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THE NHS AND PRIVATE HEALTH CARE

Michael Calnan†

I. INTRODUCTION

THE FUNDING AND ORGANIZATION of health care in the United Kingdom has never been far from the political agenda since the inception of the National Health Services (NHS) in 1948. One of the focuses of debate which has recurred over the years has been the privatization of health care and the extent to which it has challenged or "undermined" the NHS. Privatization has taken a number of different forms.¹ There has always been some form of private health care sector alongside the NHS, although its size has varied according to political, social, and economic circumstances. The aim of this Article is to examine the relationship between the NHS and the private health care sector and what impact, if any, changes in one sector have had on the other. However, before these analytical questions are considered, it is important to see the private health care sector in the context of overall health care provision in the United Kingdom and particularly to identify its extent and nature as well as any recent changes in its shape.

II. GROWTH AND DEVELOPMENT OF PRIVATE HEALTH CARE IN THE U.K.

The major focus of this Article will be on the private acute health care sector, although, as the following statistics indicate, the largest supply of services in the independent sector (private and voluntary) is in the area of long-term care of the elderly and mentally ill. For example, 1997-98 values of health services supplied by the independent sector in the acute sector are estimated to be £2,350 million compared with £6,917 million for the long-term care of the elderly and physically disabled, and

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£3,120 million for pharmaceutical products and medical equipment. However, to estimate the size of the contribution the independent sector makes to health care delivery in the United Kingdom, it is necessary to focus on data available on the hospital and nursing home care only. For example, it is estimated that in 1997 around twenty percent of expenditures on hospital and home care was derived from the independent sector, which shows a marked increase over the last decade. In 1986, the equivalent figure was ten percent. So the proportion of independent sector expenditures has doubled and private nursing homes have accounted for the largest share in the increase throughout the period. However, the rate of growth of this part of the independent sector has slowed down during the 1990s which might have been a result of the community care reform initiated in the early 1990s.

The picture of the public and independent sector in the United Kingdom is slightly more complicated than has been presented so far in that in many areas the public/private distinction has become blurred. One area is the financing of health services. While services may be provided through the private sector, they need not necessarily be financed by the private sector. For example, the proportion of expenditures for long-term care of the elderly in residential settings which was supplied by the private sector, but funded through public finance in 1997, amounted to thirty-five percent overall compared with twenty-six percent which was publicly financed and supplied, and thirty-seven percent which was privately financed and privately supplied. As another example, in 1992-93 the proportion of elective surgery cases paid for by the private sector and supplied by it was twelve percent compared to eighty-six percent paid for and provided by the NHS.

The introduction of market principles and the split between the purchaser and provider (the internal market) in 1991 encouraged the development of the NHS purchasing services from the private sector. It must be noted, however, that traditionally there have been certain services that have been provided by the private sector because of restricted provision by the NHS.

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3 See id. at 38.
4 See id.
5 See id. at 40.
6 See id.
amples of this are in the provision of abortions and complementary medicine. In contrast, services provided in general practice and maternity care are almost all provided by and financed by the NHS.\(^7\)

This provides a brief overview of the extent and nature of the private sector in the NHS. The following analysis will focus in more depth on one part of this sector – the private acute sector – where there have been significant developments in recent years and where the services provided tend also to be found in the NHS. The first part of the discussion will focus on outlining the nature of these developments and will be followed by an analysis which attempts to explain why these developments have occurred and what the impact has been.

A. The Private Acute Health Care Sector: Recent Developments

Evidence that the acute private medical care sector has been changing over the last twenty years can be derived from two sources: the proportion of the population covered and subscribing to private health insurance, and the numbers of private hospitals and hospital beds. Clearly, there is a close relationship between private health insurance subscriptions and the provision of hospital beds. They are obviously related and interdependent, although more so now than they were in the early years of NHS where access to private health care was not dependent on insurance coverage, and private hospital bills were frequently settled by patients themselves. Indeed, as recently as 1981, twenty-eight percent of such bills were still paid for by patients, although by 1997 this percentage had dropped below twenty percent.\(^8\) In addition, in 1997 just under ten percent of revenue was generated by non-U.K. patients, although this too is in decline.\(^9\)

