



# The Patient Journey

Research to support the OFT's  
private healthcare market  
study

August 2011



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# 1. Executive Summary

## Background

In December 2010, the Office of Fair Trading (OFT) announced a proposal to conduct a market study into the market for the provision of private healthcare treatment and services in the United Kingdom. The aim of the market study is to examine whether the PH market is working well for consumers, and if not, whether there is potential for improving how it functions.

Opinion Leader was commissioned to carry out primary research amongst private healthcare users to investigate their experiences in accessing, receiving and paying for private medical treatment. The study examined the patient journey in full, from GP referral to payment, and focused in particular on the timing and nature of interactions between patients and the GPs, Consultants and private medical insurance (PMI) providers they had dealings with.

## Approach

The study used a qualitative methodology and 40 individual in-depth interviews were carried out with patients who had obtained, or were in the process of obtaining, private treatment. All 40 interviews were carried out face-to-face and ranged from 40 minutes to 1 ½ hours in length.

The interviews were conducted across eight locations in the UK: Central and Greater London, West Country, South England, Midlands, North England, Scotland, Wales and Northern Ireland. The sample included 30 individuals who had received private treatment and 10 who were currently seeking it. This enabled us to develop a clear view of the nature and content of key interactions with providers.

The sample was also split between those individuals who were PMI funded (31 in total) and those self-pay patients (9 participants) who paid directly for treatment themselves. Out of the 31 who had PMI, 19 had PMI provided by their employer and 12 had directly obtained PMI.

Additional sample criteria such as treatment type and demographic criteria were also considered when recruiting participants. It was ensured that all participants had recently undergone acute elective treatment (acute elective treatment is planned, non-emergency surgery or invasive diagnostic examination) and that people from a range of demographic groups (different ages, genders, socio-economic groups and ethnicities) were included.

## Findings

The findings of the research fall into six main themes: pathways, impact of the GP, impact of the Consultant, impact of the PMI, payments and improvements for enhanced choice and information. These are discussed in turn below.

### Pathways

This research found that there were a number of pathways into private healthcare. While most participants did consult their GP about private treatment at the outset, sought recommendations about providers from them and followed a GP-led pathway through the treatment process, many did not, instead following the hospital, PMI or self-led pathways described in the table below.

**Table A: Pathways into Private Treatment**

Pathway	Description	No.
GP-led	The GP-led pathway began with the patient booking an appointment to see their GP to discuss a particular condition or a health query. During the consultation, the possibility of private treatment was raised, usually by the patient, who informed the GP that they had private medical insurance and would prefer to receive private treatment. At this stage a discussion about which private Consultant and/or clinic the patient should use took place. The level of information and choice provided by GPs during this discussion varied widely, from patients being recommended a single provider to being offered a choice of clinic/hospital and Consultant.	19
Self-led	A self-led pathway was described by participants who took a more proactive approach to seeking treatment and choosing providers. This pathway was characterised by the participant selecting a private clinic/hospital and/or Consultant themselves and contacting the provider directly to arrange treatment. In this pathway the participant may have consulted their GP about appropriate treatments and possible NHS options but had not discussed private options with them.	12
NHS Hospital-led	The hospital-led pathway was characterised by the participant having interaction and discussions with hospital staff about private healthcare during a visit to an NHS hospital.	5
PMI-led	In the PMI-led pathway, the focus of decision making was the conversations (usually by phone) that patients had with their PMI. It was during these conversations that decisions were made about the private provider to be used, rather than during any conversations the patient had with their GP.	4
<b>Total No. Participants</b>		<b>40</b>

## Impact of GPs

The level of information and choice provided by GP's during discussions about private treatment were seen to vary widely. Within the GP-led pathway there were four variations in the type of information and choice provided to participants. These are shown in the table below.

**Table B: Range of choice provided by GPs**

Choice Provided	Description	No. Participants
Recommendation only	GP recommended single clinic or hospital	6
	GP recommended single Consultant	2
Choice of Consultant	GP provided choice of Consultant working in a single clinic or hospital	6
Choice of clinic or hospital	GP provided choice of Consultant and of clinic or hospital	3
Facilitation of patient choice	Patient had preference for particular Consultant and clinic in advance of consultation and GP facilitated treatment	2
	<b>TOTAL</b>	<b>19</b>

Where a single recommendation was provided, no choice was offered by the GP. The GP usually identified a suitable provider, discussed their appropriateness with the patient, recommended that they used them and arranged the referral. In most of these cases (6 out of 8), the GP recommended a particular clinic or hospital to the patient, rather than a named Consultant. In all other cases a degree of choice was offered, either of Consultant or clinic/hospital, or with the GP facilitating a choice the patient had made prior to consultation.

Levels of satisfaction amongst participants were not consistently affected one way or another by the level of choice offered. In most cases, patients who were recommended a single provider and who were offered no choice by their GP were satisfied with this arrangement. They regarded their GP as being in the best position to make this decision on their behalf and were happy to trust and follow the recommendation they were provided with.

In fact, most participants did not expect to be offered high levels of choice and information. The reasons for this were, firstly, that patients did not expect their GPs to know about multiple providers of treatment for multiple different conditions available in the local area. Rather, they expected them to be aware of and able to recommend a single good quality provider. Secondly, in most cases patients did not feel equipped to make choices about providers themselves and did not demand that GP's gave them a choice. They were more interested in receiving clear and decisive recommendations from their GPs.

Where choice was offered, the level of information GPs provided their patients with regarding different providers appeared to be quite low. Few participants were referred to websites for the clinics, hospitals or Consultants discussed and none were referred to any data regarding their performance. Where patients were provided with a choice and did investigate this further, it was usually to find out the number of years the relevant Consultants had been practising and their areas of specialisation.

Where participants did exercise choice based on their GPs suggestions, the most important factors in selecting a provider were geographical location and immediacy of treatment. Participants in all locations wanted to be treated near their home to cut down on travel time and costs and enable their family to visit them. The only exceptions to this were cases where participants had more severe or chronic conditions which required specialist treatment. All participants wanted to be seen quickly and this was often a determining factor in the decision to take up private treatment amongst self-pay customers. The competence of the Consultant employed to carry out the treatment was not the main factor influencing patients' decisions and it was generally assumed that any recommended Consultant would be suitably skilled and experienced.

### **Impact of Consultant**

Across the 40 cases in this research, the role of the Consultant in patient choice appeared to be quite limited. In most cases a Consultant had delivered treatment or diagnosis but was not perceived to have been involved in the patient's decision-making about where treatment was carried out or who delivered it (these decisions having already been made via the GP or PMI). This finding does not correlate with existing evidence on how the industry operates (such as the annual Laing and Buisson market reports), which suggests that choice of hospital is highly influenced by the Consultant. Reasons for this apparent difference in findings are set out at page 30.

Where patients were referred to a Consultant by their GP they had usually been provided with relatively little information about them. Participants who followed the GP-led pathway often wanted their GP to make a clear recommendation of consultant and hospital (and valued this approach over provision of a range of options) as they trusted their GPs to direct them to a Consultant who was reliable, available and based in the local area.

Where participants knew which hospital they wanted to attend prior to seeing a Consultant (based on geographical proximity or the time in which they could be treated), this formed the basis of any decision they made about the particular Consultant they would see. In most cases the location of the hospital or clinic and the speed of service were more important factors for the patient than the reputation or quality of the Consultant. Most assumed that the Consultant they were recommended or provided with would be able to perform their treatment to a high standard.

A few participants stated that once they had had their first private consultation with the hospital Consultant, they would then judge/assess the Consultant and if they were not happy with him or her, enter into discussions to get the Consultant changed. However, none had actually taken this course of action in

their dealings with a Consultant and the process for changing doctor in these circumstances was by no means clear to participants.

Very few PMI patients had discussions with their Consultant about the cost of treatment and none received fee estimates. They tended to assume that all costs would be covered by their insurer, showed little interest in the direct costs of treatment and did not enter into conversation about these with their Consultant.

All self-pay participants knew what the cost of their treatment would be in advance of it being carried out. In some cases they were quoted a firm cost and in some cases an estimated cost, depending on the extent of treatment needed. Where patients were provided with a firm cost they often paid for treatment in advance. Where the cost was subject to change they paid after treatment had been completed.

However, of the nine self-pay cases in this research, only one patient discussed costs with a Consultant in advance of treatment. All other self-pay patients discussed costs in advance with receptionists or administrative staff at the hospital or clinic where they were treated (though not with the Consultant) and received a firm or estimated indication of the cost of treatment in advance.

### **Impact of PMI**

The level of choice and information provided by PMIs varied widely. In most cases, the PMI was not required to provide the patient with choice or information about the provider used as this discussion had taken place during consultation with a GP. Patients expected the PMI to approve the GP's recommendation and accept their referral and were not looking to the PMI to provide them with guidance concerning the provider.

In the four PMI-led cases, the focus of decision making was the conversations (usually by phone) that patients had with their PMI. It was during these conversations that decisions were made about the private provider to be used, rather than during any conversations the patient had with their GP. In these cases, the PMI was much more involved in the selection of the provider and was responsible for providing choices and information, with the GP providing only a formal referral.

In some instances, PMI-led patients were recommended a single provider and in others they were provided with a choice. The extent of choice offered usually depended on the presence of relevant providers within the local area and there were few complaints about the range of choice offered.

None of the PMI-led participants were provided with information about the quality of the provider suggested (e.g. success rates of the hospitals or length of service of Consultants) and felt that additional information on which they could base their choice may have been useful. Patients were somewhat less willing to trust their PMI's recommendations than those of their GP and were more likely to want to be directed to sources of information about recommended providers, if they could not be given this information during the consultation.

In two cases, participants said that their PMI expected them to pay for their treatment up-front to the private hospital and then to forward the receipts to them to be reimbursed. Neither of these participants seemed to have been aware of this expectation in advance and were surprised that they were being asked to pay in advance. This policy resulted in the participants either having to delay their treatment or contemplating whether they should have private treatment at all.

### **Payment**

GPs had no role in determining the costs of treatment in any of the 40 interviews carried out and no patients discussed costs with their GP. Where discussions about cost did take place these were either with the PMI or with the hospital and/or Consultant providing treatment.

Across the interviews, patients showed little awareness of what the cost of their private treatment had been and few had investigated the costs they were incurring during the treatment process. The main reason for this was that the majority of participants (31 out of a total of 40) had private medical insurance and were not paying for treatment directly.

The nine self-pay patients showed much higher levels of awareness of the direct costs of treatment than PMI patients. Self-pay patients were responsible for paying the full cost of treatment themselves and therefore had far more interest in finding out the costs of treatment. These patients investigated the cost of treatment in two different ways. Either they shopped around, carrying out searches of relevant providers remotely (online or by phone) and determining costs before making an appointment with a preferred provider, or they went immediately to a preferred provider and discussed costs with a Consultant during their initial examination.

A few PMI patients were able to provide details of the direct costs of treatment as their cover was limited to a set amount of money that could be spent in a given year and they had to keep abreast of the cost of treatment to ensure they were not running over their allotted budget. One patient found this process of checking the amount left in her treatment budget with her PMI inconvenient and worrying, as she did not know whether she would have enough funding to cover her ongoing treatment.

