Special Article

AMENITY AND PRIVATE PAY BEDS

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Although Section 4 (amenity) beds and Section 5 (pay) beds are the subject of continuing controversy, information about them is scattered and difficult to come by. The purpose of this paper is to bring the available facts together in one place.

The National Picture

Between 1949 and 1961 the total complement of beds in N.H.S. hospitals in England and Wales remained roughly constant. By contrast, pay beds fell by 15% and amenity beds by 13% (Table I). In 1961 there were 5,651 pay beds and 5,143 amenity beds, making up about 1% each of total beds—a slightly smaller proportion than in 1949.

TABLE I.—*National Figures: England and Wales*

	1949	1953	1960	1961
All beds:				
Total complement ('000)	501	509	500	496
In-patients discharged or died (millions) ..	2·9	3·5	4·1	4·3
Average daily occupancy rate (%)	79·3	83·3	82·0	81·5
Average duration of stay (days):				
(*a*) All departments ..	—	43·7	36·3	34·6
(*b*) General surgery ..	—	14·3	12·3	11·8
Waiting-list December 31 ('000)	498	526	466	474
Section 5 (pay) beds:				
Total complement ..	6,647	5,863	5,628	5,651
In-patients discharged or died*	86,064	70,927	82,136	83,928
Average daily occupancy rate (%):				
(*a*) Paying patients ..	n.a.	46·5†	49·5	49·6
(*b*) Non-paying patients	,,	21·6†	17·4	17·6
(*c*) Total		68·1†	66·9	67·2
Average duration of stay (days)	,,	14·5	12·4	12·1
Waiting-list December 31	1,525	889	1,146	1,552
Section 4 (amenity) beds:				
Total complement ..	5,901	6,257	5,345	5,143
In-patients discharged or died*	9,210	22,143‡	n.a.	n.a.
Average daily occupancy rate (%):				
(*a*) Paying patients ..	n.a.	45·9†	39·1	37·4
(*b*) Non-paying patients	,,	34·0†	36·3	38·7
(*c*) Total		79·9†	75·4	76·1
Section 5 (% all beds) ..	1·3	1·2	1·1	1·1
,, 4 (,,) ..	1·2	1·2	1·1	1·0

Sources: Ministry of Health, *Annual Reports; Annual Abstract of Statistics.*
* Paying patients only. †Second half of year. ‡1952.

The average daily occupancy rate for all beds is around 80%. For amenity beds it is rather lower at 75–80%, and for pay beds is well below at 65–70%. Many of the pay beds are scattered over a large number of hospitals, perhaps with only two to four such beds,[1] and this inevitably makes for a lower average rate of occupancy than for public beds. In addition, pay beds in those hospitals tend to be closed if there is a shortage of staff.[2] The opinion expressed in the Guillebaud Report lends support to the view that occupancy rates of both pay and amenity beds need to be interpreted with caution.[3]

Approximately one-fifth of Section 5 beds and two-fifths of Section 4 beds are occupied by non-paying patients. The proportion is falling in the one and rising in the other. Figures published up to 1954 (and then discontinued) showed that only half of the non-paying patients occupied pay or amenity beds on medical grounds.[4] Since 1953 the occupancy rate of paying patients has risen in pay beds (from 47 to 50%) and fallen sharply in amenity beds (from 46 to 37%).

At first sight the fall in the number of pay beds seems odd in view of the rapid rise in the numbers insured privately for hospital rooms and now totalling well over a million. A partial answer to the paradox is that 1949–61 falls into two distinct periods. During 1949–53 the number of pay beds and private patients fell sharply. Since then the number of beds has fallen very little and even rose slightly in 1961; while the number of patients has risen by 18% and has been in line with the increase in N.H.S. patients as a whole. In short, an abrupt fall in demand for pay beds during 1949–53 was succeeded by a sustained rise that shows every sign of continuing.

This rising demand has been satisfied in part by a more efficient use of pay beds. The higher occupancy rate by paying patients has already been noted and, in addition, the average duration of stay has been cut from 14½ days to 12 days, which is in line with the fall in the duration of stay throughout N.H.S. hospitals. But the existence of a waiting-list, although it must be regarded with caution in detail, is an indication of some unsatisfied demand. The waiting-list for pay beds, like that for all beds, is about the same now as in 1949. Unfortunately there is no specific information on where the excess demand is. The position in London is known to be particularly difficult, and in some of the larger teaching hospitals private patients have to wait longer for admission than N.H.S. patients.[5] In 1955 there was a waiting-list of 18 months for a prostatectomy in one London hospital if a private room was required.[6]

A further indication of shortage is the activities of the Nuffield Nursing Homes Trust, which was launched by B.U.P.A. in 1957. The Trust opened eight homes of between 25 and 40 beds in the period 1958–62 and has plans for a further seven homes in order to counter the danger of private treatment being "menaced by a pincer movement of increasing demand and diminishing supply."[7]

In contrast with pay beds, the number of amenity beds rose by 5% in 1949–53 and has since declined by almost a fifth. Again, the number of paying patients more than doubled in the earlier period, and, although information is not available, it seems likely that numbers are now lower. Thus, for whatever reason, the demand for pay beds has risen and for amenity beds has probably fallen over the past ten years.

