

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 qualitative



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Abstract

Background: The UK's publicly provided National Health Service (NHS) is primarily publicly funded but treats some private-pay patients (PPPs). Little is known about impacts of treating PPPs within publicly provided health systems. This study explores NHS health professionals' experiences and understanding of this phenomenon.

Methods: Semi-structured interviews were carried out with NHS clinicians. The interview transcripts were then thematically analyzed.

Results: A total of 17 clinicians highlighted potential impacts in five areas: (1) availability of resources for non-urgent, publicly funded patients, (2) patient safety for publicly funded patients and PPPs, (3) health professional training, (4) NHS finances, and (5) NHS direction setting and values.

Conclusions: In a publicly provided health service that is increasingly treating PPPs, clinicians had limited knowledge of policies for PPP care. Clinicians were concerned about patient safety impacts of prioritizing PPPs over publicly funded patients. Potential cross-subsidies

from public to private funding were mooted. The issues raised here require further exploration and may inform research and policy development in the UK and other countries.

Résumé

Contexte : Le service de santé public du Royaume-Uni (NHS) est principalement financé par les deniers publics, mais traite certains patients payants privés (PPP). On connaît peu l'impact du traitement de PPP au sein des systèmes de santé publics. Cette étude se penche sur l'expérience et la compréhension de ce phénomène auprès des professionnels de la santé du NHS.

Méthode : Entrevues semi-structurées auprès de cliniciens du NHS. Analyse thématique.

Résultats : Dix-sept cliniciens ont dégagé des impacts potentiels dans cinq domaines : (1) disponibilité des ressources pour les patients non urgents du volet public, (2) sécurité des patients des volets public et payant, (3) formation des professionnels de la santé, (4) finances du NHS et (5) orientation et valeurs du NHS.

Conclusion : Dans un système public qui traite de plus en plus de PPP, les cliniciens ont une connaissance limitée des politiques pour les soins aux PPP. Les cliniciens se disent préoccupés de l'impact pour la sécurité des patients si les PPP sont priorisés par rapport aux patients du volet public. Un interfinancement potentiel du public vers le privé a été évoqué. Ces enjeux doivent être approfondis et pourraient éclairer la recherche et l'élaboration de politiques au Royaume-Uni et ailleurs.

Introduction

Similar to Canada, the UK's National Health Service (NHS) is funded primarily through general taxation (McKenna et al. 2017). NHS facilities are publicly owned and maintained. All UK residents are eligible to receive publicly funded treatment, and over 95% of patients treated in NHS hospitals are publicly funded. Although most privately funded care in the UK takes place in exclusively privately owned healthcare facilities, many NHS hospitals also accommodate private-pay patients (PPPs), who fund their care out of pocket or through private insurance. PPP bills include a consultant's fee and a tariff to the NHS organization for facilities and staff costs. In some hospitals, a section (ward or building) of the hospital is allocated to PPPs; this is termed a private patient unit (PPU). NHS beds that are not in PPUs are also occasionally used for PPPs.

NHS healthcare is provided by public sector corporations called "trusts," which either serve a specific geographical area or a specialized function (e.g., providing a regional or national service, such as cancer care). Trusts can choose the extent and type of PPP care that they allow or encourage, as long as the use of facilities and staff for PPPs does not impinge on services provided to publicly funded patients.

Under increasing financial pressures, PPPs are seen as a revenue source for trusts. Under the 2006 rules introduced by the Labour Government, the proportion of income that NHS trusts could generate from PPPs was capped at about 2% (with some regional variations).The

Conservative Government's *Health and Social Care Act 2012* changed this, allowing trusts to generate up to 49% of their income from PPPs (Watt 2014). Many NHS hospitals invested in PPUUs (LaingBuisson 2014). To identify whether PPPs are financially beneficial to the trust requires accurate identification of the full costs of treating these patients. Because few trusts have good patient-level costing systems (Gainsbury 2009), however, most trusts cannot be certain that the specific PPPs admitted are indeed financially beneficial or whether their care comes at no detriment to the provision of public services.

Under specific terms and conditions, consultant doctors (and occasionally other professionals, e.g., physiotherapists) employed by the NHS to treat publicly funded patients may also treat PPPs in NHS hospitals. They must gain prior agreement from their trust before using NHS facilities or staff for PPP care and ensure that any PPP care does not infringe on their NHS duties (Department of Health 2004).