No participants attempted to negotiate with their provider on cost, though a few did shop around. Participants frequently said they did not know they could negotiate cost with the provider. However, it was also evident that participants did not always feel it was appropriate to negotiate costs with a healthcare provider or did not feel they had enough information about costs to negotiate in an informed way. Where this was the case, patients said they would like more information on standard prices for private healthcare treatments so they could make informed decisions.

### **Improvements for enhanced choice and information**

Participants generally trusted their GPs and were happy to pursue private treatment based on their recommendation even if no choices or options were provided. However, where greater information was requested, the GP was seen as the main conduit for this. Some participants felt that the GP should be



capable of identifying and explaining the differences between certain choices of consultant and hospitals and that GPs should be able to recommend a reasonable choice of a few consultants and hospitals.

The internet was suggested as a key access point for patients to review the options they were given. In most cases patients wanted quite basic information about the providers they were choosing between. Many were content to receive basic information about the Consultants suggested, including areas of specialisation and years of practice. Few felt competent to judge clinical data such as mortality rates.

Only a minority of participants supported the concept of league tables for private providers (whether Consultants or hospitals/clinics). Many were against the idea of league tables and considered them an unfair assessment of the abilities of medical institutions and clinicians. Furthermore, most felt ill-equipped to judge the kind of clinical data on which league tables might be based.

A few participants were supportive of the idea of viewing Consultants' CVs so that they could analyze their experience and expertise prior to arranging appointments with them via their GP or PMI. However, a few mentioned that a consultant's CV was less important than gauging their abilities first-hand from a one-to-one meeting and emphasised the importance of feeling personally comfortable with them. Trust was an important factor for many and this was often based more on personal feelings than on information.

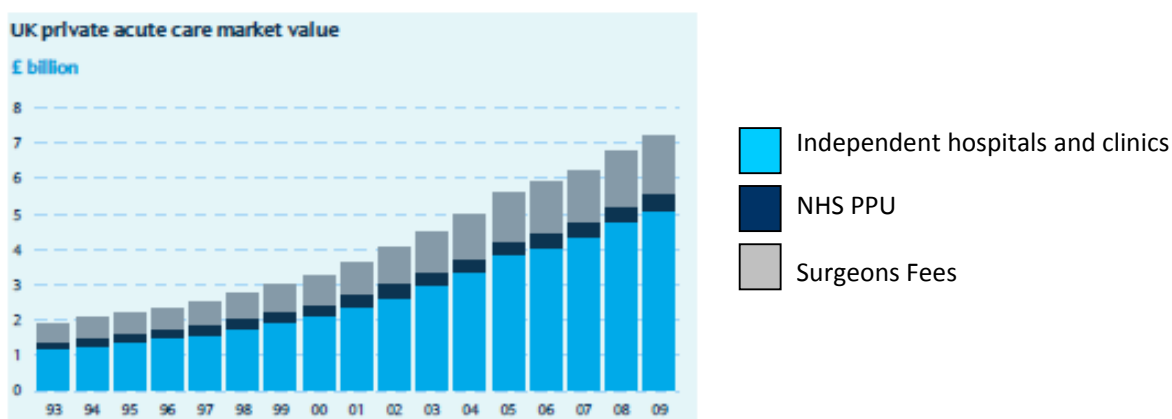
Online patient reviews were discussed, though there was concern that these were likely to provoke responses from those who had had bad experiences rather than those who had had good experiences. It was considered more reasonable for patients to review and rate a hospital, clinic or PMI.

# 2. Introduction

## 2.1 Background

The markets for private healthcare (PH) include a range of medical treatments which are predominantly privately funded and provided to patients via private hospitals/clinics through the services of consultants and other healthcare professionals who work within these facilities.

Having slowed to a real annual average rate of around 3% in 2006-08, total private acute healthcare revenue growth accelerated to 4.2% and 6.8% respectively in 2008 and 2009, and the UK private acute care market value in 2009 was estimated at £5.8 billion (Laing & Buisson estimate). The increase largely reflects growth in the acute hospital care market, which was underpinned by income from outsourced NHS care. Revenues from PMI claims (the main source of funding for independent hospitals) also remained solid, despite a record fall in cover during the recession. Increased capacity in the wider market also bolstered growth. Together, these trends offset weaker demand in the 'self-pay' market, which was hardest hit by the economic downturn.



Source: Laing and Buisson and Barclays Corporate

In December 2010, the Office of Fair Trading (OFT) announced a proposal to conduct a market study into the market for the provision of Private Healthcare (PH) treatment/services in the United Kingdom (UK). The aim of the market study is to examine whether the PH market is working well for consumers, and if not, whether there is potential for improving how it functions. Five broad areas of possible concern will be explored; the nature of competition in the provision of private healthcare, market concentration, barriers to entry, the role of consultants and constraints on consumers.

Preliminary research conducted by the OFT and prompted by submissions made by a number of participants across the sector, has indicated that the market may not be working well for consumers. The OFT has also acknowledged that the last formal review of the market was in 1999 and that there have been a number of changes in the market in the intervening period. In particular, consolidation amongst private hospital providers and a move by private medical insurers away from vertical integration towards a reliance

on network agreements with private healthcare providers. The NHS has also started to use independent sector provision to a greater degree and has become the second largest funder of private healthcare services. In line with this, the NHS Constitution also provides a guarantee of patient choice.

To explore these areas further the OFT commissioned two primary research projects to assist with its market study. The first explored the behaviour of General Practitioners and Consultants in this market. The second, to which this report relates, explored patients' experiences in accessing, receiving and paying for private medical treatment.

## 2.2 Objectives

The overall objective of this study was to understand patients' experiences in accessing, receiving and paying for private medical treatment. The study examined the patient journey, investigating the interactions they had and advice they received from GP referral through to treatment at a private facility by a medical professional.

This research focused on the timing and nature of interactions between patients and GPs, Consultants and (if involved) PMI providers and therefore produced data that was objective and verifiable regarding these providers. In particular, the research aimed to elucidate the five areas of the patient journey outlined in Table 1 on the following page.

**Table 1: Research Objectives**

Area	Questions
<b>Role of the GP</b>	<ul style="list-style-type: none"> <li>• The level of choice offered by the GP in referring a patient to a Consultant and/or hospital/clinic and what influence the GP had on the patient’s decision in making such a choice</li> <li>• The nature and timing of the GPs contact with the patient’s PMI provider</li> <li>• The enquiries that the GP made into the patient’s PMI policy, including any restrictions within that policy</li> </ul>
<b>Role of PMI</b>	<ul style="list-style-type: none"> <li>• When the PMI provider was first contacted and by whom (patient, GP, Consultant)</li> <li>• The influence the PMI had over the type of treatment offered, including Consultant and hospital</li> <li>• The involvement of the PMI in determining the nature and length of the patient’s treatment</li> </ul>
<b>Role of the Consultant</b>	<ul style="list-style-type: none"> <li>• The nature and timing of the patient’s first contact with the Consultant</li> <li>• The role and influence the Consultant had in determining the choice of private facility used to treat the patient</li> <li>• The nature of the patient’s discussion with the consultant about the Consultant’s (and the medical team’s) fees</li> </ul>
<b>Payment</b>	<ul style="list-style-type: none"> <li>• The patient’s experience of paying for private treatment, including the nature and timing of the fees paid</li> <li>• The invoicing arrangements known to the patient</li> <li>• What other interactions took place with regard to payment? (When was the final fee known? What negotiation took place over fees and how long did this last? Who did the patient discuss fees with?)</li> </ul>
<b>Patient Information and Choice</b>	<ul style="list-style-type: none"> <li>• The main influences on the patient’s choice of treatment, private facility and medical profession and the relative importance of these influences for the patient</li> <li>• How much information the patient possessed about the facility and Consultant prior to treatment and what form this information took</li> <li>• The quality of information on which the patient bases their choices, both prior and during treatment</li> </ul>

## 2.3 Method

### A) Depth Interviews

The study used a qualitative methodology, with 40 individual in-depth interviews carried out amongst patients who had obtained, or were in the process of obtaining, private treatment. All 40 interviews were carried out face-to-face and ranged from 40 minutes to 1 ½ hours in length. The interviews were conducted in various locations, depending on where the patients felt most comfortable, including the patient's own residence and hotel venues (see Section 2.4 for further details on locations of the interviews).

This approach was adopted as it gave sufficient time to explore the patient's journey and to validate it. Projective techniques were used to maximise the recall of the patient. These included 'in the moment' exercises (in which the patient was asked to focus on and describe different aspects of their interactions with their GP, PMI or Consultant at each stage of the process) and a 'pre-task' in which the patient recorded a timeline of their treatment journey prior to attending the interview. These exercises helped the patient recall the experience and enabled researchers to test and validate the information being given. Face-to-face interviews were seen as appropriate due to the possible sensitivity of the topic. Individuals may not have felt comfortable discussing their treatment in front of others, and face-to-face interviews allowed for greater rapport to be built between the patient and interviewer, in comparison to other approaches, such as group discussions.

### B) Interview Structure

Each interview had to cover five key areas for exploration: role of the GP, role of the PMI, role of the Consultant, payment and patient information and choice. To ensure all these dimensions were explored in a systematic way patients were asked to complete the pre-task timeline described above before attending the interview. The timeline detailed dates of treatment, thereby improving their recall of the situation and increasing the accuracy of the details given.

All interviews lasted one hour and a detailed discussion guide was used to structure the conversation (different guides were used for patients who had completed and who were going through treatment at the point of interview and these are included in the Appendix). The discussion guide covered the following core areas: the objectives of the research, an overview of the patients' journey, the role of the GP, PMI and Consultant in the patient obtaining private treatment and the process of paying for the treatment.

During the interviews, participants were given the opportunity to discuss their experience openly and spontaneously and interviewers responded to the participants' views in a flexible manner, ensuring all topics on the guide were covered while allowing the patient to discuss their journey in the way that made most sense to them.

## 2.4 Sample

Qualitative research does not aim to attain representative samples and its main aim is to provide detailed insights rather than statistical robustness. For this reason it was not intended that the sample be representative of the national picture. Nevertheless, it was important that the sample provided coverage to each of the relevant patient groups (by location, funding type, gender, etc.) so that insights could be compared and contrasted between them.

A total of 40 face-to-face depth interviews were carried out. The following **primary sampling criteria** were used to ensure that this coverage was met:

### **Location:**

Eight regions across the UK were selected, and in each location we interviewed five patients. The regions selected were:

1. Central and Greater London
2. West Country
3. South England
4. Midlands
5. North England
6. Scotland
7. Wales
8. Northern Ireland

### **Treatment journey status:**

Within the sample we included individuals who had already received treatment, and those who were currently seeking it. This enabled researchers to develop a clearer view of the nature and content of key interactions with providers, and provide more detailed accounts of interactions with providers. Of the 40 interviews conducted 30 had already received treatment and 10 were seeking treatment.

All 40 participants had visited their GP regarding their condition. The 30 patients who had undergone treatment had also all seen a consultant. Of the 10 patients who were in the process of seeking treatment, 5 had already seen a consultant.