The Government has not yet revealed its plans for pay and amenity beds in the current hospital building programme. One view is that the number of pay beds may well increase sharply and is based on the fact that many regional boards have asked the leading provident associations for the number of members living in their areas.[8]

An estimate can now be made of the number of beds that could be made available for N.H.S. patients if pay and amenity beds were abolished. The total number of these beds is 10,800. With an average occupancy rate

of 80%, this would mean 8,600 beds. The number of beds occupied by non-paying patients is 1,000 for pay beds and 2,000 for amenity beds. Thus a maximum of 5,600 beds would be released, or 1% of the total. Since beds unused for lack of staff in 1961 totalled over 10,000,[9] it is not easy to see that so drastic a step in public policy would do much to ease any bed shortage that exists.

TABLE II.—*Revenue and Charges*

	1952–3	1953–4	1961–2	1962–3 (Est.)
Section 5 beds:	£	£	£	£
Total revenue	2,100,000	2,172,633	4,137,000	4,470,000
Revenue per bed per year	368	370	732	791
,, ,, patient per year	29–16–0	30–12–0	49–6–0	53–6–0
Average charge per day	—	2–4–0	4–0–0	—
Section 4 beds:				
Total revenue	300,000	344,717	364,000	364,000
Revenue per bed per year	50	55	71	71
Actual charge per week	2–2–0	4–4–0	8–8–0	8–8–0

Sources: Figures for beds and patients from the Ministry of Health *Annual Reports*. Revenue for 1952–3, *Hospitals and the State*, I, Acton Society Trust 1955, p. 35; for 1953–4, Guillebaud Report, Appendix 4; for 1961–2 and 1962–3, *Hansard*, vol. 672, February 18, 1963, col. 7 (written answer).
Notes: (1) Average charge per day for Section 5 beds is derived by dividing the number of occupied beds (by private patients) into the total revenue and expressing the result per day. (2) The weekly charges for Section 4 beds were raised in April, 1953, to 4 guineas, and in January, 1961, to 8 guineas.

The revenue and cost figures are set out in Table II. Total revenue is around £5 million a year, or 1% of total hospital expenditure. Revenue from pay beds has more than doubled over the past ten years. Revenue from amenity beds, on the other hand, has gone up by only a fifth, and, as the statutory charge per week has been raised from 2 to 8 guineas, this supports our inference that the number of paying patients is declining. The average charge per day for pay beds has doubled—from 2 to 4 guineas—and is not markedly out of line with the rise in the cost of N.H.S. beds.[10] Nor does the present 4 guineas a day compare unfavourably with the 5–6 guineas a day charged by the N.N.H.T. for a single room.

The Regional Picture

National averages often conceal as much as they disclose, and this is true of pay and amenity beds. The principal facts are set out in Tables III and IV and relate to 1960. Earlier data referred to below are taken from Ministry of Health Annual Reports.

The number of pay beds designated to regional boards and provincial and London teaching hospitals has fallen since 1949 by 14, 19, and 17% respectively. By contrast, the number of amenity beds in teaching hospitals

TABLE III.—*Regional Figures—Section 5 Beds* (1960)

