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Why Do Patients Go Private: A study of consumerism in health care

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1. INTRODUCTION

The study described here arose out of research for a book on the private market in health care, financed by the Economic and Social Research Council (ESRC) in 1985/6 (Higgins, 1988). It became clear during the course of that research that, despite the rapid expansion of private sector medicine since 1979, there was very little information from private patients themselves about their use of private medicine and preference for private, rather than NHS, treatment. Research by Horne in 1986 went some way to addressing these questions as did a study by Fraser et al (1974) and one carried out by the Consumers' Association (1986). However, the findings from these studies were limited and did not provide enough information to answer the question "why do patients 'go private'?"

Research on private health care hitherto has fallen into one of two main categories: first, there have been descriptive studies of the provider market and surveys of market development (Williams et al, 1985; Thomas et al, 1988; Nicholl et al, 1989) and, second there have been a number of studies of private health insurance which have analysed market trends and looked at subscriber motivations (Laing, 1988; Propper and Eastwood, 1989; Cant and Calnan, 1992).

As well as the absence of research on private patients and their decisions to go private there is a lack of data on the ways in

which private patients exercise choice in a healthcare market. It has been presumed in much of the pro-market literature that the virtues of the market such as freedom of choice, consumer sovereignty and value for money are as relevant in the medical marketplace as they are in, for example, the market in consumer durables (Lees, 1961; Harris and Seldon, 1979; Green, 1985, 1986). However, other writers have sought to demonstrate that health care markets have characteristics which distinguish them from virtually all other types of market operation (Titmuss, 1968; McLachlan and Maynard, 1982; Taylor-Gooby, 1985; Hindess, 1987). Titmuss, in particular, argued that consumers of health care were in a uniquely vulnerable position. They are unable to determine, in advance, how much medical care they need and might not know when they need it. They are poorly equipped to assess the value of the care they receive and enter the relationship with the provider (the doctor) on an unequal basis. They are heavily reliant on doctors' advice and technical expertise and rarely challenge recommendations. They cannot return the product to the seller if they are dissatisfied and the consequences of consuming too much of the product, or the wrong product, are often irreversible. Abel-Smith (1979) has argued that the health care market is the one in which the consumer is least able to exercise his or her "theoretical sovereignty" while Culyer maintains that "the marketeers' image of a prototypical consumer shopping around for the best quality care at least price, and getting it, is not a phenomenon that is anywhere actually going to be observed (Culyer, 1982:39).

This study set out to test some of these assertions and to examine, in detail, the ways in which consumers behave in health care markets. It was financed by the Economic and Social Research Council (Grant No. R000232164) and we are grateful to them for their support.

2. AIMS

The broad aims of the study were threefold: first, to describe the characteristics of a private patient population; second, to identify the reasons people had for using the private sector for in-patient care rather than using the NHS; and, third to examine the exercise of patient choice in a health care market.

3. METHODS

The data collection stage of the research had three phases. First, a questionnaire survey of 649 private patients in eight private hospitals and pay bed patients in three NHS hospitals; second, interviews with a 10% sub-sample of questionnaire respondents and third, interviews with a control group of respondents who had private health insurance but who had recently used the NHS for in-patient care. Detailed descriptions of these three phases are discussed below.

3.1 The questionnaire survey

Between October and December 1990, contact was made with the managers of all but one of the major private hospitals in the Wessex Region with the aim of gaining access to their private patients. Twelve private hospitals were contacted. Of these, two were not for profit and the rest were part of for profit hospital chains (BUPA Hospitals, Compass Healthcare, Nestor and the Priory Hospitals Group). All but one of the hospital managers were agreeable to meeting with us and discussing the research in more detail. At the meetings with the private hospital managers, the aims of the research, the role of the hospital in the research, access to patients and the benefits to the hospital of taking part were discussed. All the eleven hospitals visited expressed some interest in taking part in the research and agreed to discuss the prospect of participating further with their hospital management committees.

From our meetings with private hospital managers it became clear that gaining the permission of the consultants working at each hospital was crucial in order for the research to proceed. Hospital managers, or even the company or charity owning the hospital, were not able to give permission for the research to take place without gaining the permission of the medical staff committee at the hospital. The permission of consultants was sought by two different methods. In some cases we ourselves wrote to all consultants working in a particular District or all consultants working at a particular hospital asking permission to include their private patients in the survey. The consultants were provided with a letter to return to us if they wished to refuse permission for their patients to participate. In the second method, the hospitals sought the permission of consultants either individually (with each consultant) or through their medical committee. The first method was used in five cases and the second, which was more successful, in six cases.

After the approval of consultants or medical staff committees had been given, eight of the private hospitals agreed to participate. Of the three private hospitals which refused to participate, one reported that their reason for not participating was that the consultants would not agree to it. The other two non-participating hospitals did not give a reason for not taking part in the survey.

Of the eight hospitals which did participate in the survey, five agreed that all their patients could participate and three agreed

that only patients of those consultants who had given permission could participate. The five hospitals who agreed to all their patients participating had sought permission from the consultants themselves. Two of the three hospitals who only agreed to some patients participating were ones where we had written to individual consultants seeking permission. In these two hospitals, 13 consultants refused permission for their patients to participate. In the third hospital it was not clear how many consultants refused permission, but a total of six consultants agreed to their patients participating.

The District General Managers in each of the eleven Districts which made up Wessex Regional Health Authority were also contacted in order to discuss the possibility of including pay bed patients in NHS hospitals in the study. At the time Wessex Regional Health Authority comprised eleven Districts: Basingstoke, Bath, East Dorset, West Dorset, Bournemouth, Isle of Wight, Portsmouth, Salisbury, Southampton, Swindon, and Winchester. Most of the Districts had low numbers and low usage of pay beds. In others, access to private patients for the survey seemed likely to be difficult because they were dispersed throughout the District, rather than being in designated pay beds or in a private wing. As a result it was decided that pay bed patients would only be included in three Districts in the Region. These three Districts had a total of 21 pay beds in 1990 (one District had no designated pay beds in 1990 but allocated single rooms to private patients on demand). The annual throughput of private patients for the three Districts in 1990 was 751. The

permission of all consultants working in two of the Districts was sought in a letter from us and in the other District was sought by the District General Manager. A total of 13 consultants refused permission for their patients to participate in the two Districts where we ourselves asked their permission. These were the same consultants who refused permission in the private sector. No consultants refused permission for their patients to participate in the District where the District General Manager sought the consultants' permission.

The consultants who refused permission for their private patients to participate in the study were spread across a number of specialties: three were orthopaedic surgeons, three were oral surgeons, three were general surgeons, two were ophthalmologists, one was a dermatologist and one a neuro-surgeon. The refusal of consultants from some specialties to allow their patients to participate in the research was not felt to be problematic in terms of the representativeness of the sample. All specialties were represented in the research, as questionnaires were distributed to <u>all</u> patients in the majority of participating hospitals. The specialties of patients participating in the survey were: orthopaedic surgery, general surgery, vascular surgery, oral surgery, gynaecology, ophthalmology, psychiatry and plastic surgery.

Following Ethical Committee approval, self-completion questionnaires were distributed to all private patients, whose consultants had agreed to their participation, in eight private

hospitals and three NHS hospitals during an eight week period between January and March 1991. The questionnaire was a shortened version of one used in a pilot study for this research in 1989. The questionnaire was designed to discover basic demographic information about the private patient population (age, sex, marital status, employment status and method of payment for treatment) and respondents' reasons for going private rather than using the NHS. It was also designed to collect data on the information and choices patients sought or were given and their previous experience of NHS and private hospital in-patient treatment. The questionnaire was structured but had a mixture of closed and open questions which allowed respondents to state their opinions. Questionnaires were confidential and respondents could not be identified from their questionnaires unless they indicated their willingness to be interviewed by including their name and address (see below in the section on interviews).

Two methods were used to distribute questionnaires. In two of the private hospitals, questionnaires were sent with patient's admission papers prior to their admission to hospital. A total of 204 questionnaires was distributed by this method. In the other six private hospitals and three NHS hospitals, questionnaires were distributed by hospital staff when the patients were admitted or at some point during their stay. A further 866 questionnaires were distributed by this method. A total of 1070 questionnaires were distributed overall, 35 of these were distributed to pay bed patients in NHS hospitals and the rest to patients in private hospitals.

A total of 649 questionnaires was returned, making an overall response rate of 61%. The following table (Table 1) sets out the response rates of the hospitals. This table shows that the method of questionnaire distribution had an effect on response rates. Low response rates resulted when questionnaires were sent with admission papers (in two private hospitals) rather than when they were distributed by hospital staff. Of the other private hospitals, most (four) had a response rate between 61-70%. The hospital with the very low response rate (15%) was a hospital for psychiatric patients. Why the response rate should be so low for this group of patients is not clear but worries regarding confidentiality and poor motivation to complete questionnaires may have accounted for this. One of the private hospitals had a very high response rate (82%). This hospital was very interested in the outcome of the research and actively encouraged people to complete questionnaires. This probably accounts for the high response rate there. Among the three NHS hospitals, response rates varied but the numbers of patients admitted over the eight week period were small and it is not possible to draw firm conclusions from these numbers.

Table 1

RESPONSE RATES

HOSPITAL	METHOD OF DISTRIBUTION	NUMBER DISTRIBUTED	NUMBER RETURNED	RESPONSE RATE
Hospital 1	staff	217	134	62%
Hospital 2	by letter	121	58	48%
Hospital 3	staff	64	39	61%
Hospital 4	by letter	85	37	43%
Hospital 5	staff	51	8	15%
Hospital 6	staff	299	211	70%
Hospital 7	staff	78	64	82%
Hospital 8	staff	120	76	63%
Hospital 9 (pay beds)	staff	20	9	45%
Hospital 10 (pay beds)	staff	3	2	66%
Hospital 11 (pay beds)	staff	12	11	92%
TOTAL		1070	649	61%

The participating hospitals were asked to keep some basic data on all the patients to whom questionnaires were distributed in order for us to make a comparison of respondents and non-

respondents. Unfortunately only three of the eight private hospitals agreed to do this. The NHS hospitals also kept this data but because the numbers were so small this information could not be used for comparative purposes. The data from the three private hospitals revealed no significant differences between respondents and non-respondents in terms of age, sex, or specialty as the following table shows (Table 2).

