RESEARCH PAPER

Health Professionals' Insights into the Impacts of Privately Funded Care within a National Health Service: A Qualitative Interview Study

Point de vue des professionnels de la santé sur l'impact des soins financés par le secteur privé dans un service national de santé : une étude d'entrevues qualitatives

SARAH C. WALPOLE

Appendix 1: Interview participant information and *pro forma*

In advance, the participants received the following information:

You are invited to take part in an interview as part of a research project to explore the scale and impact of private patient (PP) admissions to NHS hospitals. The research is led by Sarah Walpole on behalf of the Centre for Health in the Public Interest.

Ninety-one thousand PPs were treated in the NHS hospitals in England in the period 2014–15 and we are interested in what effects this has on NHS hospitals and their staff. We would like to ask about any experience that you may have of PPs being treated in NHS hospitals. This will inform our ongoing research, which may include a project analyzing quantitative data on PP admissions and NHS services.

You are invited to speak to one researcher (Sarah Walpole) for 30 to 45 minutes. If you are happy to give your consent, I will record the interview. If you are happy to give your consent, the interview recording may be shared with two other researchers. It will not be shared outside of this research team. We would use any quotes from your interview anonymously, and we would give you the chance to verify them before they were included in any published report. We can share the full results of the study with you.

If you would like to stop the interview at any time or withdraw your consent, you have the right to do so. Participating in the interview or stopping the interview early would not have any impact on your employment or any treatment you receive in the NHS.

Many thanks for your time.

At the interview, the following pro forma was used:
Check that participant has received and understood information sheet. Ask if they have any questions about the study. Ask for written consent before proceeding. Start recording if consent for this is given.

State that: "Ninety-one thousand private patients were treated in the NHS hospitals in England in the period 2014–15, and I am interested in what effects this has on NHS hospitals and their staff. I would like to ask about any experience that you may have of private patients being treated in NHS hospitals."

Questions – as many as there is time for in 30 to 45 minutes as guided by the interviewee's availability:

1. Have you had any experience of private patients being admitted to NHS facilities? Have you treated any private patients? Roughly how many? Would you know if you were treating private patients?
2. Do you know what role you are required to fulfill in the management of private patients within NHS facilities? Is there anything that you should do differently to when you treat an NHS patient?
3. Have you been made aware of any rules or regulations that hospital trusts must follow regarding treatment of private patients in NHS hospitals?
4. Are you aware of any way in which private patients are handled differently from NHS patients?
5. In your experience, do the same staff look after private patients and NHS patients? Do they spend a similar amount, more or less time with private patients?
6. In your experience has the treatment of private patients impacted on the treatment of NHS patients in any way?
7. Based on your experience, do you think the treatment of private patients has any impact on training of medical or nursing staff?
8. Do you face any particular challenges in treating private patients compared to treating NHS patients? Have you been able to access notes for the patient and request investigations and treatments for the patient? Has this taken more, less or the same amount of time as for NHS patients?
9. Hospital guidelines state that for any private patient having investigations or treatments organized, any request forms must clearly be marked "PRIVATE PATIENT." In your experience, has this guideline been followed?
10. Hospital guidelines state that when private patients are admitted to NHS hospitals, all members of staff involved in their care and the private patients' office should be informed of their admission. In your experience, has this happened?
11. Do you have any other comments?

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Appendix 2: Study findings: major themes, minor subthemes and relevant quotes from participants