NHS Commissioning Board (2013) guidance states that NHS and PPP care should be separated by location and care episode, to facilitate accurate accounting; yet, where publicly funded and privately funded elements of care are both delivered within a publicly owned NHS facility, the separation is not always clear. The UK is not alone in seeing successive policies blurring the boundaries between public and private funding and provision; insights into potential morale, equity, efficiency and cost implications of providing publicly and privately funded care under one roof have international relevance. In Canada, unlike in the UK, private *payment* (i.e., extra billing or user charges) for medically necessary hospital and physician care is currently prohibited under the *Canada Health Act* and through similar provincial legislation. An attempt was made to overturn this prohibition in 2005 in Quebec (Dhalla 2007), and the legal challenge of the constitutionality of the British Columbia *Medicare Protection Act* is currently under way. Were this challenge successful, it would imply that the *Canada Health Act* is unconstitutional, which would have nationwide implications.

This study explores perceptions of the effects of private payment within an otherwise publicly funded system. Impacts of NHS PPPs on NHS finances have been described (Gainsbury 2009; Scott et al. 2012; The King's Fund 2017), but little is known about other impacts of NHS PPP care. Experiences and perceptions of NHS healthcare professionals of varied professions, specialties, ages and regions may inform the discussion of potential impacts of NHS PPP care that merit further investigation.

Methods

Interviews were conducted between November 2016 and April 2017 by a female UK-trained doctor with four years of qualitative research experience. The researcher's motivations were experiencing ambiguity about the role of NHS-employed health professionals in PPP care and lacking relevant guidance and evidence.

An interview *pro forma* and consent form were designed by the author, then revised based on feedback from a health policy expert (Appendix 1, available online at longwoods.com/content/26071).

Inclusion criteria were being a health professional and working in the NHS. A non-representative sample was recruited. Participants were invited through e-mails sent to a mailing list for UK medical academics and to the author's work contacts in varied UK NHS hospitals. Snowballing identified further participants. Interviewees were informed of the research purpose. Only individuals who were acquaintances of the researcher knew her motivation.

Study information and a consent form were e-mailed to each participant pre-interview. Consent was given before each interview. Where practicable, interviews were conducted in person; otherwise, interviews were by voice call.

An approach to assessment of health systems, primarily their functions, financing, provision, resource generation and stewardship (Murray and Frenk 2000), was adopted as a conceptual framework to inform *pro forma* design and analysis.

Interviews were carried out in private at the interviewee's convenience, in a library or the interviewee's workplace or home. The interview was audio recorded and then transcribed in full. Results were stored securely, in an anonymous format, on a computer that only the author had access to. Field notes were made during interviews. Interviews lasted 20 to 60 minutes. Recruitment and interviewing continued until saturation was reached.

Transcripts were e-mailed to the interviewee for validation. Any edits were used in the analysis. No repeat interviews or further conversations for clarification were required.

Thematic analysis was used (Attride-Stirling 2001). No software was used for data analysis. First, the author read each transcript in full to identify themes derived from the data. Second, using line-by-line review of transcripts, quotations relevant to one or more themes were extracted and categorized. Third, data under each theme were analyzed and synthesized.

Advice was provided by an expert ethicist at the Centre for Health in the Public Interest, who reviewed the protocol, participant information sheet and consent form. Measures were put in place to ensure integrity of the research process, minimize risk of harm (including anonymization of transcripts and storage of information only on one password-protected computer), maximize benefit (rigorous approach to analysis and write-up and commitment to publish results), promote autonomy of participants (who were well informed and could withdraw at any stage) and avoid discrimination (facilitating participation of any person meeting inclusion criteria and transcription to facilitate fair approach to data analysis).

Results

A total of 17 health professionals were interviewed (Table 1), 14 face to face and three by voice call. One participant noted one error in their transcript; it was corrected. Five participants responded with information that was not mentioned at the interview that they wanted to add in retrospect. No participant withdrew from the study.

Five main themes were derived: (1) impacts on availability of resources for non-urgent publicly funded patients, (2) patient safety impacts, (3) training and service development impacts, (4) recuperation of PPP costs, and (5) direction setting and values.

