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Northern Ireland Audit Office

Private Practice in the Health Service

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

HC 1088, Session 2005-06, 18 May 2006

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Comptroller and Auditor General

Northern Ireland Audit Office
16 May 2006

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Abbreviations

HRG	Healthcare Resource Groups
NHS	National Health Service
PA	Programmed Activity
PPO	Private Patient Officer

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Background

1. Most health care systems throughout the world involve a mixture of public and private provision. In Northern Ireland health care, in the main, is provided publicly and financed by general taxation, with user charges applied to certain services (dental services). The Department of Health, Social Services and Public Safety (the Department) has the statutory responsibility to provide or to ensure the provision of health and social care for the population of Northern Ireland. It carries out this responsibility through four Health and Social Services Boards and 19 operationally independent Trusts.

2. However, when the health service was established in 1948, it was recognised that it would operate alongside a private health sector and this has remained a feature of health provision. Recent statistics[1] record that nine per cent of all households in Northern Ireland have private health insurance compared to the United Kingdom average of 17 per cent. This study examines a number of aspects of the interaction between public and private health care.

3. Private practice in hospital Trusts in Northern Ireland is carried out under the Health and Personal Social Services (Northern Ireland) Order 1972, Articles 31 and 32. The statutory framework and key principles which govern private practice in the health service are set out in the Departmental handbook '*The Management of Private Practice in Health Service Hospitals in Northern Ireland*' – known as 'The Red Book'. This guidance was first issued in 1989 and was re-issued in 1992 to reflect the formation of Trusts. It remains today as the Department's definitive guidance on the organisation and management of private practice. In addition, the Department introduced a Code of Conduct for Private Practice in November 2003, setting out a series of best practice standards for consultants in relation to private practice. It is the responsibility of Trust management to ensure compliance with the statutory framework and the "six principles" which govern private practice on their premises. The six principles are set out below:

- the provision of accommodation and services for private patients should not significantly prejudice non-paying patients;
- subject to clinical considerations, earlier private consultation should not lead to earlier Health Service admission or to earlier access to Health Service diagnostic procedures;
- common waiting lists should be used for urgent and seriously ill patients, and for highly specialised diagnosis and treatment. The same criteria should be used for categorising paying and non-paying patients;
- after admission, access by all patients to diagnostic and treatment facilities should be governed by clinical considerations. This does not exclude earlier access by private patients to facilities especially arranged for them if these are provided without prejudice to Health Service patients and without extra expense to the Health Service;
- standards of clinical care and services provided by the hospital should be the same for all patients. This does not affect the provision, on separate payment, of extra amenities, nor the custom of day-to-day care of private patients usually being undertaken by the consultant engaged by them; and
- single rooms should not be held vacant for potential private use longer than the usual time between Health Service patient admissions.

4. Under current arrangements, consultants[2] employed within the publicly funded health service have the opportunity to work in the private sector. In the United Kingdom, most private medical services are provided by consultants whose main

1 Family Resources Survey Northern Ireland 2003-04

2 Consultants are highly trained senior doctors, normally appointed following a specified programme of medical training which usually requires work as a junior doctor for at least seven years following initial qualification.

commitment is to the National Health Service. A recent estimate[3] suggests that about 30 per cent of all health care consultants in the United Kingdom do no private practice work and also pointed out that 20 per cent of those doing private practice work had private incomes of less than £10,000 per annum .

5. Until April 2004, the contract that provided the framework governing the working conditions and salary grades of consultants had been in existence since 1948. Over that period of time it had not changed substantially. The contract gave consultants the right to undertake private practice alongside their health service duties where this was not to the detriment of their health service commitments. The Department and hospital Trusts sought to ensure that consultants fulfilled their health service commitments by agreeing duties on the basis of notional half days, and by imposing limits on the income consultants could earn from private practice. Prior to April 2004, consultants who wished to undertake private practice could do so under contractual provisions in one of two ways:

- those on "whole-time" contracts could earn up to 10 per cent of their full health service salary from private practice which was regarded as a means of ensuring that whole time consultants' private practice did not interfere with their health service commitments; or
- those on "maximum part-time" contracts (i.e. receiving 10/11ths of the full salary) had no restrictions placed on their private sector earnings.

6. Following lengthy negotiations between the Government and the British Medical Association, consultants in Northern Ireland and across the United Kingdom voted to accept the provisions of a new contract in January 2004. The first important change in the consultant contract is the explicit link with an agreed job plan. The contract allows for a set number of "programmed activities" (PAs) each lasting 4 hours. A full time consultant will have a job plan based on 10 PAs, of which the expectation is that an average of 7.5 PAs will be dedicated to direct patient care (the remainder is for supporting activities such as continuing professional development, administration, research, clinical audit etc).