**Table 2: Procedures by No. Of Participants**

Procedures		Number Participants
<b>Diagnosis</b>	2 x endoscopy 1 x Colonoscopy 2 x Biopsy 2 x Diagnostic procedures for investigation into issues 1 x Knee arthroscopy	<b>8</b>
<b>Treatment</b>	<b>6 x Knee surgeries</b> (keyhole surgery, replacement, etc.) <b>11 x Removal procedures</b> (cyst from breast, appendix, gall bladder x 2, bunion, thyroid, prostate, growth on leg, hydrocele, myomectomy, lumpectomy) <b>15 x Others</b> (reconstruction of toe, triple bypass, eye lenses replaced, physiotherapy, etc.)	<b>32</b>
<b>TOTAL</b>		<b>40</b>

**PMI/ Self pay:**

The sample was also split between those individuals who were PMI funded and those self-pay patients who paid directly for treatment themselves. Out of the 40 interviews 31 were PMI and 9 were self funded. Out of the 31 who had PMI, 19 had PMI provided by their employer and 12 had private PMI. Table 2 below displays the number of participants by the primary sampling criteria used.

**Table 3: Sample Structure by Location**

Funding Type	TOTAL	Locations							
		Central and Greater London	West Country	South England	Midlands	North England	Scotland	Wales	Northern Ireland
Had treatment	30	3	4	3	4	4	4	4	4
Seeking treatment	10	2	1	2	1	1	1	1	1
<b>TOTAL</b>	<b>40</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>
PMI	31	4	4	4	4	4	3	4	4**
Self-pay	9	1	1	1	1	1	2	1*	1
<b>TOTAL</b>	<b>40</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>

\* This patient was part PMI, part self funded due to the payment arrangement with their employer. Medical cases were assessed by the employer and if they were not considered viable, the individual would have to pay for the treatment themselves.

\*\*One of these individuals paid 50% towards their PMI

Additional sample criteria were also considered when recruiting participants and these are described below.

#### Treatment type

All participants had undergone, or were considering, an acute elective treatment (acute elective treatment is planned, non-emergency surgery or invasive diagnostic examination). We also ensured that there was at least one patient per location who had been seen as an in-patient in the course of their treatment, and one patient per location who had been seen as an out-patient.

#### Demographic criteria

We recruited individuals who varied in demographics such as age, gender and ethnicity. The demographic breakdown of the sample is shown in Table 4.

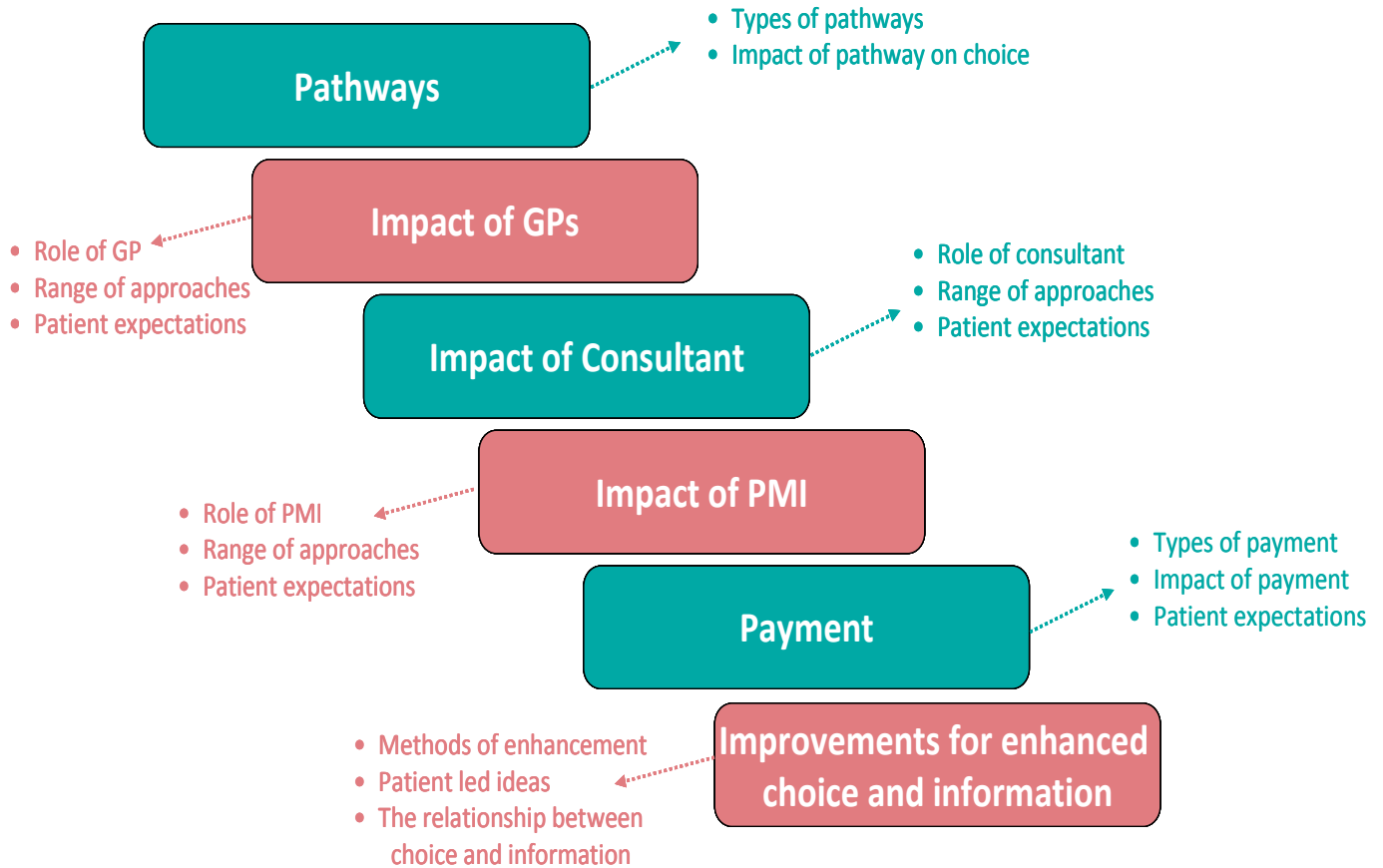


**Table 4: Sample Structure by Socio-demographic Characteristics**

Socio-demographic characteristics		Total Count
<b>Gender</b>	Male	21
	Female	19
<b>Age</b>	18-29	3
	30-44	15
	45-64	17
	65+	5
<b>Ethnicity</b>	White British	32
	BME/other minority	8

# 3. Main Findings

The findings of the research fall into six main themes. The six themes are illustrated below and each is discussed in detail in the following sections.

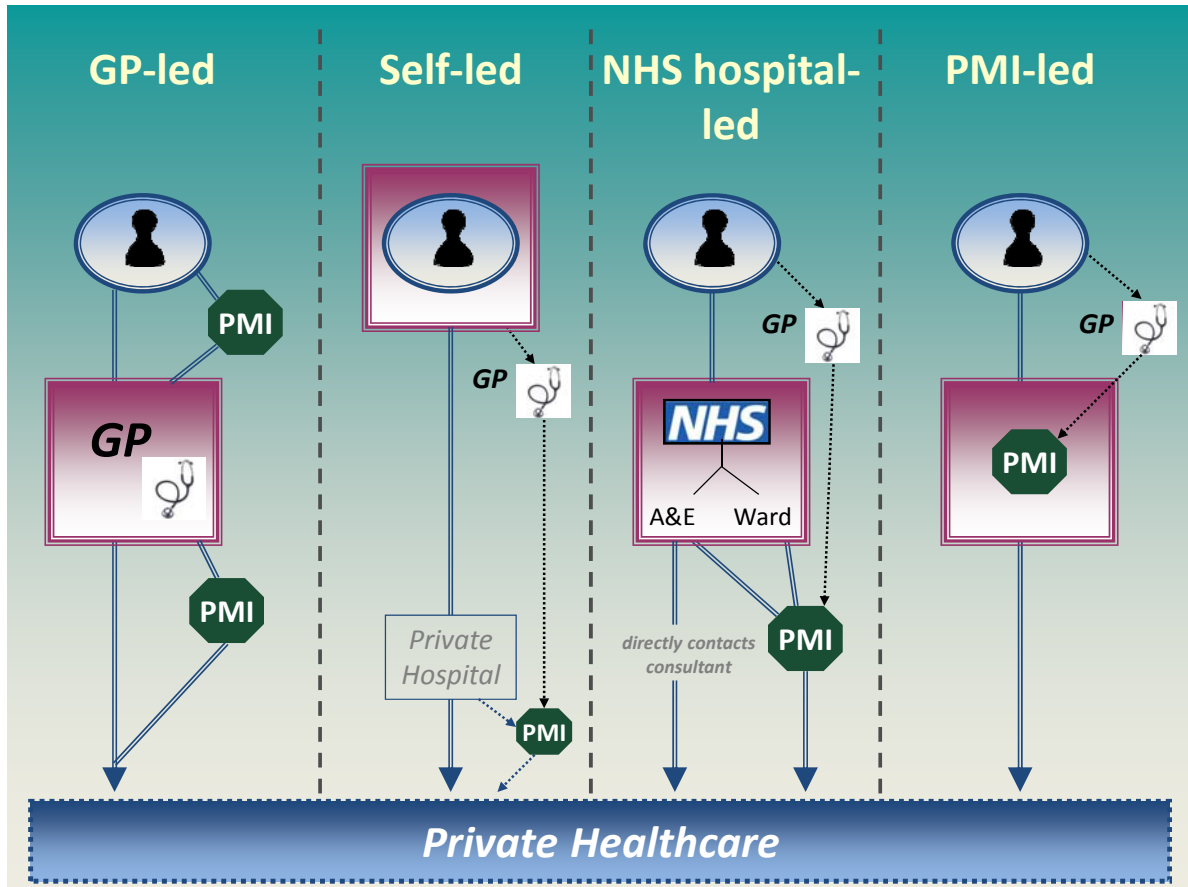


## 3.1 Theme One: Pathways

The pathway in to private healthcare is often seen as a journey beginning with the GP. The GP is expected to initiate a referral to a private consultant at a private hospital and the patient then contacts their PMI (if the patient has a PMI) or make enquiries about payment, which would ultimately lead to private treatment. While the patient may be provided with information and choice at each stage of this journey (i.e. by the GP, Consultant, PMI), the GP is regarded as the gateway into private treatment and the main provider of choice and information to patients.

The recruitment process for this research was set up to ensure that all participants had seen their GP prior to having or while seeking private treatment. While in most cases the GP did fulfil the role described above, acting as the gateway into private treatment and the main provider of choice and information, it was soon evident that this GP-led model of the private treatment process did not apply in all cases. Rather, four different pathways through the private healthcare process emerged. These were GP-led, self-led, hospital led and PMI-led and are illustrated in the diagram below.