B. Private Health Insurance: Changes in Subscriptions and Coverage

In 1997 there were an estimated 3,367,000 subscribers to private health insurance in the U.K., which, including dependents of subscribers, covered 6,457,200 people.\(^10\) This constituted about eleven percent of the population of the United

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\(^7\) See LAING & BUISSON, supra note 2, at 40.
\(^8\) See id. at 45-46.
\(^9\) See id. at 46-47.
\(^10\) See id. at 83.
While during the 1990s there was little change in private health insurance coverage (in fact there has been a slight drop since 1990 when 11.5% of the population was covered),\textsuperscript{12} the boom period for private health insurance occurred during the 1980s. In 1977, the proportion of the population covered by private insurance was only four percent.\textsuperscript{13} By 1984 it had doubled to eight percent, and throughout the 1980s it steadily increased to its peak level in 1990.\textsuperscript{14} The increase in subscriptions when the Conservatives came into power in 1979 is noteworthy because these figures refer to the net increases in subscriptions and do not record the relatively high number of ex-subscribers who had let their subscriptions lapse. It is possible to characterize the type of private health insurance subscriber in terms of those who pay individually or through a group scheme organized by a professional association or trade union, and those who have their insurance paid by their company usually as a managerial perk similar to company cars. The growth during the 1980s occurred in these company schemes. For example, in 1984 the proportion of the United Kingdom population covered by company-paid schemes was 4.3% and those covered by self-paid schemes was 3.5%.\textsuperscript{15} By 1990 these figures were 7.3% and 4.2% respectively, but by 1997 they had fallen back to 7.1% and 3.8%.\textsuperscript{16} However, once again, distinctions between company-paid and individual-paid schemes are overly simplistic in that approximately a third of those in company-paid schemes pay the whole or part of the subscription.\textsuperscript{17} Hence, the market for private health insurance is driven by both supply and demand factors.

Given the growth of company purchase schemes during the 1970s and early 1980s, it is not surprising that the majority of currently insured are in such schemes. However, as the statistics presented previously indicated,\textsuperscript{18} during the 1980s there was also an increase in the individual subscribers market due in part to aggressive marketing and careful targeting by insurers and an increase in disposable income among those groups who had tra-

\begin{itemize}
  \item \textsuperscript{11} See id. at 84.
  \item \textsuperscript{12} See id.
  \item \textsuperscript{13} See LAING & BUISSON, supra note 2, at 84.
  \item \textsuperscript{14} See id.
  \item \textsuperscript{15} See id. at 96.
  \item \textsuperscript{16} See id.
  \item \textsuperscript{17} See id. (citing data from a 1995 General Household Survey).
  \item \textsuperscript{18} See id.
\end{itemize}
ditionally been insured. This growth slowed down in the early 1990s because of the combined effects of the recession and higher premiums. Similarly, these factors are possible explanations for the lack of growth in the company schemes during the 1990s. Evidence suggests that some companies were becoming concerned about the so-called “abuse” or “overuse” of insurance by their employees and were attempting to regulate this behavior. There is also evidence that some companies have shelved plans to extend their schemes to the entire work forces, others have opted for cheaper, more restrictive coverage, and yet others have started to exclude spouses and dependants.\footnote{See generally Michael Calnan et al., Going Private: Why People Pay for Their Health Care (Chris Ham ed., 1993).}

As might be expected, those who have private health insurance tend to have professional and managerial jobs.\footnote{See Laing & Buisson, supra note 2, at 97 (citing data from a 1995 General Household Survey).} Twenty-two percent of workers in professional occupations were covered by private health insurance in 1995.\footnote{See id.} For employers and managers, it was twenty-three percent compared to just four percent in skilled manual labor, two percent in semi-skilled manual labor, and one percent in unskilled manual labor.\footnote{See id.} These distributions have not changed significantly over the last twenty years.\footnote{See id.} There are also marked regional variations in the U.K. in private health insurance coverage particularly between the north and south. For example, in the outer-London area, the proportion of the population covered by private health insurance in 1997 was twenty percent compared to nine percent in North West England and five percent in Wales and Scotland.\footnote{See Helen P. Bartlett & David R. Phillips, Policy Issues in the Private Health Sector: Examples From Long-Term Care in the U.K., 43 J. SOC. SCI. & MED. 731 (1996).} In some respects, these regional variations reflect variations in the provision of private hospitals as well as variations in locations and type of industry. For example, the type of companies (predominantly consulting and financial) that provide managers with “perks” such as private health insurance are more likely to be found in the South East of England around London.\footnote{See id.} In part, these variations reflect differences in disposable income and the unequal distribution of “benefits in kind.” However, the differ-
ences by occupational group may also reflect a decision on the part of insurers not to expand into the working class market because these potential subscribers are deemed to be a bad risk and/or high-cost patients.