Table 2

COMPARISON OF RESPONDENTS AND NON-RESPONDENTS

	Respondents	Non-Respondents
Average Age	52 years	52 years
Females	60%	62%
Males	40%	38%
SPECIALTY: **Orthopaedics**	30%	30%
Gynaecology	27%	24%
Surgical	37%	35%
Ophthalmology	6%	11%

The characteristics of respondents were obtained from the questionnaires. A total of 389 of the respondents were female and 260 were male. The largest group was aged 36-50 (Table 3) and the sample was predominantly middle class with the majority

classified as social classes II and III non-manual (NM) (Table 4). Most respondents were married or cohabiting (77%), 13% had never married and 10% were widowed, divorced or separated. In terms of employment status, just over half were in full time work (51%). Of the rest, 19% were retired, 15% were housewives, 11% were in part-time work and the rest were unemployed or students. The following two tables set out the age and social class of respondents.

Table 3

AGE OF RESPONDENTS

AGE	FEMALES	MALES	TOTAL
18-24	33	19	52 (8%)
25-35	74	51	125 (19%)
36-50	149	71	220 (34%)
51-64	63	67	130 (20%)
65-75	47	33	80 (12%)
75+	22	15	37 (6%)
non-response	1	4	5 (1%)
TOTAL	389	260	649

Table 4

SOCIAL CLASS OF RESPONDENTS

SOCIAL CLASS	FEMALES	MALES	TOTAL
SC I	28	24	52 (8%)
SC II	208	142	350 (54%)
SC III NM	88	55	143 (22%)
SC III M	25	20	45 (7%)
SC IV	7	-	7 (1%)
SC V	1	-	1
non-response	32	19	51 (8%)
TOTAL	389	260	649

The questionnaire data were analysed using the SPSS statistical package.

3.2 The interviews

Questionnaire respondents were asked to include their name and address at the end of the questionnaire if they were willing to take part in an interview after their discharge from hospital. A total of 259 respondents (40% of the questionnaire sample) did so. A 10% sub-sample of questionnaire respondents (60 people) was interviewed. These were selected from the 259 respondents willing to be interviewed according to age and sex so that, as far as possible, the interview sample reflected the questionnaire

sample. Interviewees came from all the Districts in the Region which participated in the survey.

Of the 60 people interviewed, 58% were female and 42% were male. The age and class range of the interview sample reflected the questionnaire sample: 63% were in the 25-50 age group and 82% (n49) were in social classes I, II and III (non-manual). Five patients were patients in NHS paybeds and the rest were patients in private hospitals. The following table shows the age and sex of interviewees.

Table 5

AGE AND SEX OF INTERVIEWEES

AGE	FEMALES	MALES	TOTAL
18-24	-	-	-
25-35	7	1	8
36-50	15	7	22
51-64	9	10	19
65-74	2	4	6
75+	3	2	5
TOTAL	35	25	60

The interviews took place between February and June 1991. The people selected for interview were telephoned and interviews were arranged at a time convenient to them. Most of the interviews took place in the interviewee's home during the day or evening.

Two interviews took place at the interviewee's place of employment. The interviews lasted an average of one hour.

The interviews were designed to discover more detailed information than was obtainable from the questionnaires about people's reasons for, and experiences of, 'going private'. The topics covered in the interviews were: health behaviour; past in-patient experiences (both NHS and private); their recent private experience; the choices and information they sought or were given before deciding to go private; their reasons for going private; and, their views on private healthcare and the NHS. The interviews were semi-structured with a list of questions that were asked of all interviewees, but the interviewer was free to pursue individual responses to any of the topics in more depth. The interviews were tape recorded and the tapes transcribed in full. The transcripts of the interviews were analysed manually by grouping the types of responses interviewees made in relation to the key topics of the research.

3.3 Control group interviews

Data from the General Household Survey has demonstrated that people with private health insurance do not necessarily make use of their insurance. In the 1986 survey, just over one half of the privately insured population used the NHS for in-patient treatment rather than going private (Office of Populations, Censuses and Surveys, 1986:146). It was decided that a group who had chosen to use the NHS, even though they had the capacity (in that they were insured) to go private would make a useful

comparison with the people identified in the survey who had chosen to go private.

Many private health insurance policies permit insured individuals who use the NHS to claim a daily allowance. Following Ethical Committee approval, access was given to records of insured people who had been NHS patients in a large general hospital in Wessex who had made claims against their insurance for their stays in hospital. The names and addresses of such people are kept for administrative purposes in order to record where claim forms have been signed verifying the number of nights spent in hospital. Patients who claim a nightly allowance from their insurance company are not necessarily representative of the insured population who choose to use the NHS. However, access to this group was relatively easy and it was felt that they would be a valuable source of data.

The records held at the hospital were examined in August and November 1991 and March 1992. All patients with full medical insurance who had used the NHS from January 1991 - March 1992 in the hospital were sent letters and invited to take part in an interview. Enclosed with the letter explaining the research was a post-card for people to return if they were willing to be interviewed. A total of 73 people were contacted and invited to participate. Thirty people returned the post-card agreeing to be interviewed, making a response rate of 41%. It was not possible to compare respondents and non-respondents as only name, address and insurance company details are kept by the hospital.

A total of twenty-eight of the thirty people who agreed to be interviewed were actually seen. Fifteen of these were male and 13 female. The majority were in the 36-64 age group. The majority of the control group were in social classes II (46%, n13) and III non-manual (28%, n8). Of the rest, four people were in social class I, two people in social class IV and one person in social class III manual. Most interviewees were either retired (42%, n12) or in full-time employment (39%, n11). Of the rest, four people defined themselves as housewives and one person worked full-time. The great majority of interviewees were married (86%, n24). The following table shows the age and sex of these interviewees.

Table 6

AGE AND SEX OF CONTROL GROUP INTERVIEWEES

AGE	FEMALES	MALES	TOTAL
25-35	-	1	1
36-50	6	6	12
51-64	4	7	11
65-74	2	1	3
75+	1	-	1
TOTAL	13	15	28

The control group interviews took place between September 1991 and April 1992. As with the main group of private patients, interviews took place, in most cases, in the interviewees' homes. They followed the same structure of the private patient interview

schedule but focused on interviewees' reasons for and experiences of using the NHS, rather than the private sector for their recent stay. The responses made by the interviewees were recorded on the interview schedule during the interview. These responses were then typed onto separate sheets under the main headings of the research.

4. FINDINGS

The quantitative and qualitative data collected for this research provided information, as intended, on the private patient population, their reasons for using private in-patient facilities rather than the NHS, and the ways in which consumers exercise choice in a health care market. The data also provided us with information on additional topics including women's relationship to private medicine, private patients' perceptions of the NHS, the relationships between patients and consultants in the private sector, the attitudes and experiences of people with private health insurance who have made recent use of the NHS, and the health behaviour of a private patient population. Each of these will be discussed in turn.

4.1 Private patients in a health care market

The survey data produced interesting information about the private patient population, their reasons for going private and the exercise of choice in a health care market. This data was substantiated by the qualitative data collected at the interviews. (For a detailed discussion of these findings see Higgins and Wiles, 1992a).

Of the 649 patients who took part in the survey, the majority were female (60%), middle class (84% were in social class I, II and III non-manual) and in the middle-age ranges (54% were aged between 36-64). These findings are consistent with other studies (Horne, 1984; Nicholl et al 1989; Cant and Calnan, 1992). The

majority (91%, n589) were paying for their treatment through private health insurance. Of these, 6% (n35) expected to make co-payments to top up their insurance cover.

Sixty respondents (9%) were uninsured and paying the full cost of their treatment themselves. Nearly half of the uninsured respondents (47%, n28) were aged 65 or over and 78% (n47) were female. The older uninsured group were typically individuals who had 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 partners' insurance scheme.

Nearly one half of the insured belonged to an occupational scheme with the premiums paid by their employer (46%) and almost one third had organised their own insurance cover through an individual scheme (31%). The type of insurance scheme that respondents belonged to is set out below.

Table 7

TYPE OF INSURANCE SCHEME

TYPE OF SCHEME	FREQUENCY	%
PRIVATE INDIVIDUAL	185	31%
OCCUPATIONAL SCHEME (EMPLOYER PAYS)	268	45%
OCCUPATIONAL SCHEME (EMPLOYEE PAYS)	115	20%
OCCUPATIONAL SCHEME (DON'T KNOW WHO PAYS)	10	2%
NON-RESPONSE	11	2%
TOTAL	589	100

Unsurprisingly, the major reasons cited for using private in-patient facilities rather than the NHS were to avoid NHS waiting lists and to make use of private health insurance. However, other reasons also emerged as important. For some patients the surroundings of private hospitals and the privacy of a single room were an attraction. The ability to choose a convenient admission date too was important to some people, especially the self-employed. Others felt that they would get better care in the private sector, in that the medical and nursing staff would

spend more time with them, than in the NHS. The following table sets out the reasons given by respondents for 'going private'. They were invited to list as many reasons as they wished.

Table 8

REASONS FOR GOING PRIVATE

REASON	FREQUENCY	% OF SAMPLE GIVING THIS REASON
AVOID NHS WAITING LISTS	399	61%
TO USE HEALTH INSURANCE	248	38%
BETTER ENVIRONMENT	185	28%
CHOICE OF ADMISSION DATE	165	25%
BETTER CARE	136	21%
NEGATIVE EXPERIENCE OF THE NHS	58	9%
CHOICE OF CONSULTANT OR HOSPITAL	45	7%
OTHER	18	3%

4.2 Consumerism and choice

In this sample there was only limited evidence of consumerist behaviour. Only 27% (n173) made choices regarding their consultant, the hospital where they would be treated and their admission date and only 34% (n222) knew how long they would wait before admission, how long their hospital stay would be and how much their treatment would cost. The best informed respondents were those who were uninsured, and older people. These patients felt they had good information on NHS waiting times, the likely length of wait between an out-patient appointment and in-patient treatment, length of stay in hospital and cost of treatment. It is perhaps not surprising that patients who have the financial incentive, and the time, to shop around should be the best informed. Seventy per cent (n42) of the uninsured knew about NHS waiting times compared with only 30% (n80) of those with company financed health insurance. A slightly higher proportion of patients paying their own insurance premium (34%, n63) had good information. Forty per cent of respondents aged 65 and over made choices about their care compared with 17% of respondents aged 35 and under.

