Study of patients who chose private health care for treatment

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SUMMARY. A questionnaire survey was carried out in 1991 in Wessex regional health authority of a sample of private patients having inpatient treatment in eight independent hospitals, and in pay beds in three National Health Service hospitals. A total of 649 patients replied (response rate 60.7%). Sixty respondents to the questionnaire were also interviewed. The aim of the study was to discover which groups of people chose private care rather than using the NHS, and why. In view of the current emphasis on consumerism in health care, the study also aimed to examine how patients exercised choice in a market situation and how well informed they were when they did so. The questionnaire asked about the role and influence of the general practitioner in patients' decisions to use private health care for treatment. The largest group of respondents were in the 36–50 years age group (34.2%). Of the respondents 59.9% were women, 54.1% were in social class 2 and 77.3% were married or cohabiting. The most common reason for using private health care for treatment was to avoid NHS waiting lists (61.5% of respondents) although they did not necessarily know how long that wait would have been. Patients sought their general practitioner's opinion about whether to use private health care in 187 cases (28.8%). The majority of the 649 patients (71.2%) had decided to use private health care before consulting the general practitioner. However, patients were influenced by their general practitioner's advice on the choice of consultant and choice of hospital. Although the respondents were active and well informed consumers in relation to some aspects of their care, they had very limited knowledge of the options available to them or of the likely costs of their treatment (61.9% of the 649 patients did not know in advance how much their treatment would cost).

Keywords: private health services; patient choice; patient knowledge; patient attitude; patient information; private patients.

Introduction

THE debate about consumerism in health care goes back many years, but recent changes in the National Health Service have brought the issue centre stage once more. In a classic essay in 1967 Richard Titmuss argued that medical care was quite unlike other consumption goods and that recipients of that care could not behave as if they were buying a car or a washing machine. They did not know in advance how much care they would need, they could not assess the value of the 'product' and they could not return it to the seller if they were unhappy with it.[1] This view has commanded widespread support ever since. In an editorial in the *Journal*, Alastair Campbell argued that the patient was 'a vulnerable person and not a trading partner' who could 'neither gain access to all relevant information nor act in a wholly independent manner'.[2] The extensive literature on consumerism has highlighted the power imbalance in doctor–patient relationships and patients' lack of knowledge of alternatives in the choice of treatment, as well as the constraints imposed on 'shopping around' in the context of near-monopoly provision.[3-5]

However, recent changes in government policy have assumed an active role for consumers in many areas of the public services, not least in primary care. The citizen's charter, for example, talks of 'people's rights to be informed and choose for themselves'.[6] The charter expects patients to be given more information about the services in each practice, better advice on the treatment options available to them and more help in choosing and changing general practitioners. The assumption that patients can behave and wish to behave as active consumers has not been systematically tested in the NHS and it remains to be seen how far patients' preferences (if they express them) can be accommodated within the priorities of purchasers, whether they are general practitioners or health authorities. However, there is already the opportunity in the private sector to test the claims which are made for consumerism in a health care market.

There have been a number of studies in recent years of private sector health care.[7-10] Most of them, however, have looked at market trends or at the service provision. Only two studies have examined the experiences of patients in the private sector.[11,12] Although there are reasonably good national and local data on the characteristics of individuals with private health insurance, there have been no national studies of insured and uninsured patients using private health care facilities. Some data are collected by insurance companies about their own clients, but these are not publicly available.

The present study is a detailed survey of private patients in which interviews were carried out with a 10% sample of patients. The aims of the research were first, to describe the characteristics of patients who chose private health care for their inpatient treatment; secondly, to discover why they opted for private rather than NHS care; and thirdly, to examine the exercise of patient choice in a market setting.

Method

Self completion questionnaires together with pre-paid envelopes were distributed to 1070 inpatients in eight private hospitals, and in pay beds in three NHS hospitals in Wessex regional health authority, between January and March 1991. Questionnaires were given to all patients aged over 18 years whose consultants had agreed to participate in the survey. The specialties involved included orthopaedic surgery, general surgery, vascular surgery, gynaecology, ophthalmology, psychiatry and plastic surgery. In most cases (866) questionnaires were given out either by hospital receptionists or ward clerks when patients were admitted. In two hospitals questionnaires were sent out to 204 patients in advance with their admission papers. The questionnaire sought

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demographic information, details of past inpatient experience, reasons for using private health care for treatment, choices offered, and information sought and given about private health care. Non-respondents were not followed up. Responses were analysed using the *SPSS* statistical package. Chi square tests of significance were used. Frequency tables for each question were calculated and then cross tabulations of choices and information sought and given were calculated against age, sex, employment status and method of payment for insurance scheme.

