

## FINANCE

# The profitability of private patients



NHS private patient units are a potential goldmine and can compete with private hospitals if managed well, say Adam Scott, Tom Stevenson and Victor Chua

The Health and Social Care Act 2012 has lifted the cap on NHS hospital private patient revenues. Hospital management teams are therefore reexamining how private income can be harnessed to help pay for services that cannot be financed by a stagnant NHS budget.

Here we examine two approaches to improving NHS private patient unit contribution, one involving the private sector and one relying on internal NHS resources.

Private patient units within NHS trusts are widespread – we have mapped out 73 of them, encompassing 1,123 beds – but their financial significance to most trusts is minor, with rare exceptions such as the Royal Marsden. In 2011, the NHS accounted for just an 8 per cent share of all private revenue in UK hospitals; the comparable figure in 1997 was 16 per cent.

Although the Health Act has removed the private patient income cap, which limited income to 2002-03 levels, a hospital's board of governors must agree to any expansion. This creates the opportunity to seek greater volumes of private patients or invest in further capacity, but the argument for expansion does not apply in all cases.

Where the PPU is only a single ward in a district hospital, the focus should be on better operations. The argument for growth, which would support



When dealing with conditions that are best managed by a multidisciplinary team, NHS hospitals can provide a more appropriate healthcare setting than some private hospitals, in which such teams are rare as a result of a focus on elective surgery

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NHS provision, lies in university hospitals and complex care.

The NHS has always had a love-hate relationship with private care. However, with 10 per cent of the UK population having private medical insurance and many foreigners willing to come to the UK to be treated by experts, it seems foolish not to try to maximise this source of revenue.

### Strengths versus weaknesses

Well-implemented PPU's can significantly support core NHS activities. NHS managers are, quite correctly, not solely focused on the bottom line but are now responsible for running what are, in effect, large companies with high fixed costs and low margins – they cannot afford to ignore any obvious opportunities to grow revenues. Cost cutting shouldn't be the only possibility explored to improve the bottom line.

PPUs have many advantages over private hospitals that are not being exploited as fully as possible. The convenient location of foundation trust PPU's allows consultants to see both public and private patients on a single site. Should things not go as planned, proximity to level 2 intensive care units (rare in the private sector) is reassuring. The major teaching hospital trusts also have access to rare or expensive technology that is uncommon in the private sector, such as Da Vinci surgical robots or radiotherapy.

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## 'PPUs have many advantages over private hospitals that are not being fully exploited'

Common illnesses such as cancer, heart disease and diabetes benefit from management by a multidisciplinary team; such teams are rare in private hospitals, which tend to be focused on elective surgery. Foundation trusts, however, are well placed to look after patients with multiple comorbidities.

Some foundation trusts also have particularly well known international brands. Overseas patients bring further prestige in a virtuous circle for a hospital as they tend to seek the more demanding and complex care, which can be the most professionally rewarding for consultants.

PPUs, however, currently compare unfavourably with private hospital groups in a number of important areas. It is often thought that optimal management of a PPU requires a commercial mindset rarely found in the NHS outside of the chief executive's suite. In our work, we found PPU's often misprice their services and some services are even unprofitable.

Our research shows revenue per bed in PPU's is generally half or less than that of comparable private hospitals (see graph, top right). The greater number of medical rather than (higher revenue) surgical patients is a factor but the disparity mainly is down to low utilisation and reflects the relatively low priority in management's attention. Historically, poor coding has cost PPU's up to 10 per cent of revenue. It is also difficult to recruit the best people to run NHS PPU's, as PPU management is not an obvious stepping stone for the ambitious NHS manager.

NHS PPU's rarely put the patient's convenience first as do top private hospitals. One of the advantages of care in private hospitals is that patients have much more power to decide on the timing of planned procedures and, if treatment is a multistep process, can have as many of the steps done in the same visit as practicable.

In NHS PPU's, the NHS habit of scheduling procedures to suit the staff rather than the patient tends to prevail. Private insurer Bupa says its clients notably prefer the accommodation, scheduling and hotel services of private providers to PPU's.

