

SUPPLEMENT

Talking Point

Analysis of the work of independent acute hospitals in England and Wales, 1981

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Recent legislation has removed some restrictions to the growth of the independent hospital sector. This could be seen as a means of relieving the demand on a National Health Service characterised by long waiting times for treatment, especially for non-urgent surgical conditions.

There are roughly 2500 pay beds in NHS hospitals in England and Wales. Some information about the activity associated with these beds is routinely collected for the Office of Population Censuses and Surveys Hospital Inpatient Enquiry records. There are many more beds, about 32 000, in roughly 1100 independent premises licensed under the 1975 Nursing Homes Act; information about clinical activity in these institutions is not routinely available.

Using the *Directory of Private Hospitals and Health Services, 1982* (for which hospital identifying data are supplied by the Department of Health and Social Security from its statistical returns), it is calculated that at the end of 1981, 6592 of these beds were distributed among 151 independent hospitals with operating facilities.¹ It is these hospitals that in theory could make the called for contribution to meeting the surgical demand. If an appreciable proportion of their clientele comes from overseas, however, or a substantial amount of their clinical activity is related to age groups or conditions other than those that load NHS hospitals their contribution may be relatively small. Moreover, their services may be concentrated on residents of certain parts of the country.

Most of what is known about the activity of the private sector comes via the health insurance associations, whose coverage extends only to *some* of those receiving treatment privately. A study of the work of the indepen-

dent hospitals was carried out, based on sampled time periods of 1981, and this is a report of the main findings.

Method

The study was based on existing hospital records. A sample period was allocated to each hospital so that information on roughly 100 admissions would be obtained from each—that is, hospitals shown as having small numbers of beds were observed for longer than large hospitals. There were some exceptions to this general rule. The only independent hospital in the Northern Regional Health Authority at the beginning of the year was observed during two different sample periods so that a more precise picture of the activity in that region might be obtained. Most sampling periods were from one to four weeks. Some of the least busy hospitals were sampled for longer than eight weeks. The time of year at which observations were made at each hospital was chosen so that, within a region, a similar amount of data would be collected for each season.

For each patient admitted (NHS patients admitted to contractual beds were omitted from the study) during the period as an inpatient or day patient or treated as an outpatient, administrative, demographic, and clinical details were abstracted on to a standard form, either by the hospital's staff with guidance from the project staff (two out of every three hospitals) or by the project staff themselves (the remainder). The data were coded and stored on computer file. In estimating the whole year activity, sample numbers were weighted to take account of the length of the sample period and the season, and a small correction factor was applied to allow for the absence of data from five hospitals.

Results

The 151 acute independent hospitals in England and Wales functioning at 31 December 1981 ranged in size from seven to 263 beds (mean 42) and provided a level of 13 beds per 100 000 population, compared with 291 per 100 000 in acute specialties in NHS hospitals.² We knew altogether of 153 hospitals that were open at one time or another in 1981. Only two of these refused to cooperate.

Five others had closed down before we could approach them. Access was obtained to the records of two of these. As a result data were obtained on the patients of 148 of the 153 hospitals.

LEVEL OF ACTIVITY

Based on a sample of 12 959 patient records, an estimated 344 008 patients were treated during the year. The estimated number treated in the 32 Nuffield nursing homes was checked against that organisation's record of the actual numbers treated in 1981 and was found to be correct to within 0.1%. The estimated number of terminations of pregnancy was 4% smaller than the actual number of reported abortions in non-NHS hospitals in 1981.³ This shortfall was due to three hospitals licensed to carry out abortions not being adequately identified in the *Directory of Private Hospitals and Health Services*. Excluding these hospitals, it is calculated that the estimates from the sample numbers were accurate to within 1%.

Of the estimated total of 344 008 cases, 270 572 (79%) were inpatients, 46 349 (13%) were day cases occupying a bed, and 23 163 (7%) received *treatment* as outpatients without occupying a bed. (This may be an underestimate of the true number of outpatients treated because not all outpatients seen privately in these hospitals generate hospital records.) The status of the remaining 3924 (1%) was not known.

