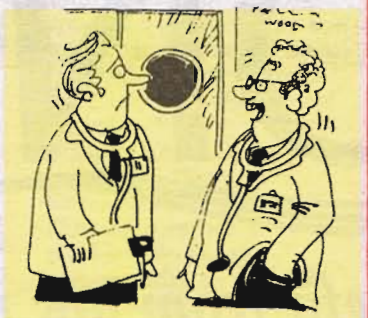
# Soaring cost of private medicine

**John Lister**



*"I'm a plastic surgeon, I only operate after I've seen their credit card"*

US employers expect health insurance plans for their employees to rise in cost by a massive 12 percent in 2000, as the privatised system struggles to rebuild its dwindling profits base.

This will be the third successive year of massive price hikes as the biggest US health corporations try to recover from hefty debts.

Figures just released show that private health care spending rose by 6.9 percent in 1998, taking the total health bill to $1.1 trillion. The estimate for 2000 is $1.3 trillion – a massive 14.3 percent of US GDP.

But an estimated 41 million Americans are now uninsured, mainly among the low-paid and ethnic minorities, and government spending on health care for the elderly has begun to fall back.

US health services have never been about meeting the needs of the population: for the major health care providers, the sole attention is on the bottom line of profitability.

Fewer than 20 percent of the "Health Maintenance Organisations" which increasingly dominate the US healthcare market made a profit in 1999, and among the high-profile casualties the largest HMO in Massachusetts is now in receivership after losses of $150m.

As they struggle to get out of the red, the HMOs are forcing up premiums even faster than the rise in prescription and medical costs.

Some have attempted to squeeze the hospital sector, by late payment of bills or refusing to pay the full amount they have been charged for treatment of subscribers. In Florida, hospitals are claiming that their income dropped 30 percent last year, with one company owing $750,000 for emergency treatment.

Some have found other ways to cash in – ripping off relatives of people disabled in accidents. A court in West Virginia recently threw out an attempt by an HMO to make a thumping profit out of a successful compensation claim by an accident victim: but courts in other states have allowed these corporations to demand payment of more than they spent on medical treatment.

## Britain

Here, too, profits are falling for the "big three" private hospital operators, which now control almost two thirds of the market.

BUPA's profits have almost halved since 1995, from £99m to just £52m.

Just 6.5 million people (around one in eight) are covered by private medical insurance, unchanged in the last few years, despite the efforts of the private firms to win new recruits.

Most of these are covered by company schemes and concentrated in the low-risk age-groups (20-50) least likely to make any claim.

For older people, subscription rates rise rapidly, with monthly fees of £100-£150 for a 60-year old couple and £140-£216 for those aged 70 plus – leaving a hefty dent in the average pension, while offering no emergency treatment, and no treatment for pre-existing health problems.


**"I have no private health insurance because, like many people, I believe that the private health insurance products on offer are too inflexible and heavily loaded, have too many exemptions and are too expensive." – Dr Liam Fox, Shadow Health Secretary.**


*PFI kill beds: Kidderminster Hospital campaigners used horse-drawn hearse to bang home the point as they fought a PFI hospital scheme that is now poised to kill off local acute services.*

# East End counts cost of biggest PFI scheme

The Outline Business Case for the biggest-ever single construction project in the NHS – the development of services at the Royal London Hospital and Bart's – was published at the end of last year.

The scheme involves a wholesale redevelopment of Bart's at a cost of £148m and a new hospital on the Royal London site in Whitechapel, costing £312m – a combined bill of £460m, double the cost of the "white elephant" Chelsea & Westminster Hospital.

In line with current government policy, the lion's share of this investment, including the whole of the financing of the Royal London would come from banks and private firms through the Private Finance Initiative.

But no private sector partner has yet been identified for this project, so the costs have yet to be finalised, and could wind up higher still.

Cost is not the only concern. A group of consultants attended the Barts and the London Trust (BLT) Board meeting on November 24 to insist that it was their "near unanimous view" that "the OBC in its present form describes a plan that is clinically unworkable and unrealistic".