**Patient Perceptions of the Pathway into Private Treatment**



Each pathway has been named according to the individual or institution responsible for co-ordinating the choice and information about and direction or referral into private healthcare. In some cases the GP was the primary influence on the patient, discussing treatment with them and directing them towards a particular provider. In others this role was performed by a Consultant or other hospital doctor and in others by the insurer. In a minority of cases (usually self-pay), the patient decided on the provider by themselves with minimal or no influence from a GP, Consultant or PMI. The number of participants following each of these pathways is shown in the table on the following page. Each pathway is then described in detail.

**Table 5: No. of Participants Following Each Pathway**

Description	No. Participants
GP-led	19
Self-led	12
Hospital-led	5
PMI-led	4
<b>TOTAL</b>	<b>40</b>

From the point of view of the research participants, the GP’s role was fairly peripheral in all but the GP-led pathway. Patients did not always know that their GP was required to formally refer them for treatment in the self-led, hospital-led and PMI-led pathways. In some instances they viewed their GP’s role as coming to an end following the initial consultation.

#### **GP-led**

The GP-led model was the most prominent across the 40 interviews carried out, with most participants following this pathway into private healthcare. The GP-led pathway begins with the patient booking an appointment to see their GP to discuss a particular condition or a health query. During the consultation, the possibility of private treatment was raised, usually by the patient, who informed the GP that they had private medical insurance and would prefer to receive private treatment. At this stage a discussion about which private Consultant and/or clinic the patient should use took place. The level of information and choice provided by GP’s during this discussion varied widely, as shown in the table below.

**Table 6: Range of choice provided by GPs**

Choice Provided	Description	No. Participants
Recommendation only	GP recommended single clinic or hospital	6
	GP recommended single Consultant	2
Choice of Consultant	GP provided choice of Consultant working in a single clinic or hospital	6
Choice of clinic or hospital	GP provided choice of Consultant and of clinic or hospital	3
Facilitation of patient choice	Patient had preference for particular Consultant and clinic in advance of consultation and GP facilitated treatment	2
	<b>TOTAL</b>	<b>19</b>

In cases where a single recommendation was provided, no choice was offered by the GP. In these instances, the GP usually identified a suitable provider (either clinic/hospital or Consultant, as shown in Table 5), discussed their appropriateness with the patient, recommended that they use them and arranged the referral. In all other cases a degree of choice was offered, either of Consultant or clinic / hospital, or by the GP agreeing to facilitate a choice the patient had made in advance of treatment.

It should be noted that the patient experience and levels of satisfaction amongst participants were not consistently affected one way or another by the level of choice offered. In most cases, patients who were recommended a single provider and who were offered no choice by their GP were satisfied with this arrangement. They regarded their GP as being in the best position to make this decision on their behalf and were happy to trust and follow the recommendation they were provided with.

In most cases where the patient wanted the GP to facilitate a choice they had already made, the patient was seeking treatment for an ongoing condition and had built up a degree of knowledge about treatments and providers through their own research. Often they had contacted their PMI before their visit to the GP and knew they were covered for treatment at the relevant clinic/hospital they wished to visit. They usually sought to discuss the appropriateness of this provider with the GP and, with the GP's approval, to obtain a referral to the provider.

There were certain situations when the participant visited their GP to discuss having their condition treated within the NHS and on being told how long they would have to wait for treatment, opted to go private (usually on a self-pay basis). While some of these cases followed the GP pathway (in that the GP then recommended a private provider), others followed the self-led pathway, with patients approaching a private clinic/hospital unilaterally following their GP consultation.

### **Self-led**

A self-led pathway was described by participants who took a more proactive approach to seeking treatment and choosing providers. This pathway was characterised by the participant selecting a private clinic/hospital and/or Consultant themselves and contacting the provider directly to arrange treatment. In this pathway the participant may have consulted their GP about appropriate treatments and possible NHS options but was unlikely to have discussed private options with them. Reasons for this were that:

- Following GP consultation, the patient discovered they would have to wait for a number of months to receive treatment on the NHS, decided to go private to speed things up and sought a provider unilaterally.
- The patient had decided where they wanted treatment in advance of a GP consultation and merely sought referral from their GP.

Participants who followed a self-led pathway were more active in seeking information about hospitals, Consultants and treatment than other patients. They obtained information via research online, or by talking

to family and friends to ask for their recommendations. In some instances participants went direct to a hospital or clinic where they had previously received treatment and familiarity with a provider and past experiences were central to the participant's decision in these cases.

### **NHS Hospital-led**

The hospital-led pathway was characterised by the participant having interaction and discussions with hospital staff about private healthcare during a visit to an NHS hospital. Most of the participants following this pathway encountered a similar scenario. On being admitted to an NHS hospital (e.g. to the A&E department), the patient was informed that they needed a particular course of treatment and would have to remain in hospital until it was carried out. Because there was a long waiting time for the treatment, the participant considered private options to reduce the waiting time and discussed these with a hospital doctor. They then decided to have private treatment. In these cases, the choices offered the patient were relatively limited, being confined to the hospital in which they had already been admitted. None objected to this and had not considered using another provider given the urgent need for treatment.

### **PMI-led**

In the PMI-led pathway, the focus of decision making was the conversations (usually by phone) that patients had with their PMI. It was during these conversations that decisions were made about the private provider to be used, rather than during any conversations the patient had with their GP.

In some cases the patient had consulted their GP but they had either not discussed private options with them or had already made a decision about where they wanted treatment to take place based on a conversation with their PMI. Here, the PMI was responsible for providing information, choice and recommendations, with the GP providing only the formal referral.

## **3.2 Theme Two: Impact of GPs**

### **Role of GP**

GPs play an important role in the lives of patients and are often the first point of call for matters relating to health. GPs are also an important link between the NHS and private healthcare. Throughout the interviews it was evident that participants had a lot of respect for their GPs and appreciated the advice and support they have received. When asked about how much trust they had in their GP, the vast majority said that they trusted them greatly.

There was a distinction between participants who often saw the same GP and those who saw different GPs based in a large practice and had less continuity of care. Participants who saw a number of GPs spoke about the lack of knowledge the GPs had about their health and private healthcare status, whereas those who saw the same GP regularly felt their doctor had a good awareness of their health and private healthcare status and were able to use this knowledge during consultations. This meant that those who had greater

continuity of GP care were less likely to have to remind their GP of the fact that they had private cover and that the GP was more likely to discuss private options with them from the outset.

Nevertheless, in the **GP-led** pathway, it was still the case that many participants with PMI had to alert their GP to this and it was frequently commented that GPs did not always discuss private options proactively. Participants described this as *'a little odd'* as they expected their GP to be aware that they had PMI (not relevant for self-pay) based on past experience or case notes. In a minority of cases, GPs showed resistance to patients going private and were seen to favour NHS treatment. This was mentioned in a few cases where the GP was thought to be concerned about the continuity of patient care, and did not want the participant's current course of NHS treatment to be disrupted.

#### **Referral to private provider during a course of NHS treatment**

In one case, a patient (Northern Ireland) had an on-going health problem and had been seeing the same NHS consultant for a number of years. When his condition resurfaced, he spoke to his GP about having private treatment so that he could be seen more quickly. He felt that his GP was a little apprehensive about moving him to private healthcare as he did not want another consultant taking over his treatment. The GP then made contact with the participant's NHS consultant to enquire whether he also practiced privately, which he did. Only then was the GP happy to refer the patient.

In a few cases the GP was first to raise the idea of seeking private treatment. This was observed where participants had been with their GP for a number of years and/or who were on 'first name terms' with them. In these instances, the GP was seen to persuade the participant that going private would be the better option, usually because they would be seen more quickly.

*"I said to her in one case I'd rather go with the NHS than a private hospital and she said 'no, we're talking about a time issue here'...there's no waiting, that's the beauty of the private."*

(Greater London)

The GP's role in making a referral took several routes. In some cases referral was made in writing to the PMI or hospital. However, in other cases a more active process was undertaken, where the GP contacted the consultant/hospital directly during the consultation appointment. This was only seen in those cases where the GP and participant relationship was a very close one, as described in the box below.

#### **Referral during GP consultation**

One participant (West Midlands) who went to her GP to discuss a health problem. Her GP was already aware that she had PMI and suggested that she have private treatment. On agreeing to go private the GP contacted the private consultant during the same consultation and booked her an appointment for the following week. The participant was very pleased that the GP had made the referral so quickly.

## **Provision of choice and information**

### **Choosing a hospital**

Participants differed in the extent to which they felt there was a choice of where to go for their private healthcare treatment. Participants in Northern Ireland and the West Country had a total of two private hospitals each in the area. Therefore, the decision of which hospital to attend was between only two options, making the choice available rather limited.

Across all locations, the most important factor for participants selecting a hospital was the distance from their home. For participants, the possibility of visiting a hospital which was further away from where they lived was less appealing as it would involve more travel and expense. In most cases, participants were keen to attend the hospital that had the minimum amount of travel involved. It was also observed that participants who were to have in-patient treatment were concerned about the disruption the travel would cause to family and friends who wished to visit. This demonstrates that choice was not the most important factor to patients in obtaining private treatment and that other factors, such as location and locality, were seen as more important.

On some occasions, patients felt that they had no choice over which hospital they were treated at, as in some locations (e.g. Northern Ireland) the expertise for a particular treatment type might not be available within a private hospital which was located near to where they lived. In these circumstances the treatment was either carried out within a hospital located further away or within an NHS hospital.

#### **NHS treatment where appropriate private provider not available**

In Northern Ireland, one participant was to be treated for a triple by-pass. However the two private hospitals located within Northern Ireland did not have the equipment for the surgery to be carried out, hence his PMI suggested having the treatment within an NHS hospital in Northern Ireland, or alternatively to travel to Dublin, Ireland for the treatment to take place within a private hospital. The participant was not able to travel to Dublin and instead he was operated on at an NHS hospital. This led to further difficulties, as the participant believed he was seen as 'jumping the queue' and was treated differently by the nursing staff as a result. He was also dissatisfied at being treated in an NHS hospital when he had PMI.

At other times participants chose the private hospital with the shortest waiting time for treatment. One of the main reasons participants selected private providers was speed of treatment and many said they wanted to avoid lengthy NHS waiting lists. Once a participant decided to go private, one of their main priorities was to get treated as soon as possible and providers were often selected with this in mind.



## Choosing a consultant

Choosing a consultant was often dependent on the patient journey pathway adopted. Within the GP-led pathway there were four variations in the type of information and choice provided to participants. These were identified in Table 5 above and include:

- Recommendation only
- Choice of Consultant
- Choice of clinic or hospital
- Facilitation of patient choice

The variation in the nature and type of information and choice provided to patients was due to several factors. Firstly, the type of choice and information provided to the patient was seen as indicative of the knowledge the GP had of the private health providers for a particular treatment type in certain cases. For example, it was seen that participants received the most choice for treatments such as knee replacement or hip replacement surgery, which were common and where local providers were well-known to GPs. Thus, they were already aware of the consultants specialising in the area and the hospitals that they worked at. In this scenario the GP was often able to provide the participant with a number of alternative Consultants and/or hospitals.

