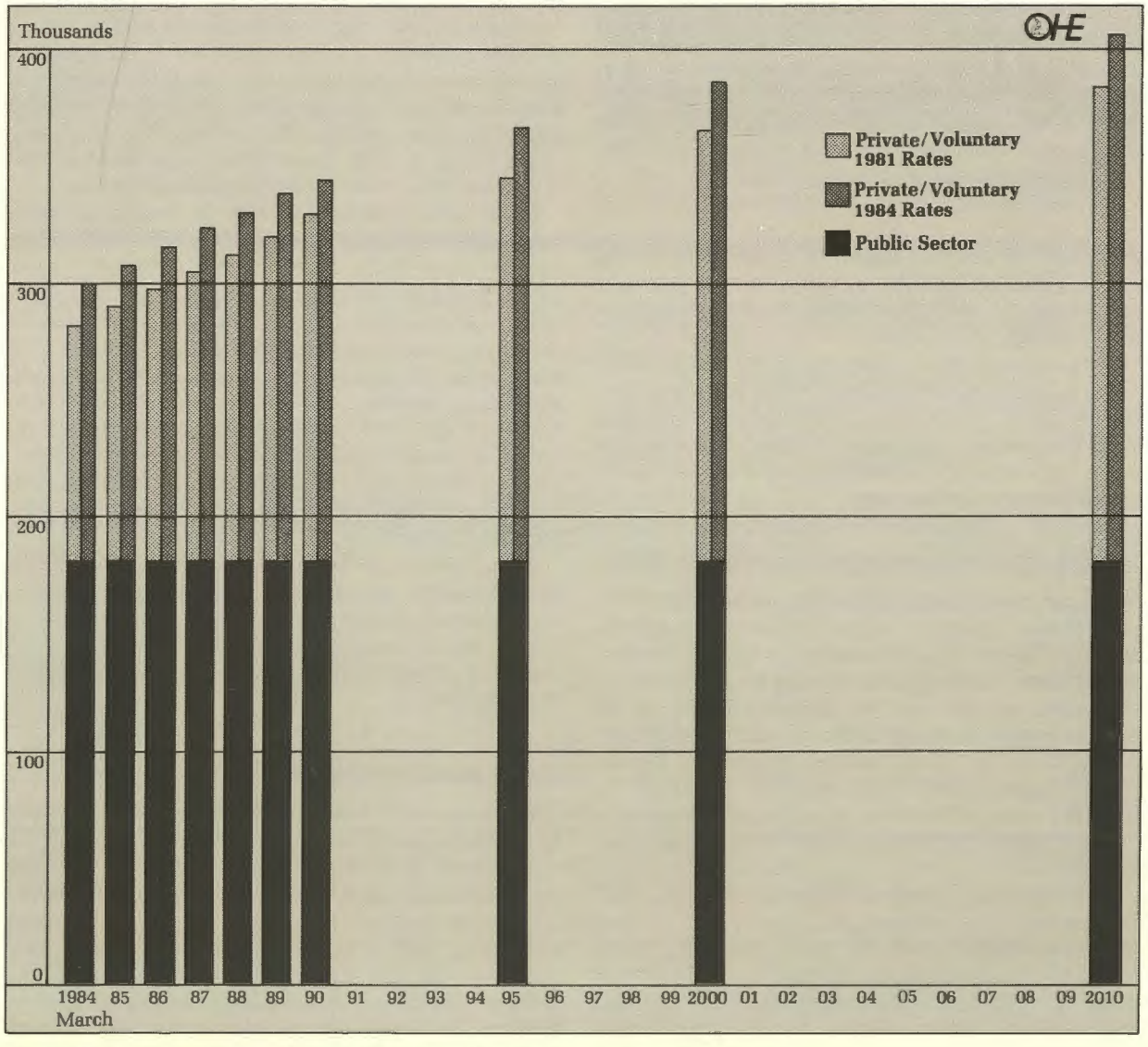
Year	Numbers	% Increase	Average payment £ pw	% Increase	Expenditure £m	% Increase
1979	11,000		18.40		10	
1980	12,000	9	28.10	56	18	80
1981	12,000	—	36.30	29	23	28
1982	15,700	31	47.70	31	39	70
1983	25,800	64	75.80	59	102	162
1984	42,500	65	88.00	16	190	86

Notes:
1 1983 figures are provisional; 1984 figures are estimated and are depressed, for expenditure, by the freeze in limits from September 1984.

2 Average benefit figures are net of non-supplementary benefit income. They do not therefore give an accurate picture of total charges met from all social security sources.

Source: Proposals for the Supplementary Benefit (Requirements and Resources) Miscellaneous Provisions Regulations 1985. Report of the Social Security Advisory Committee. Cmnd 9466, HMSO.

Figure 4.4 **Projected residents, 65+ in hospitals, nursing homes and residential homes Great Britain 1984–2010. Projected using March 1981 and December 1984 age specific rates of occupation.**



Source: Derived by application of estimated age specific rates of occupation to population projections.

Table 4.11 **Continuing care in NHS hospitals for elderly people: planned beds per 1,000 population by region**

Region	*All geriatric beds*	*Continuing care geriatric beds*	*Elderly mentally ill, long-stay*
Northern	No norm yet defined, but interim minimum target of 7.5 per 1,000 65+ for all districts	70% of total geriatric beds expected to be long stay or slow stream rehabilitation	3 per 1,000 65+ but subject to review
Yorkshire	NA	NA	3 per 1,000 65+
Trent	8.5 per 1,000 65+	3.5 per 1,000 65+	2.5 per 1,000 65+
East Anglia	8.4–9.0 per 1,000 65+	2.0 per 1,000 65+ (heavily dependent)	3.3–3.6 per 1,000 65+
North West Thames	Minimum of 17–21 per 1,000 75+	8–12 per 1,000 75+	3–3.5 per 1,000 75+
North East Thames	23.5 per 1,000 75+	70% of total geriatric beds long stay or slow stream rehab.	7.0 per 1,000 75+
South East Thames	NA	NA	3.0 per 1,000 65+
South West Thames	7 per 1,000 65+	NA (assumed that voluntary/private sectors will make a contribution)	1.0 per 1,000 65–74 and 5.0 per 1,000 75+
Wessex	7.7–8.5 per 1,000 65+	70% of geriatric beds for long stay and rehabilitation	2.5 per 1,000 65+ (long stay)
Oxford	8.3 per 1,000 65+	2.8 per 1,000 65+ (long stay only)	3.0 per 1,000 65+
South Western	10 per 1,000 65+ (but interim target of 8.5)	70% of geriatric beds for long stay and rehab	2.5–3.0 per 1,000 65+
West Midlands	No norm recommended	70% of geriatric beds off DGH sites for long stay and rehab.	2.5–3.0 per 1,000 65+
Mersey	6.5–8.3 per 1,000 65+	NA	3.0 per 1,000 65+
North West	8.5 per 1,000 65+	Some long stay facilities needed but aim to reduce dependency	2.9 per 1,000 65+

Source: Regional Health Authority strategy documents.

geriatrics. Consultants, moreover, are unlikely to fight for long stay beds. Their professional satisfaction derives primarily from shorter stay care. Finally, an analysis of regional strategy documents (Table 4.11) indicates that of the four regions which have separately identified future bed provision for 'continuing care' of elderly people, three of them, Oxford, Trent and East Anglia, appear to envisage a level below estimated existing provision, implying a continuation of the downward trend in long-term geriatric beds. The fourth region, North West Thames, gives a target range of 8–12 continuing care beds per 1,000 75+ population, implying neither reduction nor increase over present provision. Throughout the country as a whole, therefore, the established pattern of decline in long-term NHS geriatric care seems set to continue. In compensation, most regions have approved a target of 3.0 beds per 1,000 65+ population for elderly mentally ill, or more, implying some increase there.

Apart from the three experimental NHS nursing homes, many health authorities have programmes for replacing geriatric and psychiatric wards with small homely units, in keeping with current philosophies. However, as Batchelor (1984) has pointed out, few of these units have yet been built. They are unlikely to replace lost facilities one for one and they may prove to be both highly expensive and even operationally unsatisfactory in the case of small homes for mentally confused people, because of the difficulty of maintaining nursing morale without the opportunity for rotation with less demanding forms of care.