	No. of Beds	% Distribution	Average Daily Occupancy (%)			All Hospitals	
			Paying	Non-paying	Total	% Pay Beds to Total	Beds per 100,000 Population
Regional Board:							
Newcastle	259	4·6	28·2	33·7	62·0	1·1	10·2
Leeds	332	5·9	50·2	15·2	65·4	1·2	13·1
Sheffield	353	6·3	42·9	18·0	60·9	1·1	9·2
East Anglia	150	2·7	46·0	18·9	64·9	1·2	11·5
Metropolitan regions:	1,101	19·6	47·4	20·6	68·1	1·3	14·6
N.W.	256	4·5	60·0	16·2	76·6		
N.E.	207	3·7	38·1	29·2	67·3		
S.E.	332	5·9	41·8	21·5	63·3		
S.W.	306	5·4	49·2	16·9	66·1		
Oxford	206	3·7	47·2	13·3	60·5	1·6	15·3
Wales	99	1·8	31·3	23·2	54·5	0·4	3·7
Birmingham	513	9·1	37·0	23·9	60·9	1·5	13·4
Manchester	403	7·2	54·1	8·4	62·5	1·2	11·5
Liverpool	191	3·4	34·5	24·0	58·5	1·1	12·6
Wessex	201	3·6	46·6	22·0	68·6	1·1	12·1
South-Western	333	5·9	36·5	17·9	54·4	1·1	12·3
All regional boards	4,141	73·6	43·4	19·6	63·0		
London teaching	924	16·4	73·1	6·6	79·7		
Provincial ,,	563	10·0	56·1	18·4	74·5		
Total	5,628	100·0	49·5	17·4	66·9	1·2	12·2

Sources: *Hansard*, vol. 640, May 9, 1961, cols. 31–32 (written answer). *A Hospital Plan for England and Wales*, Cmd. 1604, 1962, pp. 274–5.

TABLE IV.—*Regional Figures—Section 4 Beds* (1960)

	No. of Beds	% Distribution	Average Daily Occupancy—%			All Hospitals	
			Paying	Non-paying	Total	% Amenity Beds to Total	Beds per 100,000 Population
Regional Board:							
Newcastle	212	4·0	21·5	52·2	73·7	0·9	7·8
Leeds	449	8·4	54·3	15·2	69·5	1·4	15·3
Sheffield	476	8·9	42·4	48·4	90·8	1·4	11·5
East Anglia	107	2·0	22·8	41·8	64·6	0·8	8·1
Metropolitan regions	1,726	32·3	49·1	29·7	78·8	1·1	14·2
N.W.	316	5·9	45·0	43·0	88·0		
N.E.	168	3·1	37·8	37·3	75·1		
S.E.	339	6·3	27·7	48·4	76·1		
S.W.	903	16·9	60·8	17·5	78·3		
Oxford	152	2·8	24·7	37·8	62·2	1·1	10·0
Wales	104	1·9	18·2	43·1	61·3	0·4	3·9
Birmingham	465	8·7	21·8	43·0	64·8	1·1	9·9
Manchester	355	6·6	40·7	31·2	71·9	1·0	9·5
Liverpool	146	2·7	34·2	35·9	70·1	0·7	8·6
Wessex	290	5·4	35·1	42·7	71·8	1·2	17·4
South-Western	398	7·4	36·4	40·3	76·7	1·2	13·8
All regional boards	4,880	91·3	40·2	35·2	78·4		
London teaching	253	4·7	26·5	44·5	71·0		
Provincial ,,	213	4·0	28·2	52·8	81·0		
Total	5,346	100·0	39·1	36·3	75·4	1·1	11·6

Sources: As for Table III.

has risen by 50%, although those hospitals still have less than 10% of total amenity beds, compared with more than a quarter of pay beds.

There were divergent movements as between regional boards 1949–60. Five boards (East Anglia, S.E. Metropolitan, Oxford, Birmingham, and Liverpool) increased their number of pay beds, and their share of those beds in the regions (excluding teaching hospitals) rose from a quarter to a third. The largest proportionate increase was in Oxford, where the number of beds nearly doubled. The other nine boards reduced their numbers,[11] the largest proportionate decrease being a cut of over a third in the South-West Region. It seems evident that the original designation of pay beds was too large in relation to demand in some regions and too small in others and that consequent adjustments have been taking place. Adjustments in the regional distribution of amenity beds have been more radical. The fall in the national total since 1949 conceals the fact that eight regions, taken together, have increased their numbers by a half and have lifted their share of amenity beds in the regions from under a quarter to over two-fifths. In the other six regions beds have fallen by a third. Amenity beds in North-West Metropolitan Region rose more than threefold and in South-East Metropolitan Region fell by well over a half.[12]

The limitations of national averages are underlined by occupancy rates. For pay beds the London teaching hospitals have an occupancy rate of 80%—the average of the N.H.S. hospitals. The provincial teaching hospitals and the North-West Metropolitan Region have slightly lower rates. Thus nearly a third of pay beds are used with approximately the same intensity as N.H.S. beds. Again, the average of 17% occupancy by non-paying patients in pay beds conceals a range from 6% to over a third in the Newcastle Region, where there are fewer paying than non-paying patients. There are similar contrasts for amenity beds. Occupancy rates of around 90% are recorded for the Sheffield and N.W. Metropolitan Regions. The differing proportions of paying and non-paying patients are also striking. For example, Newcastle and Leeds Regions have similar occupancy rates and have much in common in industrial and social structure. Yet Leeds has 54% paying occupants and Newcastle only 22%. The pattern in teaching hospitals is the same: Newcastle has no paying patients and Leeds has 50%. While demand may differ somewhat, the common-sense inference is that administrative policy encourages paying patients in Leeds and discourages them in Newcastle.