It should be noted that a small number of respondents displayed remarkable tenacity in getting the consultant of their choice and the treatment of their choice at the time of their choice although these were very much in the minority. Some had rung well known hospitals to ask who was 'the best man for the job', while others had checked the qualifications of their doctors in local libraries. Several had used their personal influence and

contacts to make early appointments. The majority of respondents, however, were ill-formed and trusting. They were very different from consumers in the conventional marketplace in seeking little information and making few choices about the 'product' they were buying and value for money.

At the primary care level patients were offered relatively few choices and only limited information about different private hospitals or the alternative of NHS treatment. Most had the hospital and consultant chosen for them by their GP. Only 42% (n272) were offered a choice of hospital and only 40% (260) were offered a choice of consultant. The following comments from three interviewees illustrate this: "He didn't give me any choice. He said 'This man's very good'"; "He said 'Right I'll make an appointment with Mr S.'"; "He chose the consultant. I assume the GP knew what he was doing". As well as not being offered choices or information, respondents did not seek it. People were satisfied to trust their GP in their choice of hospital and consultant. Where choices <u>were</u> made, these were generally on the basis of past experience of a particular consultant or hospital.

When patients did get referred to the private sector, however, they were given quite clear and accurate information. A total of 578 people (89%) knew how long they would wait before admission and 597 people (92%) knew their expected length of stay. One of the great attractions to patients was the benefit of a booked admission, and relatively low occupancy levels in

many of the private hospitals meant they were offered guaranteed admission dates. Equally, most patients were in hospital for minor surgery and lengths of stay were easy to predict in advance.

The most striking finding in the light of consumerist thinking, is that 62% (n402) of the sample did not know, in advance, how much their treatment would cost. Amongst those with private health insurance, few knew whether the policies would cover all the treatment costs, whether co-payment would be required or whether there were any significant exclusion clauses in their policies. Most of the insured respondents assumed that their policies would cover all the costs. However, for some of those patients who were interviewed after discharge from hospital these assumptions were not borne out. Several had been required to pay top up charges, usually for surgeons' or anaesthetists' fees.

The finding that it is only uninsured patients who act in a consumerist fashion when seeking private in-patient care illustrate clearly 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. The cushion of private health insurance certainly created disincentives - and perhaps even barriers - to well informed consumerism in this sample of private patients.

On the basis of this survey it does not appear, as Titmuss (1968) and others (Taylor-Gooby, 1985; Hindess, 1987) have argued, that consumerism is not possible in health care. However people tend not to adopt consumerist attitudes unless there are encouragements for them to do so. There are clearly many barriers to consumerist behaviour in health care, such as the problems in judging and comparing the 'product' and assessing value for money. Some respondents in this study did overcome these difficulties and chose who they wanted to carry out their treatment, where it should be carried out and when. Respondents used their own experience, and hearsay, as a basis for making these choices and - if their expectations were not met - felt able to make complaints about the service they received. However, in this study it appeared that financial incentive was the catalyst that encouraged people to behave in a consumerist manner. Younger respondents with employer financed health insurance exhibited few consumerist characteristics, giving little thought to the choice of doctor, hospital or the options available. It was mainly older people, especially the uninsured, who took the greatest trouble to become well informed and to seek out alternatives. This study shows that consumerist behaviour in the health care marketplace occurs within a limited range of decision-making and within small groups of the population who have the financial incentive to inform themselves of options and choices.

4.3 Women's use of private medicine

Research has shown that women make more use of private sector facilities than men (Horne, 1984) and that this difference is more pronounced than in the NHS (Williams et al, 1985; Nicholl et al, 1989). The interview data provided some information on why this might be so. (A detailed discussion of these findings can be found in Wiles, 1992a). Respondents were asked to state on the questionnaires why they decided to go private for their in-patient care. The three reasons most frequently cited were to avoid NHS waiting lists, to make use of their insurance and because of the better environment of private hospitals. The interviews provided scope for discovering more details about patients' reasons for going private.

The main reasons for going private given in the interviews were generally the same as those most frequently recorded on the questionnaires and there were no differences between males and females in the reporting of these reasons. However, distinct differences between male and female interviewees emerged when they were asked why these reasons were important and what benefits they felt they acquired by going private. Clearly for some people, both men and women, the reasons for, and perceived benefits of, going private were uncomplicated: the possession of private health insurance, together with the lack of waiting and the perceived better care, made the choice to go private a rational one for them. However, for others, reasons relating to the differing social roles of men and women emerged as important. For example, quick admissions and booked admissions were

identified as important for many of the men so that they could organise work commitments, but for many of the women this was important in order to plan domestic commitments and care for family members. Similarly, privacy obtainable in the private hospital environment was important for many men in order that they could work from their hospital bed and have visitors at any time. For women, privacy was viewed as important in relation to issues of dignity and modesty. The specific benefits that women identified were ones that are not always available on the NHS and may account for their high usage of private in-patient care.

Four factors were identified from the women's responses as important reasons for, or benefits of, going private. These were: first, factors related to women's roles as 'carers' which were cited by 16 women (46% of the female sample) and only one man; second, to have their health needs met in a way that they are not in the NHS, mentioned by 20 women (57%) and only three men; third, to retain an element of dignity and modesty, identified by 18 women (51%) and only three men; fourth, to maintain control over their health care (seven women (20%) and no men).

Sixteen women felt that the private sector offered them benefits not available in the NHS which related to their role as 'carers'. On a practical level, having a choice over the admission date and the length of period in hospital meant that anxieties about dependents (both children and elderly relatives) and their care could be alleviated. In addition, on an emotional level, being

'cared for' (in a way that they felt they would not be in the NHS) was seen as especially important because it was something that they felt they did not usually get, either because it was they who did the caring or because they lived alone. While these benefits may have applied to men they are less significant because it is more often women than men who are carers (Finch and Groves, 1983) and lone women are less likely to enjoy the benefits of social support found amongst lone men (Burgoyne, Ormrod and Richards, 1987). No men in this sample were primary carers for dependents. Two men lived alone and one of these noted the importance of feeling 'cared for' as a benefit of going private.

For seven women, the ability to choose admission dates, to re-arrange dates without facing a long wait and the knowledge that cancellations at short notice would not occur were primary reasons for going private in that they enabled them to make arrangements for alternative care for their dependents, with confidence. Such a facility is not normally available on the NHS, where choice over admission dates is not usually given, when admission dates may be sent at short notice and when cancellations may mean a long wait before a further appointment. The following excerpt from an interview illustrates the primacy of this reason for some women:

> "Q: Could you tell me why you decided to go private this time?
>
> A: Because I have an elderly mother which necessitated my having my operation done at a time when she could be cared

for, because I knew I would be off my feet and unable to move around. If I'd been put on a waiting list, even if they had been fairly co-operative I couldn't have arranged when I would have been admitted. I have to be dependent on my sister, who is a school teacher being able to look after my mother and therefore school holidays was my only available time." (31)

The better care that women felt they would, and did, receive in the private sector (as opposed to the NHS) was also viewed as an important factor in their decision to go private. This too was related to women's caring role in that women felt that better care was equated with a faster recovery and a quicker return home to dependents. Again, seven women noted this was an important factor in their decision to go private. In comparison with NHS hospitals, private hospitals are smaller, have lower levels of occupancy, and have patients who, in the majority of cases, are admitted for cold, elective surgery rather than for acute conditions. As a result, patients typically receive more nursing time than they would in the NHS. In addition, many private hospitals often have 'ward hostesses' who cater to patients' personal needs, thus freeing nurses to concentrate on nursing rather than domestic duties. The level of attention from consultants also tends to be greater in private hospitals.

Nine women interviewees lived alone and for eight of these the high level of attention they received in private hospitals was important more for emotional than practical reasons. The women

who lived alone included elderly widowed women and young single women. These women had low levels of social support as they had no family or close friends living locally and they noted that the high level of attention helped them to feel less lonely than they might have done and made up for their lack of visitors. In addition, the attention was welcomed by such women who, in general, rarely had anyone to 'look after' them. The following quotation was typical of the responses of this group of women:

> "I felt like royalty almost. You get waited on hand and foot and have a private room and your own television and everything and when you live on your own it makes a change for someone to look after you." (23)

A number of studies have shown that women are dissatisfied with the hospital care that they receive on the NHS and that this dissatisfaction centres around the attitudes of doctors (Kirke, 1980; Roberts, 1985). In these studies women have complained of a lack of information, poor communications and the lack of time doctors give to patients. There is considerable evidence that women experience poor doctor:patient relationships more frequently than men for several reasons. First, they present with vague, unspecific complaints more frequently than men or with complaints that may be social in origin (Roberts, 1985). Furthermore, women, in general, want to discuss their condition or the feelings engendered by it more than men (Roberts, 1985). Both these reasons mean that women desire interpersonal skills on the part of doctors more than men and therefore experience the lack of them more acutely. Second, the sexism inherent in

medical culture may mean that doctors behave more negatively to female than to male patients (Lenane and Lenane, 1973; Young, 1981).

The improved relationship with doctors that was obtainable by going private was identified as one of the great benefits of private treatment. In general, private patients are seen by consultants (rather than junior doctors) and the same consultant is seen throughout an entire course of treatment. In addition, consultants' behaviour with their private patients is often different from that which an NHS patient could expect: private patients are visited more frequently (in our research private patients were visited daily and sometimes twice a day to check on progress); they are given more time with their consultants; they are treated more informally; they are encouraged to ask any questions or seek any information regarding their condition from the consultant and they are given the consultants home 'phone number which they are invited to ring if they have any concerns or any questions they want to ask. In short, the relationship between patient and consultant tends to be more informal, friendly and more egalitarian than in the public sector.