TABLE 1. Interviewees by job role and location

Number for reference	Specialty	Job role	Region
A	Accident and emergency	Specialist trainee	Yorkshire and Humber
B	Anaesthetics	Registrar	Yorkshire and Humber
C	Cardiology	Consultant	London
D	Cardiology	Consultant	Yorkshire and Humber
E	Cardiology	Consultant	Yorkshire and Humber
F	Cardiology and imaging	Nurse	Yorkshire and Humber
G	Gastroenterology	Consultant	Yorkshire and Humber
H	General medicine	Core trainee	East Midlands
I	Infectious diseases/microbiology	Registrar	East Midlands
J	Intensive care	Nurse	London
K	Obstetrics and gynecology	Specialist trainee	London
L	Oncology	Registrar	North of England
M	Orthopaedics	Consultant	West Midlands
N	Pediatric cardiology	Registrar	North of England
O	Psychiatry	Registrar	London
P	Surgery	Registrar	London
Q	Urogynecology	Consultant	South East

Provision: Availability of resources for non-urgent, publicly funded patients

NHS PPP care does not necessarily lengthen NHS waiting lists; the alternative to privately funded care delivered in NHS facilities would be publicly funded NHS care or privately funded care delivered by NHS consultants in private hospitals, thus drawing on the same resources. Yet, interviewees indicated that running a parallel PPP system within an otherwise publicly funded NHS may negatively impact health equity, first, due to PPPs being prioritized over publicly funded patients and, second, if PPP care consumes disproportionately high quantities of NHS resources.

PPPs may “jump the queue.” Interviewees experienced PPPs being prioritized for ward-based care and for scans:

Seeing [PPPs] first on the ward round, or feeling an obligation to drop whatever else I'm doing to be able to prioritize them ... (L)

A nurse described how fitting PPPs into an NHS list can delay publicly funded patients' cardiac interventions (Quote 4, Appendix 2, available online at longwoods.com/content/26071). Although all urgent procedures are completed the same day to protect patient safety, non-urgent publicly funded procedures may be rescheduled.

Higher resource use may occur where providing PPP care takes longer relative to providing publicly funded patients' care and/or ambiguity or administration makes demands on health professionals' time. Some interviewees perceived, or were told by colleagues, that PPPs deserve more clinician time because they are paying.

[A consultant] may have more one-on-one contact with a private patient ... But I think that's probably what comes with when you pay. (P)

Interviewees suggested that extra time spent seeing PPPs often was health professionals' own time, rather than time that would otherwise be spent providing care for publicly funded patients:

If you think about our consultants, they might spend their time [seeing PPPs] perhaps, but then they stay in the hospital until 7 o'clock ... (N)

PPPs are sometimes transferred from privately funded care to publicly funded care, if an aspect of their care is outside private insurance cover or the PPU/private facility cannot meet the patient's needs. Doctors described that when a patient–doctor relationship is developed during private treatment, the consultant may spend extra time with that patient even during publicly funded elements of their care (Quote 6, Appendix 2).

A doctor described a children's magnetic resonance imaging (MRI) list running overtime when an adult PPP was added onto the list to have an MRI under general anaesthesia (not normally available for publicly funded adult patients). The NHS team worked beyond their paid and scheduled hours to avoid postponing scans, but had they not, publicly funded patients would have been deferred due to this PPP having a procedure (MRI under general anaesthesia) that takes longer than the procedure provided to publicly funded patients (MRI without general anaesthesia).

PPPs transferred from PPUs to publicly funded care were particularly time-consuming when information about previous investigations was lacking:

We didn't have access to her [private] scans or her clinic letter ... it was thyroid surgery, so you kind of need to see where the thyroid is on her scans. (B)

A nurse experienced a situation in which a patient wished to transfer from publicly funded care to a PPU. This required much administrative time without always resulting in the desired transfer, for example, if the patient's health insurance would not cover the cost (Quote 13, Appendix 2).

Health professionals said that they took longer to see PPPs because it was harder to locate PPPs' beds, navigate PPPs' notes and enact PPPs' care plans, due to organization

for PPPs being different to that for publicly funded patients and, hence, unfamiliar. Furthermore, seeing PPU patients consumed significant time due to the PPU's distance from the main hospital.

It was difficult because they have different notes, different record system ... That's the worst bit – it just takes you away, takes you away for an hour. (I)

Ambiguity about staff roles could take time:

Afterwards I kind of put it together and realized it was because it was a private patient and I wasn't supposed to [see them] ... It wasn't part of our job, because I was supposed to be looking after our ward and that wasn't our ward to cover. (K)

Health professionals had varying ideas about whether PPPs should be seen exclusively by consultants or also by junior doctors.