Major themes	Minor subthemes	Quotes from participants
Provision: Impacts on availability of resources for NHS patients	Prioritization of PPs above NHS patients	"My experience has been that they get put to the front of the queue because they are a private patient and they're paying for it. Um, but obviously if they come into the NHS it doesn't really feel correct, because they should essentially just be treated the same in my eyes." (L) "We were meant to go to them first, because their consultant would call you and ask you to go and do something in particular. There was, I guess, a sense that they should be prioritized because the consultant was asking for it." (H) "The consultants responsible for their [private patients'] care have been a bit more pressurised or wanting to ensure that they get things sorted out sooner rather than later … So, for example, seeing them first on the ward round, or feeling an obligation to drop whatever else I'm doing to be able to prioritise them … I don't think it's had any adverse impact. As I say, it's just meant that I've got held back a little later rather than anything, there's not been any bad effects technically." (L) "You can't tell how long a procedure's gonna be. So sometimes it could be complex and it could push the list back a bit … The impact that it has is that you don't get as many acute patients done, and they roll on to the next day. So, you don't cancel on the elective patients because you can always fit them in." (F)
	Spending more time with PPs (or ex-PPs) relative to NHS patients	"They will have slightly more consultant contact than a lot of other patients because they were initially private." (P) "I hear consultants saying 'She came to see me privately three years ago' and then they're in as an NHS patient, and then they still have this connection, and almost a … almost a debt to them or something. So I think [the consultant] would probably opt to do procedures, or have conversations with them, so that they have kind of responsibility to do that rather than trainees ... I guess it's a combination of factors. The money for one – you were paid a large amount of money by this patient at some point in time. But then I guess the time that you spend with them would be very much more, because you do have those longer appointments, so maybe you form a bond with this patient which you wouldn't normally with people when you are seeing so many so quickly. And then I think that they have a direct line to their mobile and their email, so you have maybe more of a personal relationship with somebody. I don't know, from what I hear, like consultants saying, you know, they go 'oh they phoned me at midnight', and you think wow, even your reg wouldn't phone you at midnight." (K) "If you end up having to cancel a child because things took a bit more time with a private patient in the middle of a list, it's hard not to think that's a bit unfair … We did, purely on the basis of good will from the MRI team and the anaesthetists, so we finished at 7 o'clock when we should have finished at half five." (B) "Generally, I've never been aware of a consultant's private work impacting on their NHS time." (P)

Major themes	Minor subthemes	Quotes from participants
Provision: Impacts on availability of resources for NHS patients (cont'd)	Lack of clarity on procedures and time-consuming administration	"It was difficult because they have different notes, different record system. What was most difficult was that you're leaving behind the take … So that means you're not there managing the take, you're not there supervising your SHO and your house officer on the ground. That's the worst bit – it just takes you away, takes you away for an hour." (I) "There was always this sort of uncertainty about whether we should be providing care for them. And we certainly weren't getting paid extra money for them, whereas the consultant who was looking after them was." (I) as a junior doctor "Notes is often a challenge as the notes are separate … I would imagine it's usually a challenge if you want previous blood tests to get hold of them." (P) "There wasn't a record on the system [from which to access the PPs results] ... And if they are not registered in the hospital then that's quite difficult …" (I) "On the stroke ward we came across patients who wanted to be moved to the private ward of the hospital we were in … and, um, there was a very big delay for them, where they were checking with their insurance provider whether it was possible, and I think in the hospital they had a dedicated team. There were just so many people who needed to be communicated with and needed to have exactly what kind of conditions the insurance provider had for this particular person, before a patient could be moved, so you, they might have a whole day on the NHS ward and perhaps even a night, waiting for the green light basically and getting more and more cross ... I think 80% of the time they would manage to go." (J)
	Investment in resources that are not available to NHS patients	"Patients that needed MRIs were shipped to [teaching hospital 45 km away] for their scans and then shipped all the way back again, when there was a scanner across the carpark." (H)
Provision: Impacts on patient safety	Use of NHS resources being determined on a basis other than clinical need	"I thought that well, yeah, this guy has just come in to us because he's his private patient, rather than it was the right place for them to be … it's a resource – a cardiology bed not getting used appropriately." (L)
	Perception of lower quality of care on PPUs	"I mean there's all this information about like medical outliers and how they get worse treatment because nurses feel resentment towards them because they're not their specialty … but if you asked a nurse whether she was treating that patient worse, they would say 'absolutely not' … but they were and they are. So maybe there's a similar thing going on with private patients." (B) "I said 'You need to put in a three-way catheter and irrigate. They didn't have one. So I put a trolley together with all the stuff and wheeled it across the carpark and said 'here's some stuff'. And then, er, a bit later got a bleep saying that the nurses weren't happy doing it. So, the patient got transferred across the carpark, I believe in an ambulance. And several hours later we saw them in A and E and put the catheter in and irrigated the bladder properly. But there was a delay." (H) regarding a call about an acutely unwell patient in a PPU
	Experience of treatment of PPs not following local protocols	"Because they really didn't want this person to have any reason to complain, is what it seemed to me. And after this particular ward round left, um, and we had this instruction for so many different layers of pain medication that we were not used to giving all together, because it's not really that safe, or not part of our protocol to give certain pain medications together. So in the back of my head I was thinking 'Wow, they've really, really layered them on so that this person knows that she's getting everything possible', um, and I hadn't noticed that ever before with anyone else, so I wondered if that was to do with her being a private patient." (J) "There's a perception, which I think is evidence-based, that you do get overinvestigated and overtreated [if you go private]." (C)

