



## **UNISON PARLIAMENTARY BRIEFING, JANUARY 2012 PRIVATE PATIENT INCOME CAP**

### **History of the cap**

The private patient income (PPI) cap was included in the legislation that established Foundation Trusts - the Health and Social Care Act 2003 and the National Health Service Act 2006.

It was designed to reassure the public that giving some hospitals more autonomy would not lead to them prioritising income from private patients at the expense of NHS patients.

Every hospital had its income capped at the proportion of PPI it was already generating in 2002-3, which was to ensure that there was no change in the access of NHS patients to services.

There have been issues about the cap, particularly because it only applied to Foundation Trusts (FTs). So in 2009 a modification was allowed to permit Mental Health FTs (that did not exist in 2003) to earn up to 1.5% of their income from PPI.

The fundamental reasons for the cap remain relevant today: to stop hospitals from pushing NHS patients to the back of the queue.

### **Abolishing the cap**

Clause 162 of the Bill will abolish the private patient income cap, meaning that hospitals can treat any amount of private patients they like, even if this is to the detriment of NHS patients.

As waiting lists continue to grow – as evidence suggests they already are<sup>1</sup> – NHS patients will find themselves pushed to the back of an ever-lengthening queue by those that can afford to pay. NHS patients could also find that urgent surgery is cancelled if private patients expect to spend longer in NHS intensive care units than is clinically necessary. In the new cut-throat system, hospitals are likely to prioritise patients that bring in extra income over “free” NHS patients, particularly as hospitals will be under a huge amount of extra pressure to increase their income from whatever source possible as they struggle to make savings.

The Bill’s revised impact assessment continues to acknowledge that there is “a risk that private patients may be prioritised above NHS patients resulting in a growth in waiting lists and waiting times for NHS patients”.<sup>2</sup> The NHS founding principle that access should be based on need not ability to pay is threatened.

Reassurances about the need for foundation trusts to reinvest their private patient income in NHS services have been completely inadequate. There is no existing evidence that foundation trusts currently use their private patient income to improve services for patients, so it is fanciful to suggest that they will do so in future. There is, however, evidence that a

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<sup>1</sup> BBC, “Patients waiting beyond 18 weeks rise by a third”, [www.bbc.co.uk/news/health-14930859](http://www.bbc.co.uk/news/health-14930859)

<sup>2</sup> Department of Health, *Health and Social Care Bill 2011: Impact Assessments*, September 2011, p64, B.155,

number of trusts, such as the Royal Marsden, Moorfields Eye Hospital and Papworth Hospital, are preparing to substantially increase their private patient work.<sup>3</sup>

Government plans to provide reassurance by making foundation trusts produce separate accounts for their private patient income and their NHS income are so far not included in the actual Bill. Putting this into the legislation itself may at least provide a level of transparency, if not a safeguard.

The author of the listening exercise report, Prof Steve Field, has said that the abolition of the cap is an area that “we didn’t put as much in our report as perhaps we could have done.” He summarised the “gut feeling” from the listening exercise as “the private cap should stay because people felt that would provide the protection”. This was because “if you opened the cap it may be more likely to be under...EU law, and from competition and from Monitor”.<sup>4</sup>

### **An issue that unites staff across the NHS**

In a joint letter to the Times on 6 September 2011, the BMA, RCGP, three other Royal Colleges and 2 other NHS professional bodies said that they “share a number of... concerns, including the removal of the private patient income cap”.<sup>5</sup>

All TUC-affiliated health unions, plus the BMA, RCN and RCM speak with one voice on this issue.

### **The problem with the “49%” amendment**

The government’s recent amendment to the Bill, prompted by the intervention of Lib Dem peer Shirley Williams, is dangerously complacent.

The amendment would mean that the total income of an FT from NHS goods and services had to exceed that made from any other sources of income – hence the suggestion that FTs could make up to 49% of their income from private patients.

In practice, given that the vast majority of FTs are never likely to get anywhere near 49%, this amendment will have virtually the same impact as abolishing the cap completely.

### **Further information**

UNISON’s Our NHS Our Future campaign pages: [www.unison.org.uk/ournhs](http://www.unison.org.uk/ournhs)

Also NHS Support Federation briefing: [www.nhscampaign.org/NHS-reforms/ppi.html](http://www.nhscampaign.org/NHS-reforms/ppi.html)

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<sup>3</sup> *The Independent*, “Royal Marsden seeks wealthy patients as budget cuts bite”, 9 September 2011; *Daily Telegraph*, “NHS trusts preparing to bid for more private patients”, 2 August 2010

<sup>4</sup> *The Guardian*, “NHS forum GP admits private patient doubts”, 29 June 2011

<sup>5</sup> [www.gponline.com/News/article/1089384/BMA-RCGP-warn-Health-Bill-destabilise-NHS/](http://www.gponline.com/News/article/1089384/BMA-RCGP-warn-Health-Bill-destabilise-NHS/)