

# The interface between NHS and private treatment: a practical guide for doctors in England, Wales and Northern Ireland

Guidance from the BMA Medical Ethics Department

May 2009

- Introduction
- General principles
- Issues for consultants
- Issues for GPs
- Advertising
- Summary

## Introduction

A large number of patients opt to have some or all of their investigations and treatment privately. Some use private health insurance, while others are willing to pay to be seen more quickly, or for the added convenience or comfort of receiving their care in private facilities. In these cases, treatment in the private sector is used to substitute treatment within the NHS.

As emphasis on patient choice within the NHS grows, it is increasingly recognised that patients are entitled to choose freely between NHS and private treatment, whether provided as a private service by an NHS body or by the independent sector, at different points in their overall care. This trend is borne out by a small but growing demand to mix elements of privately and publicly-funded care for a single course of treatment, where private provision is used because the NHS does not or cannot provide a clinically indicated aspect of the treatment due to concerns about its relative cost-effectiveness.

There has been much debate concerning the ethical and legal implications of blurring the boundaries between NHS and private care. On a practical level, the rules governing the interface between the two treatment sectors have often been applied inconsistently, leading to some confusion about patient entitlement to NHS care. For example, patients have previously been prohibited from paying to supplement single episodes of NHS care with privately purchased treatments, referred to as 'top up' payments, but this prohibition has been only selectively enforced.

This issue came under intense scrutiny in November 2008 with the publication of Professor Mike Richards' review on improving access to medicines for NHS patients.<sup>1</sup> The Government's response to the Richards' review has signalled a substantial policy shift with potentially wide-ranging implications for doctors. Department of Health (DH) guidance<sup>2</sup> now recognises that NHS provision should not be withdrawn for those wanting to top up single episodes of care with private treatment but any private additions to NHS care will be allowed only when they can be delivered at a separate time and place.

In light of these developments, this guidance aims to address the issue of managing the interaction between NHS and private treatment at a practical level where:

- private treatment is a **substitute** for treatment within the NHS; and
- private treatment is delivered **in addition** to NHS care for a single episode of treatment, where the NHS does not or cannot provide a clinically indicated alternative for reasons of relative cost-effectiveness, referred to as 'top up payments'.<sup>3</sup>

Particular focus is given to those issues doctors are most likely to confront where private treatment is requested. It includes advice on when and how the subject of private treatment should be broached, making private referrals and sharing information with those providing private treatment, managing real, and perceived, conflicts of interest, and situations where doctors believe they are being asked to help patients to 'jump the queue' for treatment.

**Please note:** Although the main sections of this guidance apply across England, Wales and Northern Ireland, those sections headed **Top up payments relate specifically to England**. The BMA has produced separate advice for Scotland,<sup>4</sup> where the Scottish Government Health Directorates (SGHD) have issued separate guidance<sup>5</sup> on patients seeking additional private care. Policy on top up treatment has still to be confirmed by the administrations in Wales and Northern Ireland.

## General principles

- Patients who are entitled to NHS-funded treatment may opt into or out of NHS care at any stage.
- Patients may pay for additional private health care while continuing to receive care from the NHS. Private and NHS care should be kept as clearly separate as possible.
- Patients who have had a private consultation for investigations and diagnosis may transfer to the NHS for any subsequent treatment. They should be placed directly onto the NHS waiting list at the same position as if their original consultation had been within the NHS.
- It would be inappropriate for consultants to pressure or encourage patients to transfer from NHS-funded treatment to private care.
- Consultants should not spend time during NHS consultations discussing private treatment with patients nor should they use their NHS patient lists to promote their private practice. An exception is where clinically appropriate treatment is not funded by the NHS. Where this is the case, patients should be informed in order to be able to consider the options open to them, including the option of seeking the treatment privately.
- All doctors have a duty to share information with others providing care and treatment for their patients. This includes NHS doctors providing information to private practitioners.

## Issues for consultants

### ***Can patients receive part of their treatment within the NHS and part privately?***

Dilemmas can arise if patients choose to seek part of their treatment privately and part on the NHS. A common scenario is where a patient pays for private investigations in order to obtain an earlier diagnosis and then switches back to the NHS for any subsequent treatment. Patients who seek private investigations:

- may opt into or out of NHS care at any stage, provided they are entitled to NHS treatment
- may subsequently be placed directly onto the NHS waiting list at the same position as if those investigations had been undertaken within the NHS (where the treatment in question is not provided by the NHS but is clinically necessary, see *Top up payments* below)
- do not need to have a further assessment within the NHS before receiving their treatment, nor do they need to be referred back to their general practitioner (GP).