The importance of the improved relationship with doctors in the private sector was noted far more frequently by the women than the men in this study. A total of 20 women compared with three men reported the attitude and behaviour of doctors in the private sector was a primary benefit of, if not a reason for, going private. The following quotations illustrate the sorts of

comments women made regarding this:

> "I felt more at ease, I think, because he had more time for me and I suppose I had more chance to say what was bothering me. I thought he was more approachable than perhaps he would be on the NHS. I've seen the same chap with my daughter on the NHS and he was very short, very brisk. (46)
>
> Things are explained to you a bit more, because you don't feel rushed, you feel happy to discuss it. I think they encourage a lot more from you because they've got more time and I think they possibly feel it's part of their service." (42)

The privacy, dignity and modesty available in the private sector emerged as reasons for women choosing to go private or benefits that women felt they gained by going private. A total of 18 women reported these factors as important, to some degree, in their decision to seek private treatment. Eight men reported privacy as an important factor in their decision to go private but their reasons differed from those given by the women. For the men, privacy was noted as important, in most cases, in that it offered them "peace and quiet". For the women there were four ways that privacy, dignity and modesty were seen as important. First, the use of single rooms in the private sector was viewed as important in that it enabled patients to control how much information other patients knew about them, their feelings and their condition. Such control is not usually possible in the NHS where the majority of patients are in wards of at least four beds

with the only privacy available being a thin curtain around the bed. Secondly, the en suite bathrooms in private hospital rooms were viewed as a benefit of going private. They eliminated the necessity of sharing the same toilet as others which many patients viewed as distasteful. Thirdly, privacy and the absence of medical and nursing students in private hospitals encouraged some people to feel they could maintain an element of dignity which was not possible in the NHS. Finally, a number of patients felt that privacy enabled them to retain some modesty concerning their bodies and their bodily functions. The following comments regarding the issues of privacy, dignity and modesty were typical:

> "Well, with that sort of problem it's better [to have a private room] than being in a ward with lots of people. It's probably better to keep it anonymous." (53)
>
> "I do like my private facilities. I'm a bit fastidious in a way and I don't like sharing loos with loads of people." (60)
>
> "I don't like the thought of having to sort of cock your leg out of bed and show the world everything you've got." (42)

Feeling 'in control' of an illness and it's treatment has been identified as important both physically and psychologically for people suffering from life-threatening and chronic conditions (Fallowfield and Clark, 1991; Kfir and Slevin, 1991). Only a minority of women in the interview sample (n7, 20%) noted the importance of being 'in control' of their treatment in some way

as a factor influencing their decision to go private. One of the reasons for this may have been that the majority of women, in common with most private patient populations, were admitted for cold, elective, routine surgery rather than chronic or life-threatening conditions. Such conditions are generally specific, operable and in many cases visible and do not, in general, lead to the strong feelings of lack of control that chronic or more serious conditions do.

All the women who noted the importance of being 'in control' were admitted for conditions that were not visible and were potentially dangerous or conditions that were chronic and incurable. While only a minority of women noted the importance of being 'in control' of their treatment, those who did stressed the importance of this very strongly and noted their inability to achieve this in the NHS. The women noted that, as private patients, they were able to maintain control by negotiating the sort of treatment that they had in a way that was not possible in the NHS. They noted that they were able to talk to their consultant about the form their treatment would take and their own perspectives on their condition and treatment for it were discussed. Interestingly, no men reported feeling a need to be 'in control' as a reason for going private. With such small numbers it is not possible to draw any conclusions from this but it may be that the desire to be 'in control' of medical treatment is more important for women than men.

This research has demonstrated that while the broad reasons for choosing to go private may be the same between the sexes the factors that go to make up those reasons are, in fact, very different and that these differences relate to men's and women's socialisation, social roles and position in society. Such findings have implications for public and private health policy makers. They indicate that health care needs may be gendered and that policy makers need to take this into account.

While the sample on which this research is based is not representative of a wider population in that it consists of people who use private in-patient facilities (rather than those who have the capacity to use such facilities) and is highly skewed towards social classes I and II, this research does indicate that sub-groups of men and women have differing health care needs and wants. Further research is needed to discover the extent to which the type of health care people desire is gendered among wider populations and the impact further divisions of class, race and age have. Without this, improvements to services may not occur. Consumers of health care are both men and women and their health care needs, and indeed underlying reasons and interpretations of these needs, are likely to be very different.

4.4 Private patients' perceptions of the NHS

The interviews produced data on private patients' views of the NHS in general and also of their perceptions of NHS nursing and nurses. (For a full discussion of these findings see Higgins and Wiles, 1992b). Interviewees were asked if they felt that the NHS

could meet their health care needs and if not, in what ways this was so. Additionally, they were asked if they felt there were any differences in nursing care in the private sector compared with the NHS.

There have been a large number of surveys of public opinion of the NHS over the last ten years and varying conclusions have been drawn regarding levels of satisfaction. Comparison between surveys is difficult because of the differing methodological approaches used (Judge et al, 1992). However, there is some consensus regarding the specific areas of dissatisfaction identified in hospital services. Waiting lists, waiting times, condition of buildings and facilities and poor communication with doctors have emerged as areas of dissatisfaction (Solomon, 1991).

In this study, a total of 80% (n48) of interviewees identified the NHS as in need of some improvement before it could meet their health care needs. Unlike other studies (see Solomon, 1991), nursing emerged as an area frequently cited as in need of improvement. A total of 35% (n21) of the sample reported some aspect of nursing as a 'problem' in the NHS. This issue followed 'waiting lists' and preceded 'management and organisation'. The following table sets out the aspects of NHS hospital services that interviewees identified as problematic:

Table 9

AREAS OF DISSATISFACTION WITH THE NHS

AREA OF DISSATISFACTION	PERCENTAGE
WAITING LISTS	38% (n23)
NURSING	35% (n21)
MANAGEMENT AND ORGANISATION	31% (n19)
POOR BUILDINGS AND FACILITIES	16% (n10)
INADEQUATE FINANCE	16% (n10)
MEDICAL STAFF	10% (n6)
NOT DISSATISFIED	16% (n10)
NON-RESPONSE	3% (n2)

The aspects of nursing that were reported as problematic were: first, organisation; second, attitudes; and third, staff shortages. The first two of these both relate to staff attitudes while the third does not. In total, 13 people cited factors relating to staff attitudes and 13 people cited staff shortages. These were not mutually exclusive and 5 people saw both as an issue.

In terms of nurse organisation, some respondents felt that nurses needed more discipline than they had at present and that this would lead to an improvement in standards, resulting in better patient care. It was felt that the changes in organisation and, in particular, the demise of the Matron in the NHS meant that

nurses were not as conscientious as they once were. One man described seeing a patient being ignored in hospital while a group of nurses 'chatted' at the end of the ward. His solution to this was to reinstate the position of Matron. He said "The whole thing worked a lot better with a Matron because everyone knew where they were and things ran like clockwork and frankly I don't think it does any more". Another interviewee commented "It seems to be that management from the top seems to be lacking quite a lot. Nurses don't do half the work they used to, they just don't seem to have the relationships with patients any more".

Other respondents were critical of what they perceived as the 'poor attitude' of NHS nurses but they did not attribute this to poor organisation. All the respondents held the view that standards had declined in recent years and that nurses were not the caring, dedicated people that they once were. The following comments illustrate this: "The student nurses act as though they are doing you a favour. I think right from the beginning they have got to be taught that their patient is their customer"; "Obviously some of the nurses are good but I do feel quite strongly that the nurses aren't of the calibre they were. I don't think their heart is in it and I don't think there is dedication".

Shortages of nursing staff were seen as a considerable problem in NHS hospitals. It was felt that the pressure of work was so great for many nurses that they did not have the time to spend

with patients or to do their job properly. However, nurses were viewed as working extremely hard in order to ensure that patients did not 'suffer' from the lack of staff. A number of respondents felt the result of staff shortages was that many nurses, particularly the 'good' ones, left the profession altogether or went into the private sector. The blame for nursing shortages was seen to lie with hospitals, Health Authorities or the Government and they were seen to result from a lack of money. The following comments were made with regard to this: "I just think they need more staff, more nursing staff"; "There aren't enough nurses on the wards, they can't afford to employ the nurses and of course a lot of them are going into the private sector".

As regards interviewees' comparisons of private and NHS nurses and nursing, only 15% (n9) of the sample reported that they felt there was no difference between the attitudes of nurses and nursing care in the private sector compared with the NHS. The majority felt the difference between the public and private sectors was largely in terms of the time and attention given to patients. A total of 55% (n33) of the sample suggested that nurses in the NHS had less time to spend with patients than in the private sector and as a result patients received less nursing care. Most of the respondents who suggested this were not critical of NHS nurses. They felt the lack of time and attention resulted from there being fewer nurses in the NHS than in the private sector. The following comments were typical: "It's the fact that they have less patients per nurse in the private sector

than they do in the NHS"; "It's quantity really, private hospitals can employ more people and therefore they've got more time to talk which makes you feel you're getting better care".

The majority of patients interviewed in this study had no recent experience of the NHS but frequently argued that it was their concern about standards in the NHS which had persuaded them to 'go private'. Despite this lack of experience many of them had clear views about nursing in the NHS and the private sector and felt that there was a difference between the two sectors in terms of staffing levels and the attitudes of nursing staff. Of those who argued that patients were likely to receive less time and attention in the NHS than in the private sector, only 21% (n7) had had treatment as an in-patient in the NHS since 1985 and 42% (n14) had never been NHS in-patients. Similarly as the following table shows, of those who said that nursing was a 'problem' in the NHS only 5% (n2) had been NHS in-patients since 1985. Indeed, only <u>one</u> of the respondents identifying nursing attitudes as a problem in the NHS had actually experienced NHS in-patient treatment in the previous eight years.

Table 10

INTERVIEWEES' MOST RECENT NHS EXPERIENCE

VIEWS OF NHS	NONE	1948-1975	1976-1983	1984-1991	TOTAL
NURSING PROB-LEMATIC	7	8	4	2	21
NURSES ATTITUDE	4	7	1	1	13
STAFF SHORTAGE	5	3	1	4	13

Most respondents used recollections of visiting people in hospital, hearsay and the media in assessing their views of the NHS. Such evidence is likely to be unreliable and not a true reflection of the situation as it exists in the NHS. While the sample in this study are not representative of a general population, the findings of this research give some cause for alarm regarding the public image of nurses and nursing. Such perceptions may have a negative impact on peoples' faith in the nursing profession and on nurse recruitment. Further research is necessary to discover how other groups who have not made recent use of NHS in-patient services view it and, if this proves to be negative, how the image of nurses and nursing can be improved.