Interviewees expressed disappointment at the lack of reciprocity between privately and publicly funded care. By definition, PPPs received care provided using NHS resources, but interviewees reported that the resources purchased for PPUs are not available for publicly funded patients, which created inequity and inefficiency. One trust invested in an MRI scanner for a PPU on the hospital grounds; however, even when the scanner was not in use for PPPs, publicly funded patients were not scanned there.

Patients that needed MRIs were shipped to [hospital 45 km away] for their scans and then shipped all the way back again, when there was a scanner across the carpark. (H)

By contrast, upon reaching capacity within NHS services, PPU beds may be allocated for publicly funded patients when NHS bed capacity is reached (Quote 16, Appendix 2).

Provision: Patient safety for publicly funded patients and PPPs

Interviewees' patient safety concerns related, first, to safety impacts of decisions made on a basis other than clinical need and, second, to the quality of care in PPUs.

Interviewees experienced patients being admitted to inappropriate locations and prioritization of clinical review according to funding rather than clinical need, which poses particular problems, whereas the NHS has high bed and operating theatre occupancy. One doctor commented that use of ward side-rooms for PPPs could result in publicly funded patients with potentially infectious conditions not being isolated or being isolated with delay, although, conversely, PPU rooms could be used for publicly funded patients requiring isolation to prevent infection (Quote 16, Appendix 2). Other interviewees noted PPPs admitted

to their private consultant's NHS ward, even if their current presenting complaint was not related to their private consultant's specialty. The ward and its staff were not specialized for the PPP's complaint:

It was a cardiology patient admitted as an inpatient for a cardiologist but actually it was more to sort out a gastroenterology issue on the cardiology wards. And 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)

Concerns about PPUs included the quality of nursing care and timeliness of medical review:

I think often, particularly for the more unwell patients, the nursing care was probably worse on that [PPU] ward. (H)

A junior doctor described one night being asked by the doctor at his hospital's PPU to provide advice on a critically unwell patient. The PPU staff were unable to follow simple treatment advice; therefore, the patient was transferred to publicly funded wards and experienced delayed care (Quote 18, Appendix 2).

The assertion by two interviewees that NHS PPUs often absorb high-quality nursing staff seems contradictory:

New initiatives often reduce the quality of staff on NHS wards because best staff go and work in the new facility. (D)

Two interviewees discussed PPPs receiving care outside of clinical protocols, which they feel compromised patient safety. A nurse described a PPP being prescribed medicines without following protocol (Quote 20, Appendix 2), attempting to meet the patient's expectations. A consultant judged that one patient was suffering from an infection with resistant bacteria due to inappropriate antibiotic treatment when he was a PPP:

That private patient took a lot of my time, and I do think that the reason that he took so much of my time was that he'd been treated irresponsibly. (I)

Another consultant said that in private pay practice even within the NHS, the consultant's financial incentive potentially drives overinvestigation and overtreatment (Quote 21, Appendix 2). An example is the PPP MRI under anaesthesia described in the previous section.

Resource generation: Training and service development

Interviewees found that PPPs present fewer training opportunities than publicly funded patients.

One consultant said that PPPs are not accessible “as training cases” (Quote 22, Appendix 2). Trainee doctors usually do not enter PPU, which are staffed by non-training grade doctors. Another said that PPPs were generally less willing to see trainees but would sometimes if they had history or examination features of particular learning value (Quote 24, Appendix 2).

Junior doctors described consultants leading most PPP (or ex-PPP) care, resulting in reduced training opportunities:

It may free up juniors’ time [when consultants lead PPP care], it’s also a loss of training opportunity, so it goes both ways doesn’t it? (A)

Although PPPs’ operations are usually performed by a consultant, surgical registrars sometimes assist, which may facilitate learning. A surgical registrar said that PPPs can provide opportunities to observe procedures that are not available on the NHS (although this may have a limited contribution to preparing the registrar for NHS consultant practice). Opportunities to assist PPPs’ operations usually are limited to more senior and more proficient registrars, to the disadvantage of registrars with most training needs:

To be asked to go and assist at a private operation is a bit of an honour as a registrar, so it’s recognising that you are good at what you do. (P)

The same interviewee said that cherry-picking for privately funded operations results in removal of simple cases from the publicly funded NHS operation pool, thus “removing a rung on the ladder,” leaving trainees seeing more complex cases without sufficient exposure to simple cases.