7. Job plans are drawn up on an annual basis, based on agreement between a consultant and his/her Trust, setting out the consultant's duties (including private work), responsibilities and objectives. The plans are anticipated to be flexible allowing agreement, for example, on some longer working days (3 PAs in one day). With planned sessions in the evening or the weekend, greater productivity and efficiency is anticipated from the use, for example, of operating theatres. In return, consultants can achieve planned flexibility in their working week, so long as it is secured with the prior agreement of their clinical manager.

8. The new contract has been available for implementation by Trusts from April 2004 with the "maximum part-time" contract ceasing to exist, the "ten per cent rule" disappearing and no restrictions placed on a consultant's private earnings. All existing consultants (i.e. those whose first consultant appointment was to a post advertised before 15 January 2004) were given the option of taking up the new contract or the old contract. Consultants taking up a post first advertised after 15 January 2004 will be employed automatically under the terms and conditions of the new contract.

What are the issues?

9. Against the background of emerging new contract arrangements, Part 1 of the report focuses on how the Department and Trusts have monitored and managed consultants to date to ensure that they fulfil their commitments to the health service. We consider that drawing out lessons from recent experience under the previous contract will be of particular relevance to the Department and Trusts as they embark on the management of the new contract .

3 J. Ford, *What Price Consultants?* , Presentation at RCOG Conference, March 2004 (www.fipo.org)

10. An issue related to consultants undertaking private practice within hospitals is that it can provide Trusts with an additional income stream. Indeed there are rigorous accounting rules in place to ensure that Trusts recover the full costs of private treatment undertaken within their facilities. Therefore, Trusts need to ensure that they have effective management and accounting systems in place, so that they are able to monitor and control costs and set fees at levels that recoup the full costs incurred. Part 2 of the report examines how successful Trusts have been in recovering the full cost of services provided to patients receiving private health care and identifies opportunities for enhancing the cost recovery process.

Methodology

11. Our examination of the issues surrounding the management of private practice in hospitals was informed to a large degree by visits to a sample of seven hospital Trusts, covering nine locations across the health service. At each Trust we examined the systems for identifying, recording and invoicing patients and the procedures in place to assure managers that all the consultants employed by Trusts were meeting their contractual commitments. The result of these visits will be referred to as appropriate. We also issued self-survey questionnaires to the Chief Executives of all Trusts where private practice takes place and we are grateful to these Trusts for the time taken to complete the survey questionnaire.

12. Advice on the report was provided by Maurice Dunlop, a retired obstetrician and gynaecologist and former Chairman of the British Medical Association (Northern Ireland). We are grateful for his input.

Executive Summary

13. Most consultants are highly committed to their work in the health service and many of them work above and beyond their strict contractual obligations. However we found that, prior to the introduction of the new contract in 2004, the quality of timetabled work programmes held by Trusts was often poor and that none of them undertook any systematic or routine monitoring of compliance by consultants with their work programmes. As a result, the relationship between the work of consultants in the health service and their private practice has been overshadowed by a lack of clarity and a lack of accountability.

14. The new contract heralds an entirely fresh approach to managing consultants, based on the overriding principle that a consultant's first and foremost commitment is to health service patients. This provides the basis for improving the management of consultants, and Trusts need to ensure that they capitalise on the opportunity if they are to provide assurance to patients and taxpayers that they are meeting modern standards and requirements of accountability.

15. We also found that the present arrangements for recovering the costs of treatment provided privately in health service hospitals were not always satisfactory. There was evidence of slow recovery of costs from private insurers and a lack of basic debtor controls to gather money owed for treatment received, which is not compatible with a commitment to good governance and accountability and fails to achieve value for money. In our view there is, therefore, an urgent need for some Trusts to improve their cost recovery systems so that the full potential of income generation is realised and the needs of accountability are fully satisfied.

Part 1

Consultants and Private Practice

Consultants are free to undertake private practice

1.1 Twelve acute hospital Trusts provide surgical and medical services in Northern Ireland at a cost of approximately £1 billion per annum. Eighteen acute community and combined Trusts currently employ 1,100 consultants spread across a wide range of clinical specialisms (see Appendix 1).

1.2 In emergency situations, patients access hospital services either through Accident and Emergency departments or through direct referral from their General Practitioner. For elective admissions a patient has an initial appointment with his/her General Practitioner after which, if the General Practitioner considers it necessary, the patient may be referred to a medical consultant. The consultant then decides whether the patient should be admitted to hospital. Depending on clinical need, a patient is either admitted immediately or put on an inpatient waiting list. While public health care is free at the point of consumption, patients may opt to visit a consultant privately and pay for treatment or cover this through private medical insurance.

1.3 There are indications that the private sector provides an increasing amount of non-urgent treatment. Some of this additional activity will reflect contracts with the health service specifically to address long waiting times. The recent independent review of health and social care services[4] reports that private activity in Northern Ireland hospitals accounted for 1.4 per cent of all finished consultant episodes in 2003-04 and 0.6 per cent of out-patient attendances. Whilst this is a relatively small proportion, the review notes that over the five years from 1999-00 to 2003-04, while the number of private day cases has fallen by 3 per cent, the number of in-patients has increased by 12 per cent and outpatients by 42 per cent. Over half of all these outpatient attendances were for two specialties, gynaecology and cardiology.