There are also variations in coverage and subscription by gender, marital status, and age. Considerably more men than women hold insurance policies, but roughly equal numbers of both sexes are actually covered. Thus married men are more likely to hold insurance, but married women are more likely to be covered. Policy holding and coverage also varies by age with the highest coverage being in the middle-age range.

C. Changes in the Provision of Private Acute Hospital Beds

The second indicator of the growth of private medicine involves hospitals and hospital beds. Once again during the 1980s, there was a spectacular increase in both these areas. For example, between 1981 and 1990, the number of acute beds in the private sector increased by almost fifty percent and the number of hospitals increased by almost a third to 211. Once again the growth rate in the 1990s was much less marked and the number of private acute hospitals in 1998 stood at 229. This growth in private hospital beds during the 1980s should also be seen against a background of a fall in the number of available beds in the NHS hospitals over the same period.

During the last thirty years the evidence suggests that there has been a dramatic fall in the NHS's share of the market. In 1972, the NHS had almost half (forty-eight percent) of the market share, but by 1981, this had been reduced to twenty-five percent, and by 1990, it was down to eleven percent. During the 1990s, however, this picked up slightly, and in 1997, the NHS’s market share stood at sixteen percent.

Despite this apparent growth in the private acute sector, perhaps the most important change has been in the patterns of

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26 See generally CALNAN ET AL., supra note 19, at 60.
27 See id.
28 See LAING & BUISSON, supra note 2, at 97 (considering 45-64 years of age as the middle-age range).
29 See id. at 51.
30 See id. at 50-51.
32 See LAING & BUISSON, supra note 2, at 60.
33 See id.
hospital ownership. While twenty-eight percent of private beds were in commercial hands in 1979, this proportion had increased to fifty-six percent by 1989 with the remainder in religious or charitable non-profit hospitals. The early 1980s saw an influx of American companies into the private market, although by the late 1980s some of these were replaced by European “for profit” companies as the private sector market became unstable and prospects were not as good.\(^3\)\(^4\) One reason was the over supply of private beds in London leading to low bed occupancy. Another factor was the over reliance on NHS consultant staff which influenced workload and admission policies. In fact, forty-five independent hospitals closed between 1979 and 1992 and most of these were charitable, religious, or single hospital organizations. In 1998, sixty-five percent of beds were owned by for-profit hospital operations.\(^3\)\(^5\) In recent years there has been considerable restructuring through merger and acquisition and the independent acute hospital sector is now dominated by five U.K. hospital operations.\(^3\)\(^6\) The growth of the private sector, particularly in recent years, has not been unproblematic and the response to this has been attempts to diversify. For example, there has been an expansion of services for sports injuries, pain control, eating disorders, alcoholism and drug dependency, and adolescent and adult psychiatry.\(^3\)\(^7\)

Private medicine has grown considerably over the last twenty years, especially in the private acute sector, which offers an alternative to the NHS. Not only has there been a substantial increase in private health insurance coverage, but there has also been a similar expansion in the number of private hospitals and hospital beds. The most marked expansion occurred during the 1980s with much less growth occurring in the 1990s. Why have such developments taken place? This is the question that will be explained next.

III. EXPLANATIONS FOR THE EXPANSION OF THE PRIVATE HEALTH CARE MARKET IN THE U.K.

Much of the debate about why private health care has expanded in recent years has been concerned with whether it was

\(^3\)\(^4\) See Bartlett & Phillips, supra note 25, at 732.
\(^3\)\(^5\) See LAiNG & BUISSON, supra note 2, at 51-52.
\(^3\)\(^6\) See id. at 51.
\(^3\)\(^7\) See Bartlett & Phillips, supra note 25, at 731-32.
a result of supply side actions such as those of the state, private insurance companies, owners of private hospitals and the medical profession, or whether it was a response to consumer demand. The two explanations will be considered in turn.