One interviewee stated, based on experience attending a private healthcare facility as a medical student, that trainees’ involvement in PPP care may improve their understanding of healthcare systems and patient experiences:

It was useful to have the comparison and to see the differences between the two systems, and start thinking about the impact that the system can have and the resources available ... it was quite a shock to see the difference ... (O)

Finances: Recuperating PPP costs

Most interviewees recognized that local and national guidance exists for the care of PPPs but did not know the content of the guidance. A consultant said that the rules were “left for you to figure out” (C). Interviewees unanimously had not received induction about PPP care, including their role.

For trusts to recuperate PPP care costs requires hospital staff to identify PPPs and mark investigation and treatment requests to facilitate correct billing of the PPP/private insurer. Should requests not be marked appropriately, it risks cross-subsidy of PPPs from public funds. A registrar and a consultant stated that they know when they have a PPP and mark requests appropriately; conversely, a nurse said that she and her colleagues did not know when they had PPPs and did not consider marking PPP investigations. Other interviewees were not aware that PPP investigations required specific marking.

Reliable systems are not in place for staff to identify PPPs:

If there's a private[ly funded] patient who's just mixed in with the ward, it might say on the board 'PP' or you'll just get the verbal communication from the nurse, that sort of thing. (B)

A surgeon said that in the operating theatres, all staff were aware of whether patients were privately or publicly funded, yet she did not consider it necessary to inform the trust:

I don't think it's necessary to tell them [the trust] that they're there. (P)

Some staff not only did not recognize the importance of identifying PPPs, they preferred not to:

I prefer not to know and treat them like any other patient. As doctors we don't have to really care whether the patient is private and paying for their care. (N)

A consultant said that other consultants may intentionally conceal PPP admissions to avoid administration or costs that they should pay to the hospital for use of facilities:

I think that, I suspect that a number of my colleagues are just simply adding them, private[ly funded] patients, to their NHS lists [without informing the trust]. (G)

Were this true, it would cause cross-subsidy from public to private funding.

Consultants described diverse approaches to tariff setting and payment sharing between the trust and the consultant. A consultant said that his trust sets PPP tariffs below the local private hospital's tariffs based on assumption of lower overhead costs, which reflects the responses of trusts. Two interviewees described informal arrangements for PPP treatment; for example, a consultant treats a PPP during an NHS operation list and in return does an extra half day treating publicly funded patients without payment.

Apart from consultants, who receive payment for PPP care from the PPP's bill, health professionals usually receive no payment on top of their NHS salary for being involved in

PPP care. An exception is that surgical registrars may receive an informal payment, its value determined by the consultant (Quote 35, Appendix 2). A consultant gave an example of a consultant paying an assisting registrar £200 of their £2,000 fee for a cardiac bypass.

Stewardship: Direction setting and NHS values

Consultants described NHS trusts having varying approaches to permitting or encouraging PPP care within the trust. Where privately funded care is not supported, administrative burden and stress may discourage consultants:

[Because of trust regulation,] I can't see private[ly funded] patients on NHS time. And actually, in reality that makes it really difficult to see private[ly funded] patients in the trust. It makes it cumbersome and complicated. (G)

In contrast, a London-based consultant said, "We've been encouraged as a body of consultants to see people privately if they want" (C). Another consultant said that his trust is "happy to have private admissions as long as it doesn't impinge on NHS work" (D).

Interviewees explored whether NHS PPP care is practicable. Some interviewees stated that with the NHS working at full capacity to provide care in the publicly funded system, trusts do not practically have human resources or facilities to plan and implement PPP care (Quotes 40–42, Appendix 2).

Interviewees explored whether PPP care provision aligns with NHS values. Some were concerned about increasing privatization exacerbating health inequities:

Some people would say if they pay then they deserve to go first. It's not fair, the NHS shouldn't be for that. The public system, we don't have to play that game. (N)

Opinions varied:

I think that people will jump the queue by being private, but that in the way is the market playing out isn't it? [sic] ... if you want something quicker you have to pay for it. (G)

Interviewees considered whether, if consultants provide PPP care, it is better that they do so within NHS premises. An advantage of consultants seeing PPPs within the NHS is their proximity to their other patients. A disadvantage is that health professionals who would not choose to treat PPPs may experience pressure to support PPP activity when it is delivered within NHS hospitals. Anaesthetists are essential to the delivery of many treatments, notably surgery, and it can be challenging to find sufficient anaesthetists for PPP operations:

In general, they actually struggle to cover the shifts, so ... people aren't like fighting over these [PPP operation] lists, it's potentially the opposite way around. (B)

One interviewee described feeling pressured into providing clinical microbiology advice for a PPP during publicly funded working hours, with insufficient patient information available (Quote 49, Appendix 2).