Some doctors are unhappy that patients who can afford to pay for private investigations are able to effectively jump the queue for treatment by reaching the waiting list earlier than those who wait for investigations and diagnosis on the NHS. Others argue that because some people seek their investigations privately, the NHS waiting list for investigations is reduced and therefore other patients are seen more quickly. There is undoubtedly an advantage to reaching the waiting list sooner but, nevertheless, NHS patients whose clinical need is greater may join the waiting list later, but could still receive their treatment earlier if they are categorised as needing more urgent treatment.

### ***Top up payments***

An alternative scenario is where a patient wishes to pay for additional private treatment or drugs for a particular medical condition, while at the same time continuing to receive NHS care for that same condition. Topping up NHS care in this way has been the subject of some controversy, owing to the increasing number of expensive treatments, for example late stage cancer drugs, not provided on the NHS due to relative cost-effectiveness rather than lack of clinical effectiveness. Although there is still uncertainty about precisely how the following principles will operate in specific clinical scenarios, it is clear that those patients who opt to supplement their treatment in this way:

- are fully entitled to receive all NHS care they would have ordinarily been given
- are entitled to NHS services on exactly the same basis of clinical need as any other patient
- should not be put at any advantage or disadvantage in relation to the NHS care they receive.<sup>6</sup>

DH guidance stresses that, in these cases, several factors should be taken into account.

- The patient should bear the full cost of any private services and NHS resources should never be used to subsidise the use of private care.<sup>7</sup>
- Patients must pay for the associated delivery and monitoring costs where these can be identified as wholly separate from care that they would normally receive free on the NHS.
- The distinction between different components of care should be achieved by keeping treatment provision in the two sectors separate but parallel, with private treatment taking place alongside but distinct from NHS treatment.<sup>8</sup>
- A distinction will usually be achieved by the delivery of private care at a different time and place from the concurrent NHS treatment.<sup>9</sup>
- Where different elements of care or treatment cannot be separated out, supplementing NHS care is unlikely to be possible.
- Where there are overriding concerns for patient safety, departing from these principles of separation may be allowed, with agreement from the Medical Director or equivalent.<sup>10</sup>

The BMA questions the practicality of this approach for a number of reasons:

- retaining a clear idea of which clinician and organisation is responsible for the assessment of the patient, the delivery of care and the management of any complications will inevitably be a complex process
- it will not always be possible to have treatments separated out and delivered at different locations, nor will it be easy to disentangle what is and what is not NHS care
- where patients may find elements of their care delivered by different teams in different settings, continuity of care will be difficult to achieve.

The issue of separateness is a complicated one and the BMA is calling for more clarity and detail regarding the practicalities of its implementation in the clinical setting.

### ***When may NHS consultants advise patients about the option of being seen privately?***

When patients are referred to a consultant within the NHS it is not unusual for a doctor to provide a diagnosis and recommended care plan while advising that the waiting list for non-urgent treatment may be many months. Although some patients may subsequently opt for private treatment rather than waiting for treatment within the NHS, it is not appropriate for consultants to:

- use their NHS patient lists to initiate discussion about their private practice
- suggest to patients who are placed on a waiting list for NHS treatment that the treatment could be provided more quickly on a private basis
- raise the issue of private practice obliquely, for example by handing the patient a business card containing the address of both the NHS hospital and the doctor's private consulting rooms, or adding the private clinic address to NHS letterheads.

If patients specifically ask for information about alternatives, including private care, doctors can respond (see the next question below) but particular care is required. The codes of conduct for private practice in England and Northern Ireland state explicitly that consultants should not, in the course of

their NHS duties, initiate discussions about providing private services for NHS patients or ask other NHS staff to initiate discussions on their behalf.<sup>11</sup> It is recommended that consultant staff in the NHS should familiarise themselves with the relevant code of conduct for private practice in England<sup>12</sup> and Northern Ireland<sup>13</sup> and guidance on private practice within the consultant contract for Wales.<sup>14</sup> NHS consultants must manage all of their private practice as set out in these codes of conduct for private practice<sup>15</sup> and in the terms and conditions of the consultant contract.<sup>16</sup>