CLINICAL CASELOAD

Twenty eight per cent of the total caseload was termination of pregnancy. Sixty three of the 153 hospitals studied were licensed under the 1967 Abortion Act. Abortions were recorded in 39 of these. In 15 hospitals abortions accounted for more than 90% of the caseload, and 92% of all the abortions recorded in the survey were performed in these 15 hospitals.

Terminations apart, the clinical activity was varied, mainly surgical, and recognisably elective in nature. Most of the operations performed on residents from England and Wales were those that characterise NHS waiting lists. Few of these are either major or complex (table I). Cosmetic operations, such as plastic operations to the nose or breasts and the remo-

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val of skin lesions, accounted for no more than 7%. There were relatively few major cardiac or intra-abdominal operations.

THE PATIENTS

Seven out of every eight patients were residents of the United Kingdom, and all but 1% of these came from England or Wales. Nearly two thirds of the overseas patients came from Eire or some other part of Europe.

Residents of England and Wales accounted for two out of every three abortions carried out, and nine out of 10 of all other types of operation combined (table II). There were only a few exceptions to this pattern. For example, residents of England and Wales accounted for only 78% of the women undergoing sterilisation and, more remarkably, only 22% of the small number of patients receiving major heart surgery, the remainder coming from overseas.

The abortion component of the caseload affects the age distribution. Even when these cases were excluded, however, over three quarters of the indigenous women patients were young or middle aged adults, and for men the proportion in these age groups was similarly high (table III). In both sexes the young and the old were underrepresented in comparison with patients treated electively in NHS hospitals. In all age groups after childhood the female to male ratio was greater in the independent hospitals than in the NHS.

Residents of England and Wales accounted for an estimated 179 851 inpatient admissions for reasons other than termination of preg-

TABLE III—Age distributions of residents of England and Wales treated in independent acute hospitals in 1981, and of inpatients and day patients in NHS non-psychiatric hospitals in 1980 (excludes maternity cases and termination of pregnancy). Figures are percentages of patients

Age (years)	Independent hospitals			NHS hospitals*		
	Men (n = 91 132)	Women (n = 120 206)	Persons (n = 211 338)†	Men (n = 1 082 850)	Women (n = 1 322 630)	Persons (n = 2 405 480)
0-14	11	6	8	18	10	13
15-44	40	47	44	30	41	36
45-64	33	32	32	28	27	27
65*	16	16	16	25	22	23

*Source of admission: waiting list or booked (Office of Population Censuses and Surveys: *Hospital Inpatient Enquiry, 1980*, personal communication).

†Sex or age not known in 11 384 cases.

TABLE IV—Independent hospitals: regional bed distribution and utilisation

Region	Acute beds per 100 000 population at 31 December	Estimated spells of treatment anywhere for residents of region*		Percentage spells within region of residence (excluding abortion)
		No	No/100 000	
Northern	2.1	4 767	153	71
Yorkshire	7.6	20 616	574	94
Trent	8.3	21 800	475	87
East Anglia	9.8	7 609	402	88
North West Thames	54.8	36 614	1054	72
North East Thames	9.1	21 732	578	55
South East Thames	20.3	24 003	667	80
South West Thames	24.0	31 735	1075	73
<i>Thames regions</i>	<i>26.6</i>	<i>114 084</i>	<i>828</i>	<i>93</i>
Wessex	8.5	17 019	619	78
Oxford	14.9	18 005	773	87
South Western	9.8	18 512	603	89
West Midlands	6.6	32 535	628	86
Mersey	11.8	15 259	622	77
North Western	9.1	14 656	365	82
Wales	6.7	12 159	433	74
All regions, England and Wales	13.3	297 021†	599	76

*A spell is a contact with an independent hospital for treatment as an inpatient, day case, or outpatient.