4.5 Relationships between patients and doctors in the private sector

The relationship between doctors and their patients has been characterised as being a relationship of unequals with doctors having the power to determine the structure, content and outcome of interactions (Bloor and Horobin, 1975; Calnan, 1984). Analysts of private health care have noted that private patients have very different relationships with their doctors than patients within the NHS system. Strong (1979) argues that in the public sector doctors tend to be anonymous and their skills interchangeable with other doctors, whereas in the private sector doctors become individuals who offer patients a personalised service based on the premise that patients can go elsewhere if they are not satisfied. The result of the personalisation of service in the private sector means that patients receive more time and attention from doctors, better communication and they have some control over the relationship with their doctor. Some evidence for Strong's hypothesis has been found in relation to private GP services (Thorogood, 1992) and private out-patient clinics (Silverman, 1987). Surveys of people who have used private in-patient facilities have not focused on this issue. Our research enabled us to examine the extent to which the relationship between doctor and patient is more equal and open for private in-patients and the extent to which this is valued by patients.

The majority of patients in this study felt that there was a difference in the attitudes and behaviour of their doctors in the

private sector, compared with the NHS. Most patients described their doctors as "pleasant" or "charming" or "gentlemanly" (all the consultants seen by the respondents in this study were male). One enthusiast, typical of many others, said her doctor was "wonderful, absolutely brilliant, a lovely man" (4). Only the occasional patient was critical: one complained that he was "a bit offish, a very mercenary sort of chap, like a bouncer somewhere" (9) and another said "if he thought he could squash you he would. He was one of those big-headed, pompous twits" (33).

Only 27% (n16) of respondents said there was no difference between the behaviour of their consultant in the NHS and the private sector. These respondents were, generally, impressed by the service their consultant provided in both settings: "he is as caring in both - the NHS and the private - that's one of the things I like about him" (59). Patients such as this one felt positively uncomfortable at the thought that their doctor might treat them differently because they were paying for their care. They were disturbed both by the feeling of privilege and also by the thought that their doctors might be motivated by money to behave in a more considerate way. "He's always the same person. He didn't suddenly become more attentive to you because you were paying him. He was exactly the same. No different on the NHS. He was just as nice. I was pleased about that" (12). Other patients, who had only seen their consultant privately, said they couldn't imagine that he would be different in the NHS, because he was so pleasant and helpful: "he just seems to be that sort

of a nice man ... I should imagine he treats all of his patients the same" (26). Another sub-group said that they didn't think their doctor ought to be any different because that would be "most unprofessional" (19).

Of the patients who reported that they felt there was a difference in the attitudes and behaviour of consultants, most noted that their consultants had more time for them than in the NHS. Patients felt uncomfortable about 'delaying' their doctors in the NHS and about asking questions. They were conscious that if they took up more time there would be less for other patients in the ward or the waiting room. There was a sensitivity and fellow feeling for other 'waiters' as well as anticipation that the doctor would be terse and abrupt. Some patients felt that the doctor had no time for them on NHS ward rounds and wouldn't linger to answer questions. There was a feeling too that the NHS ward round encouraged not just a hurried response but a less personal one. Patients' experience of the relationship with their doctor in private hospitals was in sharp contrast to the hurried and pressurised atmosphere of the NHS. One said his doctor was "so relaxed, laid back" (4) and another that "he's always been very relaxed, very nice" (12). A third commented that "they do have more time, I mean they have time for idle chat which is nice, even down to families and the like" (27). Doctors who had exuded a 'Don't ask me' aura in the NHS had slipped into 'Please ask me' in the private sector.

Although the greater amount of time available to private patients was felt to be valuable in itself, it was also important for what it signified to the patient. First, it permitted more questions and information giving, second, it indicated a changed relationship and a more informal relationship between doctor and patient (in the opinion of patients), and third, it enhanced the accessibility of doctors to their patients.

In terms of information, the patients interviewed in this research commented favourably upon the amount of information they received and their doctor's willingness to discuss their condition and treatment with them. One patient said that she had been given much more information about her gynaecological treatment than her friend (who suffered the same symptoms) had received in the NHS "I was given a leaflet explaining things that generally worry people about this particular problem, which she hadn't had, so I was able to show her things and tell her things that nobody had bothered to explain to her" (40) and another patient was pleased to be offered a video of her operation (7). Patients claimed that, on the whole, their doctors in the private sector treated them as intelligent individuals capable of understanding and assessing information about their condition. One typical comment was that "He was quiet and confident and he told me exactly what the methods of treatment were. I got positive answers which was the thing I wanted" (32).

The greater exchange of information in the private sector was important in its own right but also significant in the impact it had upon the relationship between doctors and their patients. For some patients the more frequent and intense interaction with their doctors changed the nature of the relationship profoundly to one of marked informality and even friendship. As one patient commented "I'm used to him. We're good friends. We can speak quite openly" (47). Private patients tended to see their consultant at least once a day and often more frequently. They were impressed that he just 'popped in' as he was passing, without any great formality. Several talked about the consultant 'sitting on the bed and having a chat'. Private patients spoke about 'partnerships' with their doctor, about good 'rapport' and about friendship. "You do actually get a conversation out of them on your medical case ... it's almost as if they can become a friend. You can get a lot closer to them. In the NHS you are one of thousands, you can't get any rapport. You are only in there a couple of minutes or whatever and its just a business to be done, whereas in the other you can form a friendship" (52).

A number of factors led patients to feel (perhaps erroneously) that this sense of friendship was reciprocated. Doctors called in to see them on their days off, en route to the golf course, or on their way home from their NHS duties, wearing casual clothes instead of white coats. They rang them personally to see how they were feeling and sometimes rang relatives too. Patients who had their out-patient appointments at their consultant's home (where they often met his wife) also felt that the relationship

was more personal and informal, verging on friendship. Most were given the home phone number of their consultant and told to call at any time of the day or night. This ready accessibility of doctors in the private sector signified, to many patients, a changed relationship - one based on friendship and partnership rather than on professional power.

Patients felt they had a very personal service in the private sector, geared to their own needs and requirements. Several contrasted this with what they saw as the production-line mentality of the NHS. One said of doctors in the private hospital "They just seemed more at your disposal and my impression is that they have time to treat you as an individual whereas you're more of a number in some of the hospitals" (7) while another added "You are given more time and treated more as a person" (34). A third agreed that it was the personal and individual attention which distinguished the private sector from the NHS: "You are treated as a human being, whereas I find that on the NHS you are just a lady in a queue" (53).

Private patients volunteered several kinds of explanation for this changed relationship. Some felt it was attributable to the greater frequency with which they saw their doctor (or the length of time over which contact had been built up). As one of them commented: "After fifteen months you do get, frankly, relaxed and informal - on first name terms" (28). Others commented upon the way in which the congenial surroundings and positive atmosphere of private hospitals enhanced communication. One

suggested that consultants felt more free to develop informal relationships with their patients when they practised on their own, outside the constraints of the NHS and medical hierarchy. "They're more human and they will have a chat about something, whereas in the NHS ... they have got all their junior staff under them and they have to be seen as being some kind of God, if you like. I'm the boss - I'd better make sure that I'm stern" (38).

The exchange of money between doctor and patient in the private sector (either directly or through insurance companies) also influenced the nature of the relationship in some cases. One patient summed up the views of others when she commented: "Once they realise you're private somehow or another they become much more expansive and more friendly ... this sort of 'I'm up here, you're down there' suddenly changes a bit. Now if you're honest ... it has to be something to do with the money. It can't be any other reason because each of you is the same person" (24). This shift in attitude and behaviour left some patients uncomfortable. Although appreciative of the personal attention, they were cynical about the change in their NHS consultant's manner when he saw them privately: "it makes him seem a bit smarmy ... to have him saying 'Yes Mrs A, No Mrs A' because I was private" (46). Nevertheless, most patients felt that they had more control over their health care, more power over their doctor and a more egalitarian, congenial, relationship than they had experienced in the NHS.

One element in the doctor-patient relationship in private hospitals appears to be a heightened sense (on both sides) of patients as 'customers'. Patients became more confident in dealing with their doctors and were keen to get their 'money's worth'. Many of them felt that the payment of money entitled them to easier access to their doctor and to a more equal relationship in which they would be treated as an intelligent person. As one patient put it "in a funny subconscious way you feel more like a customer than a number" (2). For some patients this was just an added bonus - they talked of "feeling quite special" (13) or "feeling like royalty" (23) - but for others it was the essence of the doctor-patient relationship in the private sector.

The patients in this sample were predominantly from Social Classes I and II (82%) and there is no doubt that some of them would have been assertive and 'consumerist' in the NHS as well as in the private sector. However, those who raised this issue argued that their right to demand a high standard of treatment and access in the private sector was greater because they paid directly for their care and that this was a right they exercised. One said that he didn't hesitate to change the times of his appointment at the private hospital and that this was something he would not have done on the NHS (6). Another was prepared to confront her doctor directly to get the information she wanted: "I came to the opinion that the only way to get any of his time was to get between him and the door. I found him initially a bit of a difficult character to deal with but I've now known him for

about fifteen months and I have the highest regard for him ... I'm reasonably assertive as an individual so I always had the data I needed at the end of the day" (28). Several patients argued that paying for care was an important lever in securing the kind of service they wanted for themselves and their families. While a more egalitarian relationship with the consultant was valued for itself it was also valued for the increased demands which patients felt they could place upon their doctors. As one of them put it: ""If you are consciously paying and <u>they</u> are conscious you are paying its different, its actually getting them off their pedestals". This same patient wished that she could also pay her GP so that she could get from him the service she wanted (60).