To obtain qualitative data on consumerism and patient choice, patients were asked in the questionnaire whether they would take part in an interview on discharge. Of those who agreed to do so, a sub-sample of 60 respondents was selected to reflect the age, sex and geographical distribution of the respondents as a whole. The interviews followed a semistructured format and were tape recorded. The interviews sought detailed information on patients' past hospital experiences, their reasons for using private health care on this occasion, the information they sought and received before making their choice to use private health care, and their views about NHS and private inpatient care. The tapes were transcribed and the data analysed manually.

Results

A total of 649 patients returned completed questionnaires (60.7% response rate). Twenty two patients in NHS paybeds (response rate 62.9%) and 627 patients in private hospitals (60.6%) returned the questionnaire. Questionnaires distributed by hospital reception staff and questionnaires sent out with admission papers were returned by 64.4% and 45.1% of patients respectively. Only three hospitals agreed to record details of all patients to whom questionnaires were distributed (157 patients), these data revealed no significant differences between respondents and non-respondents in terms of age, sex or specialty. Surgery patients accounted for 37.1% of respondents, orthopaedic patients for 30.0%, gynaecology patients for 27.2% and ophthalmology patients for 6.0%.

Patient characteristics

The characteristics of the 649 patients who took part in the survey are shown in Table 1. The largest group of respondents were in the 36 to 50 years age group, with a relatively small proportion (18.2%) in the 65 years and over age groups. Six out of 10 of the respondents were women. The highest proportion of respondents was in social class 2 (54.1%) and 44.7% of respondents were in full time work outside the home. Most patients (77.3%) were either married or cohabiting.

Private health insurance cover

A high proportion of the sample (589/649, 90.8%) were paying for their treatment through private health insurance. Of these respondents, 5.9% expected to make co-payments to top up their insurance cover. The type of insurance scheme and who paid the premiums are shown in Table 2. Private individual health insurance accounted for almost a third of insurance schemes.

Sixty patients (9.3%) were uninsured and paying the full cost for private health care treatment themselves. Twenty eight of the uninsured patients were aged 65 years and over and 43 were women. The older uninsured group were typically individuals who previously participated in an occupational scheme which ceased on their retirement. Others had a pre-existing condition which made them ineligible for insurance cover. Uninsured women tended not to have had insurance policies in their own right, or cover from their partner's insurance scheme.

Table 1. Characteristics of the patients using private health care.

Patient characteristics	% of patients
Age (years) (n = 644)	
18–24	*8.1*
25–35	*19.4*
36–50	*34.2*
51–64	*20.2*
65–74	*12.4*
75+	*5.7*
Sex (n = 649)	
Female	*59.9*
Social class[a] (n = 604)	
1	*7.9*
2	*54.1*
3N	*21.7*
3M	*7.0*
4	*1.3*
5	*0.8*
Employment (n = 649)	
Full time work outside home	*44.7*
Retired	*19.6*
Housewife	*14.8*
Other full or part time work	*21.0*
Marital status (n = 649)	
Married or cohabiting	*77.3*
Never married	*12.9*
Widowed, divorced or separated	*9.7*

n = number of respondents. [a]Registrar general's classification.

Table 2. Type of insurance scheme held by 589 patients.

Insurance scheme	% of patients
Private individual	*31.4*
Occupational scheme	
Employer pays	*45.5*
Employee pays contribution	*19.5*
Unsure who pays	*1.7*
Non-response	*1.9*

Reason for using private health care for treatment

When patients were asked why they had chosen to use private health care, 61.5% reported that it was in order to avoid NHS waiting lists (Table 3). A number of respondents (38.2%) also commented that they wanted to take advantage of their insurance, either because it was a free benefit provided by their employer or because they had paid the premiums themselves and wanted value for money. For some patients, especially those in the younger age groups (18–35 years), the decision to use private health care was uncomplicated as they wanted to make use of their health insurance. However, this was not true for many older patients aged over 50 years who described at the interviews being torn between loyalty to the NHS and a desire to ease their pain or discomfort quickly. Relatively few used private treatment because of bad experiences in the NHS (8.9%) and of those who did, most had last had NHS treatment many years previously.

For some patients (28.5%) the surroundings of private hospitals and the privacy of a single room were important in their choice of private health care (Table 3). The ability to choose a convenient admission date was important to many people, especially those in full time employment, some of whom were

Table 3. Reasons given for using private health care for treatment.