Consultants may be motivated to treat PPPs for freedom to stray from constraints of public funding (e.g., consultation length and types of intervention funded):

Private[ly-funded] practice is something that you do for fun in order that you can treat patients in the way in which you wanted to treat them when you went to medical school ... I won't make any real profit from my private practice. (G)

Such "freedom" may, however, risk overtreatment and patient safety.

Consultants described that seeing PPPs within the NHS is attractive. It reduces overhead costs (low or no consulting room fees), and more support is available from doctor colleagues compared to that in private facilities.

Discussion

By exploring health professionals' insights about PPP care in NHS-owned hospitals, this study highlights areas of potential concern and can help to build hypotheses about impacts of providing privately funded care within an otherwise publicly funded healthcare system. Participants may not fully understand the economy of NHS PPPs, yet their perspectives provide credible insights into the realities, benefits and problems of treating PPPs within NHS hospitals. Further, even where issues are perceived but do not actually exist, this can unveil misunderstandings and value judgments that are beneficial to address (Chalkley and Sussex 2018). These findings can inform health researchers and policy makers in the UK and abroad.

Regarding experiences and perceptions about NHS PPPs, even within this small sample of health professionals, there is great diversity. The study highlights that although consultants usually have a choice about whether to engage in PPP care, non-consultant clinicians had little or no choice regarding whether they are involved in caring for PPPs under the terms of NHS employment. Many interviewees opposed PPP care being provided within NHS PUs, believing that the NHS should exclusively treat publicly funded patients and want to retain choice about whether to contribute to providing PPP care. If privately funded care within the NHS continues to expand as predicted (LaingBuisson 2016), consultants who do not wish to care for PPPs may increasingly be obliged to support PPP care as part of NHS employment, for example, providing specialist advice or anaesthetics. Thus, although trusts may allow consultants to see PPPs within the NHS to reward or retain consultants (Walpole 2018), they risk adversely affecting other health professionals' experiences.

A further issue is the equity impacts of creation and support of a parallel system within the publicly funded NHS. Apart from the inequity of differentials in care arising from the existence of a parallel private-pay system, interviewees expressed concern that patients may be prioritized according to their funding rather than clinical need, resulting in delayed care for publicly funded patients and patient safety issues.

Regarding material impacts, front-line health professionals questioned whether hidden cross-subsidies from public to private may exist. Where elements of care are not measured (e.g., due to inaccurate marking of PPP investigations) or entire care PPP episodes are hidden (e.g., if PPPs have operations without appropriate permission and billing by the trust), trusts' ability to accurately measure and recuperate costs (financial and otherwise) of PPP services is compromised. Many interviewees were unaware of guidelines and policies for NHS PPP care, suggesting that procedures (such as marking PPP investigations) are unlikely to be followed. Interviewees correctly identified that NHS trusts often undercut private healthcare providers (Scott et al. 2012). Various formal and informal arrangements were described for payment of doctors and trusts for PPP care, which corresponds with the evidence of widely varying approaches to NHS PPP tariff setting (Walpole 2018), raising concern that costs may not always be covered. The Department of Health (2004) does not recognize the payment of registrars or other clinicians who contribute to PPP care and receive informal payment via a consultant.

Concerns were raised about patient safety in PPU. Although evidence suggests that quality in private hospitals is less well monitored and potentially lower than care in NHS PPU (Leys and Toft 2014), research about quality in PPU is lacking. Two consultants raised concerns that clinicians' earnings being linked to PPP activity drives overinvestigation and overtreatment, a concern that relates to privately funded healthcare regardless of location.

The suggestion that PPU absorb high-quality staff, reducing availability for NHS wards, is seemingly contradictory to the suggestion that PPU have lower quality standards but corroborated by Palley et al. (2011), who stated that expansion of private for-profit healthcare provision drains physicians from Canada's otherwise not-for-profit system. A possibility is that staff provide differing quality care depending on the patient's funding or the work environment; however, this was not explored in interviews.