A good deal of the existing literature on doctor-patient relationships seeks to illustrate the techniques which doctors use to create distance and formal relationships between themselves and their patients and to account for this phenomenon (Mizrahi, 1985). It is apparent from our interviews with private patients that, as Strong (1979) has noted, this distance is not normally maintained when patients are paying for their care direct or through an insurance scheme. Indeed, what many private patients prize is the more informal and 'friendly' relationship which they enjoy with their doctor in the private sector. This finding suggests that the doctor-patient relationship is not so much <u>structurally determined</u>, as it is often argued, as <u>situationally determined</u> and hence subject to change, according to circumstance. In other words, although the attitudes of

doctors to their patients (and vice-versa) may be profoundly influenced by, for example, medical education, class relationships and cultural expectations, these attitudes and behaviour can actually be modified to suit the context in which doctor and patient meet. In our study, doctors and patients developed different relationships in the private sector from those they had in the NHS. In the private sector, the qualities of the situation - time, space, environment, method of payment - appeared to be stronger determinants of doctors' and patients' behaviour and attitudes than the structural factors which are normally held to influence doctor/patient relationships.

In an ideal world NHS patients would receive the same care and attention from consultants that private patients value so highly. However, given the way that the NHS is currently organised, it is clearly not possible for consultants to give their NHS patients as much time and attention as their private patients. Indeed, even if it were possible, there is no evidence that consultants would <u>want</u> to do so. It may be that consultants prefer maintaining distance over their patients and only participate in informal, friendly relationships with their private patients in order to obtain and retain private patients and thus, a lucrative additional income.

However, the question arises, if consultants did have the close, personal relationships with their NHS patients evident in the private sector would large numbers of patients stop going private? In other words, is one of the major reasons for going

private to have greater time, attention and care from their doctor? Clearly, as our research has shown, private patients highly value the relationship they have with their consultants. However, it seems unlikely that private patients would stop going private if they could receive the same attention from a consultant on the NHS. The greater attention from a consultant obtainable by going private did not appear to be a primary motivation for going private in our study. However this was seen as a benefit of going private once patients had been admitted. It may be that greater attention from consultants is a **want** but not a **need** in the way that avoidance of waiting lists and choice of dates are. Patients may need to be admitted to hospital quickly in order to avoid pain and to minimise disruption at work or home, which may be crucial to their livelihood or the well-being of family members but they do not need information or to be spoken to politely in order to recover. Nevertheless, this research has shown that private patients value highly the greater care and attention from consultants and that they view this as an important benefit of going private.

4.6 People with private health insurance using the NHS

Research has shown that a significant number of people with private health insurance (PHI) have used the NHS for in-patient stays (Office of Populations, Censuses and Surveys, 1986). Very little information is available to explain this phenomenon. It is not clear whether there are a distinct group of people who have PHI but never use it or whether some people with PHI use it at some times and not others. Furthermore, it is not clear what

motivates people with PHI to use the NHS on one or more occasions and what characteristics, if any, such people have which make them distinct from those who make frequent use of their insurance cover. Research by Cant and Calnan (1992) has shed some light on this subject. In their study of people with PHI they found that while for some people decisions to use PHI were automatic, for others, decisions whether to use their insurance or the NHS tended to be influenced by resource issues such as waiting lists and the impact usage might have on their insurance cover.

People with PHI who make use of the NHS for in-patient stays are a difficult sample to locate. NHS hospitals do not keep records of numbers of patients with PHI (unless patients wish to make some sort of claim against their policy) and it would be time-consuming to identify such a sample from an insured population because many insured people do not experience ill health and so have no cause to consider using their insurance. When they do use their insurance they are more likely to do so in the private sector than in the NHS. In our research a sample was identified through a large general hospital which kept a record of people claiming against their insurance for an NHS stay. This group are not necessarily representative of people with PHI who use the NHS, in that the group all made claims against their insurance for using the NHS. Others might use the NHS but not claim money from their insurance for doing so. Additionally, the sample size is small (n28) and no firm conclusions can be drawn on the basis of this sample. Nevertheless, the data do provide some interesting information on a particular group with PHI who have

made recent use of the NHS. Furthermore, the data provide information which can be compared with that collected from the private patients.

For this sample, the major reason for using the NHS was that they were admitted as emergencies or that their GP or consultant felt their condition was not appropriate for admission to a private hospital. A total of 75% of interviewees (n21) mentioned these two factors. A further 11% (n4) were unable to go private because of exclusions in their policies. Only two people in this sample actually chose to use the NHS in preference to going private. Of those who were admitted as emergencies, six reported that they would not have gone private even if they had had the choice. Thus, a total of eight interviewees (28%) either did choose, or reported that they would have chosen, to use the NHS even though they have PHI.

The remaining 15 interviewees admitted as emergencies reported that, at the time of being admitted, they would have preferred to have been admitted as private patients. However, of these 15 people, only three transferred to a pay bed or private hospital during their hospital stay. A further four interviewees reported that they considered transferring or wanted to transfer at some point during their stay. The remaining eight interviewees, while reporting that, given a choice before admission, they would have preferred to have gone private, were satisfied with their treatment and care in the NHS so did not consider transferring once they had been admitted.

There are some interesting differences between this sample who used the NHS and the private patients sample which are worth noting. This group had a higher proportion of people who had taken out their own insurance (53%, n15) than the private patient interviewees (38%, n23). Additionally they had both more recent experience of the NHS and a higher number of NHS in-patient stays. A total of 43% (n12) of this sample had been NHS in-patients between 1984-1991 and 35% (n10) had been NHS in-patients three or more times. This compared with 23% (n14) of the private patient sample who had been NHS in-patients between 1984-1991 and 15% (n9) who had been NHS in-patients three or more times.

It is not possible to draw firm conclusions from the figures because of the small sample size. Nevertheless, the higher usage of the NHS by these patients and the higher proportion of people who had taken out their own insurance may indicate that some people with PHI using the NHS are in poorer health than people who use the private sector and may be unable or reluctant to use their insurance on every occasion for fear of an increase in premium. While a higher percentage of the private patient sample had used the private sector three or more times than had the NHS sample (17% compared with 4%) the tendency for the private sector to be used for routine elective surgery rather than for more serious acute conditions indicates the poorer health of the NHS sample. It may be that one group of people with PHI using the NHS are those who are too ill to be admitted to private hospitals (although they could, of course, be admitted as pay bed patients in the NHS) or those who have already exceeded, or expect to

exceed, their annual benefit level allowed on their insurance. Certainly for most of the patients in this study, it was an inability to go private because of the seriousness of their condition which explained their use of the NHS.

An alternative explanation is that people with PHI who use the NHS do so for ideological reasons. Clearly a separate group from those discussed above are those who actively **choose** to use the NHS. For this group, an ideological commitment to the NHS may be a better explanation of their reluctance to use the private sector even though they have insurance. Cant and Calnan (1992) note that a political and moral commitment to the NHS inhibited the use of the private sector by people with PHI in their survey. Such people are unlikely to have taken out insurance for themselves and are more likely to belong to a company scheme as a 'perk' of their employment. Surprisingly, five of the eight people in this sample who reported that they chose, or would have chosen, to use the NHS rather than the private sector had insurance that they had taken out themselves. They reported that they took out the insurance as a safeguard in case of a long waiting list but that they would nevertheless be reluctant to use it. In fact none of the eight people had ever made use of their insurance. The reasons given for not making use of their insurance were either a moral commitment to the NHS or because of very satisfactory past experiences in the NHS. These people either saw no reason to use the NHS or were ideologically opposed to using it. Nevertheless they felt that there might be occasions when they might want or need to use it in the future.

The following two quotations are illustrative of the views of these interviewees:

> "I would be very unlikely to use it [her insurance] in this country unless I was in pain and there was a long waiting list. I don't believe in private medical care as a first option." (26)
>
> "It would be a last resort [going private] because I hate to think of queue jumping. I wouldn't want to do it but I would if I had to." (17)

The interviews with this sample also provided information on this group's views and experiences of the NHS. These provide a source of comparison to the private patients' perceptions of the NHS. A total of 39% (n11) of the group with PHI who made use of the NHS reported that they were completely satisfied with their NHS stay. Typical comments were: "They couldn't have done more for me. I was more than satisfied" (15) and "I was 100% satisfied with my stay, it couldn't have been better. The nurses, the tea ladies, the cleaners, everyone was fantastic" (22).

A total of 50% (n14) of the sample reported that they were generally satisfied but had some minor complaints about their stay in the NHS. The lack of privacy was by far the most frequently reported area of dissatisfaction. Some people also mentioned the catering, the state of repair and the level of cleanliness as areas of dissatisfaction. None of these interviewees reported dissatisfactions relating to their treatment or care whilst in hospital. On the contrary, they were

anxious to point out that they were highly satisfied with these aspects of their stay. Rather it was the 'extras', like the privacy and a wide choice of meals that they knew they would have got by going private, that were highlighted by this group. The following quotations are examples of the sorts of comments that were made: "It [his stay] was marvellous, they couldn't have done more. It was absolutely first class but the catering was absolutely appalling. My wife used to bring in soup and a sandwich for me every day" (17) and "I was very satisfied with my stay. I've got no complaints at all - just the privacy" (20)

Only 11% (n3) reported that they were dissatisfied with their hospital stay. These people did identify dissatisfactions with their care and treatment but they were very much in the minority.

It needs to be noted that the majority of private patient interviewees were similarly highly satisfied with their in-patient stays. Studies of patient satisfaction invariably find the majority of patients expressing satisfaction with their experiences in hospital. Porter and Macintyre (1984) observed in their study of patients' views of ante-natal care that reports of satisfaction are often not an accurate representation of people's feelings but are a result of deference, conservatism or politeness. The high levels of satisfaction with their NHS stays reported by the majority of people interviewed indicates that satisfaction was an accurate representation of people's feelings, but the limitations of satisfaction studies do have to be borne in mind.

The interviews also produced data on this group's perceptions of the main differences between the NHS and private sector. Interviewees were asked to state what differences they felt there were between the NHS and private in-patient care. Most interviewees stated more than one difference although two people (7%) reported that they felt there were no differences between using the NHS and going private. The majority (82%, n23) considered the differences to be in terms of the 'extras' offered by private hospitals such as, comfort, privacy, a choice of menu and a private bathroom. Waiting was also identified as an important difference and was cited by 28% of people (n8). Very few of the people who responded to this question felt that there were any differences in the medical care of patients in the NHS and the private sector.

However eight people (28% of the sample) reported that they felt that some aspect of treatment or care was superior in the private sector compared to the NHS. An additional three people reported that they felt that patients in the private sector got extra attention in general. In contrast, just over half of the interviewees (56% n33) in the sample of patients who had used private hospitals reported greater attention or superior treatment as major benefits of going private.

