RISK MANAGEMENT AND PRIVATE HEALTH CARE IN UNITED KINGDOM

by **Yvette Gillies, B.A.(Hons)**
and **Alan B.Watson, M. Phil., FCII.**

Although public and private health care have continually coexisted in U.K., with the advent of the National Health Service, there was a dramatic decrease in subscribers to medical insurance; however in 1970, private health care re-emerged.

The failure of the reorganisations of the National Health Service in 1974 as well as in 1982 caused a wave of dissatisfaction and criticism which put the blame on poor management and allocation of funds within the service; as a result, patients returned to the private sector. (1)

This surge of private hospital insurance in the eighties with growing private hospital facilities and the restructuring of contracts meant that there were indead a sufficient number of consultants and adequate facilities to meet this demand. The presence of risk management philosophies became evident in the private sector from the increase in efficiency and subsequently, popularity and credibility of private health care.

Although an NHS Directive 'Risk Management in the NHS' was published in 1994 and was recommended reading for all chief executives and their staff, this represented the first service publication with direct reference to risk management. Prior to this publication, the National Health Service had evidently been struggling with the

concept of risk management within the system. (2) (3)

Current literature makes limited reference to management or risk management and appears to concentrate on the medical structure and sources of funds without acknowledging that the National Health Service is a business.

In his article "The Role of the Risk Manager in Hospitals" (4), Jim Roy suggests a model risk management structure which should be adopted by all hospitals. Similarities between this model and that proposed by the NHS Executive (5) can be established.

History and Development of Private Health Care

Throughout the nineteenth century, working men entered contributory schemes whereby medical treatment was received in the event of ill-health. Following the launch of the National Health Service in 1948, it was expected that the demand for private health care would evaporate as the public took advantage of the 'free' public system. However, the public and private health care sectors have normally operated in parallel. (1)

Prior to the launch of the National Health Service, Aneurin Bevan (the then Minister of Health) had negotiated with consultants and had allowed a number of pay beds in National Health hospitals which were to be allocated to private patients. Consultants were permitted to have part-time contracts with the National Health service thus enabling them to also pursue a private practice career. These general practitioners enjoyed this status as independent contractors to the National Health Service. (3)

Beds in private nursing homes were often allocated to National Health patients such as the elderly or infirm, the cost being met by subsidies from the State. (6)

In 1951 optical and dental charges were reintroduced by the Labour Government. The Conservatives supported this change by later including prescriptions within the charges. These charges have remained part of the National Health Service as a means of additional funding. (7)

As stated in the beginning of the article, with the advent of the National Health Service, there was a dramatic decrease in subscribers to medical insurance. However, in 1970 private health care re-emerged on the political scene. Critics of private practice feared that it would have a detrimental effect on the public

attitude to health care. (6)

- pay beds in National Health Service hospitals were heavily subsidised from public funds.
- many attributed the increase in waiting lists to the fact that pay beds remained empty to accommodate private patients who required treatment.
- a two-tier system would seem to have been created.

In February 1974, the Labour Government won the General Election and pledged to phase out private practice from the hospital service. This attitude was mirrored by the National Union of Public Employees (NUPE) which launched a campaign against paybeds via industrial action and strikes throughout the country.

In an attempt to remedy the situation, the Labour Government negotiated a new contract for consultants. The new contract encouraged consultants to work full-time for the National Health Service. The NHS offered incentives to consultants to work in deprived areas and to provide services such as provision for the elderly or mentally ill. The consultants were willing to be paid according to the amount of work undertaken, and the Government offered rewards to those consultants who worked exclusively for the National Health Service and not on the then existing merit award system. (8)

Although Labour insisted that its intentions were simply to separate public and private practice, the consultants believed their motive was to abolish private medicine, thus making the consutants financially dependent on the State and without professional independence. The proposals were rejected and industrial action ensued.

A compromise was eventually negotiated by Lord Goodman and this centred upon the establishment of the NHS Health Service Board in 1977. The aim was to regulate the process and permit the retention of paybeds in those areas where the demand for private medicine was insufficient to support alternative facilities.