The public sector as a whole, therefore, including local authorities and NHS psychiatric and non-psychiatric hospitals, is currently planning for approximate standstill in its own volume provision of long-term residential or nursing care.

Against a backdrop of public sector standstill, there is every reason to believe that age-specific demand for residential and nursing care will remain at least as high as in the seventies, thus generating numerical growth for the remainder of the century and beyond. There is no validity in the view, frequently expressed by Directors of Social Service and by Health Authorities, that community care policies have reduced, and will continue to reduce, the underlying likelihood of people going

into residential or nursing care rather than staying in their own homes. Though not an optimistic conclusion, it is based on an objective analysis of past and present trends, in particular the observed fact that age-specific residential home occupancy rates did not decline during the seventies when substantial investments were being made in both local authority support services and sheltered housing (Figure 4.3). Frequently, the 'ageing' of the residential home population is adduced as evidence for the effectiveness of community care policies in keeping less dependent people in their own homes. But it simply reflects increased numbers of 'old old' people. The 'young old' are no less likely to enter care than they were 10 years ago.

Threats to private sector stability

Public sector economic policy appears to require a growing capacity within the private sector. However, two other policy streams have coincided in 1985 to threaten its stability, First, a new code of practice for residential homes 'Home Life' was introduced in January 1985 as part of a legislative and regulatory package to enhance standards of care and eradicate abuses. It was broadly welcomed by proprietors' associations, but two of its recommendations, one on minimum staffing levels and the other on phasing out of multi-occupation rooms, could if taken at face value make a large part of the 'industry' uneconomic. The proposed phasing out of multiple rooms has provoked the greatest opposition. According to the survey carried out by OHE at the end of 1984, 31 per cent of private residential home residents occupied double rooms and a further 17 per cent were in multiple rooms (Table 4.12).

Interestingly, neither the minimum staffing nor the mutiple occupation issue affects nursing homes. Their code of practice is much less rigorous on those points and may lead to transfer of registration from local to health authorities in some cases.

The second source of instability is the introduction in April 1985 of new national limits for supplementary benefit funding, which in most cases represent a reduction, sometimes substantial, on previous, locally determined limits. Following modification in July 1985, effective from November 1985, these levels are:

Residential care homes for:	*£ per week*
the elderly	120
the mentally ill	130
drug and alcohol misusers	130
the mentally handicapped	150
the physically handicapped below pension age	180
Nursing Home Supplement	50

Table 4.12 **Room occupancy (percentages)**

	Nursing homes		*Residential homes*		*All homes*
Occupancy	*Private*	*Vol*	*Private*	*Vol*	
Single	39	72	52	57	51
Double	33	14	31	21	29
Multiple	28	14	17	21	20
All occupancies	100	100	100	100	100

Source: OHE survey of 158 residential and nursing homes, end 1984.

Table 4.13 **Supplementary benefit funding by weekly charges**

£ per week	*Percentage funded by SBS %*
200+	29
180–	33
160–	32
140–	30
120–	34
100–	45
80–	32
under 80	64

Source: OHE survey of 158 private and voluntary residential and nursing homes, end 1984.

Table 4.14 **Distribution of charges in private and voluntary sector homes, end 1984**

Gross charges £ per week	*Private and voluntary nursing homes %*	*Private residential homes %*	*Voluntary residential homes %*
200+	13	1	—
180–	16	1	—
160–	27	4	3
140–	28	11	2
120–	11	30	10
100–	5	30	35
80–	—	20	19
60–	—	3	26
<60	—	—	6
	100	100	100

Average public sector costs
Financial year 1983–84

	£ per week
NHS geriatric hospitals (excludes capital)	243
NHS mental illness hospitals (excludes capital)	232
Local authority residential accommodation for the elderly (gross cost, including loan charges)	107

A substantial minority of private and voluntary home clientele is now dependent on this source of finance. The OHE survey found that 39 per cent were wholly or partly supported by SBs at the end of 1984 (Table 4.13). This compares with a figure of 31 per cent derived from the DHSS's own provisional estimate of 42,500 residents in receipt of SBs in Britain at December 1984. Whichever is correct, withdrawal of funding is a potentially grave threat to home income which will materialise gradually as residents in occupation in April 1985, whose funding is 'protected', leave and die. Among residential homes, estimates from the OHE survey (Table 4.14) suggest that almost half of residential and nursing home residents supported by SBs at the beginning of 1985 were then paying in excess of the national limits set for November 1983. For many, of course, the funding gap would be marginal, but for many others it would be substantial.

Table 4.15 **En-suite bathrooms by charge level**

Charges £ per week	*% with en-suite bathroom*
250+	48
200–	30
180–	15
160–	17
140–	14
120–	9
100–	7
80–	4
under 60	3
All charges	9

Source: OHE survey of 158 private and voluntary residential and nursing homes, end 1984.

Public policy issues

Recent changes in residential and nursing care of the elderly raise a whole range of public policy issues, including efficiency, appropriateness of admissions into care and regulation of the private and voluntary sectors. The green paper on social services, expected in the autumn of 1985, will futher stimulate debate, for example on the desirability of local authorities developing a more strategic role involving more extensive contractual arrangements with the voluntary and private sectors.

The wisdom of current policies has been questioned, for example by Godber (1984). His major concern is that a system of indiscriminate subsidy for any person wishing to enter a home, without any assessment as to need or suitability of care, is likely to draw mildly disabled people prematurely into a dependent life in residential care. Godber cites the experience of Australia where a similar system of subsidy has been associated with proportions of elderly people in residential care much higher than in other countries. Analysis of recent English trends in age-specific occupancy rates (Figure 4.3) does indicate that more people have entered homes with the availability of SB funding. On present information, however, it is not possible to distinguish the extent to which this reflects 'unsuitable' admissions or 'suitable' admissions where entry into residential care would previously have been denied by public sector supply constraints or lack of private funding.

Assessment for SB funded residents

The issue of assessment is now widely acknowledged. In its comments on government proposals for reducing SB funding limits, the Social Security Advisory Committee identified the problem and welcomed the establishment of a Joint Working Party between the DHSS and the local authority associations looking at ways of ensuring people enter the type of care most suitable for their needs. The committee went on to commend a move towards making eligibility for SBs subject to professional assessment as the best way forward in the long term, despite staffing implications for social service departments.

In its reply to the Advisory Committee's comments the government confirmed its discussions with local authority associations and said it was considering extending them to nursing homes. There was no indication, however, of the timescale envisaged.

Should a system of assessment be established, overall volume growth, and the private/voluntary sector's share of it, may fall back to the lower level indicated in Figure 4.4, though the broad picture of expansion to the end of the century and beyond would remain unchanged.

Efficiency

A second set of public policy issues relates to the costs and benefits of different modes of care, where public/private comparisons are part of a wider debate on the whole range of alternatives from hospital to community care.

The shift from public to private sector supply which started in the mid seventies was not preceded by, nor informed by, any technical debate over the relative costs and benefits of different modes of care. It is only relatively recently that a start has been made to developing a theoretical framework (Wright (1984), Maynard and Smith (1983)) and collecting empirical data on costs, benefits and clientele such as to permit something more than crude comparisons of average costs (Judge and Knapp (1984)).

The distribution of weekly charges in private and voluntary institutions at the end of 1984 is set out in Table 4.14, together with average costs for NHS long-stay hospitals and local authority Part III accommodation. The average cost of long-term hospital care is at the very top of the range of private/voluntary charges, whether in nursing or residential homes. More significantly, Wright (1985), has carried out a pilot study of long-stay hospital accommodation and contract beds in 10 private nursing homes in a south of England health authority. He came to the tentative conclusion that costs of caring for people by contracting-out

arrangements were approximately 33 per cent below the costs of the local long-stay hospital, even allowing for the fact that patients in the long-stay hospital were on the whole more dependent than those in contract beds. No indication, however, was given of the source of lower costs in private homes.