A. The Role of the Supply Side

Supply-side arguments concentrate on the actions of the state, private insurance, hospital companies, and the medical profession (both hospital doctors and general practitioners). Of these, the state is perhaps the key actor and can support the provision of private health care either through the expansion of private pay beds in NHS hospitals or by encouraging the growth of the independent private health care sector. In many respects the Conservative Government from 1979 onward pursued both policies, although with more emphasis on the latter.38

Certainly, the ideological climate in the United Kingdom favored the growth of free market initiatives.39 To some extent this was fueled by the Conservatives coming to power in 1979. The new government was driven by ideological convictions (the "New Right" ideology) where emphasis is placed on individual freedom and personal responsibility and state involvement is rejected because it is perceived to constrain such freedoms and creates dependency.40 The mechanisms through which such freedom and personal responsibility are pursued and achieved are private ownership and rewards. Health care is seen as part of the reward system and as a result, access to health care is determined by the ability to pay. Likewise providers of care are directly rewarded according to market forces mainly through fee-for-service payments. Thus, the following changes that the Conservative government facilitated fitted in with their ideological convictions, although it is difficult to know whether changes in welfare track changes in socio-political values or vice versa.

The first of these changes was the Health Services Act in 1980 which contained a number of provisions designed to reduce the restrictions on private health care such as: the reduction of the number of NHS pay beds was reversed, controls on

38 See LAING & BUISSON, supra note 2, at 62 (discussing the political and regulatory environments of the 1980s and 1990s which affected the British private health care sector).
39 See Bartlett & Phillips, supra note 25.
40 See id. at 732.
private hospital development were relaxed, and health authorities were encouraged to contract with private hospitals for the first time. Secondly, the Town and Country Planning legislation was relaxed which made it easier for new hospitals to be built regardless of the impact on the local community. Thirdly, introducing the Finance Act in 1981 increased the attractiveness of private health insurance by making insurance premiums paid by employers on behalf of employees tax-deductible. In addition, at a later date, there was the introduction of tax relief on health insurance premiums for low-paid and elderly people, which have only recently been abandoned.\textsuperscript{41} The Act also facilitated the raising of capital for small scale entrepreneurial activity through the small-business start-up scheme. Fourthly, the Conservative government changed consultant contracts and allowed full-timers to earn up to ten percent of their NHS salary from private practice.\textsuperscript{42} Part-timers were required to forego less of their NHS salary from private practice (one-eleventh instead of two-elevenths) while being allowed to undertake as much private practice as they wished. As a result, the amount of private practice such doctors were able to undertake without forfeiting NHS privileges increased dramatically, and the potential for the expansion of private practice changed tremendously.

Fifthly, policies were pursued during this time which also encouraged greater collaboration between the two sectors. One such policy was the introduction in 1983 of competitive tendering for domestic catering and laundry. A second form of collaboration has involved the NHS contracting out-patient care to the private sector. Health authorities were directed by the government to use private hospitals as a way of reducing NHS waiting lists for non-urgent cases and those waiting more than one year. A more recent example of this form of collaboration is the private finance initiative (PFI) launched in 1992 which forms "part of a range of measures in which individual, community and private corporate resources are harnessed in order to supplement the resources available from general taxation for welfare state expenditures."\textsuperscript{43} PFI is used particularly as a way

\textsuperscript{41} See Bartlett & Phillips, \textit{supra} note 25; Laing & Buisson, \textit{supra} note 2, at 62.
\textsuperscript{42} See Laing & Buisson, \textit{supra} note 2, at 62.
of resourcing capital investment in the NHS from private finance. Since 1994 all planned capital developments are required to include an option appraisal of viability for PFI. \(44\) "Two key criteria form the basis of this assessment: value for money and the transfer of risk from the public to the private sector."\(45\) Finally, there has been a limited degree of regulation of the private sector. For example, "[t]here is little scrutiny of the surgical procedures undertaken by private . . . hospitals." \(46\) Conservative governmental policies, mainly during the early 1980s, created the necessary conditions for the rapid growth of private hospitals and beds, and in insurance coverage which, as has been shown, took place during their first period of office.