The BMA believes an exception to this general rule is where clinically indicated treatment is available but, as an entire single episode of care, is not funded within the NHS. If treatment is *only* available privately, patients should be told that. Patients are generally aware of the availability of private treatment and so the option is always open to them to enquire, but where there is a new treatment available that is not provided on the NHS, patients cannot be expected to know about it. Therefore, it is appropriate to provide balanced and factual information about the treatment, although this needs careful handling to ensure the patient or the family do not feel pressure to choose the private option. They should be given sufficient information – including the availability and price of private treatment – in order to decide whether to join the NHS waiting list for standard treatment or seek private treatment using the procedures not available on the NHS. As good practice, a record should be kept of all discussions with patients about care not routinely funded on the NHS in the patient's medical notes.

### **Top up payments**

Another exception to the general rule is where an *additional*, clinically indicated treatment or element of care cannot be provided on the NHS but is available privately and can be delivered alongside a patient's NHS care entitlement as part of a single episode of care.

Patients should not be made to feel they have to seek top up treatment. DH guidance suggests that all possibilities for securing NHS funding should be exhausted, within the time available, before suggesting the patient's only option is to pay for care. NHS funding should be available where:

- NICE has issued a positive technology appraisal for the relevant indication
- the relevant primary care trust (PCT) has a local policy to fund the treatment in question
- exceptional funding can be secured for the patient via the PCT's exceptions procedure.<sup>17</sup>

Only where this is not the case should it be suggested that the patient make a decision about purchasing additional treatment. At this point patients should be provided with full and accurate information about the private services and treatments available.

There is an apparent tension between the recommendation in the DH guidelines, that consultants should make all care options available to patients, and the code of conduct, referred to above, which explicitly states that consultants should not initiate discussion about providing private services to NHS patients. The BMA sees some potential for confusion in maintaining the integrity of the code of conduct for private practice for consultants, while performing the new duty of informing patients about private alternatives or additions to their NHS care. For example, there is increased potential for actual or perceived conflicts of interest:

- where a consultant is the only person on hand qualified to talk about the evidence base for an additional private therapy; and
- where that consultant may also be the only person qualified to deliver the treatment in the private sector.

However, the BMA believes that it is acceptable to discuss private treatment where the aim of that discussion is achieving a clinical benefit otherwise unavailable to the patient via the NHS. In these circumstances, any apparent conflicts of interest will be minimised.

The priority for doctors should be enabling patients to make informed choices in relation to their clinical need, without placing them under pressure with regard to the paid element of their care.

***How should consultants respond to questions from NHS patients about being treated privately?***

With the exceptions discussed above, consultants should generally avoid spending time discussing private treatment with patients during NHS consultations. It would be inappropriate for them to pressure or encourage patients to transfer from NHS to private care, but in practice patients themselves frequently raise questions about the availability of private treatment. While there is a clear difference between providing information to patients on all of the treatment options available to them, some of which may only be available privately, and actively advertising private practice to NHS patients, doctors can still be placed in a difficult position where they could be perceived as having a conflict of interest. It might be suggested, for example, that patients have been put under pressure to seek private treatment or that doctors are using their NHS consultations to promote their own private practice. In order to avoid this perception, there should be a clear separation between NHS and private treatment. Views about how consultants should handle such direct questions, however, differ.

- Some people believe that where patients raise the option of private treatment during a NHS consultation they should be directed back to their GP for a separate private referral.
- Where the patient expresses a clear preference to see the same doctor privately, however, insisting on a separate referral from the GP can seem to the patient to be unnecessarily bureaucratic as well as adding to the workload of GPs. In such cases doctors can respond factually.
- There may be some circumstances where a referral back to the GP is the most appropriate course of action, if, for example, something unexpected is discovered during the consultation and referral to a different consultant is needed.

It is for individual consultants to decide how to respond to patients' questions about private treatment within the terms agreed locally. Some consultants prefer not to discuss their private practice at all during NHS consultations and refer all enquiries to their private secretaries. Consultants may, however, briefly answer factual questions about the availability of private treatment and there is no requirement for the patient to be referred back to the GP (although the GP should be kept informed of any change to the patient's care plan). A consultant in this position should make a contemporaneous note on the medical record, and inform the patient's GP, that the patient has requested information about private treatment. Patients should be informed of the option of seeing a different doctor for private treatment and some patients may wish to discuss the options with their GP before making a decision.