In the case of local authority Part III accommodation, and its private/voluntary sector counterpart, Table 4.14, indicates substantial overlap in the distribution of each sector's costs. Because of this there is unlikely to be any generally valid answer as to which is the more efficient at present, even apart from any question of long-term mutability of public/private cost structures in a competitive environment.

Voluntary residential home charges are typically lower than private home charges. In part this is due to some voluntary homes charging well below the economic cost of services, either because they rely on voluntary or religious labour or because they are using charitable donations to subsidise the current cost of care. A degree of altruism, or failure to charge at full economic rates, exists in the private sector as well.

Thus crude calculations of the potential benefits of transfer from public to voluntary/private supply are likely to prove naively optimistic. The market must sustain growth by new investment for the remainder of the century and beyond and it will not be possible to do this by replicating the cheap cost structures of religious institutions or private homes with no outstanding debt to finance.

In their study of residential homes in 1981 Judge and Knapp (1984) found that private homes were cheaper than local authority homes. Though absence of quality indicators vitiated like with like comparisons, cost function analysis drew them to the conclusion that private homes' cost advantages were concentrated in smaller homes and could be explained most plausibly by a substantial degree of proprietorial commitment, willingness to work long hours, ability to recruit low cost labour and readiness to forgo an economic return for non-financial rewards of independence. If this is so then continuance of the cost advantages of the private residential sector will depend on its retaining a cottage industry structure with low barriers to entry to traditional small entrepreneurs (but see below).

As to the relative efficiency of institutional and 'community' care, the debate is still in its early stages, relatively uninformed by empirical data. The University of Kent community care project has reported significant benefits from giving social workers discretion to spend up to two-thirds of the cost of long-stay hospital care to maintain in the community clients who might otherwise have entered long-stay hospitals. On the other hand, it is increasingly recognised that there is a dependency level above which institutional care may be preferred to community care on both cost and benefit grounds (Wright 1984).

Regulation of the private/voluntary sector

The growth of private sector supply has brought with it an expanded regulatory and quality assurance role, for both health and local authorities. It is widely recognised that private residential homes, which are typically small family enterprises, offer both the best and worst standards of care. In the case of nursing homes, Day and Klein (1985), in a national survey of how health authorities regulate private/voluntary hospitals and nursing homes, found 'no cause for major concern' over standards.

Raising a more general issue, they point out that the British system of regulation relies very heavily on informal advice and support. In this it differs sharply from the more legalistic American model, which minimises subjectivity and inconsistency but only at the risk of pushing up costs and creating rigidities.

Despite the relative informality which characterises British regulation, recommendations on minimum staffing levels in the code of practice for residential homes may strongly reinforce economies of scale and raise barriers to entry among traditional husband and wife teams with limited capital. At present the average number of registered places is 15 for residential homes. Most new entrants are financially restricted to smaller homes, perhaps of 7–10 places and may later trade up. If operation on this scale becomes uneconomic because of minimum staffing levels then the route of entry will be closed off to people of limited means. Much will depend on how the code of practice is implemented by local authorities.

Market changes

Private nursing/residential care of the elderly can be described as a 'boom' industry in crisis and transition. The boom and crisis elements, discussed above, will favour volume growth at the bottom end of the market while economies of scale resulting from regulatory changes may lead to larger units and a trend towards employee managed rather than owner operated homes.

The major transition in prospect is a change in the structure of the industry at the top end of the market, generated by entry of major health care organisations such as BUPA, HCA, GM Health Care and Nuffield Hospitals. These and most other acute hospital providers have identified a potential demand for high quality, new build nursing homes for more affluent clientele, More significantly, the market is experimenting with new forms of care and new forms of tenure, different from traditional nursing homes. One concept under discussion is resident ownership of rooms or flats to which flexible care could be delivered, an owner-occupied version of 'Abbeyfield Extra Care'. Only a handful of such hybrid sheltered housing/nursing home establishments exist but numerous experiments are under way. Their success will depend on the formulation of viable financial and care packages in which flexible delivery of on-site care can be combined with secure arrangements for tenure and resale. The process of innovation is likely to be stimulated by parallel interest from

substantial building concerns, entering the newly forming market from the sheltered housing side. The potential market is substantial. Thirty-six per cent of single people over the age of 60 are home owners with no mortgage liabilities. Moreover, they are used to standards of amenity, such as private bathrooms, which are infrequently offered by traditional residential and nursing homes (Table 4.15).

The major constraint on the growth of high quality new build establishments is historically high real interest rates in what is a very capital intensive sector. The market is likely to seek a variety of means of reducing long-term financing costs. One is equity stakes for residents. Another is direct investment by financial institutions, with health care and related organisations concentrating on management services rather than property ownership.

References

Batchelor, Sir I. (1984) Policies for a Crisis. Nuffield Provincial Hospitals Trust. Occasional Papers 1.

Centre for Policy on Ageing (1982) Mental Illness in Old Age.

Day, P. and Klein, R. (1985) Maintaining Standards in the Independent Sector of Health Care. *BMJ* 290. 1020–2.

DHSS (1981) The Respective Roles of the General Acute and Geriatric Sectors in Care of the Elderly Hospital Patients.

Godber, C. (1984) Private rest homes: answers needed. *BMJ* 288. 1743–4.

Health Authority Service (1982) The Rising Tide. p 32.

HMSO (1985a) Proposals for the Supplementary Benefit (Requirements and Resources) Miscellaneous Provisions Regulations 1985. Cmnd 9466.

HMSO (1985b) The Supplementary Benefit (Requirements and Resources) Miscellaneous Provisions Regulations 1985. Cmnd 9467.

Judge, K. and Knapp, M. (1984) Efficiency in the Production of Welfare: the public and private sectors compared. PSSRU Discussion Paper 331. University of Kent.

Maynard, A. and Smith, C. (1983) The Elderly: Who Cares, Who Pays? Nuffield/York Portfolios No 1. Nuffield Provincial Hospitals Trust.

Wade, B., Sawyer, L. and Bell, J. (1981) Different Care Provision for the Elderly: Report to the DHSS by the Department of Social Administration. London School of Economics (Unpublished).

Wright, K. (1984) Community Care. Nuffield/York Portfolios No 4. Nuffield Provincial Hospitals Trust.

Wright (1985) Contractual Arrangements for Geriatric Care in Private Nursing Homes. Centre for Health Economics. University of York.

5. PSYCHIATRIC CARE

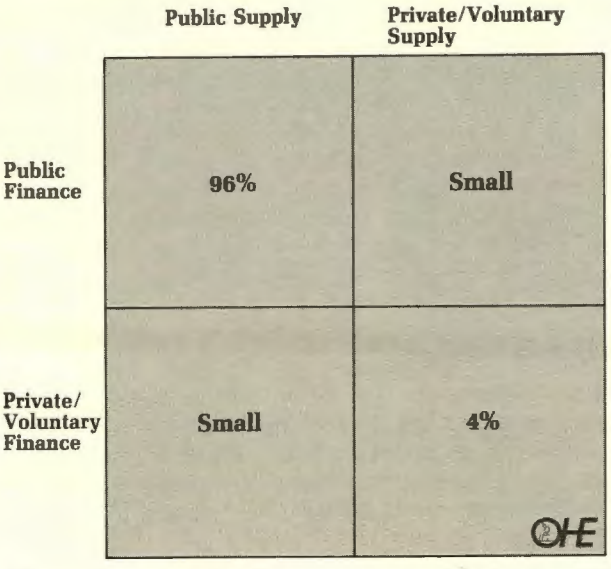
Acute mental illness

The market for private acute psychiatric treatment is small, with a total independent sector bed occupancy of about 500 in England in 1984 generating revenue of perhaps £25 million per annum. It is an area of activity where there is little interchange between public and private sectors. Few private patients are treated in NHS pay beds and there is little contracting about of acute psychiatric treatment by the NHS. Figure 5.1 illustrates the four combinations of public and private supply and demand. It is estimated that 96 per cent is publicly financed and supplied with most of the remaining 4 per cent privately financed and supplied.[1]

With 8–9 per cent of the population medically insured, the proportion of acute psychiatric treatment located in the independent sector appears low. Two factors peculiar to psychiatry may offer a partial explanation. First, the phenomenon of downward social mobility of people with mental illness may reduce the medically insured population liable to psychiatric admission. Second, private psychiatric treatment has traditionally been provided in a small number of specialised mental illness hospitals which are geographically remote from a large proportion of their population. Moreover, most private hospital treatment has hitherto been provided by full-time staff within these institutions and private psychiatric practice among NHS consultants has remained underdeveloped. It has focused mainly on out-patient treatment of neuroses tather than hospital treatment which requires, in addition to access to independent hospital facilities, a significantly larger commitment of time than is typical in other specialities.

