HSJ LOCAL briefing

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# DISTRICT GENERAL HOSPITALS PRIVATE PATIENT INCOME

HSJ Local Briefing is our new in-depth analysis of the key issues facing the NHS's major health economies

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## In brief

**Issue** District general hospitals often have a small income from private patient work but recent changes in the law and economic pressure mean many are looking to increase this. A number have looked at – or invested in – more extensive facilities for private patients, and research by an MP suggests that more than 70 district general hospitals were hoping to make more from private work in 2012-13 than previously. Some have ambitious plans but may not be realising the income they had hoped to generate.

**Context** The private patient market is far from healthy but the amount of NHS income from it did increase a little in 2011-12. The prospects for district general hospitals to increase their income from this will vary according to their local situation and what they can offer. Business acumen is crucial. District general hospitals will need to plan carefully for theatre and diagnostic access for private patients, and concentrate on customer service. In addition, they need to ensure that increased revenue delivers increased profit.

**Outcome** While, over a period of years, trusts may make a useful amount of money from building up private work, it is unlikely to be a quick fix for financial problems. Some trusts may baulk at putting too much emphasis on private work and prefer to concentrate on improving their core offering; others may exploit their strengths or look at areas the NHS is not fully funding, such as IVF for certain age groups. A few will misjudge the market or get their offering wrong but, overall, private patient work is likely to grow slowly but steadily.


## Context

Treating patients privately is nothing new for NHS hospitals; for some of them it brings in tens of millions of pounds a year from both UK and overseas patients. But these tend to be big teaching hospitals, often internationally renowned and with well known clinicians who are pioneering new treatments. It's no surprise that trusts such as the Royal Marsden or Great Ormond Street Hospital are sought after for life saving or life changing treatments.

For district general hospitals, the picture is different. While some have always done a little private work or offered what used to be called "amenity beds", for the vast majority, income from this was minimal. Consultants suggest that many private patient units will have an income of £750,000 to £2m, but often district general hospitals don't have a dedicated unit and may have considerably smaller income from private patients. Could this be about to change?

The Health Act means foundation trusts are no longer bound by the "cap" – limiting their income from private work to a fixed, historical level. Technically, they could earn whatever they like from private work, as long as their NHS income still exceeds it.

As finances tighten, an increase must seem tempting. Leonid Shapiro, managing partner of consultancy Candesic, suggests the move of work into the community will leave trusts looking for other sources of income.

A number of trusts have invested, or are investing, in private facilities, and in 2012-13, according to the blog NHS Privatisation, a number of foundation trusts indicated plans to increase private patient income in their forward plans for Monitor. They included Derby Hospitals, Countess of Chester Hospital and Milton Keynes Hospital, among others.

Derby, for example, said it was exploring options for increased private patient income as some "clinical capacity becomes available for a dedicated PPU"; it now expects this to open in October. Meanwhile, Milton Keynes wanted to invest in its private patient facilities and had already identified increased income from them in its cost improvement programme; it says it made "modest" investment in facilities last year.

Information released to Labour MP Gareth Thomas under the Freedom of Information Act, and shared with HSJ, found that more than 70 trusts running routine district general hospitals had planned for more for private patient income in 2012-13 than they had received in 2011-12.

## Increasing interest – and challenges

This upswell of interest is evident to those advising both foundation and NHS trusts. Adrian Stevensen, chief executive of Independent Care, has seen a slow but steady increase in trusts interested in this market. David Lawrence, executive director of Capita Symonds' health division, says his company is seeing more district general hospitals interested in private patients. Some are sprucing up and extending existing facilities while others are tendering for private operators to run units.

But both Mr Stevenson and Mr Lawrence stress the need for trusts to be realistic about what can be achieved – and the length of time it will take to build up a successful PPU.

The first challenge is that trusts are trying to move into a market that has not been uniformly healthy over the last few years. Laing and Buisson suggest the value of private healthcare for NHS acute trusts grew by 5.3 per cent in 2011-12, compared with the previous year, when it increased from £448m to £471m.

At the same time the value of private acute work carried out in independent hospitals fell slightly, and the number of people covered by private medical insurance was the lowest in 2012 for 20 years. However, the self-paying market seems to be growing, despite the financial squeeze.

Certainty about costs is important to the independent sector and some PPUs, such as the Shalbourne Suite, a 20-bed unit at Great Western Hospitals Foundation Trust, have responded with fixed prices for some common procedures.

However, there is stiff competition from both private hospitals and from other, perhaps better known, NHS providers – especially those close to London. Consultants often have established working relationships with private hospitals and may be reluctant to bring all their work across to their NHS employer, even though having all their patients under one roof might seem to make their working life simpler.

Another factor to take into consideration is that reducing waiting times in the NHS and offering improved hotel facilities in many hospitals – such as single rooms with en suite facilities – may make some patients more reluctant to pay for either treatment or more timely care.

## Investment required

However, if trusts want to push ahead, their first challenge is likely to be investing in a PPU that is clearly differentiated from their NHS offering. The refurbishment of an existing area may cost some hundreds of thousands of pounds, but building a new unit will run into millions. The new Tunbridge Wells Hospital has a 26-bedded PPU; it says this is using space that would otherwise have been empty.

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Trusts may struggle to fund these investments themselves and may look for a partner to develop and run a new unit. This can bring in commercial expertise and investment but will come at a price: Mr Lawrence says any partner will be looking for an 8-12 per cent return on capital over a 25 year period. In 2011, Wrightington, Wigan and Leigh Foundation Trust took out an advert in the Official Journal of the European Union as it sought a partner to develop its PPU; it was unable to find a commercial model that worked for both sides.