Concern about conflict of interest in consultant contract arrangements in Great Britain

1.4 As pointed out at paragraph 5, the contractual arrangements governing the employment of consultants had, until 2004, been in place virtually unchanged from the inception of the National Health Service (NHS) in the United Kingdom in 1948. However, over the years criticism of the contract in Great Britain continued to grow from both Parliament and the medical profession[5], and was highlighted in a report by the Health Select Committee in 1999[6]. Focusing specifically on the situation in Great Britain, the Committee highlighted what it considered to be a number of drawbacks linked to the operation of the contract. In particular, it found that accountability was limited by a general absence of information about the public and private work of consultants. In its view, this was compounded by the failure of Trust managers to adequately monitor and control the activity of consultants through the effective use of job plans and appraisal.

Experience in Northern Ireland

1.5 The Select Committee's concerns and findings were based on evidence from Great Britain and did not refer to Northern Ireland. Indeed, the situation in Northern Ireland was and continues to be markedly different to that in Great Britain. Not only is private work in health service hospitals significantly lower, but also the private

4 *Independent Review of Health and Social Care Services in Northern Ireland*, Professor John Appleby, August 2005

5 For example, *Private Eye, Heart and Hip: Surgical Consultants, the National Health Service and Private Medicine*, J. Yates, London, Churchill Livingstone, 1995; and *The two tier syndrome behind waiting lists*, D. Light, British Medical Journal; 320: 1349, 2000.

6 *Consultants' Contracts*, Westminster Select Committee on Health, 3rd Report, Session 1999-2000, June 1999, HC 586.

sector itself is much smaller. For instance, of the total acute health care spend of around £1 billion in 2003-04, some £6.2 million was generated from private practice, a contribution of £3.60 per head of population. In Great Britain, in the same year, the National Health Service earned about £408 million from private practice, proportionately just under double that of Northern Ireland and the equivalent of £7.00 per head of population. However, against the background of the Committee's concerns, and prior to the introduction of the new contract from April 2004, we visited seven Trusts in 2003 to gain an understanding of how well they had performed in managing the contractual obligations of the consultants they employed. These Trusts were:

- Royal Group of Hospitals HSS Trust;
- Belfast City Hospital HSS Trust;
- Green Park Healthcare HSS Trust;
- Altnagelvin HSS Trust;
- Craigavon Area Hospital HSS Trust;
- Down Lisburn HSS Trust; and
- United Hospitals HSS Trust.

1.6 In general, we found that the quality of timetabled work programmes held by Trusts was often poor and that none of them undertook any systematic or routine monitoring of compliance by consultants with their work programmes. As a result, there was insufficient evidence at the Trusts visited to enable us to make a judgement as to the extent to which health service commitments were fulfilled. All Trusts visited reported that the great majority of their consultants worked more than their contracted hours. Although systematic and routine monitoring of compliance by consultants with their work programmes was not in place, the limited evidence that was available did not suggest significant non-compliance by consultants with their contractual obligations.

1.7 With regard to the small percentage of total activity delivered privately, in addition to the limited evidence available from Trusts' medical infrastructure arrangements as set out in paragraph 1.6, they also monitored consultants' contractual commitments by sending whole-time consultants a statement, asking them to declare that their earnings from private practice had not exceeded ten per cent of their health service earnings over the previous 12 month period. In our view, a declaration of earnings statement provided little additional evidence to Trusts that consultants were fulfilling their contractual obligations. While Trusts may have requested audited accounts if they had grounds to seek further information, none of the Trusts we visited had ever done so. If the ten per cent limit was exceeded in two successive years, the consultant was required to reduce earnings below the limit in the third year or transfer to a maximum part-time contract (see paragraph 5). The effectiveness of this control largely depended on consultants' declarations. However, we observed from an Internal Audit report that, in 2002, one Trust had not actually issued declarations of private earnings to consultants despite the fact that there was substantial private practice in the Trust. While the self-declaration mechanism was in place at the seven Trusts we visited, some applied it more rigidly than others. Audit testing in three of the Trusts we visited also revealed minor administrative errors which led to the overpayment of consultants, raising some doubts as to the application of this control in those institutions.

The new contract offers the opportunity to improve the management of consultants' activity

1.8 To transfer to the new contract, consultants have had to give a formal commitment to the Chief Executive of the Trust. This commitment is subject to agreeing a satisfactory job plan with their clinical manager. Consultants who have taken up a post advertised after 15 January 2004 have been employed automatically under the terms and conditions of the new contract. Consultants appointed to a post advertised before 15 January 2004 were given the choice of remaining on the old contract or transferring to the new contract. The Department told us that, by 1st October 2005, 70 per cent of consultants had agreed to job plans and signed up to the new contract and this is expected to rise substantially in future months.