Besides these political considerations, governmental policy towards private medicine has also been influenced by broader economic concerns. Faced with financial pressures created by the persistent upward movement of health spending and a reduction in income which resulted from a series of economic crises, the government has argued that an open-ended commitment to the Welfare State is unaffordable.

At the same time, the nature of these changes has also been influenced by the reactions of those working in the NHS itself. Encouragement for the expansion of the private sector has been received from those segments of the medical profession who have stood to gain financially from such developments. Thus, Conservatives’ plans have been endorsed by hospital consultants who have been the major beneficiaries of the growth in medical fees paid out by insurance companies in recent years. According to Klein (1987) such fees increased from £37 million to over £200 million between 1979 and 1987 which would represent an average income from private practice in 1987 for each consultant of £17,000. Furthermore, some of the consultants have also made money out of their ownership, wholly or in part, of the new private hospitals, having invested in the Government’s Business Expansion Scheme in order to benefit from the substantial tax relief that it allows.

Given this government commitment and other vested interests in private medicine why was a full-blooded neo-liberal approach not taken in the 1980s, and why did the NHS not become

\(44\) See id.
\(45\) Id.
\(46\) Bartlett & Phillips, supra note 25.
fully privatized? One part of this explanation appears to lie on the demand side which will be discussed in the next section.

B. The Role of the Consumer

What are some possible explanations for the apparent increase in “consumer” demand for private medical insurance and private medical care? One of the most common explanations is the claim that there has been an increase in dissatisfaction with the NHS. According to one study, forty-seven percent of those surveyed in the Social Attitudes Survey in 1990 were generally dissatisfied with the NHS, compared with only twenty-five percent in 1983. Respondents complained about waiting lists, inadequate staffing levels, and day-to-day organization of hospital services, although there was confidence in the overall quality of NHS care. Health was seen as a priority for government spending. There are, at least, three possible reasons for this apparent increase in dissatisfaction. First, it may be a response to the perceived deterioration in health services stemming from constraints on public expenditures and concessions to the private sector. Second, it may be a product of the vehemence with which the view that the NHS is collapsing has been expressed in public debates over the years. Certainly, the public debate in the 1980s about the funding of the NHS was specifically characterized by the ferocity of the confrontation between the medical profession and the government. Finally, mounting dissatisfaction with the NHS may be associated with broader social changes such as fluctuations in consumption. Dissatisfaction may be a response to increasing consumer expectations about choice and standard of service in light of greater disposable income, and not merely a response to the perceived decline in the quality of health services. Certainly for those who can afford it, the perceived attractions of the private sector are usually articulated in terms of choice, privacy, and control, in other words, choice of consultant, pre-arranged admissions, or having a private room. It might also be that the growth in private medicine reflects changing expectations from an acceptance of neoliberal values and a belief that private health insurance enhances control over health and its management.

48 See generally id. at 49-56.
While the idea that when dissatisfaction with the NHS increases the public turns to private medicine seems logical, the evidence to support it is inconsistent. For example, during the 1990s, the figures have shown that growth in the private acute market has been slow and minimal.\textsuperscript{49} Yet evidence from the Social Attitudes Survey shows that between 1991 and 1996 the percentage of dissatisfied respondents has increased from forty-one percent to fifty percent.\textsuperscript{50} In addition, evidence suggests that despite dissatisfaction with certain aspects of the NHS, there is still strong loyalty to the NHS, in other words, to the principle of a health service for all, "free" of charge. Certainly, the evidence suggests that the public supports the NHS, but also sees the need for a private sector. This does not appear to be for ideological reasons or for reasons of enhancing "choice," but the support for the private health care sector appears to be mainly for pragmatic reasons. People tend to hold private health insurance for a number of reasons. Two of these are related to the supply side where the employer gives the insurance as a "perk," and the very existence of a mixed economy of health care means that people use it.\textsuperscript{51} Three other reasons are related to the demand side. Private health insurance is taken out because it is believed to provide care which is more tailored to individual needs, providing more privacy and comfort. It is also believed that it minimizes the risk of not being treated immediately and therefore, eliminates the consequent loss of time and money caused by being placed on an NHS waiting list. This seems to be particularly important for the self-employed. Finally, private health insurance is seen as a rational response to the perceived risk of deterioration in the subscribers or other family members' health status. Whatever the pragmatic reasons, however, this did not seem to undermine respondents' support for the NHS. While they recognized the advantages of private medicine, they also continued to support the principles behind the NHS.