Major themes	Minor subthemes	Quotes from participants
Resource generation: Impacts on training	PPs (or ex-PPs) not willing for students to see them for practice and learning purposes	"[PPs being seen in NHS hospitals] reduces the number of patients suitable as training cases in the main NHS hospitals." (M) "There's nothing about that [private] patient which makes them less of a useful learning environment than a non-private patient, but then there's nothing tangible to put your finger on this, but you do feel, I guess, that they are here and they're paying for a service, they're not here to be trained on." (B) "I think there's a real risk that you end up with cherry picking of the most profitable services and a neglect of those [services where patients are primarily seen privately], and also the training and the research and everything else that goes along with that." (O) "I think PPs, um, have an expectation that they are not going to be subjected to medical students. But I think in reality that if you've got something really interesting that you want to show the medical students, actually most patients, be they private or NHS, are actually very willing to engage with trainees to get trained. So I think that's … often a kind of cultural inhibition put in place by the medics rather than the patients." (G) "There is a complication and they get transferred in, so they are technically becoming an NHS patient, but they maintain the private patient mentality." (P)
	PPs care mainly being carried out by consultants, reducing opportunities for junior doctors to gain experience	"We tended to be not very involved [in PP care]. We would see them on the ward round, but most things would be done by the consultant directly. Occasionally we would have to do things like take blood." (O) "[If there were more PPs in the NHS,] training would be worse for the junior doctors. Because private patients, they will expect the consultant to be there all the time. Not the trainee, isn't it? Because I'm paying for a service, so I want to be seen by the consultant, not to be seen by the trainee." (N)

Major themes	Minor subthemes	Quotes from participants
Finances: Recuperation of costs	Lack of awareness of clinical staff about protocols for PPs	"I did try to have a look at that, but I couldn't really find any policies on the intranet about private patients … if there is [any guideline], it's not easily available about what role we can play." (B) "I think everyone would be aware it was a private patient, and quite open about it and not hidden … because they're coming in, having the operation and going straight out again it's not like they're admitted to the hospital as such, I think it's different, I don't think it's necessary to tell them [the private patients' office] that they're there." (P) "I don't know exactly where the boundaries of care lie, but I treat them the same as other patients." (L)
	Lack of awareness of clinical staff about which patients are private and how to mark investigations and treatments	"I have to say that I don't always know for sure, unless I have to do some specific tests or treatments, whether they are private or NHS patients … They don't have a big placard above the bed. I think it's all quite subtle." (J) "I was often called on to the [private ward] where I may have had to review someone … but it wasn't really clear whether they were a private patient or not … I guess that I could have unknowingly had dealings with them [private patients]." (A)
	PPs' office awareness of PP admissions	"Oh yeah, I think that, I suspect that a number of my colleagues are just simply adding them, private patients to their NHS lists. And that would be an easy thing to do. But it's just … but then you'd get into trouble if the organisation found out. And I think to generate more income from PPs, they need to make that process [of treating patients privately] easier." (G)
	Variable approaches to tariff setting and billing for NHS PPs	"There are no tariffs agreed with private providers, because of the low number of private procedures/admissions … the tariff is probably worked out case by case, roughly based on the local [private hospital name] rate minus 10%." (D)
	Informal arrangements for payment to surgical registrars who assist with PP surgery, not affecting NHS trusts' income from PPs	"If it's a private list and you were in the hospital, some consultants will still pay you a small fee [for assisting] because they're being paid for that operation, um, and, if you weren't doing anything else and you came to assist them some may pay, that's consultant dependent … Generally it's just a cheque that they pass to us, I've never really looked to see if it's a company cheque or a personal cheque ... [The value of the cheque is] very varied, again, consultant dependent (i.e., the amount of time it takes and how complex it is), so it's usually set against their, um, whatever their tariff is ..." (P) "The good, ethical consultants will pay them, [registrars who assist]. Everybody the same amount of money for assisting. It obviously goes to the patient's bill or the insurance or whatever, so it doesn't come out of your pocket." (Q)