Secondly, the patient might have already decided on which Consultant they want to see. Here, the GP did not always feel the need to provide the patient with any further choices or recommendations and saw their role as being to facilitate the choice made by the patient (following discussion with the patient and agreement).

### Facilitation of patient choice by GP

A patient living in the South of England went to his GP to discuss having private treatment, the participant then informed his GP that he would like to visit a particular consultant who had been recommended to him. The GP discussed this with him, but did not offer any alternatives of provider or consultant. The GP helped the patient obtain treatment with his chosen clinic.

Thirdly, continuation of treatment was an important factor for some GPs when recommending a consultant to their patients. Where participants had an on-going health problem, and where treatment had already started within the NHS, participants reported that their GP was often keen for their NHS consultant to be the one who treated them privately, to ensure continuity of care. This option was appealing for the participants as they had already built trust and rapport with the consultant. In this situation the GP provided no choices, only a single recommendation.

Within the *NHS Hospital-led* pathway, the route to choosing a consultant was twofold. Either the participant contacted a private consultant/private hospital after visiting the NHS A&E department, or the participant discussed moving to private treatment whilst being at A&E or in a NHS hospital ward with their healthcare professional, and then subsequently contacting their PMI to arrange the private treatment. In these situations it was observed that the participant would not get a chance to speak to their GP about

wanting private treatment due to their condition being an emergency (hence why they went to A&E). As a result arrangements for private treatment were made independent of any discussions with the GP.

#### **Hospital led cases with no intervention from GP**

One patient (Wales) had experienced extreme pain from gallstones and was taken to A&E. There she had a diagnosis from a surgeon. He gave her the option of staying in the hospital and taking the chance of having an operation within a week but could not guarantee that this would become available. On hearing this, the patient asked what the likely waiting times of a planned operation would be. When told that it would be over six weeks (the minimum waiting list time required by her PMI) she informed the surgeon that this meant she would prefer to have the operation done privately.

The patient asked which consultants within the hospital did the treatment and *“he just mentioned a few”*. The patient knew one of the consultants as she had had an appointment with him for an unrelated condition and was impressed. The surgeon then phoned the private unit and they sent appointment details in the post.

Within the **self-led** pathway, participants often took the initiative to contact a consultant themselves. Consultants were usually chosen either on the recommendation of family and friends, or because the patient had used them before or because they were locally based. Where participants had more severe or ongoing conditions, the specialist expertise of the Consultant was also a factor in their decision.

Within the **PMI-led** pathway, participants decided to contact their PMI to assist them to choose a private consultant. These participants saw such facilitation of choice as a role of the PMI rather than their GP. They described contacting their PMI due to being confident that their PMI would hold information on the best consultant for their treatment type located within a private hospital which was convenient. A total of 4 participants from the 31 with PMI followed a PMI-led pathway (see Table 4 above). The role of the PMI will be further discussed within Section 3.4.

When participants who went down the self-led and the PMI-led pathway were asked why they did not speak to their GP about private treatment, some interesting findings emerged. Participants displayed feelings of embarrassment and sometime guilt at wanting private treatment. They felt that it would come across as being ‘ungrateful’ to the service provided to them by the NHS if they discussed this with their GP and worried that their GP would be offended.

### **Bypassing the GP and choosing a provider via the PMI**

One participant in London did discuss her treatment with her GP but did not discuss private providers with him as she believed he would not have been happy with her seeking treatment outside the NHS. Instead she contacted Bupa directly by phone. The operative provided her with a number of different locations at which she could have her treatment and the patient chose the most convenient of these.

It should be noted that receiving a choice of consultant or hospital (or even receiving a recommendation from the GP) does not necessarily mean that the participants were provided with detailed information about the various providers or Consultants available. In most cases, patients were simply provided with the name of hospital/clinic and/or Consultant and given a recommendation by the GP. They were not provided with detailed information such as the number of procedures carried out or mortality rates for these providers. Indeed, most did not feel equipped to assess such information and did not think it was necessary for the GP to provide this level of detail. For most, a discussion of the GPs view of the recommended providers was enough.

*“There was no good or bad information because there was no information; it was a process from start to finish.”*

(Northern Ireland)

Where GPs did make recommendations, clear reasoning was not always provided and participants did not always know why a particular Consultant or hospital had been recommended. Where lack of information caused the most confusion was when the GP provided a number of choices, but gave no information about what differentiated one Consultant from the other. In such a situation, participants did not see a benefit in being provided a choice. The box below shows the low level of information and reasoning on which GPs recommendations were often based.

### **Examples of information and reasoning in GP recommendations**

A participant in Greater London was told that the preferred consultant (from a list of three) was someone the GP had referred a lot of patients to and who had received positive feedback from them.

Another participant from the West Midlands was told that the recommended consultant was somebody the GP had attended medical school with. The GP said he believed his work to be good. The participant did not question the GP about his recommendation.

## Patient expectations

As has been discussed, patients received different levels of choice and information from their GPs. Most participants did not expect to be offered high levels of choice and information. There were two reasons for this:

- Firstly, patients did not expect their GPs to know about multiple providers of treatment for multiple different conditions available in the local area. Rather they expected them to be aware of and able to recommend a single good quality provider.
- Secondly, in most cases patients did not feel equipped to make choices about providers themselves and did not demand that GP's gave them a choice. They were more interested in receiving clear and decisive recommendations from their GPs.

*"No I don't think he (the GP) would've done [i.e. recommended a hospital], I can't imagine that...I wouldn't expect him to do that, that's quite a far reaching statement to recommend hospitals"*

(South England)

### Patient expectations of provision of choice and information from GPs

A participant from South England said her GP explained to her that there were a number of hospitals that she could get treated at and that her PMI would be in a better position to advise her which they were able to accept referrals to. She followed this up by contacting her PMI directly who were able to tell her about the available hospitals. The patient felt that it was more appropriate for the hospital to recommend a Consultant than her GP and did not obtain a Consultant recommendation until she visited the hospital.

*"I wouldn't expect him (GP) to know that information, I wouldn't bother to ask him what hospital he'd recommend but if he could it would be helpful...you're sort of more prepared to say to your PMI where you want to go."*

However a little later in the conversation she said that she felt it would have been helpful if her GP could have recommended a hospital or a consultant because then she could have been more prepared to make a decision when her PMI presented her with choices.

Participants also discussed the limitations of discussing private treatment with their GP and the reasons why they did not expect their GP to provide them with information. When prompted about whether GPs should give information some participants often believed that there wasn't enough time in the appointment to discuss things adequately.

*"Your appointment times are so short when you see a GP anyway...they can't have a great long chat with you."*

(North England)

At times it was seen that the participants expected their GP to simply refer them to their closest private hospital and not recommend a consultant. However one participant (Northern England) who did not expect her GP to recommend a Consultant but refer her to a hospital said that, following the referral, she expected that the private hospital would tell her which Consultant she would be seeing. She was not aware that she could ask to see a particular Consultant or that she even had a choice of who she could see. Though the participant stated that she did not expect her GP to recommend a Consultant, with hindsight, she felt it would have been beneficial if he had.

### **Choice vs. Recommendation**

The way participants viewed choice and recommendation was quite distinct. Choice was often seen as *'confusing'* and time consuming and patients were more interested in receiving clear direction from their GP, who they believed was better equipped to make choices about secondary care for them.

*"I wasn't offered a choice, no, but I'm not bothered about a choice"*

(North England)

Most did not feel that they had the knowledge, expertise or experience to select a consultant or a hospital when choice was given to them.

*"I don't know if an ordinary person would be qualified to make that decision."*

(Northern Ireland)

Most patients were reluctant to assume responsibility for making choices about their healthcare themselves. This was observed across all the pathways. Participants mentioned on several occasions that if their condition or the treatment they required was more serious, only then would they have expected to be provided with a choice and in-depth information from their GP. In support of this, patients who did have more serious or ongoing conditions tended to know more about their conditions, the treatments and providers available and were often more involved in decision making about their treatment.

In addition, participants seeking particular types of treatment expected specific choices around how they were treated or who they were treated by. For example, a woman requiring gynaecological examination expected to be given a choice of whether she was treated by a male or a female Consultant. Simply receiving a recommendation would not be sufficient, especially if the recommendation is for a male gynaecologist and the participant wants to see a female consultant.

Across the sample as a whole, participants seemed keener for their GP to provide a recommendation rather than giving them a list of consultants and hospitals to choose from.

*"I said 'give me the name of a consultant'; I didn't ask for a couple of names I just said who would you recommend?"*

(Northern Ireland)

Receiving a recommendation put participants at ease and made them feel that it is at this point that their patient journey has truly started. Receiving a recommendation (even when information about the recommendation was not given by the GP) made the participants feel that their GP must have based the recommendation on certain information that he/she knew about the consultant/hospital. Receiving a recommendation also saved the participant's time as they would not have to do their own research or seek for information themselves.

### 3.3 Theme Three: Impact of Consultant

#### **Role of the Consultant**

The role of the Consultant in patient choice and the delivery of information appeared to be quite limited. In most cases a Consultant had delivered treatment or diagnosis but was not perceived to have been involved in the patient's decision-making about where treatment was carried out or who delivered it. From the patient's point of view, these decisions had already been made in conversation with the GP or PMI.

This finding does not correlate with the existing evidence on how the industry operates (such as the annual Laing and Buisson market reports), which suggests that choice of hospital is highly influenced by the Consultant. There may be two reasons for this:

- Firstly, this research can only report on the experiences and perceptions of the patients interviewed. No interviews were carried out with GPs, Consultants and PMIs. In most interviews, the patient's primary concern was the location of treatment. The identity of the Consultant was a secondary concern to the patient, so long as the Consultant was suitably qualified and the GP was happy to recommend him or her.
- Secondly, the research took place in a number of locations where the number of private hospitals and clinics was rather limited (such as Northern Ireland, Wales and the West Country) and where the number of available Consultants may not have allowed for very much choice.

It was clear that patients with more severe and ongoing conditions showed greater interest in having a choice of Consultant than those with less severe conditions, as their needs were more complex and the treatment they required potentially more specialist. The relatively low levels of those with severe and ongoing conditions (less than 10 out of 40 participants) in this research may also explain the relatively low levels of interest participants showed in having a choice of Consultant.

Patients who were referred to a Consultant by their GP were often provided with relatively little information about the Consultant. As documented in the previous section, participants who were in the GP-led pathway often wanted their GP to make a clear recommendation of consultant and hospital (and valued

this approach over provision of a range of options) as they trusted their GPs to direct them to a Consultant who was reliable, available and based in the local area.

*“I don’t know what I’d gain by looking at reviews of disgruntled patients...perhaps abroad would be different but here, I trust the system at it is.”*

(South England)

Once they were informed of the Consultant they would be seeing, very few participants did any research into them, although some did view biographical details on the website of the relevant hospital or clinic. Where participants did seek out this data they were most interested in finding out the Consultant's areas of specialisation and their years of service.

Participants seemed keener to act on the recommendation of their GP, PMI or family/friends than a Consultant who they did not have a prior relationship with. A few participants stated that once they had had their first private consultation with the hospital Consultant, they would then judge/assess the Consultant and if they were not happy with him or her, enter into discussions to get the Consultant changed. However, none had actually taken this course of action in their dealings with a Consultant and the process for changing doctor in these circumstances was by no means clear to participants.