Despite its limited size, the market has generated active investment interest. Two American health care organisations entered the British market in the early 1980s. At mid-1985 Charter Medical of England had two facilities in London with a total of 72 acute beds. Community Psychiatric Centres (CPC) had three facilities operating, two in London and one in Birmingham, with a total of 165 acute beds together with a ward of the BUPA Nightingale Hospital. AMI has recently set up a psychiatric division with a brain damage unit in Cambridge and a planned network of out-patient alcohol counselling services. It also has an adolescent psychiatric facility on the south coast of England. In addition, a number of other major health providers have demonstrated active interest in the market. The major British commercial psychiatric provider is Nestor, with four units providing acute treatment, rehabilitation and long-term nursing care.

Figure 5.1 **Segmentation of public and private activity: acute psychiatric treatment, Britain 1984, occupied beds**



Source: Unpublished Market Research, Laing and Buisson.

As in the larger acute surgical/medical independent sector, United States based multinationals entered a market initially dominated by long-established charitable institutions. One facet of competition between commercial and charitable institutions has been a challenge to the traditional 'closed' model of psychiatric in-patient care, where treatment is provided entirely by full-time hospital staff. The alternative 'open' model, in which local psychiatric consultants have admitting rights, has been pioneered by both Charter Medical and CPC, while CPC has also developed a 'semi-open' model at the Priory in south-west London. The older established charitable institutions have now started to experiment with admitting rights. Another recent innovation is an agreement whereby one floor of the BUPA Nightingale Hospital in London will be used by CPC for acute psychiatric treatment. This represents the first independent sector experiment in locating significant psychiatric facilities in an independent general hospital, along the lines of District General Hospital psychiatric units in the NHS.

Non-acute mental illness

The partition into publicly and privately financed long-term nursing care of mentally ill people is illustrated in Figure 5.2 (excluding elderly severely mentally ill, included in section 4, above). An estimated 98 per cent are NHS patients in NHS hospitals. Most of the remaining 2 per cent are privately

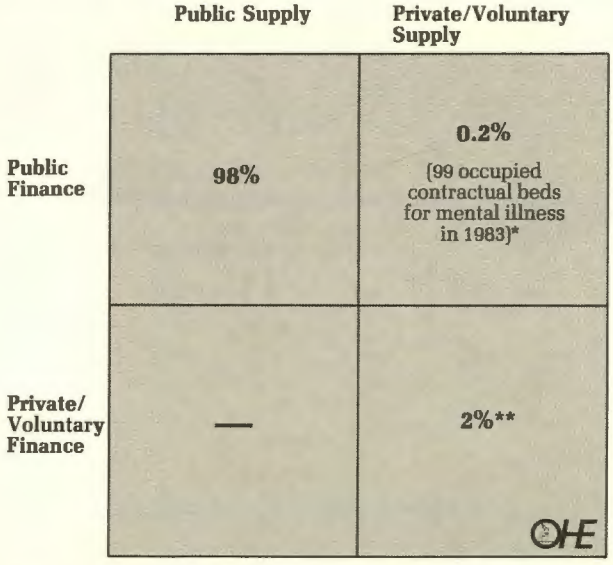
1 In this context, 'acute' psychiatric treatment is difficult to distinguish precisely from non-acute care, though medical insurers are unlikely to reimburse hospital stays in excess of two or three months and this provides a practical definition for the privately financed independent sector. A rough measure of the number of NHS 'acute' psychiatric beds is provided by NHS planning norms. A number of regions have adopted a target of 30–35 acute psychiatric beds per 100,000 population. It is this comparator which has been used to estimate the relative activity of public and private sectors.

Table 5.1 **Homes and hostels for the mentally ill and the mentally handicapped, England** *Number*

	1977	*1978*	*1979*	*1980*	*1981*	*1982*	*1983*	*1984*
Mentally ill								
Local authority homes								
Staffed premises	125	130	139	137	146	149	152	151
places	2,143	2,186	2,310	2,333	2,467	2,514	2,557	2,523
Unstaffed premises	194	246	278	304	343	351	375	391
places	949	1,141	1,282	1,391	1,514	1,549	1,616	1,723
Voluntary and private homes								
Premises	94	105	113	122	141	142	171	189
Places	1,864	1,894	2,015	2,142	2,063	2,157	2,367	2,558
Mentally handicapped								
Local authority homes								
Staffed premises	443	484	504	534	579	593	617	647
places	9,203	9,964	10,453	10,941	11,494	11,862	12,280	12,800
Unstaffed premises	117	163	206	253	272	290	346	375
places	548	719	928	1,121	1,218	1,282	1,453	1,550
Voluntary and private homes								
Premises	154	176	191	192	156	220	292	363
Places	3,266	3,595	3,773	3,746	2,981	4,187	5,046	6,271

Source: DHSS Residential Accommodation Statistics.

Figure 5.2 **Segmentation of public and private activity: non acute nursing care of mentally ill people, England, 1983, available beds**



Sources:
*Hansard. Written Answers 21 January 1985, Col 338.
**Residue (990) of SBH 212 beds in England after deducting those reserved for long term care of elderly.

financed in independent mental hospitals or nursing homes.

In common with services for the elderly, long-term care of mentally ill people within the public sector is a shared responsibility between health and local authorities. With joint funding and early discharge policies from NHS mental hospitals, increasing numbers of people with long-term mental illnesses such as schizophrenia have been transferred to 'community' alternatives ranging from local authority homes and hostels to home support. In addition, significant numbers have found their way into private and voluntary sector homes and hostels for mentally ill people registered with local authorities, funded either by local authorities or, more recently, by supplementary benefits. Few such people are able to finance their own care.

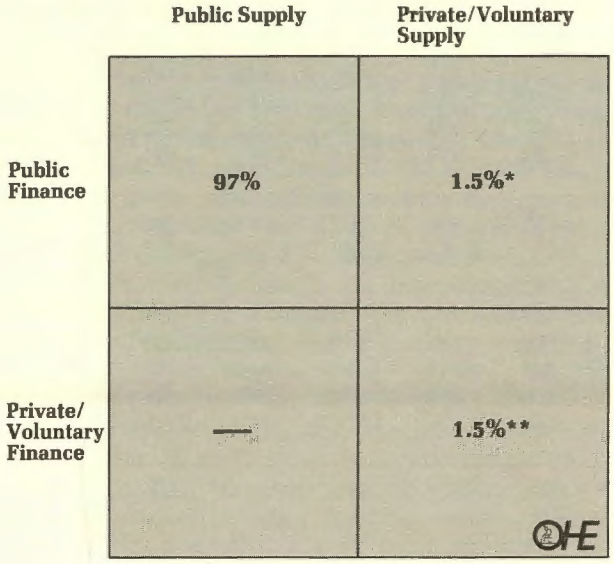
Data on accommodation for the mentally ill are believed not to be as reliable as corresponding statistics for elderly people, Table 5.1, however, shows recent recorded trends. For mentally ill people, there has been a significant increase in private/voluntary sector accommodation. But in contrast with care of the elderly, there has also been an increase, though proportionately somewhat smaller, in local authority provision.

Future prospects are dominated by the planned closure of large mental hospitals in most parts of the country and an accelerated transfer of existing patients into 'community' care. To the extent that funding is not transferred at the same time there is likely to be an increased demand for private/voluntary sector residential accommodation for mentally ill people. In the recent revision of supplementary benefit funding (see section 4, above) provision was made for a separate national limit for mentally ill residents (£130 per week) and mentally handicapped residents (£150 per week).