The Health Service Act 1976 was aimed at reducing the number of private beds in National Health Service hospitals besides being an attempt to appease the consultants by allowing and protecting private practice. (3)

Growth in Private Sector

In an attempt to attract new

customers, the Provident Association (the main private insurer) built new hospitals and offered group insurance schemes to skilled workers and union members. However, the dispute was not fully resolved until the Conservative Government which was elected in 1979 reversed the policy. (The Health Service Board was abolished under the Health Service Act 1980). The new consultants' contract of 1979 would also allow a full-time consultant to earn up to 10% of his National Health Service earnings from private practice. (9)

As pointed out already there were sufficient consultants and adequate facilities to meet the spurt in demand for private medicare.

There was considerable internal support for the concept of privatisation within the 1979 Conservative Government. However committed to a free market, Thatcher was unable to reduce the role of the National Health Service and replace it with a system based on private provision: this presented unacceptable political costs. The solution was to combine the provision of public health care with a secondary provision from the private sector. Larger proportions of the population were urged to include private health care and pay beds in National Health hospitals increased. (10)

Private Health Insurance

The costs involved in a routine private operation were high and would increase in the event of complications forcing the patient to remain in hospital longer than anticipated. For those reasons, patients met the costs through private medical insurance.

The existence of the Provident Association was threatened by the National Health Service and commercial activities reduced dramatically in the years inmediately following 1948. But business activity actually showed a spurt in the Fifties. This could be attributed to an increase in the prosperity of the 'middle class' as well as the growing financial constraints and subsequent popular dissatisfaction with the National Health Service. The private sector enjoyed a slow but steady growth during the following two decades, though there was evidence of a fall consequent on industrial action against National Health Service pay beds system in 1975 and 1976. (11)

The confidence in the private health sector did not diminish, and new hospitals were being built. Though considerable growth had been achieved in the health care market when the Conservatives returned to power in 1979, the

increased costs of private health care and increased premiums did contribute to a reduction in growth. Statistically speaking, one in every 10 adults were insured by 1990. (1)

The existing and new markets

Three main Provident Associations account for 90% of subscribers to private medical insurance as follows: (12)

1. British United Provident Association (BUPA): 45% of market.
2. Private Patients Plan (PPP): 27% of market and
3. Western Provident Association (WPA): 7% of market.

Although these organisations have non-profit status, they are not charitable organisations but are, in fact, commercially administered with a market value of L1 billion.

The newcomers to the private Health care insurance market include the following :

- commercial life insurance companies,
- building societies and
- high street banks.

Private Hospitals

In 1957, BUPA established an independent charity called the Nuffield Nursing Homes Trust (now Nuffield Hospitals) with the aim of developing a chain of private hospitals throughout the country.

Following Labour's attempt in the 70s to phase out private health care, the private sector embarked on an ambitious programme to increase the number of private health beds outside the National Health Service. This hospital building programme was aided by Thatcher's decision to scrap the Health Service Board in 1979.

The change benefited American companies which aimed to provide for the luxury sector of the market and overseas patients. In 1970, American Medical International (AMI) became the first American hospital company established in Britain when it purchased the Harley Street Clinic. (13)

In 1976 the Humane Corporation bought the Wellington Hospital in London. The advent of this new commercial market forced the closure of several religious and charitable private hospitals who could not compete. By 1984, AMI was rivalling the Nuffield Hospitals as the largest private hospital group in the UK. In an attempt to maintain and

create its own chain of hospitals, BUPA established its own organisation, BUPA Hospitals Limited.

Throughout the 1980s, there was an increase in demand for private health insurance and a subsequent growth in the number of private hospital beds. Between 1979 and 1990, the number of private acute hospitals rose from 149 to 216, reflecting an increase of 10,906 beds. (12)

Private hospitals are subject to considerable pressure from shareholders to ensure a high return on investment. If the public observe private health care costs to be excessive, the hospitals will be priced out of the market as will private health insurers. (14)

Health Care Risk Management

Health care risk management had come to be established in American hospitals in the early eighties and by the early nineties, similar developments were beginning in the UK. The growing interest in the area may be attributed to the increasing problem of medical litigation. (15)

In the context of health care, risk management identifies untoward incidents which put a patient's safety at risk. It aims to reduce those risks with a consequent improvement in patient care and a reduction in medical negligence claims.