	% of patients ($n = 649$)[a]
To avoid NHS waiting lists	61.5
To use private health insurance	38.2
Better environment	28.5
Choice of admission date	25.4
Better care	21.0
Negative experience of NHS	8.9
Choice of consultant or hospital	6.9
Other	2.8

[a]Respondents could list more than one reason.

probably self employed. In some cases, patients were getting an admission date no earlier than they would have done in the NHS but they were more confident that their admission would not be cancelled and satisfied that they could arrange the date to suit themselves. This was found at both the questionnaire and interview stage.

A fifth of patients (21.0%) expected to get better care in the private sector. The 136 who expected better care referred to having more time with the medical and nursing staff in an unhurried atmosphere rather than to higher clinical or professional standards. A small number of patients (6.9%) used private health care for treatment because they could go to the hospital or consultant of their choice. Some displayed remarkable tenacity in getting the consultant of their choice. Two interviewees had telephoned well known hospitals to ask who was 'the best man for the job', while another two had checked the qualifications of their doctors in local libraries. Ten respondents had used their personal influence and contacts to make early appointments. Two had used masonic or business connections to identify a suitable doctor.

Advice about using private health care

Patients were asked whether they had received advice on private treatment from the general practitioner or anyone else. General practitioners advised respondents to use private health care for treatment in 28.8% of the 649 cases and this was normally to avoid NHS waiting lists or to take advantage of health insurance. Approximately half of these respondents (91) reported they had been influenced by their general practitioner's advice, while a small number of others (107) sought the advice of family, friends and colleagues (especially from those who had undergone similar treatment). There were no significant differences between those individuals taking the advice of their general practitioner and the rest of the sample, although a higher proportion of them (63.0%) were women.

Patients generally made up their own minds about whether to use private health care, with little advice from anyone else, illustrated by two quotes from patients:

> 'We have got private insurance so I just said to him [general practitioner] "Well, it might be a good idea to use it" '.

> 'I said straight away, when he said about waiting time, I said "Oh, I'll go privately" '.

Of the 60 people who were interviewed about their choice of private care only five had taken advice about using private health care from their general practitioner. The other respondents gave three main reasons for not consulting the general practitioner: the majority (37) said that they had made the choice themselves before consulting the general practitioner, eight said there was no discussion because they had used private health care on previous occasions and their general practitioner knew that they would wish to do so again, and 10 respondents bypassed their general practitioners completely because they were already in touch with the consultant who would be treating them.

Having made the decision to use private health care for treatment, patients were influenced by their general practitioner regarding choice of hospital and consultant. Only 255 (39.3%) said they were given a choice of consultant when they decided to use private health care, and only 273 (42.1%) were given a choice of hospital. The general practitioner made the choices for the other patients. This is illustrated by the two quotes from patients:

> 'He didn't give me any choice. He said "This man's very good" '.

> 'He chose the consultant. I assume the GP knew what he was doing'.

Knowledge about private health care

Patients often had inaccurate or no information about the alternatives of NHS treatment, although 67.3% of respondents knew about NHS pay beds (22 respondents were patients using NHS pay beds). Over half of the sample (361/649) said that the wait for inpatient treatment in the NHS had influenced their decision to use private health care but, in fact, only 192 (29.6%) knew what the length of wait in the NHS would have been. Similarly, 48.8% of respondents to the questionnaire were concerned about waiting times for an NHS outpatient appointment, but only 185 (28.5%) knew how long they would have had to wait. A number of patients had been frightened off NHS treatment by media scares about ward closures and the numbers on NHS waiting lists. Although 503 respondents to the questionnaire (77.5%) had been NHS inpatients in the past, 348 of these had been inpatients more than five years ago.

When patients were referred to the private sector, they were given clear information: 88.9% of respondents to the questionnaire knew how long they would have to wait before admission and 91.8% knew their expected length of stay. One hundred and nine patients appreciated the benefit of a booked admission, and relatively low occupancy levels in many of the private hospitals meant they were offered guaranteed admission dates. However, 61.9% of the sample did not know in advance how much their treatment would cost. Among those with private health insurance, 69.5% did not know whether the policies would cover all the treatment costs, whether co-payments would be required or whether there were any exclusion clauses in their policies; most of the insured respondents assumed that their policies would cover all the costs. However, for the patients who were interviewed on discharge these assumptions had not been borne out; 11 patients were required to pay top up charges, usually for surgeons' or anaesthetists' fees.