1.9 The new contract is designed to provide a much more effective system of planning and timetabling consultants' duties and activities for the health service. For health service employers, this will mean the ability to manage consultants' time in ways that best meet local service needs and priorities. For consultants, it will mean greater transparency about commitments expected of them by the health service and greater clarity over the support they need from employers to make the maximum effective contribution to improving patient services.

1.10 As indicated in paragraphs 5 and 6, the job plan spells out clearly what the health service can expect from its consultant workforce. It is based on a committed number of programmed activities per week, each of four hours. While the full-time commitment is ten programmed activities, there is no specific limit on the number of programmed activities that may be agreed in a job plan although this will be influenced by the provisions of the European Working Time Directive.[7]

1.11 Job planning is also linked closely with an agreed appraisal scheme for consultants. Both the appraisal and subsequent job plan review are informed by information on the quality and quantity of the consultant's work over the previous year. Appraisal is a process to review a consultant's work and performance, to consolidate and improve on good performance and identify development needs that will be reflected in a personal development plan for the coming year. Job plan review will take into account the outcome of appraisal discussion on working practices, including the role of the individual consultant in the clinical team, and clinical governance responsibilities and continuing professional development as set out in the agreed personal development plan. Both processes will involve discussion of service objectives and linked personal objectives, including to what extent these objectives have been met (or what factors outside the control of the consultant have affected delivery) and to what extent the objectives were realistic.

7 The European Work Time Directive was introduced in 1998 to protect workers against excessively long working hours.

1.12 Regardless of the provisions of the new contract, consultants were already required to have job plans for more than ten years previously. However, the level of information held at Trusts on the private practice activities of consultants (see paragraphs 1.7 and 1.8) reflects the fact that these do not appear to have been comprehensively maintained nor used as an effective management tool. The lack of information meant that it was not always possible to assess accurately the extent to which consultants' private practice had an effect on their contractual commitments to the health service.

1.13 The new contract stresses the importance of tighter management by Trusts of consultants' work for the health service, based on a clear specification of expected outputs as set out in agreed job plans. This provides the opportunity for Trusts to increase the accountability of consultants, reduce the conflict of interest implied by working in both public and private sectors and improve the management and prioritisation of their activity, thereby securing more cost-effective use of consultant resources. We acknowledge that adherence to the Code of Conduct for Private Practice introduced in 2003 (paragraph 3) should further ensure that consultants honour their health service commitments and allow Trusts more scope for action in cases where this is not occurring. We recommend that the Department ensures that Trusts effectively manage the process of agreeing job plans and undertake systematic monitoring of contract performance. The Department has acknowledged the need for a more robust contractual agreement and monitoring process to be established under the new arrangements and these have been put in place. This will allow greater scope for Trusts to manage consultant activity and will be achieved through the annual job planning and appraisal processes.

Ensuring that the pursuit of private practice by consultants is consistent with improved performance within the health service

1.14 Defining and managing the activities of consultants in a more explicit way is expected to help provide more timely and better quality care for patients and thus enable health service managers to plan and deliver services more effectively. This is based on the premise that the contract will provide incentives for increased health service activity by consultants. However, the expectation that the new contract arrangements will improve the efficiency and effectiveness of consultants' activity during their health service time will need to be matched by available resources, beds, theatre time and nursing support. While in-patient waiting times have been improving and the Department has recently announced changes to tackle the significant outpatient waiting times, many Trusts have severe constraints on bed availability, exacerbated by the delayed discharge of patients and by limited availability of support teams.

1.15 At the same time, the Department advised Trusts in March 2004 that they "should not approve any consultants' job plans that would be in excess of 10 PAs a week, without prior reference to their host Health Board." However, it is probable that many Trusts will be required to agree contracts in excess of this for a period of time to maintain the current level of service. For example, the Department's workforce plan, published in 2003, indicated a need for a 40 per cent whole time equivalent increase in the consultant workforce in Northern Ireland over ten years. Given this potential under-capacity within the health service, it is likely that if patients continue to have to wait longer for treatment, the more likely they will be to seek a private alternative. We acknowledge, of course, that this could cause delays within the private health care sector too.

1.16 One of the 'six principles' underpinning the management of private practice (paragraph 3) states that, subject to clinical considerations, patients who seek to avoid waiting for treatment by paying for it or taking out private insurance should not receive treatment earlier than a patient awaiting treatment in the health service. Where patients do have private consultations to obtain earlier diagnoses, they are free to revert back to health service status should they wish. However, we note that some of the Trusts' internal audit functions have highlighted a potential risk in this process. They point out that poor documentation and the lack of approval by senior Trust personnel in cases where private patients change status could mean that, having availed of a private consultation, they are being given preferential treatment and are able to circumvent health service waiting lists. The Department indicated that as part of its wider reforms of elective care it had introduced specific arrangements for the management of waiting lists that meant that after all clinically urgent cases had been dealt with, patients were selected from the waiting list in strict chronological order. Under these arrangements there was no scope for patients who had previously accessed consultations privately to be given preferential treatment or priority over other service users.