*“You’re going on a recommendation from somebody but you don’t actually have to go with him, you can go and see if he seems competent and understanding”*

(Northern Ireland)

*“If I didn’t like what the consultant had said, I would have gone back to my GP. I’m not scared of coming forward.”*

(North England)

*“I was open minded to who it was gonna be as long as they were good, if I didn’t think their methods were good I would have said ‘look I want to go somewhere else’.”*

(Greater London)

The main priority for participants was the knowledge that the Consultant is well qualified to carry out the treatment they needed. In most cases, this clarification was provided by the GP.

*“If they are qualified to do the procedure then that’s fine with me...if I meet with the consultant and there was something I really didn’t like about them or wasn’t happy with then I’d say to whoever that I wanted to see someone else.”*

(North England)

## Role of the Anaesthetist

None of the patients participating in this research discussed their anaesthetist in any detail. The role of the anaesthetist was mentioned by only two patients, both PMI.

The first commented on how his anaesthetist had asked to see his authorisation code for private treatment before administering the anaesthetic to him (no other participants mentioned that this had taken place and it did not seem to be standard practice). The second mentioned that the anaesthetist's fee had appeared on the breakdown of costs he received from the hospital following treatment. As he was a PMI patient paying a subscription and did not have to finance the treatment personally the participant did not question the costs provided in this case but kept the cost breakdown for his records.

## Provision of choice, information and participant expectations

In most cases the location of the hospital or clinic and the speed of service were more important factors for the patient than the reputation of the Consultant. It was only in those cases where participants had more severe or ongoing conditions and wanted to see a particular specialist that choice of Consultant was prioritised.

Few patients felt equipped to judge the quality of individual Consultants and preferred to leave this decision to their GP. However, it was also the case that in areas where the number of private facilities was limited, there was a restricted choice of Consultants, with few for patients to choose between, and this had an impact on the level of choice patients were able to exercise.

### Choice of hospital and consultant in more densely populated areas

A participant seeking treatment in the West Midlands was recommended a Consultant by her GP but found that he was based at a private hospital on the far side of Birmingham. The participant was keen not to travel to the hospital as there was another private hospital located nearby and her husband had died there. The participant's GP made enquiries directly with the Consultant's secretary and agreed that the participant would be operated on in the hospital that has been originally suggested as the relevant equipment was set up there. However it was also agreed that face-to-face consultations pre and post surgery would take place at an advisory room rented by the consultant in a different location, closer to where the participant lived.

In areas such as Northern Ireland, West Country and Wales, where there were fewer private hospitals and clinics, patients appeared to be provided with less choice as to where they might be treated and were more likely to be directed to NHS hospitals for private treatment. Two out of five participants in Northern Ireland were treated at NHS hospitals in wards that were open to both NHS and private patients. These two patients had not been aware that they might be treated in an NHS hospital on deciding to take up private treatment and were concerned about being perceived as being 'snobs' or unappreciative of the NHS whilst



they were in hospital, especially as they would not be treated in a Private Patient Unit (PPU). Both participants would have preferred to be treated in a PPU or at a separate hospital altogether.

*“It would have been nice to have been informed that ‘it’s an NHS hospital, we’re (PMI) paying for the surgery and that’s it, the rest is down to the NHS’... I would have liked to have known before that happened.”*

(Northern Ireland)

These two cases were distinguished by the fact that the participant did not know that they would be treated in a NHS hospital in advance of opting for private treatment and were not informed about this until after their consultation with a GP (e.g. during subsequent treatment at a specialist eye clinic or by the PMI). Given that no real choice of hospital/clinic was offered in these situations, no choice of Consultant was available to the patient either.

Most participants saw their Consultant for an initial examination prior to treatment taking place and saw this as an important part of the private medical service. This initial meeting gave patients an opportunity to assess the Consultant’s ‘bedside manner’ and review what would take place during treatment with them. It also provided patients with an opportunity to review their choice of Consultant and change them if they wanted to (as there was time between the initial examination and treatment for them to consult their GP again and call a halt to treatment with the chosen Consultant), though none had taken action of this kind.

In a few cases, however, patients had not met their Consultant until treatment was due to be carried out and expressed a high degree of dissatisfaction with this. One self-pay participant did not see her consultant until she was ‘on the table waiting for him to do the surgery’. She felt as though she was not ‘socially high enough for him to speak’ to her in advance of the treatment and had not been provided with an opportunity to review the Consultant and make a final decision about whether she wanted to be treated by him.

## 3.4 Theme Four: Impact of PMI

### Types of PMI

Of the 40 patients interviewed, 31 had private medical insurance and interacted with their PMI at different points during the treatment process. The 9 self-pay patients had no interaction with a PMI. PMIs do not all operate in the same way and the patient relationship and experience of dealing with them varies quite widely. Below are a number of factors where patients' relationships with their PMI differed.

#### All treatment paid for

Some participants had cover for ongoing treatment, regardless of how many treatments were required and the duration of treatment.

#### Set amount to spend on treatment annually

Three patients had a set amount of money they could spend with their PMI in any given year. Once this was exceeded, the patient was unable to receive treatment unless they paid further amounts. After each treatment. These participants would call their PMI to enquire about the remaining balance for the year. If they exceeded their balance then they would have to pay for the overspent amount. Some participants spoke about the difficulty of constantly calling their PMI to obtain the balance and expected the PMI to be more proactive in providing this information.

#### Pay up-front and then get reimbursed

In two cases, participants said that their PMI expected them to pay for their treatment up front to the private hospital and then to forward the receipts to them to be reimbursed. One participant stated that he could not afford to pay such large sums in advance as he had been off work due to ill health.

#### Requirement for up-front payment and reimbursement

The patient (Northern Ireland) received PMI through his employer. He contributed half of the fee and his employer contributed half. He paid £45 per month for himself and two children and received only limited cover. He contacted the PMI about treatment and explained his condition. The PMI confirmed they would cover him but later informed him that he would have to pay for the treatment up-front and claim reimbursement.

Because he was not in work due to illness, he could not afford to pay this sum. *"The problem is I've been off since July and money's run out and that's another reason why I didn't go with the private thing."* The patient was reconsidering treatment and providers at the point of interview.

Neither of these participants seemed to have been aware of this expectation in advance and were surprised that they were being asked to pay in advance. This policy resulted in the participants having to delay their treatment or contemplating whether they should have private treatment at all.

### **Authorisation code**

Most participants were obliged to provide the private hospital/consultant with an authorisation code. Sometimes one authorisation code was sufficient for the entire duration of the treatment, at other times authorisation codes were required for each stage of the treatment. Each time it was the responsibility of the participant to call their PMI to obtain the code, which many found laborious and inconvenient, especially when they were not in good health.

### **Provision of choice and information from PMI and patient expectations**

The level of choice and information provided by PMIs varied widely. In most cases, the PMI was not required to provide the patient with choice or information about the provider used as this discussion had taken place during consultation with a GP. In these situations, patients expected the PMI to approve the GP's recommendation and accept their referral and were not looking to the PMI to provide them with guidance concerning the provider.

In the four PMI-led cases, the focus of decision making was the conversations (usually by phone) that patients had with their PMI. It was during these conversations that decisions were made about the private provider to be used, rather than during any conversations the patient had with their GP. Here, the PMI was much more involved in the selection of provider and was responsible for providing choices and information, with the GP providing only a formal referral.

*"She [the PMI operative] said the nearest hospital where I live was X, and I said yeah that's fine...she said they'd send a confirmation letter and mentioned a consultants name...at the time the name didn't really mean much to me."*

(South England)

Again, levels of choice varied. In some instances, PMI-led patients were recommended a single provider and in others they were provided with a choice. The extent of choice offered usually depended on the presence of relevant providers within the local area and there were few complaints about the range of choice offered.

*"The first name I wanted, he was on holiday. The second name I wanted was full. The third name on the list...wasn't covered by the insurance company. They told me they had a list, two of the people on my list didn't work to their standard. After that, I just went with theirs."*

(North England)

Patients were less satisfied with the amount of information provided by their PMI. Even where the patient followed a PMI-led pathway, they said they were provided with very little information with which to assess and compare different providers. None of the PMI-led participants were provided with information about the quality of the provider suggested (e.g. success rates of the hospitals or length of service of Consultants) during conversations with operatives and felt that additional information on which they could base their choice may have been useful. Patients were somewhat less willing to trust their PMI's recommendations than those of their GP (as the PMI operative they spoke to on the phone was not usually a clinician) and were more likely to want to be directed to sources of information about recommended providers, if they could not be given this information during the consultation.

In addition, a few participants felt their PMI did not give them sufficient time to make a decision about where to be treated and by whom. Often the PMI would make a recommendation of provider over the phone and participants felt pressured to respond straightaway, although they would have preferred to have been given some time to consider their options and make a decision.

*"I felt, because I was on the phone, you think if they're saying this is the closest then I'll just go with that...it doesn't leave an avenue for doing your own research."*

(South England)

Nevertheless, many participants did not question the recommendations made by their PMI and were happy to use the recommended provider, even where little choice or information had been provided.

*"If I'm paying for something and Bupa recommend a hospital because they're doing the work in it, then I think that's good enough."*

(North England)

*"I think they have fantastic customer relations...it's not a call centre, they make suggestions...very good at putting you to ease...really well trained staff, fantastic."*

(South England)

Overall levels of satisfaction with PMI's varied widely. In a few cases, patients commented on the efficiency and friendliness of their PMI, while others participants had found them obstructive and difficult to deal with.

*"It's never an easy yes, they always say they'll look into it and see if you're covered. There were loads of questions about the (initial) consultant...I was never sure they were going to cover it...and when I went back and said I wanted to see a different consultant they were like 'oh so you want to change again!'...I thought oh gosh, I've had my time up on this one."*

(Greater London)

*“It should be hassle-free- that’s the whole idea. If you are really really sick it should be made a lot easier...you nearly want someone to come out to the house and do it all for you.”*

(Northern Ireland)

At least one participant spoke about their PMI operative becoming annoyed when she asked questions about her recommended provider. This participant (Greater London) had seen a number of different Consultants about her condition and felt that her PMI was rather obstructive when she sought to use Consultants of her own choosing, rather than those the insurer had recommended.

*“That’s the whole reason I’m with them because I’ve got a pre-existing condition...I feel that what they want to cover is one consultant, one surgery and end...but treatment isn’t like that, they should be more open to alternative treatments and that isn’t happening out there at all.”*

(Greater London)

Issues relating to payment, including the role of the PMI in communicating to and dealing with the patient and health professionals in relation to payment for private treatment are discussed in the following section.

## 3.5 Theme Five: Payment

### Awareness of Cost

Across the interviews, patients showed little awareness of what the cost of their private treatment had been and few had investigated the direct costs they were incurring at any point during the treatment process. The main reason for this was that the majority of participants (31 out of a total of 40) had private medical insurance and were not paying for treatment directly. As long as they had reassurance that the cost of their treatment was covered by their insurance premiums, those with PMI took little or no interest in the associated costs.