The elements of risk identification, analysis, control and evaluation can be applied to health care in the following ways:

Risk Identification

In health care risk management, incidents must be dealt with. Incidents include any adverse occurrences regardless of whether or not actual injury or harm has been suffered by the patient. To identify the risks, specific incidents or specific areas of practice must be targeted.

Examples:
- casualty departments
- intensive and coronary care units
- anaesthetic rooms
- operating theatres
- pharmacies
- delivery suites

Identification measures can be implemented at little additional expense in most hospitals and practices.

The following, among others, could be useful secondary sources of risk information:
- patient services office
- chaplaincy service
- social services department

- infection control staff
- audit reviews
- medical records

In the same manner, it is imperative that risk management philosophies and policies are communicated from senior management to the shop floor and medical professionals and other service employees must not feel that the purpose of risk management is to make their job more laborious: their co-operation is vital.

It must be fully understood that incident reporting ensures that injuries to patients are investigated and recorded to prevent further occurrences of 'near misses' and to enable departments to carry out quality assurance.

Risk Analysis

The second stage of the risk management process is risk analysis.

Central to risk analysis is the risk management committee, which should include:

- medical staff, including nurses
- pharmacy
- administration and legal advisors

The committee may analyse individual incidents and assess patterns of incidents in order that preven-tative measures can be instituted.

The committee should also co-ordinate educational programmes for all employees.

Risk Control

This stage is concerned with controlling the risk of loss and also the financing of potential loss. It is an assessment of the medical standard of care provided by a particular service.

This can be as elementary as ensuring that there is an appropriate count procedure in the operating theatre for surgical instruments.

Control may also be achieved through loss reduction. This may involve decreasing the potential severity of a loss exposure.

Risk Evaluation

The risk management process must be constantly reviewed and reevaluated in its entirety in order to ensure its accuracy and effectiveness.

This may involve a review of:

- incident reporting
- input of medical staff
- policies and procedures and
- staff education

Achieving Risk Management Objectives in Hospitals

To be effective, any risk management programme must involve:

- staff education
- data collection
- incident prevention and
- claims management

Employee education is crucial as medical professionals and other service employees may initially be hostile towards the implementation of risk management: it may be seen as an easy option for hospital management to allocate blame to individuals and department.(16)

Only by involving employees in educational seminars will the nature of the legal concepts of the risk management process be understood and co-operation achieved. Prevention of incidents prior to their occurrence is preferable to identification following their occurrence. By utilising data collected, specific high risk areas may be targeted.

RATIONALE: The Need for Risk Management within Health Services

Major incidents such as King's Cross, Hillsborough and the Clapham Rail Disaster in the UK have increased the public's awareness of risk and their expectancy of the implementation of safety systems. Additionally, the 'trials by media' following such incidents have greatly influenced the public's perceptions of organisations.

Recent alterations to Legal Aid Regulations state that Legal aid is no longer determined by an individual's means. Subsequently there has been an increase in legal action by the British public. There has been an increase in patient's claims, for example awards in excess of L 1 million in respect of children who suffered brain damage at delivery. The National Health Service has also experienced increasing claims by employees, for example, in 1992, L 203,000 was awarded to a nursing assistant after sustaining a back injury while lifting a patient.

Legislation such as the Health and Safety At Work Regulations 1974 requires compliance from all organisations. Due to the removal of Crown Immunity in 1991, the National Health service is now as vulnerable to the consequences of failure to comply with legislation as other companies.

The recent National Health Service reforms and the introduction of Crown Indemnity in January 1990 have meant that the financial consequences of risk now fall on National Health Service Trusts and Health authorities directly. Hospitals

are now liable for acts of negligence or omissions by medical as well as non-medical staff including ancillary workers and contractors.

The responsibility of claims settlements and other indirect expenses now lie with the Service itself, for example:

- investigation time (court appearances)
- cost of replacement staff (who may have less experience which may increase the risk)

If shortfalls in patient care are apparent, purchasers of health services will look less favourably on hospitals.

The costs resulting from risks must be met from already limited budgets and by paying for the consequences of untoward incidents, less funding will be available to the National Health Service for the treatment of patients, research of new technologies and education: the ethos of the service.

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