Interviewees felt that PPPs offer some training opportunities but less willingly and often than publicly funded patients. Although the same number of patients may be receiving care, this quantitative equivalence in training opportunities may not translate to a qualitative equivalence. A hypothesis of practising healthcare professionals, relevant both as a perceived problem and potentially a real problem, is that training opportunities may be few when patients are private pay, as they do not perceive that they should be involved as "cases" in training.

Strengths and Limitations

This study was not intended to provide a representative sample of views. Recruitment via e-mail lists and snowballing causes sampling bias toward individuals with stronger views and those who felt most able to articulate opinions. There may be some merit in identifying stronger views, which can help to build hypotheses about this issue. Although the sample size was relatively small, the range of professionals interviewed is a strength.

Privacy and anonymity of interviews gave interviewees opportunity to express views that may not have been shared in focus groups or were participants identifiable. That interviews were transcribed in full and validated by participants enhances reliability. Ideally, “member checking” would also have been used to validate themes.

Limitations include single authorship, which makes reflexivity particularly important in interpretation of findings. The author has worked in the NHS and been asked to support PPP care there. She is a member of the People's Health Movement and Medact, organizations that advocate for publicly financed, publicly provided healthcare, and has worked with researchers from the Centre for Health in the Public Interest, which has exposed problems and fragmentation arising from private healthcare provision. Emphasis and interpretations of data emerging from the study may thus have been different to those that another researcher might have made.

Conclusion

The implications of this study of privately funded care provision within a publicly provided health service are relevant to other nations considering the efficiency of and/or looking to expand private healthcare funding. Many issues raised reflect challenges related to co-existing public and private systems as seen in multiple countries (Patel et al. 2015; Rannan-Eliya et al. 2016; Rosen et al. 2015). Like the UK, Canada has extended the scope of private for-profit healthcare delivery within a publicly funded healthcare system, as a result of politically perceived needs and resource limitations (Contandriopoulos et al. 2012; Palley et al. 2011).

Governments should consider that running privately funded services within otherwise publicly funded healthcare services may not provide the anticipated financial rewards unless careful attention is paid to tariff setting, activity monitoring and revenue collection with guidance and oversight in place. The issues raised here require further exploration through examination of local policy and practice and wider consultation and may inform research and policy development by governments and healthcare providers.

Registration + Protocol

The pre-determined protocol is available from the author. It was not submitted to a registry. The interview *pro forma* was first drafted at the time of developing the protocol and then revised based on feedback. The revised version is appended.

Ethical Approval

Ethical approval was gained from the Centre for Health in the Public Interest, whose committee included an expert ethicist. It was deemed that the study entailed very limited risk of harm and would not affect patients.

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

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Glossary

- Consultant/consultant doctor*: A senior physician specialist who has completed the training for their specialty.
- Cross-subsidy*: Funds generated from or resources allocated for one activity (in this discussion, publicly funded NHS care) being used to pay for a different activity (in this discussion, privately funded NHS care).
- Finished consultant episode*: A measure of hospital activity; the period during which a patient is continuously seen by one consultant, ending with discharge, transfer or death.
- Junior doctor*: A doctor who has completed medical school but not completed training, that is, who is not yet a consultant (or an associate specialist, an equivalent to a consultant).
- NHS Commissioning Board*: A public body, sponsored by the Department of Health and Social Care, established in 2012 to implement the reforms of the *Health and Social Care Act*. In 2013, its name changed to NHS England, but its roles remain the same, including leading the NHS by planning, commissioning and regulating NHS services.
- Non-training grade doctors*: Graduate doctors who work in paid roles delivering health services, not at the consultant level and without being enrolled in (and thus benefitting from the structure and support system of) a training program.
- Private patient unit (PPU)*: A section (ward or building) of an NHS hospital that is allocated to treatment of private-pay patients.
- Registrar*: A doctor in training who has completed foundation and core training and is undertaking specialist training.
- Surgeon*: A doctor who has chosen to pursue a surgical specialty, that is, a surgical registrar or surgical consultant.
- Tariff*: The set price for a service; the amount that is due to be paid.
- Trainee/trainee doctor*: A medical graduate working as a doctor below consultant level and in a foundation or specialty training scheme.
- Trust/NHS Trust*: An NHS organizational unit that serves a specific geographical area or serves a specialized function, such as provision of a regional or national service.