†Including 10 006 whose area of residence in England and Wales was not known and who have been apportioned to regions on the basis of the distribution of known addresses.

TABLE I—Distribution of certain operations in independent hospitals, residents of England and Wales

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
Appendectomy	1 644	0.6
Prostatectomy	2 720	0.9
Vasectomy	7 956	2.8
Circumcision	2 591	0.9
Dilatation 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

TABLE II—Country of residence and nature of caseload

Country of residence	% of		Total No of patients	% undergoing termination
	Terminations (n = 96 871)	All other operations (n = 247 137)		
England and Wales	66.4	90.1	287 015	22.4
Other United Kingdom	2.6	0.3	3 115	79.4
Eire and Europe	26.8	1.8	30 456	85.4
Outside Europe	1.3	4.9	13 391	9.3
Not known	3.0	2.9	10 031	28.5
All countries	100.0	100.0	344 008	28.2

nancy. It is calculated from the summary reports of the 1981 Hospital Inpatient Enquiry that there were an estimated 2 108 539 episodes of elective (waiting list or booked admission) inpatient stays in NHS hospitals—including non-surgical cases—other than for abortion. This is 12 times the number of inpatient admissions to independent hospitals.

REGIONAL DIFFERENCES

The ratio of independent hospital beds to population varied by a factor of 25 between the lowest English region and the highest (table IV). Fifty two per cent of the beds were in the Thames regions and, mirroring this, half of all patients were treated in those regions during the year. Almost all (96%) of the 43 847 non-United Kingdom residents were treated in hospitals in the Thames regions.

Broadly, residents of different regions used independent hospitals according to their local availability. Utilisation rates varied within narrower limits than did bed availability, however, from 153 per 100 000 residents of the Northern region to 1075 per 100 000 for the South West Thames region.

The pattern of interregional migration for abortion is largely dictated by the uneven availability of facilities for this operation and is documented in the annual statistical reports of the Office of Population Censuses and Surveys. Abortion cases apart, three quarters of the patients were treated within their region of residence. Within the four Thames regions there was considerable interregional transfer, but demand from residents of these regions was satisfied almost entirely within one or other of them. Elsewhere there was a more consistent

Independent family practitioner committees

The Health and Social Security Act has received the Royal Assent and from 1 April 1985 family practitioner committees will become autonomous, responsible for employing staff and directly accountable through their chairmen to the Secretary of State for the whole range of their responsibilities. District health authorities and family practitioner committees have been notified in health circular HC(84)19 of the arrangements for appointing members. Nominations are requested by the end of September and ministers would like chairmen appointed by the end of October and members by November or December so that the new authorities can meet at least once as shadow authorities before April 1985. The chairmen will be appointed directly by the Secretary of State and the vice chairmen elected from within the committees. Members will be nominated by various nominating bodies including local medical committees and the latter have been asked by the General

Medical Services Committee to convene special meetings to consider their nominations.

Doctors and the courts

"Doctors and the courts"—a one day symposium to be held at the Pharmaceutical Society of Great Britain, 1 Lambeth High Street, London SE1, on Wednesday 24 October—will provide an opportunity for members of the medical and legal profession to exchange views and experiences on some difficult areas of medicolegal practice.

The symposium, which has been organised by the BMA in conjunction with the Law Society will include the following sessions: Medical evidence in preparing a court case (Mr John L Williams, solicitor); confidentiality and the medical report (Dr Jane Richards, general practitioner); medical evidence and the coroner's court (Dr Douglas Chambers, coroner); the expert witness (Professor Alan Usher, Home Office pathologist and senior police surgeon); and the role of counsel (Mr George

Carman, Queen's Counsel). The sessions will be chaired by Dr Brian Lewis, chairman of the senior hospital doctors' negotiators, and Sir David Napley, member of council and past president of the Law Society.