The adjustments since 1949 have brought the number of pay beds in the regions (including teaching hospitals) into some rough equality in relation to population. The outstanding exception is Wales, which was low to start with and now has only 4 beds per 100,000 population, compared with the national average of 12. Oxford has achieved the most rapid increase in relation to population and now stands well above average.

Amenity beds are less uniformly related to population, but again Wales comes out at the bottom. Leeds stands out as an area which started relatively well endowed with amenity beds and which has since improved its position.

Charges for pay beds vary widely. In 1958 a range of £26 to £38 a week in a London teaching hospital contrasted with £14 to £19 a week in a small country-town hospital.[13] Earlier, the Guillebaud Committee made a detailed investigation of maternity hospitals in three regions and found a range of £14 to £26 a week.[14] Little is known about why charges differ so widely, often between hospitals that appear to be comparable.

Conclusion

This necessarily dry survey will serve its purpose if it leads to more accurate and balanced public discussion. For example, it should no longer be possible for a prominent authority to say: ". . . the occupancy of Section 4 beds is probably around 80%. . . . In other words, the beds are filled with patients who need privacy on medical grounds. This does not happen with Section 5 beds. The implication of all this is that, on present demands, there are probably about the right numbers of Section 4 beds. . . . But, by the same calculation, the implication is that we have rather too many Section 5 beds, since their occupancy rate is so low."[15]

Our survey enables us to make the following corrective comments: (1) The occupancy rate for amenity beds varies regionally between 60 and 90%. Four regions have rates of less than two-thirds. (2) Not more than 20% of amenity beds are occupied by patients needing them on medical grounds. (3) Around 10% of pay beds are occupied by non-paying patients needing them on medical grounds. In some teaching hospitals non-paying patients occupy 60% of pay beds, and the proportion is over a fifth in six regional boards. (4) Our regional picture suggests that, for both pay and amenity beds, there may be shortages in some areas and surpluses in others. There is no evidence that, overall, there are too many pay beds or enough amenity beds. (5) Low occupancy rates do not apply to one-third of total pay beds, and, for the rest, factors other than lack of demand may account for lower occupancy rates. More detailed inquiry would be needed to be certain either way.

Finally, we would plead for more published information from the Ministry of Health and urge the need for further research. Whatever the direction of public policy with regard to pay and amenity beds, it should be charted firmly on knowledge. This paper may help a little, but it does no more than scratch the surface.

REFERENCES

1 *Hansard*, vol. 603, April 14, 1959, col. 1000.
2 Ibid., vol. 540, May 4, 1955, col. 1746.
3 *Report of the Committee of Enquiry into the Cost of the National Health Service*, Cmnd. 9663, 1956, para. 420.
4 Ministry of Health, *Annual Reports*.
5 *Hansard*, vol. 603, April 14, 1959, col. 1000.
6 Dr. J. Hunt, *Brit. med. J. Suppl.*, 1955, 2, 81.
7 Nuffield Nursing Homes Trust Leaflet, 1963, p. 1.
8 *Financial Times*, January 12, 1963.
9 Ministry of Health, *Annual Report 1961*, Cmd. 1754, 1962, p. 148.
10 *Hansard*, vol. 636, March 14, 1961, col. 1337.
For information on the basis of charging for pay beds and the changes that have taken place since 1948, see:
Hansard, vol. 468, October 19, 1949, col. 570.
Ibid., vol. 514, April 29, 1953, cols. 2283, 2299.
Lancet, 1952, 2, 229; 1953, 1, 637; 1958, 2, 1361.
11 For comparative purposes, Wessex is included in the South-West Metropolitan Region.
12 Official policy on increases in the numbers of pay and amenity beds was stated in 1958 by the then Minister of Health, Mr. D. Walker-Smith: "I am always prepared to consider proposals both for private or amenity beds where this is possible and where, in the view of the regional hospital board, there is a demand." *Hansard*, vol. 587, May 5, 1958, col. 826.
13 *Lancet*, 1958, 2, 1361.
14 *Report of the Committee of Enquiry into the Cost of the National Health Service*, Cmnd. 9663, 1956, para. 421.
15 Mr. Kenneth Robinson, *Hansard*, vol. 636, March 14, 1961, col. 1328.