This reassurance was provided by the PMI at the point of referral. In cases where insurance was provided by an employer, the patient was often given go-ahead for treatment by a representative of the employer (e.g. a member of the HR team), who was responsible for liaising with the PMI. In cases where PMI was arranged privately, the patient was provided with go-ahead directly, either by phone or in writing.

Few of those with PMI could even say how much their monthly premiums were and awareness was at its lowest where patients received private medical insurance through their employer. Patients tended to show greater awareness of their premiums where they arranged insurance privately and where they either had recently changed provider or recently had their premiums increased.

As might be expected, the nine self-pay patients showed much higher levels of awareness of the direct costs of treatment than PMI patients. Self-pay patients were responsible for paying the full cost of treatment themselves and therefore had far more interest in finding out the costs of treatment. These patients investigated the cost of treatment in two different ways. Either they shopped around, carrying out searches of relevant providers remotely (online or by phone) and determining costs before making an appointment with a preferred provider, or they went immediately to a preferred provider and discussed costs with a Consultant during their initial examination.

All self-pay participants knew what the costs of their treatment would be in advance of it being carried out. In some cases they were quoted a firm cost and in some cases a variable cost depending on the extent of treatment or diagnostic examination needed. Where patients were provided with a firm cost they often paid for treatment in advance and where the cost was subject to change they paid after treatment had been completed.

When self-pay participants were invoiced for treatment, this invoice covered all associated costs (i.e. Consultant costs, hospital costs, anaesthetist costs where appropriate). Not all self-pay patients could remember how their invoice was broken down, but those who could remembered that different costs were itemised (e.g. one patient remembered that 'theatre costs' and 'food costs' were separated on the invoice). Invoices were provided either before or after treatment, depending on whether a firm or estimated cost was supplied.

A few PMI patients were able to provide details of the direct costs of treatment as their cover was limited to a set amount of money that could be spent in a given year and they had to keep abreast of the cost of treatment to ensure they were not running over their allotted budget. One patient found this process of checking the amount left in her treatment budget inconvenient and worrying, as she did not know whether she would have enough funding to cover her ongoing treatment.

*"I don't want to keep worrying about how much money is left in the pot for me to have this procedure or the out-patient appointment. Maybe they should give you a statement when they send you a letter...where they give you your balance."*

(West Midlands)

*"Before every operation I tend to say 'is that gonna come more than my limit?' and they say no."*

(Wales)

## **Role of the GP, PMI and Consultant**

GPs had no role in determining the costs of treatment in any of the 40 interviews carried out and no patients discussed costs with their GP. Where discussions about cost did take place (i.e. for self-pay patients, PMI patients with annual budget or other PMI patients who were interested in the cost of treatment), these were either with the PMI or with the hospital and/or Consultant providing treatment.

As has already been stated, most PMI patients were unaware of the cost of treatment and did not feel they needed to discuss payment with their PMI as they paid a subscription rate. Where they did discuss payment with their PMI (because they had cover up to a limited amount limited), there was still little discussion of cost with the healthcare provider and no negotiation took place (either with the provider or the PMI) to try and keep costs to a minimum so that their allocated budget would stretch further.

Self-pay patients preferred to discuss cost with secretaries, receptionists or other administrative staff working for the hospital or clinic where they received treatment, wherever possible. In many cases, patients were able to find out the cost of treatment in advance and make payment in advance if they wished.

Most self-pay patients did not want to enter into discussions about payment with the Consultant who was treating them. Of the nine self-pay cases in this research, only one patient (London) discussed costs with a Consultant in advance and was given an estimated cost for treatment. A confirmed cost, which fell within this budget, was provided at the end of treatment and payment made. All other self-pay patients discussed costs in advance with receptionists or administrative staff at the hospital or clinic where they were treated (though not with the Consultant) and received a firm or estimated indication of the cost of treatment in advance.

No self-pay patients attempted to negotiate with the provider on cost, though some did shop around. Participants frequently said they did not know they could negotiate cost with the provider. However, it was also evident that participants did not always feel it was appropriate to negotiate costs with a healthcare provider or did not feel they had enough information about costs to negotiate in an informed way. Where this was the case, patients said they would like more information on standard prices for private healthcare treatments so they could make informed decisions.

*“To me this was something I wanted to go and get done and whatever it cost that was it, it wasn’t like I was going to shop about and see if I could get it any cheaper.”*

(Scotland)

## **Payment Process**

The payment process was seen as simple and straightforward in virtually all cases. Most PMI patients did not have to enter into a payment process as they (or their employer) paid subscriptions to a PMI and did not have to pay for individual treatment. As far as they were aware, payment for the specific treatment they had received was paid by their PMI to the hospital or Consultant they had used, though none were communicated to about this stage of the process. In some cases, patients of this kind did have to pay the excess on their policy and this was usually around £150. In most cases, this was paid to the PMI in advance of treatment taking place.

The only PMI cases in which payment was not seen as simple and straightforward were those where patients had to keep abreast of the cost of treatment to ensure they were not running over their allotted annual budget. Three patients were in this situation. They endeavoured to keep abreast of costs and their remaining budget but often found this process laborious and inconvenient.

Self-pay patients also found the payment process relatively easy. Once they had a firm cost from the provider they paid the fee by cheque, cash or card. Payment was made either before treatment or following treatment, depending on when a firm cost was given.

When asked if they tried negotiating the fee at all, all self-pay patients said they had not. Some stated that they didn't realise that they could have attempted to negotiate the fees. Others thought that it would be embarrassing trying to do this.

*"I wouldn't have known to start to negotiate the price. I wish I could, but I didn't know you could do that."*

(North England)

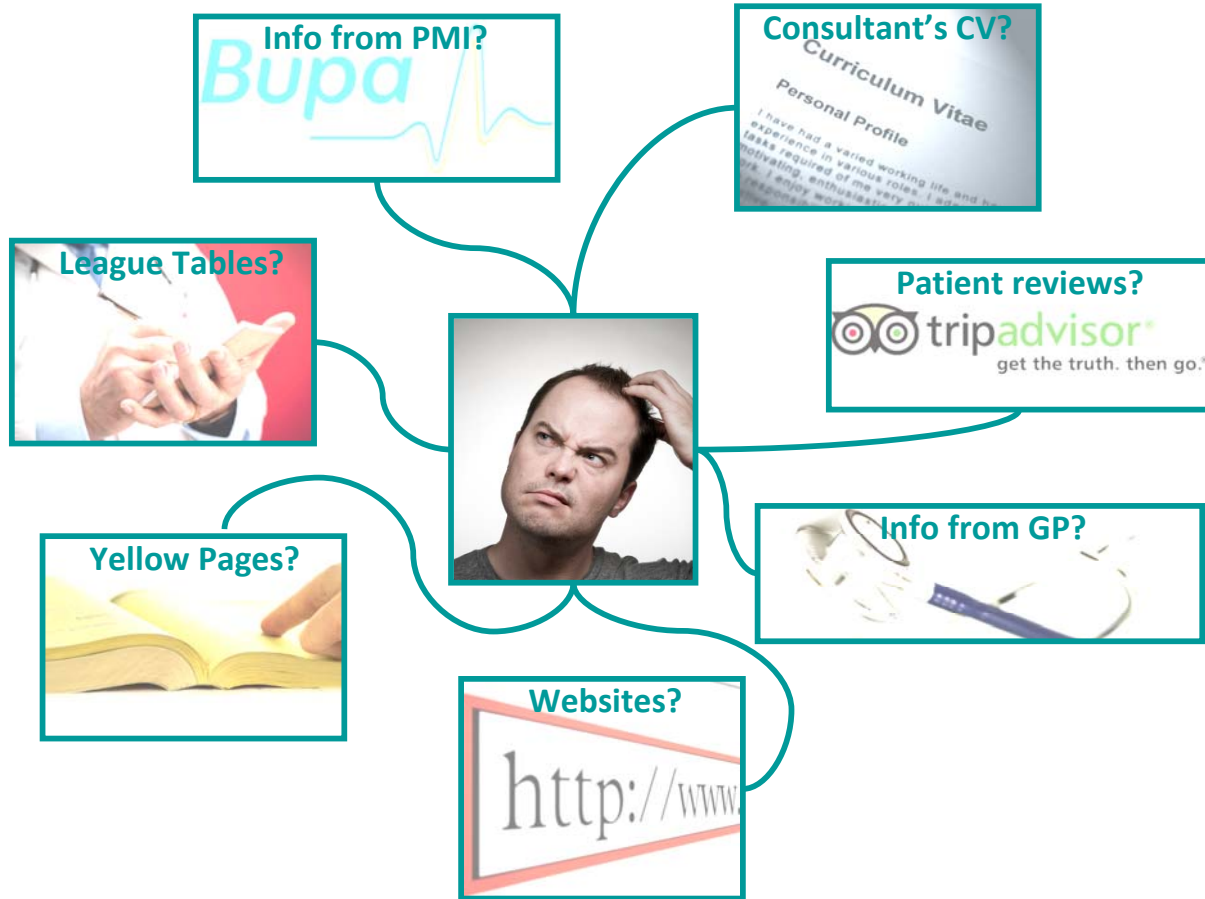
Finally, two PMI patients (both based in the West Midlands) received additional charges from their hospital following treatment for bandages and medication that were purportedly not covered by their insurance. In each case the charge was less than £20. One participant paid this charge herself but was rather resentful about this given that she had not been forewarned. The other participant forwarded the invoice on to his PMI who paid the charge on his behalf.

*"If you have private health insurance they should pay for everything."*

(West Midlands)



### 3.6 Theme Six: Improvements for enhanced choice and information



Participants were asked to make recommendations for improvements to the current system of accessing private healthcare in relation to the supply of choice, advice and information. They were forthcoming with ideas on how improvements could be made and the criteria against which they evaluated hospitals and Consultants and these considerations are detailed below.

#### Who should provide choice and information?

There was general consensus amongst participants in whom they thought should be the provider of choice and information through their patient journey. Views on the provision of information and choice centred on two channels of supply; GPs and the PMI.

Participants felt that the GP should be responsible for providing information and choices regarding private healthcare. Some participants felt that the GP should be capable of identifying and explaining the differences between certain choices of consultant and hospitals and that GPs should also be able to recommend a reasonable choice of a few consultants and hospitals.

Surprisingly, even participants who began their interview by stating that they did not expect their GP to have knowledge about private hospitals and private Consultants, towards the end of the discussion they often changed their mind and stated GPs should be one of the main sources of information. Due to GPs being present at the point of decision making for most GP led participants it would have been preferred and valued if their GP had knowledge about what differentiates one Consultant or hospital to another.

*“They [GPs] should be able to advise you, or point you in the right direction, or say, look, this consultant does private outside of the NHS and he is very good.”*

(Northern Ireland)

The majority of participants who visited their GP without a preference for who they would like to be treated by, often made their private healthcare decisions during their first GP consultation; and most referrals would subsequently follow the first visit. Thus, it is understandable why participants would want their GP to have information on the Consultants and hospitals, as there is no time between having the initial discussions with the GP and the referral. This makes it very unlikely for the patients to carry out research independently. Participants were usually confident and trusting of their GPs recommendations, however when prompted about their knowledge of the consultant prior to their first consultation the majority of participants stated that it would have been nice to have known a little about the Consultant.