Mental handicap

The partition between public and privately financed and supplied hospital and nursing care is illustrated in Figure 5.3. Like mental illness, both finance and supply are dominated by the NHS.

Figure 5.3 **Segmentation of public and private activity: mental handicap, England 1983, bed numbers**



Source:
*643 Contractual beds, Hansard. Written Answers 21 May 1985.
**SBH 212 Returns.

It is now widely recognised that few mentally handicapped people are best cared for in a hospital environment. Transfer to 'community' alternatives has resulted in substantial reductions in hospital populations and increases in residential accommodation provided by local authorities and private and voluntary homes and hostels registered with them. Since 1982, private and voluntary provision has been growing significantly faster than local authority provision, reflecting the availability of supplementary benefits funding and local authority resource constraints. But local authorities still provide most residential care (Table 5.1). Future prospects will depend on the pace at which NHS mental handicap hospitals are run down and the extent to which NHS funding is transferred to local authority budgets.

6. PRIMARY CARE

At the inception of the NHS all family practitioner services were made free at the point of service. In 1951, to limit the government spending consequences of unexpectedly high demand, charges were instituted for the supply of spectacles and dental treatment. They were followed by prescription charges which, except for a short period from 1965–67, have been in existence since. There have never, however, been any charges for services which General Practitioners perform under their NHS contracts.

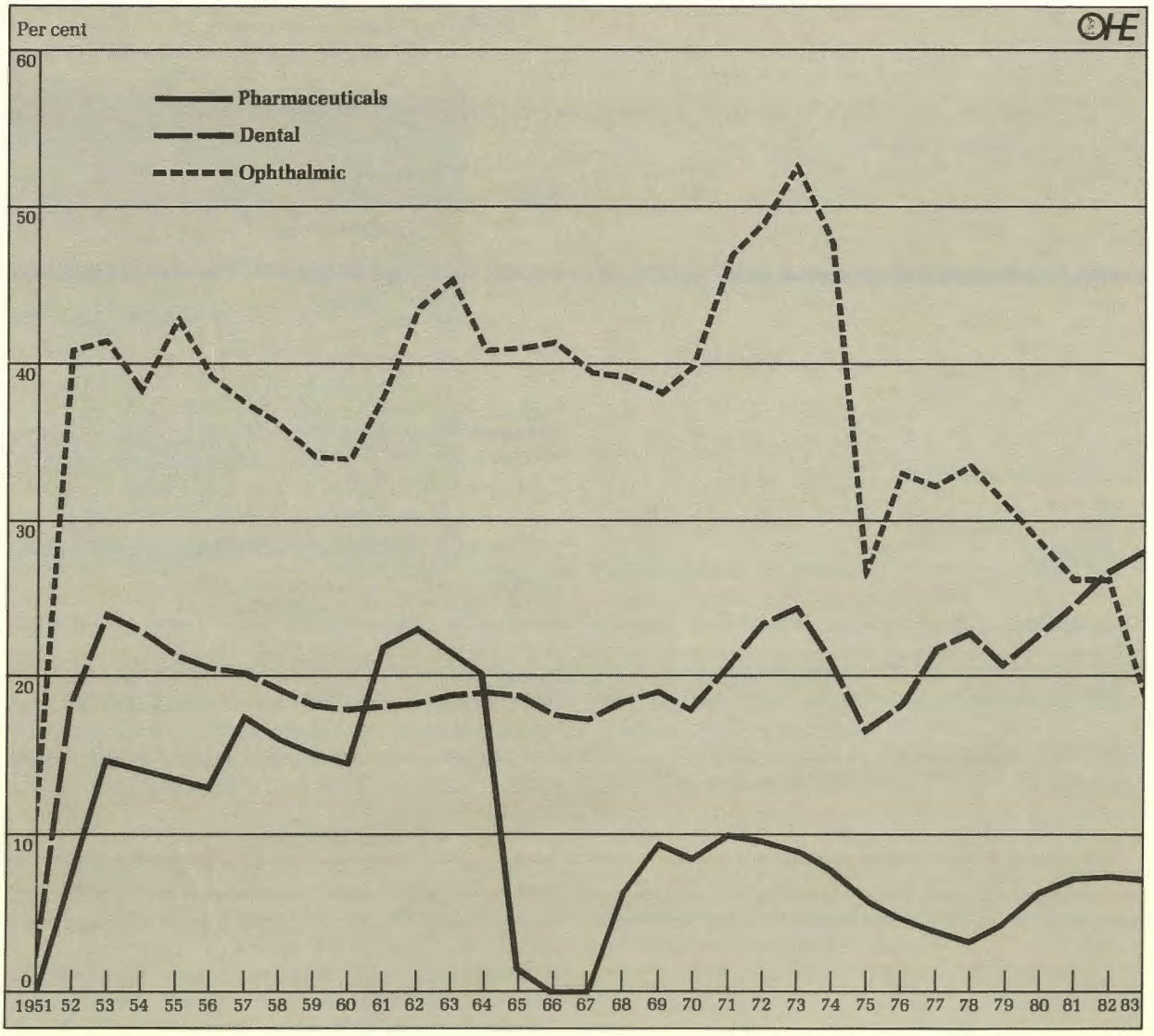
The pattern of NHS charges in each sector is illustrated in Figure 6.1 and aggregate figures for all sectors combined (including hospital and community services) are given in Figure 6.2. Forward projections of gross costs and charges within the family practitioner services are notoriously inaccurate. Only actual spending figures are used, therefore, up to 1983.

In each case, prescription medicines, dentistry and spectacles, a new principle was introduced in April 1985 which will change the public/private mix of finance and supply, though it is not possible to predict what the precise effects will be.

Dentistry

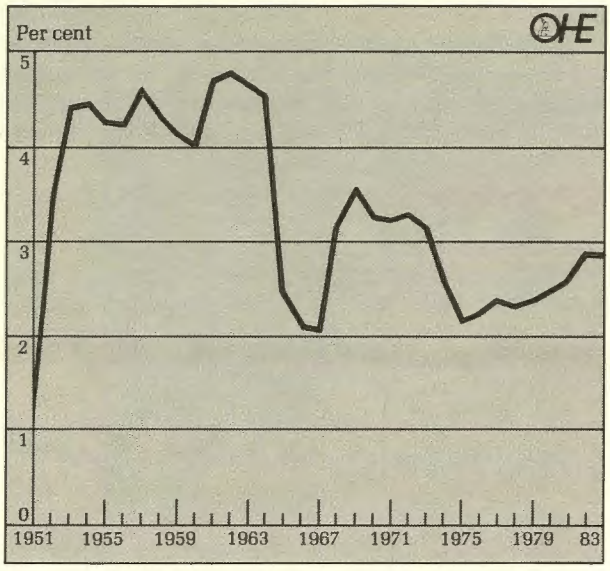
Dental charges, as a proportion of gross NHS spending on the service, have been rising steadily since the mid seventies. By 1983 they had reached 27 per cent. The existence of charges at this level reduces the marginal cost to consumers of seeking treatment outside the NHS system of fees and charges. To the extent that the NHS does not pay for some more sophisticated cosmetic dental procedures, this supply constraint further encourages private dental treatment. There is a significant volume of privately performed dentistry.

Figure 6.1 **Family practitioner services: patient charges as per cent gross cost, UK.**



Source: OHE Compendium.

Figure 6.2 **All patient charges as per cent of gross NHS expenditure, UK**



Sources: OHE Compendium, General Household Survey.