The consultants' Iwant Barts Hospital closed down rather than redeveloped as a specialist cardiac and cancer unit. But they also objected to the reduced number of beds in the new Whitechapel hospital, and complain that it would not include a Paediatric Intensive Care Unit.

There are other reasons for concern.

- East London & City health authority (ELCHA) has identified a potential "funding gap" between the cost of the scheme and the amount available to the Bart's & London Trust, and agreed to underwrite this gap "up to a limit of £3.5m".
- The Trust itself has projected its operational deficit at £4.7m a year once the new facilities are fully open. Worryingly, the OBC admits that:

"This figure has not been adjusted for risk and takes no account of the possible costs of operating facilities and non clinical services under private finance arrangements."

- The ability of the new hospital to function with the proposed reductions in beds also depends upon the establishment of a new system of working designed to reduce "unnecessary" emergency admissions and shorten average lengths of stay in hospital. This in turn requires a substantial shift of responsibilities (and costs) from the Trust to primary and community services.
- ELCHA has therefore also agreed "to fund the necessary level of intermediate care required to deliver the performance targets on which the business case is predicated." It is not clear whether the ongoing revenue costs of providing this alternative system of care – many of which would then fall onto Primary Care Groups and Community Trusts – have been included in the costings of the new hospital.
- The Business Case also requires substantial savings from a reduction of medical staff (£3.35m) nursing staff (£3.2m) support staff (£2.8m) and a massive £5.9m from records and secretarial staff.

The OBC itself is unusually candid in admitting that there is "a very real anxiety that the proposed facilities, in particular critical care, may be insufficient to meet the needs of the patients the Trust serves."

# The case of the vanishing figures

**SPIN DOCTORS seem to have had a hand in the disappearance last year of a familiar set of statistics which help chart changes in the NHS.**

**Every autumn under the Department of Health Statistical Office publishes figures showing Bed Availability figures for England during the previous financial year.**

**But when LHE ordered the figures for 1999, we were told that they were not yet available.**

**Further inquiries revealed that the figures *have* been compiled, and are ready for publication – but no date has yet been set for their release, since they are awaiting ministerial approval!**

**Why would Mr "Open Government" Milburn, who in opposition was such a devastating critic of government cover-up, now be seeking to keep these figures from the public?**

**Could it be that while the "enquiry" into bed numbers commissioned by the government has been taking place, bed closures, driven by cash problems, have escalated to an embarrassing level?**

# Top docs backtrack on call for "super-hospitals"

THERE are signs that doctors' professional bodies are beginning to rethink their call for the establishment of new "superhospitals" to centralise services for populations of up to half a million.

Previous suggestions along these lines by the Royal College of Surgeons and the BMA have been widely – but very selectively – quoted by health authority and Trust bosses as justification for wholesale rationalisation and closures of local hospitals.

But late last year a new report by the Joint Consultative Committee (including Royal Colleges and the BMA) has argued that the district general hospital will continue "as the basic unit providing the majority of emergency and elective services to communities".

While new, superhospitals serving populations twice as large as the 200-300,000 catchments of most general hospitals was still their "preferred model", the medics have dropped their insistence that most smaller hospitals will disappear.

The report, Organisation of Acute General Hospitals, lays new stress on smaller units working together to share strengths and lessen weaknesses, and a call that "where possible" district general hospitals should merge with others to form a "single acute general group".

James Johnson, chair of the JCC, told the Health Service Journal that "Hospitals do not always need to exist on one site, however administratively tidy that may seem."

This welcome – if belated – shift of line by the consultants echoes the consistent theme of London Health Emergency's opposition to many hospital rationalisation and PFI schemes, which have been forced through by health bosses referring to a few key sentences torn out of context from the previous JCC guidance.

But the new policy still focuses narrowly on the needs and concerns of doctors, making no reference to the financial realities of today's NHS, and failing to address the central issue of how many beds are needed to enable the hospitals to cope with current and future levels of demand.


**You've got something extremely rare, Mr Winston – a hospital bed'**