Patients in the sample who had used the NHS were asked the same questions as the private hospital interviewees about their perceptions of the NHS. While the majority of interviewees expressed satisfaction with their experience within the NHS, only

three people reported that the NHS in its present state could satisfy their health care needs fully. The areas of improvement identified by the interviewees who had used the NHS were similar to those identified by the private hospital interviewees with one clear exception. In the private patient sample, nursing emerged as an area of dissatisfaction for just over one third of the sample but, in the sample who had used the NHS, nursing was not specifically identified as in need of improvement by any of the interviewees. The major areas perceived as in need of improvement were waiting lists, inadequate finance and management and organisation. The areas of the NHS in need of improvement identified by this sample are similar to those identified in other studies (Solomon, 1991). The following table sets out the aspects of NHS hospital services that the interviewees identified as problematic:

Table 11

AREAS OF DISSATISFACTION WITH THE NHS

AREA OF DISSATISFACTION	PERCENTAGE
WAITING LISTS	32% (n9)
MANAGEMENT AND ORGANISATION	28% (n8)
INADEQUATE FINANCE	28% (n8)
UNDERSTAFFING	18% (n5)
POOR BUILDINGS AND FACILITIES	7% (n2)
ATTITUDES OF DOCTORS	3% (n1)

The comparative data from the two samples indicates that the image and the reality of the NHS are very different. The sample who had PHI but who had made recent use of the NHS expressed, in the great majority of cases, high levels of satisfaction with their NHS stays. Some interviewees noted that they would have liked some of the 'extras' that they would have had if they had gone private but that this did not detract from their overall level of satisfaction regarding their in-patient stay. Only a small minority of interviewees reported that they felt the treatment and care was superior in the private sector to that obtainable in the NHS when they were asked about satisfaction with their NHS stay. A larger proportion of the sample identified differences in treatment and care when interviewees were asked specifically about the differences between the NHS and the private sector but these were still a minority of the sample. For this sample it is clear that the NHS was perceived as

providing a good service when it was needed. While the NHS was seen as being unable to provide the 'extras' in terms of comforts that the private sector could provide, most people saw these as luxuries that, while pleasant, were not essential to recovery. One reason for the low emphasis on the comforts obtainable in the private sector may have been because many of the people in this sample were admitted for serious conditions. Clearly, if somebody is very ill, extra comforts such as a television and telephone in the room would not be likely to be priorities. For this sample, good care and treatment were the priorities and these were not seen to be lacking in the NHS. It may be that the 'extras' offered by the private sector are less important in encouraging people to opt to go private than it is assumed, although clearly more research on this is necessary.

The views of this group of privately insured patients who used the NHS contrasted markedly with those of the private patients who had never been patients in an NHS hospital. The first group did not share the negative perception of levels of care and attention and of NHS nursing which the latter held. The research indicates that - at least at the hospital used in this study - it is the image rather than the service that is poor.

4.7 The health behaviour of a private patient population

The interviews provided an opportunity to collect some data on the health behaviour of a private patient population. We sought to examine if this group participated in the sorts of health-enhancing behaviours that have been associated with middle-class

populations. A full discussion of the findings can be found in Wiles, 1992b.

In recent years there has been an increasing emphasis on encouraging people to adopt health enhancing behaviour following the assertion from medical professionals that some of the major diseases that cause premature death, such as coronary heart disease, are preventable by lifestyle changes (BMA, 1990). It has been argued that middle-class people are more likely to adopt health enhancing behaviour than working-class people because they tend to hold more 'positive' definitions of health, to view illness causation as controllable and to have greater health knowledge (d'Houtard and Field, 1984; Blaxter, 1983; Charny and Lewis, 1987). However, a number of studies have disputed the extent to which middle-class people employ health-enhancing behaviour (Backett, 1990). It is argued that, while positive conceptions of health, beliefs about control over health and health knowledge may be factors which provide middle-class people with an <u>orientation</u> towards health enhancing behaviours, and may encourage them to <u>report</u> health enhancing behaviour, this does not necessarily mean that health enhancing behaviour will actually occur. It may be that certain conditions and motivations are necessary to turn a desired, or reported, action into a reality. Some research has acknowledged that the everyday circumstances within which people live their lives are important in encouraging or discouraging 'healthy' behaviour (Calnan, 1987) but little attention has been paid to identifying the nature and effect of these circumstances. Our research provided us with

some data that allowed us to identify some of the motivations and constraints which may encourage or discourage the adoption of health enhancing behaviour in a middle-class population.

During the interviews, data were collected on interviewees' views about health in general, their own health and health behaviour. Respondents were asked if they felt they were healthy at the present time, how they would describe feeling healthy and if they did anything to look after or protect their health. As was expected with such a middle-class sample, the majority of interviewees (75%) reported that they made some attempts to look after their health. All the people who reported undertaking some health enhancing behaviour reported actions concerning diet and exercise.

The interviewees who reported taking action on their diet quoted the advice given in health education and reported in the media about low-fat, high-fibre diets. Twenty-eight people said that they restricted the fat and increased the fibre in their diets, 15 people had added bran or oats to their diet and 14 ate more fruit and vegetables. Respondents took part in a variety of sports and physical activities including walking, gardening, running, weight training, gym and exercise classes, as well as participation in very active sports such as squash and badminton and less active recreational activities such as bowls and golf. Walking was the most frequently reported form of exercise (n14) and squash/ badminton the least frequently reported (n6).

However, while the majority of the sample reported that they made some attempts to look after their health through diet and/or exercise, a number of factors were identified which were reported as encouraging or discouraging this behaviour. These included factors relating to people's everyday living situation which were reported as militating against the adoption of health enhancing behaviours (constraints) and factors relating to the benefits, additional to health, that people viewed as encouragements to them adopting such behaviour (motivations).

Because of the wide age range of the sample, the interviewees were divided into two groups to examine these motivations and constraints. The first group comprised interviewees aged between 20 - 50 (n30) and the second group comprised interviewees aged between 51 - 79 (n30). In the 20 - 50 age group, the majority of interviewees (73%) were female. In the 51 - 79 age group, numbers of men and women were more equal: 57% of this sample were male and 43% female.

In the 20 - 50 age group, the major factor constraining the adoption of health enhancing behaviour was reported to be employment. One third of interviewees in this age group reported that their employment prevented or inhibited them from pursuing the health enhancing behaviour they would have liked. While the sample of men in this age group was quite small, nearly all of them identified employment as a constraint on their behaviour and, in addition, four of the women noted this. Employment environment, lifestyle associated with employment, and,

employment demands in terms of time were all noted as constraints on adopting health enhancing behaviour.

Several of the people who noted employment factors as constraints were self-employed. The constraints posed by such a lifestyle for health enhancing behaviour are summed up in the following quotation. This interviewee, a publican, felt that he not only worked in an unhealthy environment but that his long hours of work meant that he had a very unhealthy lifestyle:

> "In my previous job I had plenty of time off. I used to swim at least twice a week and I used to have a long walk once a month so one kept pretty healthy by doing that. In this environment, where you are indoors in a smoky environment, one doesn't do quite so well. Coming and working for yourself seven days a week means you can't do the things you would like to: not having the proper rest periods, not having the proper meal times, grabbing a sandwich where you can." (8)

However, it was not only the self-employed who were constrained in terms of health enhancing behaviour because of their employment. Other people whose jobs involved them in travelling, spending periods of time away from home, or entertaining clients, noted how difficult it was to eat 'healthily'. Indeed, even people who ate food supplied at work noted difficulties with diet. Both groups found that they often consumed a rich diet with a high fat content and that it was very difficult to change this because these foods were often the only ones available.

Taking regular exercise was also difficult for those people who travelled and spent periods away from home. These problems may be specific to a middle-class group who are more likely to have jobs that demand this kind of lifestyle.

A minority of the female interviewees in the 20 - 50 age group reported that family responsibilities were a constraint on adopting health enhancing behaviour. Only a minority of the sample had pre-school or young children, which accounts for the low reporting of this, but it is reasonable to suppose that a sample concentrating on younger age groups might identify this as a major disincentive to adopting health-enhancing behaviour. The women who did identify childcare as a constraint noted that they had neither the time nor the opportunity to take regular exercise. This was particularly so for women with pre-school age children. While these women had opportunities to take part in exercise activities in the evenings when partners were home from work, many women did not take this up. Some of these women appeared to subordinate their own needs to those of their partner's so that they were the ones who stayed home looking after the children while their partners went out to exercise.

Family responsibilities were not explicitly identified as a constraining influence on the adoption of a 'healthy' diet by any of the women. However, other research has noted that women generally subordinate their own food needs to those of their partners and children and that this can discourage the adoption of a 'healthy' diet (Charles and Kerr, 1988).

In the 51 - 79 age groups, two constraints against adopting health enhancing behaviour were reported. Each was reported by only a minority of interviewees. The first, which was reported by just over one quarter of interviewees, was that confusing media messages discouraged health enhancing behaviour and the second was that interviewees felt that they were 'too old' to worry about changing their behaviour. This latter factor was reported by just under one quarter of interviewees.

In recent years the views, attitudes and research findings of the medical profession have become newsworthy items and there is widespread reporting of health issues in the media. However, the reports that are filtered down from the medical profession and reported in the media are aimed at a popular audience and, as a result, are popularised and summarised versions of medical knowledge and opinions which inevitably conceal the complexity of medical issues. One of the outcomes of this is that the media often report conflicting 'health' messages leading to confusion among the general public about what constitutes 'healthy' behaviour. This is particularly true in the case of diet where certain foods may be condemned as unhealthy one day but extolled as healthy on another day as a result of sensationalised reporting of research findings. There was some evidence of confusion over health messages in the sample which, in some cases, led to some of the people in the older age group ignoring health messages regarding diet altogether. Typical comments made by the interviewees were: "I don't bother about eating the 'right' food, because I think if I listen to everything I was

told about that I don't know what I'd do so I just eat what I want" (54) and "There are so many confusing things and all these experts keep coming up with what is good for you and what is bad for you" (5).