Figure 6.3 **Segmentation of public and private activity: dentistry UK, 1983, cash**

	Public Supply	Private/Voluntary Supply
Public Finance	**65%** £467.5 million (Net NHS expenditure)	—
Private/ Voluntary Finance	**25%** £181.9 million (NHS charges to patients)	**10%** £72 million (based on 10% private working hours at same income per hour as NHS work)

However, surveys carried out for the Review Body on Doctors' and Dentists' Remuneration have found that, even at a time of increasing NHS charges, which might be expected to stimulate private practice, dentists have continued to devote a constant 90 per cent of their working time to NHS practice and the remaining 10 per cent to private practice. Moreover, the most recent hours of work survey, given in evidence for the 1985 Review Body report, indicates a reduction in time spent on private practice to below 10 per cent.[1]

Figure 6.3 analyses dentistry into the four combinations of public and private finance and supply in 1983. The privately financed and supplied sector is likely to increase its share of overall spending as a result of a change in the basis of NHS charging, effective from April 1985. In addition to annual increases in charge levels, a system of co-payments has been introduced for the first time, whereby the consumer pays the first £17 plus 40 per cent of the remainder up to £115 gross. The government has estimated an additional 29 per cent in income from this change.

Figure 6.4 **Segmentation of public and private activity: sight testing, spectacles and lenses, UK 1983, cash**

	Public Supply	Private/Voluntary Supply
Public Finance	**42%** £213 million (Net NHS expenditure)	—
Private/ Voluntary Finance	**10%** £50 million (NHS charges)	**49%** £250 million (based on numbers of dispensings and unit prices among a sample of members of the Federation of Optical Corporate Bodies)*

Sources: FOCB, OHE Compendium Optics at a Glance, Federation of Optical Corporate Bodies 1984.

Spectacles

By the mid seventies, more than 50 per cent of the cost of sight testing and supply of spectacles under the NHS was financed by charges to consumers. Since then, the proportion has dropped to 20 per cent in 1983. This does not, however, represent any diminution in overall private funding of spectacles. Rather, it reflects a transfer to private purchase and supply of spectacles and contact lenses entirely outside NHS arrangements. The transfer may be attributed to relatively low marginal costs of opting out and restriction of NHS supply to a fairly narrow and functional range of frames and lenses. Figure 6.4 analyses the market into the four components of private and public finance and supply in 1983. Major changes from April 1985, however, will radically alter the pattern. From that date, supply of spectacles under the General Ophthalmic Service has been terminated for all groups of consumers except for children, low

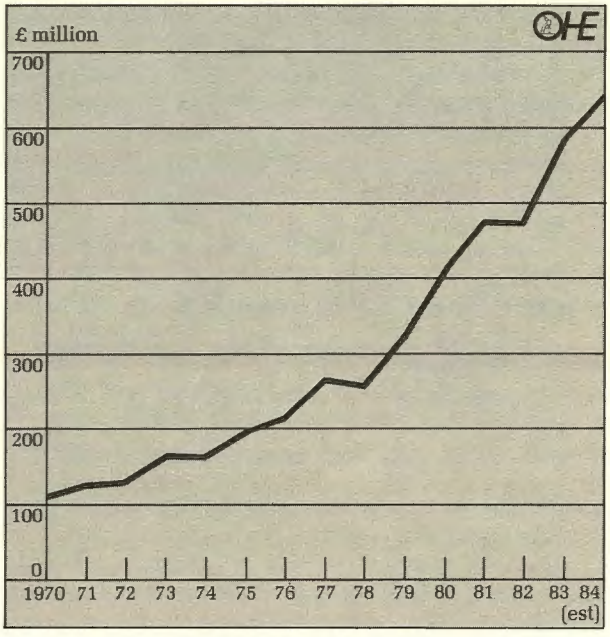
1 The samples upon which the hours of work survey are conducted are drawn from FPC lists. Thus they will exclude dentists whose practice is exclusively private and thus underestimate the total amount of private work. However, any error is unlikely to be substantial since few dentists (perhaps 200–400 in Britain) are whole time in private practice. And even these may do occasional NHS work and would thus be within the population sampled for hours of work surveys. In any case, though there may be error in any given year, the error in trends will be less.

Figure 6.5 **Segmentation of public and private activity: pharmaceuticals, UK 1983, cash**

	Public Supply	Private/Voluntary Supply
Public Finance	**67%** £1,511 million (Net NHS expenditure)	—
Private/ Voluntary Finance	**5%** £117 million (NHS charges)	**27%** £597 million 'Over the Counter' Medicines £16 million* Private Prescriptions Total £613 million

*Estimate based, *pro rata*, on 1% of GP consultations being private, General Household Survey.

Figure 6.6 **Spending on Over the Counter ('OTC') medicines at retail prices, UK**



Source: Association of the British Pharmaceutical Industry.

income groups and those with complex prescriptions to fill. Moreover, it is intended to replace this residual service with some form of voucher or grant (not yet specified), with the aid of which eligible consumers would purchase their own spectacles or lenses. Thus public finance in the future will be restricted to continued provision of free sight tests and spectacle purchase subsidies to certain groups of consumers.

Pharmaceuticals

When prescription charges were reintroduced in 1967 an exemption system was introduced and charges have remained under 10 per cent of gross NHS expenditure since. The analysis into the four combinations of public and private finance and supply is illustrated in Figure 6.5. £597 million of consumer expenditure on 'Over the Counter' (non-prescription) medicines (Figure 6.6) is included.

In April 1985 charges were increased to £2.00 per item. In addition, the government introduced a limited list of reimbursable medicines in certain therapeutic areas. This novel supply constraint may be expected to generate some private prescribing for those people who wish to obtain prescription medicines no longer obtainable under the NHS. There is as yet no indication of the extent to which the private market has developed in response to the existence of the limited list.

General practice

Private general practice has remained negligible since the inception of the NHS. From General Household data it is known that private GP consultations make up only about 1 per cent of the total, largely concentrated in central London. The proportion has remained unchanged since the data were first collected.

One major reason why private general practice has not taken off in the same way as consultant care is the nature of the general practitioner's contract. It controls the economic activities of GPs far more tightly than consultants, dentists or opticians. Since they are not entitled to treat their NHS patients privately they must set up two separate practices in order to undertake private care. Prescriptions raise a further, price barrier to private practice. If a patient consults privately then he/she must pay for any prescription in full. Patients are not entitled to opt out of the NHS for the consultation and back into the NHS for the prescription. In 1959 BUPA introduced an insurance plan for general practitioner care. But it did not include reimbursement for prescriptions and it failed to generate market support.

Exclusion of GPs from private practice has been identified by some commentators as a brake on the development of medical insurance and private practice generally. It is argued that GPs have neither a financial nor professional interest in making private referrals to consultants, and that they may even prefer to avoid them in the belief that contact with a private consultant may make patients more demanding.

Insurance schemes based on the existing 'cottage industry' structure of general practice seem unlikely to find a ready private market. A different model, however, is offered by the Harrow Health Care Centre, bought by AMI in July 1985. It offers a pre-paid alternative to NHS general practice and has attracted sufficient patients in an affluent area of north west London to remain viable, even if the patients have to pay the entire marginal cost of private primary care, together with the cost of medication. More centres are planned and other private health care interests, including BUPA

Hospitals, are keenly interested in the whole area of primary medical care, seeing it not only as a means of exploiting health screening facilities but also as an opportunity to experiment in new systems of delivering medical care.

The Harrow Health Centre offers a much more extensive range of services than typical NHS general practices, including screening, minor surgery and on-site x-ray and diagnostic equipment. To pay for these extensive facilities it has depended on selling spare capacity to other purchasers, in particular local firms requiring occupational health services. For this reason, the Harrow Health Centre model is essentially a commercial one, probably requiring corporate planning and finance to flourish.

Some commentators have seen this sort of practice as forming the focus for development of GP based health maintenance organisations (HMOs) drawing from American experience. At least one United States based HMO operator, Family Health Plan, has plans to open primary health care centres in Britain. The HMO dimension broadens the issue for debate from one of 'privatisation' to the development of mechanisms to improve efficiency in the supply of health services generally. Full exploitation of HMO type incentive structures, however, would require contracting for hospital services. Since the NHS remains the dominant hospital supplier this means in essence contracting with the NHS. But the Griffiths reforms have a long way to go before the NHS has the sophisticated management budgeting systems to deal with such contracting. Any such development, therefore, must be for the long term.