In addition, because each NHS PPU is a separate entity, it lacks the benefits of scale in negotiating coverage and pricing with private medical insurers. Our review of insurers' networks revealed that most NHS PPU's are covered by Bupa and PruHealth, but many PPU's are outside AXA PPP and Aviva networks (see graph, bottom right).

The importance of inclusion in networks is illustrated by the establishment of new hospitals such as CircleBath – AXA PPP initially refused to recognise this modern and efficient new hospital as it had a favourable arrangement for the incumbent BMI Healthcare (private) hospital in the same city. Our research shows the lack of negotiating muscle results in PPU's receiving lower pricing from private medical insurers. Pricing data we have seen in specific specialties suggests the cost of common procedures is often two thirds that of prices achieved by neighbouring private hospitals that are part of major groups.

NHS PPU's are rarely of a scale necessary for staff to be offered appropriate training in non-clinical aspects of their job. Large private hospital groups, on the other hand, are able to

send staff for training in customer service and hospitality, which differentiates them from NHS staff.

NHS consultants also often do not wish to have both their public and private appointments in the same NHS organisation, particularly if they have an acrimonious relationship with their NHS management. Conflating the two gives the NHS trust too much leverage with the consultant; this is important as the consultant is, in many ways, the principal customer of the PPU.

### Delivery models

There are two delivery models that can take the burden out of delivering PPU's. Over the past 24 months, many NHS hospitals planning new or refurbished PPU's have adopted a public-private partnership approach.

We know of at least 10 foundation trusts that are seeking to expand their PPU's. The Clatterbridge Cancer Centre and Guy's and St Thomas' Foundation Trust have selected private partners to develop their PPU's, and University Hospitals Bristol Foundation Trust has a tender out for a private partner. This model has dedicated staff and clearly distinct wards, with an arm's length relationship between the public hospital and the joint venture. NHS staff are not core to the venture, the commercial risk of the operation is shared and there is no long-term increase in the management burden from the PPU beyond its planning, contracting, setup and supervision.

The business model for the partnership has the private provider operating the unit while the foundation trust provides the brand, location and access to services including operating theatres. The private provider may take over the existing PPU or a new PPU can be built. In either case, there is no standard arrangement for the relative shares of capital investment, revenues or profits. In some cases the capital

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investment is shared equally while there is a set annual “rent” and profit share paid by the private provider.

A single operating company for multiple PPUs could create additional value. We would like to propose for discussion a second business model: if the major teaching hospitals in a large city such as London, Birmingham or Manchester could cooperate to create an NHS owned “operating company”, this may have enough scale to overcome many of the drawbacks experienced by NHS-managed PPUs.