Some of the interviewees in this older age group reported that they felt they were 'too old' to do anything to protect their health. They took the view that healthy behaviour in terms of diet and/or exercise was something for young people and that once they had got past a certain age it 'wasn't worth' doing anything on that score. The sorts of comments made were: "I think I'm too

old to worry about it. I'm inclined to advise my daughter but I don't worry for myself." (30)

As regards motivations for healthy behaviour, the 20 - 50 age group identified two motivations additional to health-benefit ones which encouraged them to adopt health enhancing behaviour. One third of the sample identified the desire to be slim as a motivation for health enhancing behaviour and just under one quarter identified the enjoyment of exercise as a motivation.

Notions of attractiveness were reported as a major motivator encouraging people to adopt and maintain healthy behaviour. There appeared to be a gender division in behaviour here that is very much related to the social roles that men and women occupy. Many of the women reported that they were engaged in constant 'battles' to become or stay slim. These women did not talk so

much about 'healthy' diets as weight-reducing ones. It was clear that becoming slim rather than becoming 'healthy' was the chief motivator here and the degree to which slimness is equated with attractiveness for women explains this behaviour (Lawrence, 1987). For the women, diet was seen as the chief way that slimness (and attractiveness) could be achieved. For the men, however, it was not so much slimness as physical fitness that was equated with attractiveness. Consequently, the types of behaviour that the men adopted to achieve their goal involved exercise. Again, fitness leading to attractiveness rather than health enhancement appeared to be the chief motivator. Both the men and women identified their behaviour as health enhancing; nevertheless, it was clear that this was not the chief motivator for their behaviour. The following quotations, the first from a man and the second from a woman, demonstrate this:

> "I diet continually. I think all women are chronically aware of their weight. I do try very hard, I used to be very thin and I'd like to get back to that again." (42)
>
> "I find that , well if you don't do some physical exercise in terms of pumping iron or weights, then you might have a strong heart but your body doesn't look right. It's just to keep your stomach flat and your chest from caving in, sort of thing." (54)

Enjoyment was another major motivator of health enhancing behaviour. In some cases, routine exercise had been adopted for health enhancing reasons but the enjoyment of the activity had taken over so that this became the prime motivator for continuing

the activity. For others, the activity may never have been taken up for health enhancing reasons and this was viewed merely as a side benefit of an enjoyable activity. Whatever the reason behind the adoption of routine exercise it was clear that the enjoyment element was an important motivator in maintaining such an activity as the following quotations illustrate: "I do aerobics and dancing and I walk for an hour every day. I do it for enjoyment, I don't do much to keep fit or anything" (60); "We have a lot of exercise, for the sheer enjoyment although we realise it does help as well" (29) and "I've always done sport, it's always been there so I can't live without it now" (44).

In the older age group (51 - 79), enjoyment was identified as a motivator by one fifth of interviewees. However, more frequently reported (by just over one third of respondents) was that retirement or the experience of a health scare prompted health enhancing behaviour. Middle-class people reaching retirement age are often given advice about their approaching retirement and may be provided with pre-retirement courses by their employers or may opt to go on such courses in their spare time. The informal and formal advice people receive about retirement generally stresses the importance of finding useful activities to make appropriate use of new-found leisure time and of 'looking after oneself'. The retired men in this group were aware that retirement marked a major life change and that they had to re-assess their situation and adopt a different kind of lifestyle. The older women in this group did not identify retirement in the same way, probably because retirement has a different meaning for women than for

men. Given the advice this group of men would have been likely to receive, it is unsurprising that they reported adopting health enhancing behaviour at this point in their lives. Several of the men took up various forms of exercise. The provision of particular clubs or sessions at sports centres for this age-group may have been a factor encouraging this. Additionally, some men made a re-assessment of dietary requirements and attempted to consume a 'healthier' diet upon retirement. The following quotation illustrates these points and was typical of the responses:

> "In retirement I had to think things through and there were three things I had to deal with. I had to make sure I kept physically fit, I had to make sure that my mind kept fit and I had to make sure that I was doing something in social terms that made me feel that I was worthwhile. So I play squash, badminton, swim two half days a week. I'm doing an Open University course and I help out at a school and I'm on a low fat diet." (10)

The experience of a health 'scare' was also reported as a motivator for 'healthy' behaviour. Two of the men in this group had had heart attacks and had changed their health behaviour quite markedly on the advice of their doctors in order to minimise the risks of further problems. Both these men had adopted low fat diets and had incorporated some routine exercise into their lifestyle. Another man had a painful digestive problem and changed his diet on the advice of his consultant to alleviate this. One of the men who had had a heart attack noted:

"Until I had my heart attack last year we cooked in butter all the time and had cooked breakfasts and things and I didn't really have time for exercise but now I am trying to do as I've been told by the heart specialist. We have stopped having butter in the house, nobody smokes here anymore. I have a minimum of one ounce of bran a day and vegetable fats rather than animal fats and I play golf twice a week instead of once a month." (11)

There are a number of limitations that make drawing conclusions from this data difficult. First, the sample size is small and not representative of a general middle-class population. Second, the study relied on interviewees' self-reporting of their health behaviour at one point in time. Studies have shown that alternative methods and, in particular, repeating interviews over a period of time may provide more accurate information on people's health behaviour than single interviews (Cornwell, 1984; Backett, 1990). Nevertheless, bearing in mind the limitations of the data, this study does highlight two issues of importance. First, it illustrates how people's social situation can determine their participation in health enhancing behaviours. Second, it identifies factors, unrelated solely to health-benefit ones, that influence the level of health enhancing behaviour people employ. The findings of this study, then, indicate that while broader issues such as health definitions and views about illness causation may be important in providing people with an orientation towards the adoption of health enhancing behaviour, specific constraints or motivations may determine, to some

degree, the extent to which it is carried out, or indeed, if it is carried out at all.

Perhaps one of the most interesting findings from the study is that, even in a population which might be viewed as one most likely to adopt health-enhancing behaviour, significant barriers to adopting such behaviour still exist. Clearly, the advantages associated with being middle-class are not adequate to overcome all the constraints that exist which discourage health-enhancing behaviour. While research has found evidence of a link between poverty and ill-health (Townsend, Phillimore and Beattie, 1988) it should not be assumed that the opposite is true and that middle-class people automatically have healthy lifestyles. It is not clear the extent to which a private patient population differs in their health behaviour to a more general population but it is nevertheless interesting to note that the health-enhancing behaviour exhibited by this sample is similar to those found in studies of more general populations (see Backett and Davison, 1992).

5. CONCLUSIONS

This research produced data on a wider range of topics than was envisaged when it was originally planned. Each of these has been discussed in full and conclusions drawn at the end of each section. Rather than repeating these here, we will conclude by identifying the issues for policy that have emerged from the study as a whole.

5.1 Issues for policy

A number of policy issues emerge from this study. First it is clear that most private patients have poor information about the NHS and the services it provides. They are particularly ill informed about waiting lists and waiting times and General Practitioners do not always supply accurate (or any) information. It is likely that the actual waiting times for NHS out-patient appointments and in-patient treatment are shorter than many patients believe. A recent survey of out-patient referrals shows that, even though waiting times for a first appointment are the longest in Europe, the average wait is only 35 days (Fleming, 1992). Furthermore, around 70% of patients are admitted for their in-patient treatment within three months of their out-patient appointment. Although NHS lists are often longest for the kind of treatment in which the private sector specialises, many patients may have been driven into the private sector by poor information about waiting times and unwarranted assumptions about the length of lists.

Second, many private patients form their impressions about the NHS (which are often negative) on the basis of little or no recent personal experience. Their opinions are shaped by the media, by friends and by hearing the experiences of others. Those with recent direct experience of the NHS are, in general, satisfied with all aspects of their stay. However, the public image which private patients have of the NHS is far from positive.

Third, private patients may be less motivated by the desire for good physical surroundings in hospitals than is often assumed. Although they appreciate en suite bathrooms and the privacy of a single room, these are not key factors in attracting them to the private sector in the first place. Rather, these things are attractive 'extras' but not necessities. The same may be said for the greater degree of attention that private patients perceived they received by going private. Rarely was a difference in **medical treatment** between the public and private sectors acknowledged. Rather, differences were seen in attitudes and behaviour which again, though welcome, are not viewed as crucial to recovery. Both superior surroundings and attitudes can be seen, for most patients, as 'wants' but not 'needs'. Such factors may encourage people to go private but are unlikely to make going private a necessity. Issues such as waiting and the ability to choose an admission date are likely to be stronger determinants ('needs') than physical surroundings and medical and nursing attention. They provide a means to end pain or discomfort quickly and to plan hospital admission without facing

a loss of income or lack of alternative care for dependents. NHS hospitals preparing to compete for private patients in the health care market may face less competition in terms of the physical facilities they can offer than they may expect.

Fourth, this study substantiates the arguments about 'moral hazard' found in earlier literature. Those patients who had private insurance, with premiums paid by their employers, were least likely to shop around for low cost and good value care.

Fifth, the research suggests that a re-evaluation of Titmuss's arguments about patients in health care markets is necessary. His analysis assumed that health care was a product rather than a service. The problems faced by consumers in their relationships with powerful professionals can be applied to many service agencies, in both public and private sectors. To a degree, problems such as the inability to anticipate need and to achieve redress are characteristics of the service relationship as much as they are of the market relationship. The results of this research and other work on patient participation and empowerment suggest that Titmuss's original analysis may have been unduly pessimistic. Although consumers in health care markets are indeed vulnerable they also exercise choice and enjoy good relationships with health professionals on what they believe to be an equal footing. While patients in this study had large gaps in their knowledge about costs, value for money, quality and options in private health care they did, nevertheless, express some preferences in the marketplace and secure services which

they valued, at a time and place to suit their needs. The potential for consumer power in both the NHS and private sector, though limited, may be greater than Titmuss envisaged. More importantly, the nature of consumerism in a health care market is both more complex and more subtle than this early work suggests.

Sixth, different groups of the population are likely to have different needs and wants for health care services and these need to be fully addressed. The needs and wants of women for health care services are very different from those of men and similar findings are likely in relation to race, age and class. The customer-oriented private sector has acknowledged some of the wants and needs of particular groups of the population who use such services but for other groups there still remain problems in ensuring the sensitivity of health services to patients' real requirements.

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