***Top up payments***

The BMA is particularly concerned that, in the context of discussions about top up treatment, there is potential for the doctor-patient relationship to suffer, especially where consultants are required to address financial considerations as part of the consultation process. Further clarification is being sought by the BMA on the issue of how exactly doctors will be expected to negotiate the new requirements being placed upon them in the context of top up care.

In addition, the BMA has concerns about the administrative expectations likely to be placed upon doctors where patients receive public and private care at the same time. Although there may sometimes be an expectation that doctors will carry out certain administrative tasks associated with transferring patients between the two sectors, there is no obligation for them to do so.

#### ***How should consultants respond to patient requests for a second opinion in the private sector?***

A patient's right to request a second opinion should be respected<sup>18</sup> and requests for second opinions should generally be complied with unless there are good reasons to justify a refusal. A second opinion will usually be provided within the NHS (see CCSC guidance on second opinions).<sup>19</sup> Some patients, however, may specifically request a further opinion on a private basis. This might be because they believe that further treatment options will be open to them that are not funded within the NHS or because they believe they will receive better quality care. Patients are entitled to seek a second opinion on a private basis and the treating NHS consultant should facilitate this where possible or liaise with the patient's GP about arranging a private referral. The same general principles apply to private patients seeking a second opinion.

#### ***Can consultants involve NHS staff in the treatment of private patients?***

NHS staff are sometimes asked to clerk in and look after private patients on the ward on behalf of consultants who are being paid privately for the treatment. The consultants' guidance on private practice is clear that consultants may not use NHS staff for the provision of private services without the agreement of their NHS employer.<sup>20</sup>

## **Issues for GPs**

#### ***Can GPs raise the issue of private practice with NHS patients?***

GPs have an important role, both as their patients' advocate and in ensuring that patients have all necessary information about the treatment options open to them. This may include asking patients whether they wish to be referred within the NHS or privately and, if they request a private referral, whether they have private medical insurance. Such questions need to be handled carefully to ensure the patient does not feel pressured to opt for private treatment.

#### ***Are NHS GPs obliged to issue a private referral at the patient's request?***

Whether there is any obligation on a NHS GP to issue a referral letter for a particular patient will depend on whether, in the view of the GP, the referral is clinically necessary.

- If specialist assessment or treatment is needed, the GP is obliged to refer the patient and, if the patient wishes to seek the treatment privately, a private referral should be made. The General Medical Council (GMC) states that 'when you refer a patient, you should provide all relevant information about the patient, including their medical history and current condition'.<sup>21</sup>
- Referrals are usually made to a named consultant and some GPs have concerns about referring to a consultant they do not know, either at the request of the patient, or because the patient's medical insurance company has its own list of consultants. Such concerns should be explained to the patient.
- If the GP does not consider the treatment to be clinically necessary, then there is no obligation to refer; the patient may then seek treatment without a referral.
- Although the GMC no longer requires specialists to accept patients only with a referral, the BMA believes this to be best practice in most cases. Furthermore, patients are not normally able to obtain private referrals independent of their GP, as insurance companies usually require a letter of referral.

The BMA recognises the potential for conflict to arise between what a doctor regards as clinical need and what patients may want, particularly in relation to specialist treatment and referral. GPs are sometimes asked to refer where doing so would be clinically unnecessary and could actually be harmful to patients, for example when invasive procedures or investigations are involved. In these circumstances, doctors should always discuss the clinical implications of such procedures before making a private referral. If patients still request a referral, doctors may wish to refer them to a colleague for a second opinion. Doctors cannot be compelled to arrange treatment where it is not clinically indicated and GMC guidance states that investigations or treatment must be arranged and provided on the basis of clinical judgement.<sup>22</sup>

All specialists are advised by the GMC that 'if you provide treatment or advice for a patient, but are not the patient's general practitioner, you should tell the general practitioner the results of the investigations, the treatment provided and any other information necessary for the continuing care of the patient, unless the patient objects<sup>23</sup>...If you do not inform the patient's general practitioner, you will be responsible for providing or arranging all necessary after-care.'<sup>24</sup>

#### ***Can NHS GPs charge their patients for referral or information?***

GPs may not charge their NHS patients for private referrals, nor may they charge for the provision of relevant information to other doctors providing care for the patient.