The Calnan study also threw light on the use of private health insurance.\textsuperscript{52} It appears that a considerable proportion of respondents do not use it and many of these let their subscriptions lapse. For many subscribers the decision to use the private sector was also influenced by pragmatic considerations like

\textsuperscript{49} See LAING & BUSSON, supra note 2, at 43.
\textsuperscript{50} See Judge et al., supra note 47.
\textsuperscript{51} See CALNAN ET AL., supra note 6.
\textsuperscript{52} See id. at 60-61.
time and money. Some of the variations in the use of private medicine was related to the mode of payment for private health insurance. While individual subscribers were to some extent more "pro-private" at the level of specific beliefs, they reported using the private sector less than other subscribers because they paid individually for any increased costs incurred through use. Employer-paid subscribers were more strongly anti-private but appeared to use their insurance more readily because there were no financial costs to bear and subscribers were concerned with getting their moneys worth, especially if their insurance was introduced as part of a wage deal.

IV. THE IMPACT OF THE DEVELOPMENT OF THE PRIVATE ACUTE SECTOR

The previous sections have described the nature and extent of private medicine in the United Kingdom and how it exists within a country dominated by an NHS model of health care funded primarily through public taxation with universal coverage and free access at the point of delivery. Attempts have also been made to explain recent developments in the private acute sector, identifying the possible influences of both supply and demand side factors. In this final section, the implications of these changes will be considered. More specifically, the analysis will explore the overall contribution the private sector makes to meeting health care needs in the U.K. and how far it complements or acts as a substitute to NHS care. The possible impact of these developments on equity and the potential for a two-tier system of healthcare, quality and standards of care, and consumer choice and control will also be explored.

The focus of this Article was mainly on the private acute sector. It is clear that a significant proportion of in-patient elective surgery is being paid for and provided by the private sector.\(^53\) However, there is evidence that the private sector's share of the elective surgery workload is dropping significantly.\(^54\) The private sector also makes a significant contribution to the provision of services which are restricted on the NHS such as abortions.\(^55\) However, it is difficult to judge whether the private acute sector complements the NHS by relieving waiting lists. For example, according to one commentator:

\(^{53}\) See LAING & BUISSON, supra note 2, at 70-71.
\(^{54}\) See id.
\(^{55}\) See id. at 72.
[T]he work carried out in the private sector was, to some degree, a substitute for the NHS workload and not an addition to it. Certain kinds of activity have simply been transferred from one sector to the other . . . . What it has done is to redistribute access to resources and manpower in favour of better off patients of working age who live in London and South East England. The more privileged sick (in terms of income, class and power) have been “substituted” for the less fortunate sick who remain on NHS lists.56

Also, a proportion of private sector income comes from care for patients from abroad which once again raises questions about whether the private sector is being used to complement NHS care.

There is also the question about whether the growth of the private sector particularly in the 1980s, has been a drain on NHS resources, particularly with respect to doctors and nurses. Both of these groups of health professionals are trained and employed in the public sector, and only a very small proportion is employed full-time by the private sector. It is difficult to estimate the impact if the private sector were to be abolished and consultant doctors and nurses were to reinvest their time into the NHS.

What kind of impact has the private sector had on equity and access? Has a two-tiered system resulted from the existence of both public and private sectors in health care? The answer to this seems to be yes, to a limited extent. It is clear that those who have access to private health care can “jump the queue” for access to elective surgery. These people will tend to be the well-off or those in professional or managerial positions covered by company insurance schemes. However, the waiting list initiatives commissioned by successive governments in the 1990s,57 have probably created a more competitive and consumer-oriented NHS.