It must be a matter of speculation whether facilities such as the Harrow Health Centre can succeed in the market place without the sort of economic stimulus that would come from allowing prescriptions to be filled on the NHS, or more radical policies to reduce the marginal cost of opting out of the NHS. At £85 per person (in 1985), plus the cost of medication, the Harrow Health Centre is certainly expensive in relation to NHS costs. However, it is not substantial in relation to total disposable income for many consumers. Besides, private medical insurance for acute hospital treatment has already achieved a 10 per cent market penetration despite its equally high marginal cost.

7. INTERCHANGE BETWEEN THE NHS AND THE INDEPENDENT SECTOR

Two surveys carried out in 1984 by the Royal Institute of Public Administration (RIPA) and the Nuffield Centre for Health Services Studies at the University of Leeds (NCHSS) have provided, for the first time, information on the extent and nature of interchange between the NHS and the independent sector. Their results are summarised in Tables 7.1 and 7.2.

The RIPA questionnaire was sent to all 202 district and special health authorities in England and Wales. 170 of them (84 per cent) responded. NCHSS sent its questionnaire to 101 health authorities with hospitals or acute nursing homes over 20 beds. In addition, it surveyed 158 independent sector institutions/agencies within the health authorities' areas. Taking into account differences in sample and questions asked, the results of the two exercises are broadly compatible.

Both found that use of clinical facilities, such as pathology laboratories, was the most frequently reported form of interchange. Over 40 per cent of all health authorities had some sort of arrangement in place. The RIPA survey showed that the two way flow was heavily weighted to the NHS as provider and the independent sector as consumer, though the balance may be changing since a number of private hospitals and groups have identified this as an area for investment.

For chronic care, the flow is almost exclusively in the reverse direction, with about one third of health authorities contracting out long-term care to the independent sector. RIPA found that existing arrangements were generally long established with religious or charitable institutions which had remained outside the NHS in 1946 but had become, in effect, an integral part of local NHS facilities. Interest in contracting out care of the elderly to nursing homes was quite rare. In a recently reported case where it did take place the ultimate objective was to transfer funding to the supplementary benefits budget (Horne and Haywood 1984). This pattern is probably still typical, even though the viability of SB funding is now threatened by new, lower national limits.

Contracting out of acute care was less common. As with chronic care, nearly all of it is provided in the long established voluntary sector, rather than in newly established private sector hospitals (*Hansard* 1985). Seven per cent of the RIPA respondent authorities had it in place and another 9 per cent had it under active consideration. Some of the latter had come to fruition by 1985. Without exception, however, all the authorities responding to the RIPA survey looked upon the collaboration as short term until their own facilities could be brought on stream or until a backlog of operations had been cleared. Most of the backlogs involved orthopaedics in general and hip replacement in particular. The remainder involved Ear, Nose and Throat surgery. Neither did the independent hospitals, for their part, expect this sort of arrangement to be anything other than temporary.

Little is known of the comparative opportunity costs of in-house provision and contracting out of

Table 7.1 **Royal Institute of Public Administration Survey collaboration between public and independent sectors of health care. District health authorities reporting various kinds of collaboration, 1984, England and Wales.** *Numbers and (percentages)*

Type of collaboration	*Under active consideration*	*Currently in place*	*Considered within last year but rejected*	*Not considered within last year*
Arrangements for joint discussion of planned levels of provision	16 (9%)	11 (6%)	5 (3%)	138 (81%)
Joint developments for use by NHS and private patients	8 (5%)	2 (1%)	8 (5%)	152 (89%)
Contracting out of Acute Patient Care	16 (9%)	12 (7%)	18 (11%)	118 (72%)
Contracting out of other Patient Care eg, mental illness, mental handicap, treatment or rehabilitation of disabled people	20 (12%)	52 (31%)	4 (2%)	94 (55%)
Contractual arrangements for NHS to USE diagnostic etc facilities and equipment PROVIDED by the independent sector	4 (2%)	17 (10%)	3 (2%)	146 (86%)
Contractual arrangements for the NHS to PROVIDE services eg, pathology to the independent sector	13 (8%)	70 (41%)	5 (3%)	82 (48%)
Joint staff training	5 (3%)	12 (7%)	1 (1%)	152 (89%)

Note: Response rate 84 per cent of all district and special health authorities in England and Wales.

Source: Unpublished RIPA research.

Table 7.2 **Nuffield Centre for Health Services Studies survey of working relationships between the public and private health sectors. Results of questionnaire sent to 101 health authorities with hospitals or acute nursing homes over 20 beds within their boundaries and 158 private/voluntary sector agencies/institutions.**

	Percentage of health authorities (HA) and private sector agencies (PS) giving certain responses													
	Implemented but failed		*Implemented partial success*		*Successfully implemented*		*Under consideration*		*Considered but rejected*		*Never considered*		*No reply*	
Collaborative arrangements for:	*HA* %	*PS* %	*HA* %	*PS* %	*HA* %	*PS* %	*HA* %	*PS* %	*HA* %	*PS* %	*HA* %	*PS* %	*HA* %	*PS* %
Purchasing of supplies	1	2	1	3	13	9	3	—	4	8	67	68	11	10
Joint purchasing or leasing of equipment	—	—	7	2	15	25	15	11	7	3	52	53	7	6
Care of acute NHS patients	—	1	3	2	9	7	12	23	25	11	44	50	7	6
Care of chronic NHS patients	—	—	4	2	38	12	9	15	—	3	43	60	6	8
Use of non-clinical facilities (eg, laundry)	2	1	—	—	12	13	6	3	10	7	63	67	7	9
Use of clinical facilities (eg, pathology)	1	1	6	4	39	38	4	6	—	3	41	47	9	4
Research	—	2	2	—	10	2	7	4	—	—	70	80	11	9
Exchange of good management techniques	—	—	3	4	8	7	8	7	—	—	71	72	9	11

Source:
Rathwell, T., Sics, A. and Williams, S. Towards a New Understanding. Nuffield Centre for Health Service Studies, February 1985.

surgery. Indeed, since they vary locally, no comparison of average costs could validly be used as a general policy indicator. What contracting out offers to health authorities is the possibility, not available in the NHS, of specifying the procedure to which marginal expenditure is to be applied. Within the salaried NHS hospital service such financial incentives have never been available, with the exception of some limited and local funding for item of service payments to surgeons carrying out sterilisations.

Figure 7.1 illustrates trends in contractual beds in England for all specialities combined. Following a decline in activity in the sixties, the volume of service provided under contract has paralleled trends in overall provision in the NHS. During the seventies and early eighties, the number of beds has remained at about 1 per cent of the NHS total while the number of cases treated has remained at rather less than half a percent, reflecting concentration in the longer term specialities of geriatrics, mental handicap, terminal care and rehabilitation (Table 7.3).

One of the principal conclusions to emerge from the NCHSS follow-up interviews, and confirmed by more limited follow up of RIPA respondents, was that collaborative and co-operative arrangements are second order issues; that is, an avenue of last resort when efforts at achieving an in-house solution fail. On the other hand, their data show that where interchange does take place it is usually implemented successfully.

An unexpected NCHSS conclusion was that relatively few health authorities express concern about competition for staff. On the other hand, the use of pay beds is seen as an important, and competitive, issue on both sides.