The registration fee, which includes coffee, lunch, and tea, is £23 for BMA members and £57 for non members. Application forms and further details may be obtained from Mr Andrew Bosi, BMA House, Tavistock Square, London WC1H 9JP.

Pay rises for clinical academic staff

Agreement has been reached between the Medical Academic Staff Committee and the Committee of Vice chancellors and Principals on pay rises for clinical academic staff. Pay parity with NHS doctors has been maintained and clinical academic staff will receive a rise of 3% backdated to 1 April 1984 and a further rise of some 3.9% on 1 November 1984. Details of the revised scales will be published when they become available.

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pattern. Residents of Wales and the Northern region were among the lightest users and were the most likely to have to migrate for treatment.

FINANCIAL PROVISION

Information was provided about the way in which the episode was financed for 80% of the cases in the sample. Excluding patients from overseas and abortion cases, nearly a third (31%) were self financed and 69% were covered by some form of health insurance, 57% through provident associations and 12% through other institutions.

Discussion

Reporting in 1979, the Royal Commission on the National Health Service acknowledged that the private health care sector made important contributions nationally to the provision of nursing care for the elderly and for abortions. In other respects, however, because of the differences in scale, it was considered that the private sector could have at most only a marginal and local effect on the public sector.⁴

The present study has confirmed the wide difference in scale between the NHS and the independent acute hospitals, which form the major part of the private sector. Two years after the Royal Commission reported, however, the independent hospitals' share of elective admissions in England and Wales was at least 7-8%. This is by no means unimportant. Moreover, their collective workload did not consist largely of non-essential, "sideline" surgery. The greater part of it was similar in nature to what the NHS had to deal with, sometimes only after considerable delay, and it did not imply that expensive high technology was being duplicated to any great extent. But neither did it suggest that there are many areas where the NHS might contract out the more complex clinical tasks.

Much of the increase in demand for NHS services relates to repair activity for the aging population. New private health insurance is rarely available to the retired, and the premiums of existing contributors are loaded in old age. In addition, the ability of retired people to self finance their private health care is less than for the working age groups. This explains why the clientele of the independent hospitals is mainly young or middle aged. Abortion apart, however, one in six of the patients in this study was over 65 (of whom two out of five were over 75), and this contribution to the elective surgical care of the elderly should not be dismissed as negligible.

Most indices of medical care usage show a relatively greater uptake among women at all ages after childhood and this is even more pronounced among users of independent hospitals than in the NHS. Most provident association subscribers are in occupational or company schemes,⁵ so this suggests that the main beneficiaries of occupation related health insurance, assuming that a disproportionate number of workers concerned were male contributors, may not have been the workers themselves but their families.

One of the unresolved issues in health care delivery in the United Kingdom is the extent to which the availability of private facilities should bear on the local distribution of NHS resources. The provision of independent hospital resources for acute care varies considerably between the regions. In the well provided regions, however, these facilities are not used to an extent that reflects their greater availability. In part this is because some of the resources are devoted to meeting the demand from overseas—from Europeans whose national policies compel them to seek certain treatments elsewhere, and from patients further afield who come for more advanced surgery. In part, too, some of the additional demand in the well off regions may be for more complex treatment, requiring longer time in hospital. The possibility remains, however, that in some regions all the demand for private

care that can be afforded is being met, and that there is underutilisation of facilities.

If on closer examination this proves to be so this suggests that the independent hospitals are oversupplying resources in some regions and undersupplying the demand in others. This is of some consequence because, though patients do not on the whole seem to be willing to travel out of the undersupplied regions to obtain treatment, they might be willing to use additional locally based facilities.

Rational development of a planned, mixed health economy calls for the fullest intelligence about the activities of each component sector. The sampling methods for data collection used in the present study proved simple to operate and were acceptable to the staff of all but two of the independent hospitals. They could serve therefore as a model for providing both sectors with data to complement that given by the NHS hospitals in the Hospital Inpatient Enquiry, and by the independent hospitals in the statistical return of facilities.

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