1.17 In view of the potential risks highlighted by internal audit, we consider it important that the process of changing patient status is effectively controlled and documented as an assurance that the delivery of service is equitable, as intended in the six principles.

Part 2

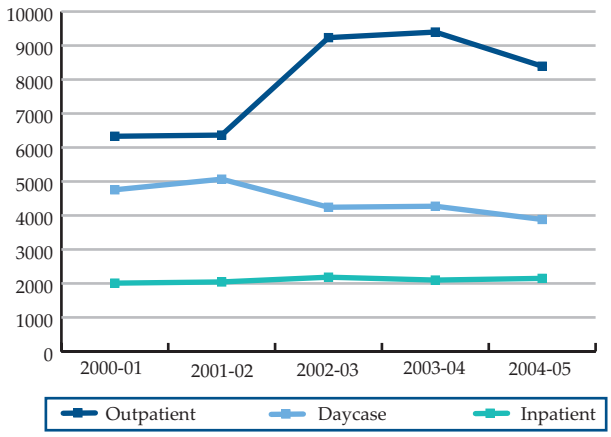
The Treatment of Private Patients in the Health Service

2.1 While private consultations may take place at a private clinic, quite often consultants may not have private consulting rooms available. In these circumstances, consultants will use health service facilities and equipment. In addition to the consultants' professional fees, the patient will be invoiced separately by the hospital for accommodation, services, theatre fees, tests, investigations, physiotherapy etc, based on length of stay and the charges associated with a particular medical procedure. Private patients can either self fund their private treatment or take out private medical insurance to cover it. The Family Resources Survey calculated that in 2003-04, nine per cent of the Northern Ireland population had private medical insurance cover compared to a United Kingdom average of 17 per cent (see paragraph 2). This practice allows hospitals to generate and retain additional revenues from patients who can pay for the use of facilities and "hotel" benefits and to utilise these revenues to supplement hospital operating costs and invest in preventative care.

There has been a growth in private patient activity in recent years

2.2 According to Departmental statistics, over the five years from 2000-01 to 2004-05, the total number of patients choosing to be treated privately in health service hospitals has risen by some ten per cent in Northern Ireland. The largest increase has been among outpatients, where the numbers going for private treatment have increased by 33 per cent (see Figure 1).

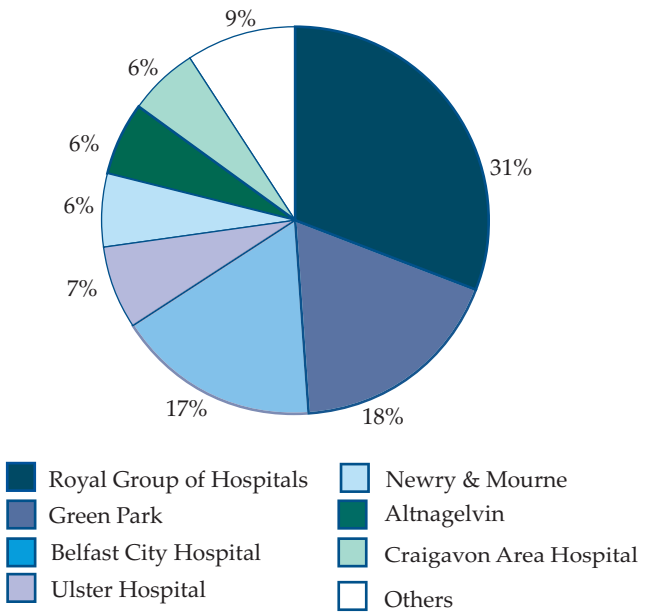
Figure 1: Private Patients treated in HPSS Hospitals



Source: Department

2.3 Revenue from private practice provides a useful additional source of income for the health service in Northern Ireland. Departmental figures show that income from private patients totalled £6.2 million in 2004-05, similar to the previous year. The income is spread across the health service, with almost 70 per cent of income earned by the Royal Group of Hospitals, Green Park and Belfast City Hospital as shown in Figure 2.

Figure 2: Private Patient income by Trust 2004-05



Source: Department

Pricing the cost of private treatment

2.4 On the basis of the cost information and patient statistics each Trust holds, they calculate an extensive range of average daily costs for the accommodation, services and treatments provided for private inpatients and outpatients. These will cover,for example, charges for nursing, housekeeping, catering and administration costs, medication, radiology, laboratory, physiotherapy, etc. In the case of operations, we found that all but one of the Trusts surveyed (see paragraph 11) calculated the charges payable by private resident patients by classifying each type of medical procedure according to its complexity, generally using vocabulary such as "minor, intermediate, major, major complex". The level of charges increases with the complexity of the surgery involved and the likely length of the operation and the use made of the operating theatre.