Major themes	Minor subthemes	Quotes from participants
Stewardship: Direction setting	Varying opinions on whether PPs should be seen within the NHS and whether this is practically feasible	"I think the NHS is caught in this difficult position where it's not quite sure whether it's a business, or whether it's a charitable organisation ... an organisation that's delivering healthcare to a community whatever the cost … with financial balances as secondary concern rather than a primary concern" (G) "If the private hospital is on the same site or on the NHS site, it probably means that the consultants are there more often because they'll often go to the private hospital and then may nip across, whereas if they're at home they may not necessarily have done that." (P) "I think your relationship with the patient was probably a bit different, in a way that's a bit hard to put your finger on. But it felt a bit, felt a bit more commercial I guess, perhaps patients were slightly more demanding." (H) "The trouble is it doesn't have space for … to provide for those [private] lists. You can see how it might generate revenue, but in order to do so it would need capital investment in the building." (G) "There is a massive bed crisis, a bad situation, we can't manage. So there are no private patients at all. It is not banned, but there simply is no room." (Q) "It doesn't make any sense to have private patients … we don't have enough beds on the ward, we don't have enough beds in PICU, we don't do enough surgeries because we don't have places to put the patients after surgery … the procedures are delayed because of that." (N)
	PPs being seen in NHS in order to reward and retain consultants	"Consultant's costs for private work per annum, approx. £66,000 to MDU for spinal surgery (this was the figure quoted when I changed insurers), £15,000 for secretarial services, £12,000 for rent of consulting rooms." (M) "I think there is a lot of pressure on you to do private, not least because everybody else is doing it. There's a profile issue. You might feel that if you're not doing it you're the only person in the department, so how are you going to grow your … reputation … [private practice] is a kind of right of passage." (C) "Sometimes patients come and ask to go private and initially I said 'no I don't do private' and people said 'is he not confident of himself? Why is he hiding in the NHS?" (Q) "The advantage was that it was cheaper for patients than in the private sector, and you have the back-up, the junior doctors' availability 24 hours, other consultants are around, somebody's on call, you don't have to worry about the named person being around." (Q) "I can't see private patients on NHS time. And actually in reality that makes it really difficult to see private patients in the trust. It makes it cumbersome and complicated. There are other trusts which work differently … The hassle of organising private patients to be done on additional lists that aren't NHS lists is difficult, particularly in the context of an environment where there isn't much capacity." (G) "You find your freedom outside the NHS [doing private work]. In NHS you are under scrutiny. People push you in corners … in the private sector nobody will tell you 'use this, don't use that'. You choose." (Q)
	PPs being seen in NHS results in some staff, including consultants, being pressured into supporting PP care against their choice	"I felt pressured into giving more specific advice [about a private patient], this is as a registrar by a professor of orthopaedics. And in terms of my time, I stopped what I was doing on the ward round, I spoke to him. I didn't have all the information that I would usually like to have in order to be able to give advice, things that I would ask about he didn't really know." (I)