Patients with private health insurance using NHS facilities in preference to private care

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During 1988-9 we noticed that some patients were receiving NHS treatment at this hospital despite being covered by a private health insurance scheme. We therefore studied why such people had chosen NHS care rather than the private alternative.

Patients, methods, and results

For one week in June 1989 we asked all patients attending the surgical wards, the accident and emergency department (serving a population of about 200 000), the surgical day unit (which carries out minor operations under local and general anaesthetics), and the surgical outpatient department in the department of surgery at this hospital to complete a questionnaire anonymously. The questionnaire asked whether the patients had a private health insurance policy and, if so, whether they were using their insurance for the attendance. Those not doing so were asked their reasons why. Patients were told that the study was confidential, and they were not put under any pressure to transfer to the private sector.

The questionnaire was completed by 587 patients. Five patients were unable to complete the form and one refused. Between 6% and 27% of patients in the four clinical areas held private insurance policies but were not using them. Overall, this represented about 10% of patients attending the department during the week studied (table).

When asked why they were using the NHS despite being insured for private treatment 42 (72%) patients stated that they were happy with NHS care (25 added that the short waiting list at the hospital had influenced their decision); three had forgotten about their insurance; five were unaware that private facilities existed in Kingston; three were unsure how to use their private

policy; and the remaining six patients gave no reason.

Patients with private insurance who attended outpatient clinics or the accident and emergency department did not transfer to the private sector after their consultation or after completing the questionnaire.

Number of patients with private health insurance attending department of surgery during one week who were treated privately or by NHS

	No of patients	Patients treated privately	Patients treated by NHS (%)
Surgical ward	104	3	6 (6)
Outpatient clinic	233	2	19 (8)
Accident and emergency department	186	5	17 (9)
Surgical day unit	64	7	17 (27)
Total	587	17	59 (10)

Comment

Kingston Hospital is in an area with several private hospitals that could have catered for the 10% of patients attending the department of surgery who had private health insurance. Our data suggest that most of these patients chose to remain in the NHS system because they were happy with NHS care, being influenced in particular by a short waiting list; the typical waiting time for admission to wards is one month, for admissions to the surgical day unit two or three weeks, and for non-urgent outpatient appointments two weeks. Presumably if patients with private insurance policies were treated privately waiting lists in the hospital would be shorter still.

Some of the patients with private insurance may not have been paying for it themselves—for example, those belonging to a company scheme; we did not ask about this. Some of these patients might not want to take up the private option. Our results, however, suggest that satisfaction with the NHS rather than a reluctance to use the private sector was the main reason for patients with private health insurance receiving NHS treatment.

We believe that this study has important implications for planning health care facilities.

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Comparison of oral preparations of heroin and methadone to stabilise opiate misusers as inpatients

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Many opiate misusers express a preference for heroin over methadone, and possibly more misusers would seek treatment if heroin was given for maintenance and withdrawal rather than methadone mixture. Because of the risks of intravenous administration it is preferable to give all drugs orally. We report what we believe to be the first comparison of oral heroin and oral methadone for stabilising opiate misusers as inpatients.

Patients, methods, and results

In a double blind study 57 patients who were dependent on opiates and aged 19-42 (mean 29.2 years) were randomly allocated to receive heroin or methadone mixture (1 mg/ml) in otherwise identical solutions. A 10 ml aliquot was given whenever signs of physical withdrawal were observed, and the total given to a

patient during the first 24 hours was taken as that patient's daily requirement. This was subsequently given in three doses, with further aliquots being given if signs of opiate withdrawal were observed. Subjects who had been comfortable for two successive days were said to be stabilised.

The severity of withdrawal was assessed on the first day by administering a questionnaire before each dose of opiate; the nursing staff's rating of the presence or absence of classic signs of opiate withdrawal; and recordings of physiological variables. Subjective and objective withdrawal scores were calculated for each subject. This procedure was repeated on each subsequent day at 4 pm. Subjects were also asked to note if and when they first noticed craving after the dose of opiate given at 8 am, and at the end of the stabilisation period they completed another questionnaire aimed at detecting whether they had noticed particular effects due to their treatment.

The table shows the personal characteristics and drug histories of the 57 patients. Thirty six patients completed the stabilisation procedure, 14 of whom received heroin. The mean dose of heroin required for stabilisation (55 mg) was significantly higher than the mean dose of methadone (36 mg) ($t=2.78$, $p<0.01$), although the mean reported daily doses of heroin in the two groups before admission were not significantly

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