The best informed respondents were those who were uninsured, and older people (aged 65 years and over). These patients felt they had good information on NHS waiting tmes, the likely length of wait between an outpatient appointment and inpatient treatment, length of stay in hospital and the cost of their treatment. Of the 60 uninsured respondents, 70.0% knew about NHS waiting times compared with 30.1% of the 393 patients with company financed private health insurance and 34.1% of the 185 patients paying their own insurance premium. Of those aged 65 years and over, 40.2% made choices about the hospital and the consultant compared with only 16.9% of those aged 35 years and under.

Discussion

Analysis of the characteristics of patients taking part in this study revealed that 60% were women. This higher usage of private sector care by women has been noted in other studies and this proportion is higher than the proportion of women using the NHS, even when termination of pregnancies is excluded.[7,12,13] The finding that the largest group of respondents were aged between 36 and 50 years is consistent with the findings of Nicholl and colleagues[7] and Horne.[12] The respondents in this survey were of a higher social class and were younger than typical NHS patients.[12,14] Two national studies by Nicholl and colleagues showed that the proportion of patients who were uninsured and paying for their own treatment fell from 28% in 1981 to 21% in 1986.[14] The figures from this study for Wessex in 1991 (9%) suggest that this decline may have continued.

It is no surprise that the majority of patients gave as their reason for using private health care for treatment the desire to avoid NHS waiting lists. However, less than a third of the respondents knew how long the wait would have been in their particular case. Many of them said that their general practitioners had talked in fairly general terms about the length of NHS waiting times, but relatively few had precise information on what it meant for them. For some, this was an irrelevance because they had already decided to use private health care, but for others it was a key factor in their decision making. Most general practitioners now have good, and up to date, information about waiting times in each specialty and for each consultant. In Wessex regional health authority, the Help for Health Trust has pioneered a 'waiting line' telephone service, providing general practitioners with accurate information about the state of NHS waiting lists.

The respondents in this study were different from consumers in the conventional marketplace in having little or no information about the cost of the product they were buying. This illustrates the problem of moral hazard in paying for health care. The theory of moral hazard maintains that, where a third party (usually an insurance company or employer) is paying for health care, the consumers of that care have little incentive to restrict their consumption of it or to inform themselves about costs and alternatives.[15] The cushion of private health insurance appeared to create disincentives, and perhaps even barriers, to well informed consumerism in this sample of private patients. The British Medical Association's advice to its members, that they should warn patients before treating them that their fees may not be fully covered by insurance (*Sunday Express*, 16 June 1991), is clearly not being observed in all cases. Only patients who were uninsured, and buying their treatment direct, and, to a lesser extent older people were well informed.

It is clear from both the survey and the interviews that general practitioners played a relatively minor role in patients' initial choice of private treatment. For the majority of patients the decision to use private care was uncomplicated: they had insurance cover and wanted to use it. The role of the general practitioner was more important in advising patients how to use private health care rather than whether to use private health care. Patients, on the whole, did not feel the need to discuss the principle of private treatment with their doctors. As they saw it, this was a non-medical decision which they made for themselves. The key role of the general practitioner, for them, was in facilitating access to the private sector and in advising about the choice of consultant. Although there is some anecdotal information to suggest that general practitioner fundholders may be encouraging their insured patients to use private health care for treatment only a small percentage in this study (29%) were doing so before 1 April 1991. Research on the impact of recent legislation and the introduction of general practitioner fundholding on referral patterns is already being carried out at the University of Manchester and it will be important to examine the changes in referrals to private hospitals which can be attributed to these shifts in policy. Giving advice on whether to use private health care has ethical, financial and political dimensions as well as clinical ones. So long as patients do not seek this kind of advice and so long as general practitioners do not give it, the issues may remain dormant. However, if the public–private mix in health care persists and patients become more active consumers, questions about the proper role of general practitioners are unlikely to go away.

Even when general practitioners are not buying 'by proxy' (either through district health authority allocations or from their own funds) they have a powerful impact on service consumption. One study in 1987 (the most recent national survey of private sector activity) showed that 509 379 people received inpatient treatment, and 873 182 patients received outpatient treatment over one year in private hospitals.[10] There are no national data for the numbers of patients treated in NHS pay beds since 1986 but, in that year, the numbers of inpatients and outpatients were around 60 000 and 250 000 respectively.[6] In the face of quite considerable consumer ignorance and passivity in the purchase of private health care, the role of the general practitioners as gatekeepers to the private, as well as the public, sector of health care is of increasing significance.

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