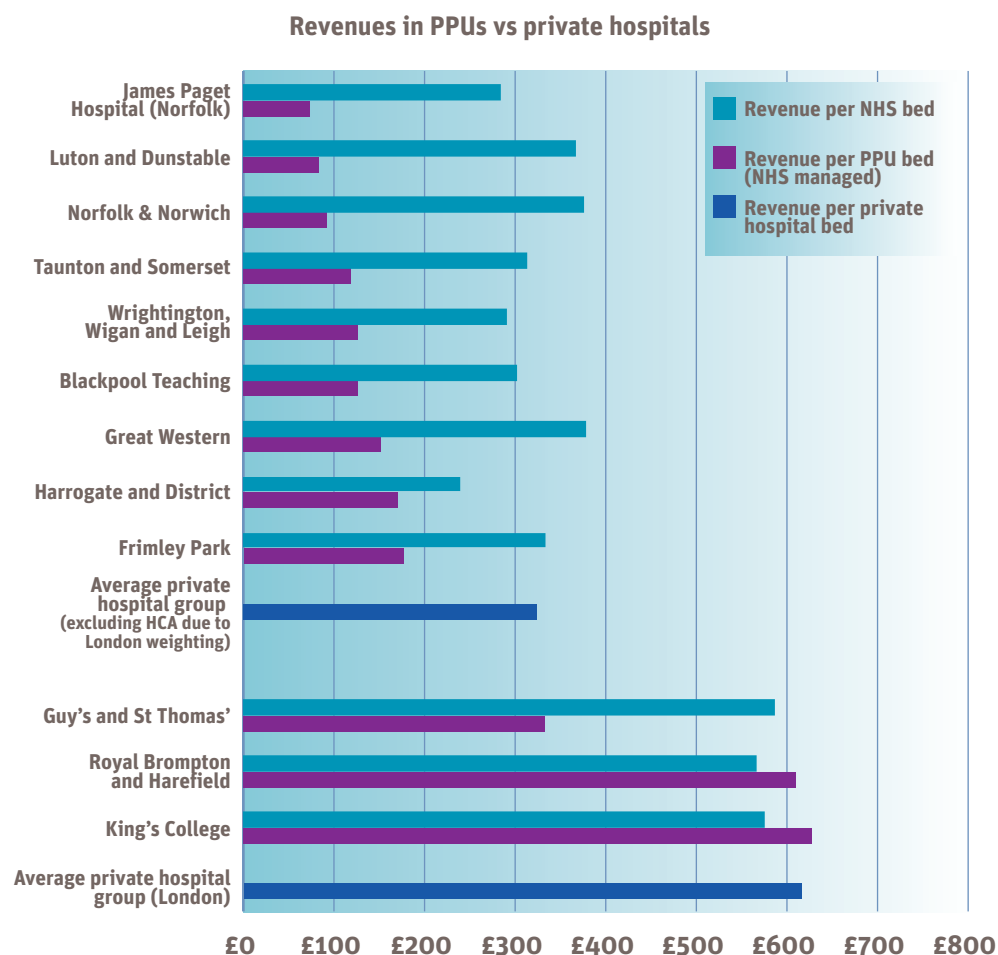
We would model this kind of partnership on the highly successful Four Seasons Hotels and Resorts chain. Many people do not realise Four Seasons is an operating company – it does not own its hotels, it merely has an operating contract with the owners of them. The terms of the contract incentivise Four Seasons on a variety of financial – and, crucially – customer service metrics.

If all the major foundation trusts in one city were to work together to create a third sector operating company to manage their combined PPUs, this would address many of the disadvantages that standalone NHS PPUs face.

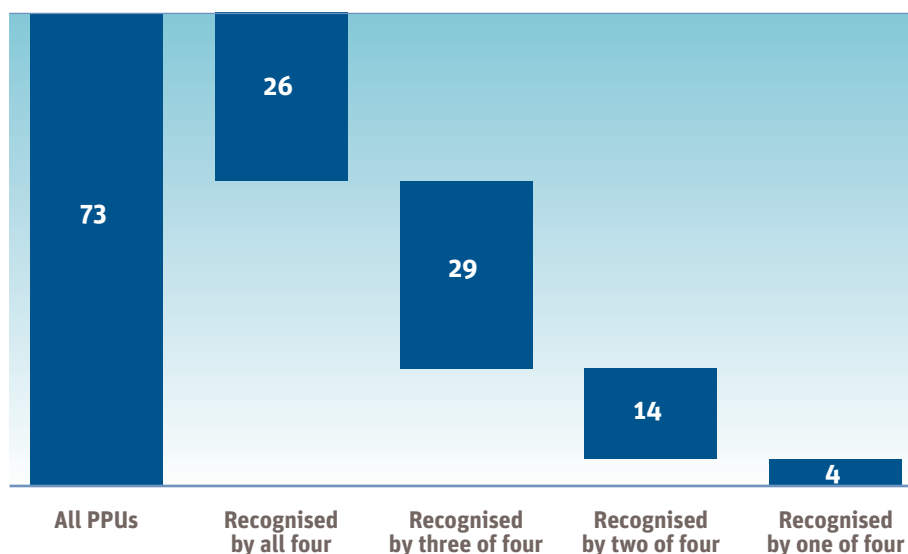
Such an operating company would be of sufficient scale to attract high-quality standalone management and it would have sufficient local market share to negotiate from a position of greater strength with insurers and other suppliers. It would be of sufficient size to set up its own internal staff training programme, so staff could be trained to put the patient first. Consultants would be reassured, as they would not be putting all their professional eggs in one basket – and all profits would return to the NHS to be used for NHS patient care. ●

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## REVENUES GENERATED BY HOSPITAL BEDS



## PPUs by network – Bupa, Axa PPP, Aviva and PruHealth



Source: Candesic database