57 See generally Myfanwy Morgan, Waiting Lists, in In The Best Of Health? The Status And Future Of Health Care In The U.K., supra note 56, at 207, 220-25.
The idea of equal access is clearly challenged by the introduction of the market principles in health care and the expansion of the private sector. However, as Joan Higgins points out private sector growth need not necessarily create inequalities in health care provision. She argues that the patterns of the privileged and disadvantaged found in the public sector are replicated in the private sector, the privileged groups who gain the most from the NHS also benefit from the private sector. Certainly, the claims that the introduction of market economy principles into the NHS in 1991 has led to a two-tier system of care (patients registered with fund holding practices have easier access to care than those in non-fund holding practices). This might have been one of the reasons why the new Labour government has abolished the internal market and fund holding. However, while patients registered with fund holding practices may have easier access to hospital care, there is no evidence that these patients are more likely to be referred to the private sector.

It has also been suggested that the introduction of private health care extends choice for patients or for those who can afford it. However, evidence suggests that access to and use of private health insurance extends choice only slightly. Certainly survey respondents who had experienced private health care stressed the quality of the "hotel" facilities and the individualized nature of care, but in practice there is little shopping around between the private and public sector. Moreover, the extent to which private health insurance confers choice and autonomy is restricted by a series of barriers. To respondents the most important of these are: ideology (a strong moral commitment to the NHS which appears to inhibit the use of the private sector), money (cost of premiums), and the family doctor (subscribers relied on their general practitioner family doctor to decide whether or not they were to be referred to the private sector). Whatever the reasons, however, the effect of these barriers is to limit the power of the consumer and thus the notion of consumer sovereignty.

Finally, with regard to the quality of health care in the private sector, there is a lack of information regarding this due to the difficulty in gaining access to it. Certainly, private health care might be more convenient and comfortable, yet the medical and technical care is similar (the same doctors work in both

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58 See CALNAN ET AL., supra note 6, at 79-82.
sectors) and there is evidence that private care encourages some over-testing and over-treatment. On the other hand, there are no incentives for doctors in the private sector to maintain detailed records or to take part in clinical audits.\(^5\) In addition, there are concerns about safety, particularly for complex medical procedures. Geographical and professional isolation, the use of part-time staff, and inadequate emergency coverage and clinical support, are just some of the factors believed to challenge safety,\(^6\) causing private hospitals to transfer patients to NHS hospitals when problems arise from routine procedures. Most of these factors appear to be an artifact of the small size of private hospitals.

The analysis has shown that the private sector in the U.K. is a mixture of organisations run for profit and altruistic reasons, but dependent on its main competitor, the NHS, for its key staff. In the 1980s, the private sector experienced significant growth fueled by the direct and indirect policy initiatives of a Conservative administration. However, the introduction of market economy principles into the NHS in the 1990s has not been totally beneficial to the private sector as a more competitive NHS, through the expansion of NHS pay beds and waiting list initiatives, has sharpened competition for private patients. The private sector appears to act as a complement to and substitute for the NHS particularly in the public acute sector. There is some evidence of a two-tier system of health care, but this is not particularly significant because of the restricted range of services provided in the private sector.

Growth in the private acute health care sector in the 1990s in the U.K. has been slow. This is not expected to change under the new Labour administration. Private practice, although not necessarily encouraged,\(^6\) appears to be of limited political importance compared with the major challenge of dismantling the internal market and promoting cooperation rather than competition. Certainly the governmental endorsement of the principles of PFI (Private Finance Initiative) in the NHS suggests that a mixed economy of health care funding may be more acceptable to the “new” Labour party. PFI not only involves the investment of private capital into the NHS infrastructure, but also involves

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59 See Higgins, supra note 56, at 307.

60 See Bartlett & Phillips, supra note 25, at 733.

61 In fact, NHS commissioners have been instructed to use the private sector for clinical services only as a last resort. See LAING & BUISSON, supra note 2, at 62.
the introduction of market principles and mechanisms into the culture of the NHS. However, as the Conservative administration found out, the loyalty and commitment of the public to the NHS as an institution suggests that there is little likelihood that private practice will expand dramatically in the current cultural climate of the U.K.. Recent evidence suggests that the public in the U.K. still sees the NHS as a cherished institution. Over three-quarters of respondents in the Social Attitudes Survey in 1996 were opposed to a proposition that the National Health Service should be available only to those with lower incomes.\textsuperscript{62} The survey also revealed that a growing proportion of people (three-fifths) would ideally deny the choice to others to buy themselves out of the system.\textsuperscript{63}

\textsuperscript{62} See Judge et al., supra note 47, at 60-61.

\textsuperscript{63} See id. at 61.