2.5 It is not unreasonable to classify operations in the way currently practiced. From the point of view of Trusts, such an arrangement has the advantage of administrative ease, while the relative simplicity of the charge calculations eliminates the need for sophisticated costing systems for the wide range of treatments available in health service hospitals. However, it is important that the charges applied relate as closely as possible to the actual costs incurred to avoid both under and over-recovery of costs. The recent independent review of health and social care services by Professor John Appleby (see paragraph 1.3) points out that, while health service hospitals in Northern Ireland treat a higher proportion of patients privately than in England and Wales, the level of income from private patients per head of population in Northern Ireland is significantly less than that for the United Kingdom as a whole. According to the review "this would suggest that, either private activity in Northern Ireland hospitals is less costly than in Great Britain, or the HPSS is not charging the full economic cost for the use of facilities." We asked the Department whether it agreed with the findings of the review. It told us there is no evidence that the difference in costs recovered per head of population is the result of under-recovery of costs. In its view, this could be explained by many factors, such as possible higher average cost of procedures recharged to private patients by NHS hospitals elsewhere in the United Kingdom, or a greater tendency for the costs in Northern Ireland to relate to cheaper day case procedures.

2.6 We acknowledge the positive action which is already underway in the health service to deal with the potential anomalies and variations in charges which can lead to the under-recovery (and indeed over-recovery) of costs actually incurred by private inpatients. Altnagelvin Hospital has already taken steps to move away from the broad-banding approach to setting operation charges. It has used its management information systems to enable it to identify more accurately the cost of particular treatments to private inpatients to ensure that it sets more refined charges. Improving the identification of the full costs of private patient provision will provide Trusts with greater assurance that the health service objective of promoting and protecting accessibility for all to medical treatment is not undermined through the public sector subsidisation of private patients. This

is particularly important in view of the growth of private sector health activity.

2.7 In line with this approach, the recent development within the health service of case-mix statistics, known as Healthcare Resource Groups (HRGs), to provide reference cost data for groups of medical procedures that consume like resources should help to sharpen the focus on whether the costs attributable to private patients are being fully recovered. The HRG process is designed to move management information from the allocation of hospital costs by specialty to the sub-division of specialty costs into a "care profile", constructed by clinicians and clinical managers within Trusts. The care profile describes the resources expected for a typical patient and might include estimates of items such as theatre time, radiology, significant drugs and consumables. In Great Britain, HRG costs for most of the treatments offered by acute NHS hospitals in England have been published since the late 1990s, the intention being that they provide the basis for benchmarking costs to give hospitals a strong lever with which to tackle inefficiency. In Northern Ireland a full set of HRG reference cost data was published for the first time for the 2001-02 financial year.

2.8 The main purpose of HRG data is to focus attention on variations in costs reported for ranges of similar procedures that consume similar resources and to help improve the general efficiency of the hospital sector. We asked the Department and Trusts whether they had considered applying the principle of HRGs to the reimbursement of private patient fees to ensure that full cost recovery is achieved.

2.9 The Department told us it recognises that the concept of reimbursement on the basis of HRG costs has merit but considers that they do not, and cannot be expected to, form a direct basis for pricing all private patient treatment as they are not yet sufficiently sensitive to do so. The Department also told us that, in order to maintain comparability with England, it cannot unilaterally change definitions and coding to allow more sensitive costing. As such, it considers that it would not be possible to apply the use of HRGs to the recovery of private health care costs. However, we recommend that the Department continues to encourage Trusts to recover the full cost of private treatment based on the application of appropriate costing techniques.

Identifying all those patients who receive private treatment is a key element in the recovery of costs

2.10 Guidance in the "Red Book" (see paragraph 3) places the onus on consultants to identify all private patients whether they are admitted to a health service hospital as inpatients, outpatients or day cases. The guidance states that the status of any patient admitted by a consultant to the hospital must be established in writing at the outset of the episode of care and that the patient should not be permitted to have treatment of any sort until this process has been completed.

2.11 The Private Patient Officer (PPO) plays an important role in the administration of private practice in Trusts, as they act as the link between the patient, consultant and the Trust. Departmental guidance states that a PPO must be designated at every Trust where private practice is permitted. Our survey of Trusts' Chief Executives (see paragraph 11) found that all but one Trust had a PPO in place, with four Trusts employing the PPO in a full time capacity.

2.12 While the identification of patients admitted to hospital for private treatment depends on consultants communicating this information to the PPO, our visits to Trusts revealed that this does not always work in practice. We found that the process for identifying private patients varied from Trust to Trust. For example, some Trusts provided consultants with standardised pre-printed documentation to forward to the PPO, while others relied on a phone call from the consultant to advise of a private patient admission.