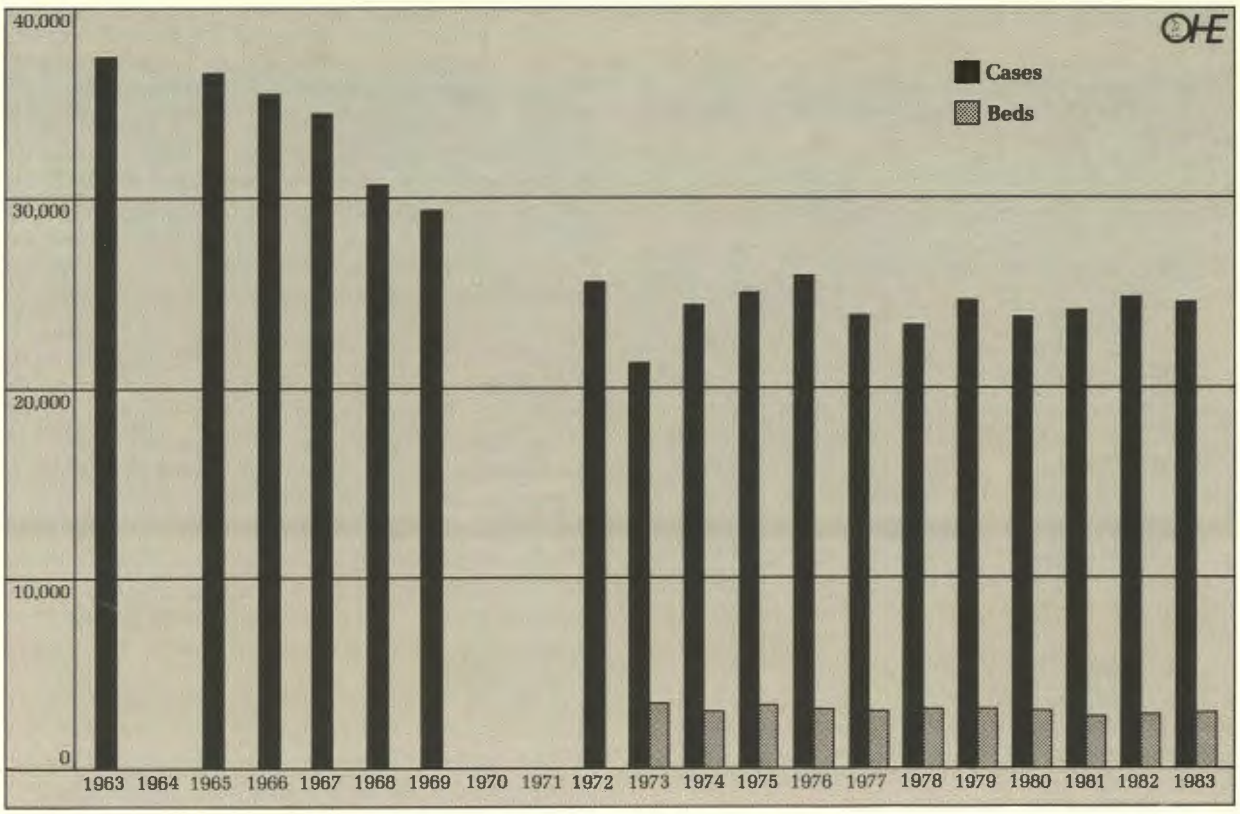
The most fruitful direction for collaboration to take may be joint developments. There have been relatively few instances, for example the BUPA/St Thomas's Hospital lithotripter and the installation of BUPA managed NMR imaging equipment at the National Hospital. But where it has taken place there has been a sense of long-term commitment. With the continuing shortage of NHS capital resources, this is likely to be a focus of some activity in the future.

References

Hansard (1985) Written Answers, 21 January, cols 328–330.

Horne, D. A. and Haywood, S. C. (1984) Contracting Out In-Patient Care. Hospital and Health Services Review, July 1984.

Figure 7.1 **Contractual beds, England**



Source: SH9 Returns, *Hansard*. Written Answers, 21 January 1985, Cols 338–41.

Table 7.3 **Patients receiving treatment under contractual arrangements with institutions outside the National Health Service in 1983**

Speciality	**Deaths and discharges*	*†Beds occupied at 31 December*
England		
Medical	1,384	269
Surgical	9,010	105
Preconvalescent and post operative	565	18
Convalescent	5,978	172
Geriatric	957	787
Diseases of the chest	961	53
Maternity	560	7
Mental illness	441	99
Mental handicap	302	643
Rehabilitation	373	75
Terminal care	3,796	313
Others	174	315
Totals	24,501	2,856

8. CONCLUSIONS

Some of the major conclusions of the review are highlighted and briefly summarised in this concluding section:

Private sector no longer insignificant

In 1979 the Royal Commission on the NHS reported that the private sector was 'too small to make a significant impact on the NHS, except locally and temporarily' (HMSO 1979). That view can no longer be sustained. Only two years after the report, 13 per cent of elective surgery was being undertaken either in independent hospitals or NHS pay beds (see Section 2). The percentage is certainly substantially higher now. Taking all hospital services combined (excluding local authority provided or registered accommodation for the elderly) the 1984 value of independent sector supply was 7 per cent of NHS and independent sector spending combined. Similarly, the independent sector employs 7 per cent of the total NHS and independent hospital nursing establishment.

Private sector now established in all regions

The acute private sector is no longer a phenomenon observed principally in the affluent South East of England. Though medical insurance cover is lower in provincial locations, it is nevertheless significant. New hospital development has recently focused on provincial locations and it is likely that the creation of new acute facilities and the demand for medical insurance will continue to be mutually reinforcing. Similarly, growth of private sector supply of long-term care of the elderly has recently been proportionately higher in those regions, outside the South and South West, without any longstanding tradition of private care.

Regulation

With private sector expansion, the potential scope for regulation by public authorities has enlarged. In the acute sector, where quality of care has not developed into a significant issue, and where there are no effective controls on development, regulation is at present a second or third order issue. For long-term care, however, regulation has become an important issue with the passage of the 1984 Registered Homes Act and the new codes of practice for residential and nursing care.

The existence of substantial private provision of long-term care is no longer in question. Its growth appears inevitable for some years to come. A more relevant public policy question now is what sort of private supply should be stimulated. In particular, should central and local government adopt a policy objective of sustaining small, owner-managed family enterprises as one of the principle modes of delivering long-term care for elderly people? If so, should the interpretation of the code of practice for residential care be modified if in practice it leads to barriers to entry and if economies of scale induced by regulatory requirements start significantly to favour larger, employee-managed units?

Innovation within the private sector

Perhaps one of the most important themes to emerge concerns innovation and the creation of new health care delivery systems within the private sector.

At the beginning of the current phase of its expansion it could fairly be said that the private sector offered nothing new, except for convenience and amenity. In later years it developed preventive and screening programmes that are not generally available within the NHS, and has often led the way in short stay and day care, though it remains true that in other respects quality of care remains poorer than the NHS, for example in those independent hospitals which have no medical cover at night.

In the mid-eighties, however, it seems genuinely poised to contribute positively to the development of new systems of health care delivery. A growth phase in the traditional acute sector is coming to an end and a number of organisations now firmly entrenched in the health care market are looking for new investment opportunities. Two examples have been referred to above. The first, which is now beginning to materialise is the creation of new modes of long-term care for elderly people. The second, which is more speculative, is innovation within primary medical care and possible experimentation with something akin to GP based Health Maintenance Organisations. Other areas not mentioned above include industrial medicine. A major stimulus to development here may be the Control of Substances Hazardous to Health Act which lays an obligation on all employers to monitor and control their work environment much more rigorously than hitherto. Organisations with expertise in screening and sophisticated record keeping, such as the BUPA group, are seriously exploring possibilities. Another potentially significant area of private sector innovation is renal dialysis. Two USA based companies have recently been given contracts to run dialysis centres in Wales. New and higher patient acceptance targets being adopted here and in other regions will necessitate the development of nurse assisted dialysis (for older patients) rather than the home dialysis mode on which British treatment programmes have been based. The Welsh contracts represent a means of tapping into technology and delivery systems developed outside Britain, through the international links of private sector organisations.

'Corporatisation' of private health care

In each of the examples given above, significant private sector innovation seems likely to be located within large organisations with substantial capital

and management resources. Thus the future is likely to witness a continuation of the process of transformation of private health care from a cottage industry supported by voluntary institutions into a sector of commercial corporate activity. In the United States, a similar process of corporatisation took place rapidly in the sixties and seventies. The emergence of American based health care multinationals, now operating throughout Europe, is a product of this development. The implications for cost and quality of private health care in Britain, and its relationship with the dominant public sector, are likely to be significant, if at this stage speculative.

References

HMSO (1979) A Service for Patients: Conclusions and Recommendations of the Royal Commission's Report.