#### ***Are NHS GPs obliged to provide patient information to private practitioners?***

When patients self-refer to private practitioners, this is frequently followed by a request to the GP for any information that might be relevant to the treatment in question. The exchange of information between those providing care for a patient, including liaison between NHS and private practitioners, is important.

- GPs' primary concern should be for the interests and safety of their patients, with due regard to confidentiality.
- Good communication between colleagues, with the patient's consent, is required so that medical information can be exchanged on the basis of a clear 'need to know' in connection with the care of the patient. This is in line with the GMC's guidance, which states that 'sharing information with other healthcare professionals is important for safe and effective patient care'.<sup>25</sup>
- NHS GPs should provide relevant information on request about the patient's medical history or current condition to other doctors providing care, including doctors working in the private sector.
- Patients should not be made to feel that they need to withhold information about private treatment from their GP for fear of losing their entitlement to NHS care.
- If the GP is aware that treatment is being sought privately and has information that might affect the safety or outcome of the treatment, this should be shared, with the patient's consent.
- Failure to provide relevant information when the patient's consent has been obtained could result in a complaint against the GP – either to the GMC or through the courts – if the patient is harmed as a result.

#### ***Should GPs issue NHS prescriptions for medication recommended during a private consultation with a consultant?***

When patients seek specialist treatment privately, the private consultant may prescribe any necessary medication. Often, however, consultants recommend a particular medication and patients ask their GP to issue a NHS prescription rather than paying for it privately. Even though individuals opt for private treatment or assessment, they are still entitled to NHS services. Where the GP considers that the medication recommended is clinically necessary:



- he or she would be required under the NHS terms of service to prescribe that medication within the NHS, even if the assessment from which the need was identified was undertaken in the private sector; however
- if the medication is specialised in nature and is not something GPs would generally prescribe, it is for the individual GP to decide whether to accept clinical responsibility for the prescribing decision recommended by another doctor. (The same principles apply to requests to undertake diagnostic tests or other procedures within the NHS.)

The issues raised are the same as those where a NHS consultant asks a GP to prescribe, and the existing procedures for shared care should be followed.<sup>26</sup> In all cases there should be proper communication between the consultant and the GP about the diagnosis or other reason for the proposed plan of management, including any proposed medication.

Common enquiries to the BMA on this matter concern fertility treatment, where patients seek IVF in the private sector and ask their GP to issue NHS prescriptions for the drugs, or medications recommended by private consultants that are more expensive, but without good evidence that they are more effective, than those locally prescribed for the same condition within the NHS. The decision about whether to comply with such requests rests with the individual GP or commissioning body. GPs may be concerned about prescribing in these circumstances where they feel:

- they are being placed in the position of appearing unsupportive of their patients
- they are being asked to accept legal, financial and ethical responsibility for a course of medication which they had not initiated and which, in some cases, they may not consider to be clinically necessary
- they have insufficient expertise to accept responsibility for the prescription when the product is of a very specialised nature, requiring ongoing monitoring.

Where such concerns exist, it may be possible to initiate discussions with the relevant consultants to reach a position with which all parties are content. Local prescribing advice from the PCT may be followed by the NHS GP and this advice should be explained to the patient who will retain the option of purchasing the more expensive drug via the private consultant. The obligation to prescribe does not arise if the medication recommended is not clinically necessary or if the medication is generally not provided within the NHS.

Many of the problems and concerns that arise in relation to prescribing shared between the private sector and the NHS could be avoided by improved communication between the parties concerned. Consultants are advised to:

- avoid simply informing patients that their GP will prescribe the recommended medication
- recommend patients ask their GP if he or she is happy to prescribe, being sensitive to the objections the GP may have (outlined above)
- communicate directly with the GP themselves, as with NHS referrals.

Direct communication is the most appropriate course of action and this is not just a matter of etiquette. If the GP does not feel able to accept clinical responsibility or, in the case of medication that is not clinically necessary, financial responsibility for the recommended medication, this could cause difficulties for the doctor-patient relationship. Those requesting GPs to take over prescribing should be sensitive to these points when discussing the matter with patients.

**Top up payments**

Ambiguities inevitably arise for GPs treating patients who are paying to top up their NHS care. As paying for such care has been recognised as acceptable, it is the BMA's view that GPs will need further, specific guidance on the practice of issuing prescriptions for patients who wish to purchase drugs not funded by the NHS or at the request of consultants who are seeing a patient privately. It is important that GPs identify who will retain overall clinical responsibility for prescribing in these circumstances. GPs should not accept clinical responsibility where they feel they have insufficient expertise.