2.13 It is important that the PPO is notified of the admission of a private patient prior to the commencement of treatment so that an "Undertaking To Pay" form can be signed. Private patients are required to give a signed undertaking to pay for all charges for treatment and services received. This document legally binds the patient (or patient's insurance company) to meet the costs of treatment and ensures that the Trust is in a position to recover the costs of treatment promptly and in full. If the patient's signature is not sought until after the care has been received there is an increased risk that the patient could contest the payment request. An internal audit examination at one of the Trusts noted a case where one consultant saw private patients out of hours in the outpatients department and did not obtain an undertaking to pay.

2.14 Our survey of seven Trusts indicated that in the majority of cases, the PPO was not notified about private patient admissions until after treatment had been provided. In one case notification was not received until two months after the patient had been treated, while we found other cases where patients had been admitted, received treatment and been discharged without the knowledge of the PPO. As a result, for a sample of private patient episodes across the seven Trusts surveyed, we found that in some instances an "Undertaking to Pay" form was either obtained after treatment or not at all. Only one Trust had obtained the necessary signed documentation before the private episode began, for the entire sample of private patient episodes we examined. Failure to obtain this documentation may have significant consequences for the debt recovery process in terms of delaying or preventing the invoicing stage and increasing the risk that the Trust may not recover all the income due to it.

There is scope for Trusts to pursue outstanding private patient accounts more aggressively

2.15 In addition to being able to accurately itemise private practice provision for billing purposes, it is also necessary to ensure that the recovery of fees due is maximised. We found that at December 2004, the total amount of private patient debt outstanding for more than 6 months at all Trusts was £809,000. This represents some 13 per cent of total private patient income for 2003-04 (see paragraph 2.3) ; 60 per cent of these outstanding fees were due to the Royal Group of Hospitals. As a result, we examined the debt recovery procedures in place at Trusts and examined the extent to which Trusts are proactive in recovering all monies due to them for providing private treatment.

2.16 The 'Red Book' states that Trusts should be satisfied of the patient's ability to pay before the patient is admitted and recommends that deposits should be obtained except where there is no reason to believe that any difficulties over payment will arise. We noted that only two Trusts obtain deposits from private patients – Altnagelvin require private dermatology and orthodontics patients to make stage payments in advance, due to the extended nature of their treatment and the Royal Group of Hospitals require self-pay cardiac and cataract patients to provide a deposit equivalent to 50 per cent of the total cost before surgery is carried out.

2.17 Where deposits are not collected, patients will be invoiced by the Trust for the total amount. Self-pay patients are required to settle their costs within 30 days and patients with medical insurance will be sent their invoice and are responsible for forwarding this to the relevant insurance company. If an outstanding account is not paid, it is also standard practice to send reminders after 60 and 90 days. If payment is still not forthcoming at this stage, legal action would be initiated via the small claims court.

2.18 From a sample of patients selected at each Trust visited we found that, for at least one of the patients at each, a debt took more than 30 days to be settled. Of the 45 patients sampled in total, only 21 (45 per cent) had settled their debt within 30 days. The remaining patients' debts were settled between 6 weeks and 8 months after the first invoice had been issued. Our testing also revealed that private patients with medical insurance proved the most difficult debts to recover. At the time of testing

(mid- 2003), seven accounts receivable (16 per cent) totalling £14,000 and outstanding for between six and 12 months were due to be recovered from BUPA.

2.19 As pointed out at paragraph 2, in 2003-04 nine per cent of the population in Northern Ireland was covered by private medical insurance. Those who choose to finance their private care in this way are required to inform the consultant responsible for treating them. In addition, insured patients are required to provide evidence to the Trust on admission that they have adequate cover to meet the cost of treatment and must provide an authorisation number from the insurance company. We found that Trusts do not routinely contact insurance companies to confirm the level of insurance, preferring to leave this issue with the individual patient. We also found that, because insured patients are responsible for passing invoices to their insurers, this inevitably leads to a delay in recovering charges as patients often failed to forward the invoice in a timely manner or were unaware of the need to do so.

2.20 Some of the Trusts we visited told us that recovering the costs of private treatment received by non-UK residents was particularly time consuming and that pursuing these debts by legal means was often considered uneconomical. Some also cited instances where patients had given false addresses so as to avoid receiving an invoice for treatment received privately. We found that four of the Trusts surveyed did not routinely collect details of the numbers of such patients who had received private care in hospital Trusts in Northern Ireland over recent years.