There is also the investment in management, which will ideally be an investment in someone who not only understands what patients, consultants and insurers expect from a PPU, but also can deliver a high quality experience for all. These skills may be hard to find within the NHS but are essential to the success of the unit, suggests Mr Lawrence.

Mr Stevensen points to the importance of access to theatres and diagnostic equipment – both to ensure patients are treated swiftly and to get acceptance from insurers. The NHS has equipment and facilities, such as intensive care, that are harder to find in the private sector. Patients who are very sick or need complex care – more common as the population ages – may need this sort of back up, which makes PPUs look attractive. They may also be cheaper than sending patients to more highly equipped private hospitals in London.

Being accepted by the main health insurance providers is important – but not automatic. Research by Candesic found that, of 73 NHS PPUs, only 26 were part of the networks of the four major health insurers; an additional 29 were recognised by three out of the four.

Alex Perry, director of health and benefits management at Bupa Health Funding UK says: "Feedback from our members consistently shows lower patient satisfaction scores for the majority of PPUs than for private hospitals."

However, the Competition Commission has been looking at the private health market and may be keen to promote more competition in some areas; this may translate into pressure on insurers to accept more hospitals.

## Making profits

Given all this, are district general hospitals likely to get the numbers of patients needed to make a worthwhile profit? There is room for some scepticism: at Tunbridge Wells, for example, the new PPU has not been fully utilised – despite the trust expressing hopes in 2011 that it would capture up to a third of the area's £30m annual private healthcare spend. In November, the trust's chief executive said it was making a "positive contribution" financially, but that early targets for the unit might have been overoptimistic.

The unit was predicted to make £1m profit in its first year – it opened in late 2011 – and the trust told a local paper that figure was expected to rise to £2.9m in the second year and £4.1m in the third. However, board papers show it has been red rated as a corporate objective with its own "recovery plan" and in September the finance committee suggested the unit was "seriously underperforming" and was £2.6m behind plan. Clinicians were only bringing a small proportion of their private work into the unit, it said. The same meeting approved a new consultant post with the proviso that consultants be encouraged to develop their private practice within the hospital.

The trust told HSJ that, in 2012-13, the unit delivered £714,000 in profit, which was reinvested in NHS patient care. "We see no reason why this shouldn't grow, given the quality of the service and positive feedback from patients. The Wells Suite makes careful use of spare capacity, while generating additional income for NHS patient care," it added.

Over-optimism about private patient income is common: March board papers for the Royal Surrey County Hospital Foundation Trust showed it was underperforming by £250,000 on this measure.

According to the information released to MP Mr Thomas, large numbers of district general hospitals underperformed against budget for private income in 2011-12, but in some cases then went on to predict income for 2012-13 that was even higher. Lower than expected income can mean trusts lose much of their profit on PPUs as the fixed costs of maintaining and running a unit account for a greater proportion of income.

Information on units' profitability is limited. Typically, if board papers include any mention of them at all, it is purely in terms of income, with no indication of costs. Mr Stevensen suggests there can sometimes be significant confusion between income and profit. Trusts should be aiming at a minimum of 15 per cent operating margin, he says. Bed occupancy may be key to this but so is pricing. One expert suggested to HSJ that "many have no real idea of profitability".

## Opportunities – but not for all

Some of these practical concerns may be causing trusts to draw back from their initial enthusiasm for PPUs. North Bristol Trust, for example, issued an Official Journal of the European Union tender last year for an "established independent healthcare provider" to build and run a standalone PPU next to its private finance initiative hospital.

The opportunity was estimated to be worth between £8m and £20m a year, with the trust getting a share of the income – potentially extra money for providing support services and a fee for leasing the land. It now says these plans are on hold while it considers its options for the redevelopment of the land.

Medway Foundation Trust was looking to do private surgical work in 2013-14 but has recently withdrawn its plans as the directorate said there was no spare capacity.

Where district general hospitals may stand a better chance of attracting customers, however, is in those areas where the NHS does not provide, or is withdrawing from providing, care. This may also appear to be less politically sensitive, although there are still controversial issues such as those who fall outside the criteria for NHS funded procedures for clinical reasons.

Private fertility work is thought to account for about a third of the income of NHS fertility units and Dr Shapiro of Candesic has suggested there is already a blurring of the lines between private and NHS providers. He expects to see some NHS units seeking more private work as well as the growth of NHS clinics doing some part of the process – for example, egg collection – for private clinics.

Some trusts have ventured further into the cosmetic field – Rotherham Foundation Trust, for example, offers Careplus Skin, "paid for hair removal delivered by NHS professionals". With prices low, however, starting from £12 a treatment, the potential for income is limited.

Another approach being explored is offering patients the hotel amenities of private care – without the private healthcare offering. Surrey and Sussex Healthcare Trust has recently opened 11 amenity beds – offering enhanced "hotel" facilities

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for patients at a cost of £250 a night but with NHS treatment.

Mr Lawrence feels trusts should think carefully before developing PPUs. They need to ask how they are performing on their core product first, he says, with outstanding clinical care and clinicians with a fantastic record. They should also be wary of PPUs proving a distraction from that.

And Mr Stevensen, who also works with Laing and Buisson, stresses the importance of running such units properly: "The expectation is it is easy money. It's not. It needs to be run as a commercial business."

He suggests there is a minimum size for such units to run efficiently and offer the right sort of patient experience: that may be around 20 beds. "It's concentrating on what makes you special, what is your unique selling point," he says. "But in my view there is a significant opportunity."