Other participants who were provided with a choice of Consultant / hospital also complained about the lack of information provided to them by their GP and PMI. This made it very difficult for them to choose between the list provided.

*“If they (the GPs) could tell you the difference (between the consultants) because otherwise they’re just names...”*

(London)

With regards to the supply of information and choice from the PMI, some participants expected information to be provided on consultants with a few expecting it to be on the PMI provider's website. The information was expected to cover consultants' experience, education and ratings and success rates. Information from the PMI on the hospital choice was also expected by a number of participants, regarding overall performance and success rates. Participants thought that the PMI would have more knowledge about the private healthcare sector than the GP; however they were disappointed by their experience where the knowledge was not exhibited.

The participants discussed and were prompted about what improvements could be made to facilitate the GP and PMI interaction with them and what type of information they would find useful as patients to enable them to make an informed decision. Below are the types of reforms discussed in the interviews.

## **What improvements could be made?**

The potential improvements below were all suggested spontaneously by research participants during the interviews. The improvements are listed in order of frequency of mention.

**League tables-** A number of participants supported the concept of league tables for consultants and hospitals with some suggesting it would help inform patients about choosing private healthcare. The seriousness of the treatment required and the condition was an important factor in how useful the league tables would be with some participants acknowledging that life-threatening conditions such as a cardiac procedure would make rankings significant.

*“It depends on what you’re having done. To me it’s not life threatening, if it was [life threatening] I’d be interested in what the consultant’s done and how long he’s been doing it.”*

The criteria which participants thought that league tables for Consultants should be based on were; success rates of consultants, length of practice, patient ranking, bedside manner and personality. Some felt that a league table for consultants might help keep them ‘on their toes’ and they considered the league table to be particularly useful as it was natural for potential patients to want to go for the best.

*“I think that’s really good, because I’ve done IVF and they have similar things and that really helped me... on there it’s like success rates and things like that”.*

(West Country)

Participants in favour of league tables for hospitals wanted to see rankings on factors such as operation success rates, cleanliness, staff, facilities, patient turnover and post-operation care and recovery time. However, a significant number of participants were against the idea of league tables and considered them an unfair assessment of the abilities of consultants and medical staff as there is often more beneath the surface; participants considered that some consultants had lower success rates due to a run of challenging cases and that ‘everybody has their bad days.’

*“They’re open to misrepresentation... say he had three complaints about him, they might have been from particularly difficult people... some people like to complain anyway. It’s like I do a lot on eBay, and somebody put a bad report about me, but I know that they were just being unreasonable, that it wasn’t my fault at all... so a league table isn’t always the answer”*

(West Country)

Some participants were sceptical about the purpose of league tables and considered them to be a bureaucratic target-focused tool that wouldn't necessarily help in making the best healthcare choice because the medical profession would become too focused on meeting targets than treating individuals. Other participants also suggested that league tables could be misrepresentative of the abilities of consultants and hospitals and that even though they could be useful to differentiate between 'good' and 'bad', it would discriminate against the consultants at the bottom of the table and distort the provision of patients to the top end, making them difficult to implement effectively.

*"I'm not a great believer in league tables... they'd be trying harder to see more patients instead of spending time with the ones that needed time spending with them, just so they could tick a box and say 'I saw 25 people today'..."*

(West Country)

*"There are some who would like a league table, I don't. It's like doing the horse races isn't it? Jockey number one has won fifteen races but jockey number two could win the race. It doesn't mean anything. If I trust the physician after I've met him then he'll do a good job. I disagree with league tables, its bureaucracy."*

(North England)

**Yellow Pages-** As discussed earlier not all participants expected to receive a choice of hospitals or Consultants, yet they were keener to receive a recommendation. A reason for this might be that when they received a choice, they were not aware how the Consultants or hospitals differed from one another. A few participants discussed a need for having a 'yellow pages' type directory where a list of private Consultants and hospitals is provided. It would differ from a league table as the directory would not compare the Consultants but instead would provide a description of their area of specialism, past experience and where do they practice.

*"...like a website but not the NHS website, that's got too many arms to it...something very concise like a Yellow Pages."*

(West Midlands)

Participants with PMI discussed that they would have liked to have received a directory like this from their insurer upon taking out the policy or when their employer took out the policy on their behalf. Some also mentioned the benefits of the directory being available to GPs, as it was perceived to be a useful tool, especially when GPs lacked were seen to be lacking knowledge about private healthcare.

The directory was seen as a quick and handy tool that would be a 'one stop' source of information, cutting out the need to search on hospital websites (which patients often thought were biased and not very impartial) and would enable the patients to have easy access to the information that they require.

**Websites-** The internet was suggested as a key access point for patients to review their choices and examples were given of existing websites (e.g. Dr Foster) that provided the basis for online-based information delivery.

*“An online tool that rates people’s experiences, and states Doctor’s qualifications and things like that, and their GMC numbers and things like that... where they qualified, when they qualified...”*

(West Country)

*“I would like to see something similar to the Dr Foster website, for consultants.”*

(West Country)

Some participants were likely to conduct research online regarding their condition and possible avenues of private treatment and therefore the idea of accessing information regarding choices was expected to be on websites set up by the PMI or even the NHS. Participants also expected to view the hospital and consultant performance information online although it was stressed that only reputable websites, where you could rely on the veracity of the information, would be visited by potential patients. The patient felt that the GP could have pointed her towards some other websites containing information.

**Patient reviews-** In relation to patient reviews of consultants and hospital services, a number of participants considered them to be a helpful aid in ‘making your mind up’ and cited the TripAdvisor and even Argos website of an example of customers being able to provide feedback on services (and products) and influence the likelihood of others to use that service. This was also felt to be potentially influential in raising the standard of communication and treatment provided by the consultant and hospital. However, there was some scepticism that such a review system would be ‘permitted’ by the consultants and there was concern that reviews were not appropriate for complex medical procedures.

*“If you go on Amazon...you can look what ratings it’s got from other people, you can’t do that with medical practitioners obviously but nevertheless it was useful to see him listed on this website as a specialist in knees.”*

(Wales)

Some participants felt that reviews, though a good idea, were likely to provoke the most responses from those who had had bad experiences rather than those who had had good experiences and it was also suggested that patient ratings of consultants were not realistic as one consultant may suffer the misfortune of one or two bad reviews from particularly difficult, demanding patients and that could prejudice the way they are perceived by potential patients. However, it was considered reasonable for patients to review and rate a hospital or PMI.

**Consultant CV’s-** A few participants were supportive of the idea of viewing consultants’ CVs so that patients could analyze the experience and expertise of the consultant prior to meetings or prior to arranging appointments and making choices with the names recommended by GPs or the PMI.

*“That’s what I would like on the CV – this Surgeon’s done one hundred operations of this kind in the last month or year with an 80% pass rate, no problems. It would be nice to have something broken down exactly like you’d get with your car, your MOT. This garage has done this many MOT’s, you can find that on the Internet. I’d like to see that before I saw the surgeon.”*

(North England)

*“Hindsight’s a wonderful thing. The more knowledge you’ve got, the better decisions you make. If I had known he was first a consultant, b) specialises in knees or knees and ankles... and of those people who specialise in knees he’s 7 out of 10 or 8 out of 10. And you can make a very informed decision rather than putting your faith in Mr Medical Man.”*

(North England)

It was even suggested that a photograph of the consultant would assist in making a decision and that appearance can sometimes play a part in feeling the right decision has been made.

*“This makes me sound shallow, but if I had a picture of him...”*

(West Country)

*“I met up with him and I could see he was an older man, experienced...and that matters.”*

(West Midlands)

However, a few mentioned that a consultant’s CV was less important than gauging their abilities first-hand from a one-to-one meeting and emphasised the importance of feeling comfortable after personal meetings. Trust was also a factor of more importance for some, with some participants suggesting that good previous experiences with consultants would lead them to trust other consultants in the same way for further procedures.

# 4. Conclusions

The main conclusions of this research are set out below.

1. There were 4 pathways into private treatment: GP-led, self-led, hospital-led and PMI-led. The majority of participants accessed private healthcare via the GP led pathway. However, this was not the only route into private treatment. Participants could choose to co-ordinate their own route in to private treatment (self led), they could be referred from and given information by NHS hospitals/departments (hospital led) or their PMI could assist and lead in referring the participants in to private treatment.
2. Choices and recommendations do not necessarily lead to the provision of information. Participants often received either a choice or a recommendation from their GP and/or PMI, however very few were given any information on the choices or the recommendation made. If information was provided then it usually was limited to the consultants' area of speciality and hospital of practice. This left participants confused and often unable to make a distinction between the choices provided, thus disabling them to make an informed decision.
3. Some participants were not aware that they might choose a hospital or consultant for private treatment. These were predominately participants who were accessing private healthcare for the first time. GPs and PMIs did not always provide participants with choice and assumed they would want to go to a hospital located close to where they lived.
4. Patients' primary concern was the location of treatment. All wanted to be treated as close to home as possible and wanted a choice of hospital or clinic that would facilitate this. Choice of Consultant was less important to most patients (excepting those with more severe or ongoing conditions who required specialist care). Most participants said they would prefer to have a clear recommendation of Consultant from their GP or PMI than have to make a choice themselves. The main reason for this was that few participants felt they had the knowledge or expertise to evaluate and decide between different Consultants.
5. Participants did very little research independently on consultants or hospitals. Participants who had minor ailments or minor problems stated that they would have only carried out research if their condition was more serious. However, participants who had a more serious condition said that they did not have the time to carry out research or that because it was serious they did not think that they have the expertise to select a consultant.
6. Participants found it difficult to compare between different consultants and hospitals. At times they did not have sufficient information to be able to compare between them or when information was provided, the decision was based upon the speed of treatment and location of the hospital.

7. PMIs did not provide their policyholders with a lot of choice about providers. Some participants did not feel they required a choice as they were keen to attend a hospital located close to them with immediate availability. When PMIs did provide patients with the details of a Consultant or hospital some felt they were not given sufficient time or information with which to make an informed choice.
8. The majority of patients were unaware of the fees they had incurred during treatment. Where participants had PMI, they did not discuss fees prior to treatment, provided they had reassurance from their PMI that all costs would be covered, and rarely discussed fees with their GP or Consultant at all. Self-pay patients were far more aware of the cost of their treatment and had discussions about cost in advance of treatment with their Consultant (in one case only) or administrative staff at the hospital or clinic (in the remaining eight cases). No patients negotiated costs with their PMI, hospital or Consultant.
9. Patients tended to receive little in the way of detailed information which they could use in order to inform a decision between different private providers and Consultants. A lack of detailed information provision was seen for both GPs and PMI providers – the two main channels of information supply, as identified by patients. Views on how improvements could be made to the level and nature of information differed between patients, and the pros and cons of different methods were acknowledged in the interviews. The internet was suggested as a key access point for information, but concern was expressed about the impartiality of information currently provided by PH providers' websites.