**Can patients pay for treatment abroad and claim the cost from the NHS?**

A number of cases concerning patients seeking private treatment overseas, and recouping the cost from the NHS, have been heard by the European Court of Justice in recent years. Court rulings in favour of patients' right to receive treatment in this way effectively mean that, under European Union (EU) case law, UK patients are now recognised as having the right to be treated in another member state and receive reimbursement of the cost from the NHS under certain conditions, namely that the treatment in question is offered on the NHS but is not available without 'undue delay'.<sup>27</sup>

There are two ways in which patients may go abroad for treatment within the EU:

- where a commissioning body decides to commission care abroad for its patients; and
- where a patient makes a request to go abroad for care.

Doctors who are approached by patients who wish to seek treatment in another country should advise them that they need to receive prior approval from the DH by making an application using form E112. The form must be accompanied by an opinion from a NHS consultant in the UK and the local commissioning body. Patients considering such an application should be referred to the information available from the DH.<sup>28</sup>

The EU is currently looking to clarify the law and codify all existing rules relating to patients' rights in this area, otherwise known as *cross-border patient mobility*. These proposals are not expected to come into force in the UK until 2010 at the earliest.

**Are NHS GPs obliged to complete medical insurance claim forms for their patients?**

There is no obligation on NHS GPs or hospital doctors to complete medical insurance claim forms and, if they decide to do so, they may charge the patient. In most cases the doctor who has provided the treatment is in a better position to provide the information needed.

**Can NHS GPs offer specialist treatments on a private basis?**

Increasing numbers of GPs are able to provide specialist treatments, such as complementary therapies or minor surgery, in addition to their general practice. These treatments may be offered to private patients and advertised in the usual way (see below) but GPs may not charge patients of their NHS practice for these services.

**What should GPs do if they believe a consultant is inappropriately directing patients towards private practice?**

As with any suspicion of inappropriate behaviour, if a GP suspects that a consultant is using NHS time and patient lists to promote his or her private practice, or may be putting pressure on patients to switch to private treatment, he or she should first seek to establish the facts. This might involve:

- seeking information from the patients involved about the way in which the option of private treatment was raised with them
- discussing any worries, either with other partners in the GP practice or other GPs in the locality and/or directly with the consultant concerned.

If these steps do not resolve the suspicion, the GP may need to invoke the established local procedures to investigate the concerns. Advice can be sought from the BMA or from the medical defence organisations about how to take such matters forward.

### ***Can private GPs refer patients for NHS diagnostic services and treatment?***

Provided patients are entitled to NHS treatment, they may opt into or out of NHS care at any stage. Private GPs are entitled to make referrals to NHS facilities, if that is the patient's wish, and the referral should be treated in the same way as if the referral came from within the NHS. A patient's need should be assessed to determine his or her place on the waiting list.

## **Advertising**

### ***How may private doctors advertise their services?***

In the late 1990s the GMC withdrew its restrictions on specialists advertising directly to the public. The same rules on advertising now apply to all doctors. These state that any information provided about medical services:

- must be factual and verifiable
- must not make unjustifiable claims about the quality or outcomes of services
- must not offer guarantees of cures, nor exploit patients' vulnerability or lack of medical knowledge
- must not put pressure on people to use a service, for example by arousing ill-founded fear for their future health.<sup>29</sup>

This guidance applies to all advertising, irrespective of the medium used (including information provided on the internet). Provided the material fulfils these broad criteria, it would not breach the GMC's guidance. The BMA believes that, in addition, specialists should as a general rule make it clear to members of the public that they usually do not accept patients without a referral from a GP or other practitioner.

Private practitioners may also send factual information about the services they provide to GPs in the area.

## **Summary**

Although some doctors feel unhappy about their patients switching between the NHS and private sector, this is not unethical as long as the patient – when rejoining the NHS – is treated in the same way as those receiving all of their care within the NHS. Although it remains to be seen how the separation between the two sectors is to operate in practice where patients wish to top up their NHS care, there should always be as clear a separation as is practically possible between the two treatment sectors, in order to avoid the NHS subsidising private care and patients being charged for NHS treatment. Doctors should not put pressure on patients to seek private treatment or use their NHS patient lists to initiate discussion about private practice. At all times doctors' primary concern should be for the safety and wellbeing of their patients.