2.21 In our view, Trusts can enhance the revenues recoverable from private patients by improving the procedures for their identification and by more actively managing and co-ordinating the process. In particular, we recommend that the Department and Trusts give consideration to the following issues:

- given the implementation of a new contract for consultants (Part 1), we consider that it is an opportune time for the Department, in consultation with Trusts, to re-issue guidance that restates the respective responsibilities of consultants and Trusts in managing episodes of private care in health service hospitals;
- as part of this process, we recommend that the documentation relating to the registration and admission of private patients is reviewed in order to standardise it within Trusts. This should help to streamline the process, improve communication and co-ordination between consultants and Private Patient Officers and ensure that private patients adhere to their legal obligation to meet the costs of treatment;
- in order to lessen the risk that charges for treatment cannot be fully recovered, there is a need for uniform application by Trusts of existing guidance, which requires prospective patients to pay a deposit based on the estimated cost of treatment; and
- where the treatment costs for a private patient are recoverable from an insurance company, we consider that reimbursement would be enhanced if Trusts were to invoice the companies directly rather than sending the invoice via the patient. We also consider that there is scope for greater communication between Trusts and insurance companies: both to establish, at the outset of a proposed episode of care, whether a private patient has sufficient cover to avoid the possible incurring of a debt; and to encourage the more timely settlement of debts.

Appendices

HPSS Consultants by Department and by Trust as at 31 December 2004

Appendix 1

		Medical Specialties (inc. Oncology)	Anaesthetics	Radiology	Obstetrics/ Gynaecology	Surgical Specialties	Pathology Specialties	Mental Health Specialties	Paediatrics	Dental Specialties	Public Health/ Community Medicine	Other	Variance (Sum of Specialties with <5 per Trust)	Total
Altnagelvin Group HSS Trust	H'count	16	15	6	5	26	9		5				3	85
	WTE	15.73	15.00	6.00	4.91	24.19	8.64		5.00				3.00	82.47
Armagh & Dungannon HSS Trust	H'count							8					2	10
	WTE							7.82					1.28	9.10
Belfast City Hospital HSS Trust	H'count	45	26	18	6	19	18					6	4	142
	WTE	42.64	24.11	17.02	5.55	18.55	17.55					5.20	4.00	134.62
Causeway HSS Trust	H'count	6	5			5							14	30
	WTE	6.00	4.82			4.00							13.19	28.01
Craigavon & Banbridge Community HSS Trust	H'count							8						8
	WTE							8.00						8.00
Craigavon Area Hospital Group HSS Trust	H'count	22	16	7	6	17	8		5				1	82
	WTE	20.09	15.91	6.91	5.73	16.37	7.91		5.00				1.00	78.92
Down Lisburn HSS Trust	H'count	7	11		6	10		7					8	49
	WTE	7.00	11.00		5.70	10.00		6.82					8.00	48.52
Foyle Community HSS Trust	H'count							8					2	10
	WTE							7.76					1.09	8.85
Green Park Healthcare HSS Trust	H'count	5	8			16							5	34
	WTE	4.73	7.09			14.50							2.63	28.95
Homefirst Community HSS Trust	H'count							18					3	21
	WTE							16.99					2.28	19.27
Mater Infirmorum Hospital HSS Trust	H'count	8	6			12		8					6	40
	WTE	7.24	5.28			11.36		6.83					5.14	35.85
Newry & Mourne HSS Trust	H'count	7	7			5							14	33
	WTE	7.00	7.00			4.82							13.73	32.55
North & West Belfast HSS Trust	H'count							7					2	9
	WTE							6.64					1.28	7.92
Royal Group of Hospitals HSS Trust	H'count	59	53	15	11	58	19		14			5	6	240
	WTE	55.65	51.63	13.28	10.00	54.39	18.55		12.69			2.36	3.86	222.41
South & East Belfast HSS Trust	H'count							10					3	13
	WTE							9.55					2.50	12.05
Sperrin/Lakeland HSS Trust	H'count	10	9			11		9	5				9	53
	WTE	9.09	8.09			10.00		8.50	5.00				9.00	49.68
United Hospitals Group HSS Trust	H'count	20	14	7	7	21	10		6				1	86
	WTE	17.27	11.89	6.09	6.09	19.00	9.91		5.10				0.09	75.44
Ulster Community & Hospitals Group HSS Trust	H'count	21	21	9	7	25		8	5				8	104
	WTE	20.73	21.00	8.64	5.68	24.01		8.00	5.00				7.37	100.43
Other - Agencies & Board HQs	H'count										35	12	4	51
	WTE										26.28	5.08	2.18	33.54
Variance (Sum of Trusts with <5 per specialty)	H'count	2		18	15		7	16	19	12	2	4		
	WTE	0.18		16.73	14.05		7.00	12.59	15.43	10.09	1.55	4.00		
Total	H'count	**228**	**191**	**80**	**63**	**225**	**71**	**107**	**59**	**12**	**37**	**27**		**1,100**
	WTE	**213.35**	**182.82**	**74.67**	**57.71**	**211.19**	**69.56**	**99.50**	**53.22**	**10.09**	**27.83**	**16.64**		**1,016.58**

Source: HRMS

Notes: Department name may be used as an approximation to Consultant Specialty, but does not guarantee that this is the main specialty of the Consultant.

Blank cells represent either 0 or cell count less than 5 in order to avoid personal disclosure.

The "variance" row and "variance" column are summations of the entries zeroed, for confidentiality reasons, in respect of combinations of Trust and Specialty where consultant numbers are less than 5.

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