## References

- 1 Richards M (2008) *Improving access to medicines for NHS patients*. London: DH.
- 2 Department of Health (2009) *Guidance on NHS patients who wish to pay for additional private care*. London: DH.
- 3 Although there is some disagreement over the use of terminology, for ease of use throughout this document the term *top up payments* refers to the circumstances outlined here, in which patients make specific payments to purchase drugs or treatments over and above otherwise free NHS care because those drugs or treatments are not or cannot be provided on the NHS.
- 4 See [www.bma.org.uk/sc/ethics/index.jsp](http://www.bma.org.uk/sc/ethics/index.jsp)
- 5 Scottish Government Health Directorates (2009) *Arrangements for NHS patients receiving healthcare services through private healthcare arrangements*. Edinburgh: SGHD.
- 6 Department of Health. *Guidance on NHS patients who wish to pay for additional private care*. Op cit: para 6.1, bullet point 1.
- 7 Ibid: 6.1, bullet point 2.
- 8 Ibid: 4.2, bullet point 2.
- 9 Ibid: 4.2, bullet points 3 and 4.
- 10 Ibid: 4.3.
- 11 Department of Health (2004) *A code of conduct for private practice: recommended standards of practice for NHS consultants*. London: DH. Para 2.9; BMA (NI) Consultants and Specialists Committee and the Department of Health, Society Services and Public Safety for Consultants In Northern Ireland (2003) *A code of conduct for private practice. Recommended standards of practice for HPSS consultants*. Belfast: DHSSPS. Para 2.9.
- 12 Department of Health. *A code of conduct for private practice: recommended standards of practice for NHS consultants*. Op cit.
- 13 BMA (NI) Consultants and Specialists Committee and the Department of Health, Society Services and Public Safety for Consultants In Northern Ireland. *A code of conduct for private practice. Recommended standards of practice for HPSS consultants*. Op cit.
- 14 NHS Wales (2004) *Amendment to the national consultant contract in Wales*. Cardiff: NHS Wales.
- 15 The draft revised guidance on NHS patients receiving private care applies to all secondary and specialist health care in England and supersedes para 2.13, bullet point 1 of *A code of conduct for private practice: recommended standards of practice for NHS consultants*. Op cit.
- 16 Department of Health (2003) *Terms and condition of service for NHS consultants*. London: DH.
- 17 Department of Health. *Guidance on NHS patients who wish to pay for additional private care*. Op cit: para 4.5.
- 18 General Medical Council (2006) *Good medical practice*. London: GMC. Para 3 (e).
- 19 BMA Central Consultants and Specialists Committee (CCSC) (2006) *Patients requesting a second opinion*. London: BMA.
- 20 Department of Health (2004) *A code of conduct for private practice: recommended standards of practice for NHS consultants*. London: DH. Para 3.7; NHS Wales. *Amendment to the national consultant contract in Wales*. Op cit: para 9.14; BMA (NI) Consultants and Specialists Committee and the Department of Health, Society Services and Public Safety for Consultants In Northern Ireland. *A code of conduct for private practice. Recommended standards of practice for HPSS consultants*. Op cit: para 3.7.
- 21 General Medical Council. *Good medical practice*. Op cit: para 51.
- 22 Ibid: para 7.
- 23 Ibid: para 52.
- 24 Ibid: para 53.
- 25 Ibid: para 50.
- 26 British Medical Association Ethics Department (2004) *Medical ethics today. The BMA's handbook of ethics and law (2e)*. London: BMJ Publishing Group. pp.472-477. Also note that in May 2004 the

Northern Ireland Regional Group on Specialist Medicines produced guidance on the Red/Amber List, defining where clinical and prescribing responsibility should lie for certain specialist medicines, including a template for the development of shared care guidelines for amber-listed medicines. This guidance can be found at: <http://www.ipnsm.n-i.nhs.uk/>

- 27 Department of Health (2007) *Patient mobility: advice to local healthcare commissioners on handling requests for hospital care in other European countries following the ECJ's judgment in the Watts case*. London: DH.
- 28 Department of Health (2007) *Overseas treatment for NHS patients*. London: DH.  
<http://www.dh.gov.uk/en/Healthcare/Entitlementsandcharges/OverseastreatmentguidanceforNHS/index.htm>
- 29 General Medical Council. *Good medical practice*. Op cit: paras 60-62.

