Does the UK have a Private Welfare Class?

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Abstract

The use of private welfare services in the UK has risen. But relatively little is known about the patterns of use of private welfare services. This article investigates whether there is a private welfare class, and how attitudes to welfare state spending are linked to use of private services. It finds that there is considerable use of the private sector, but the size of the group consistently using a range of private welfare services is small. Changes in attitudes to public financing of welfare spending do not appear to be directly linked to use of private services.

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Key words

Private welfare; private medical insurance; private health care; private education; attitudes to public welfare

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INTRODUCTION

Private welfare is growing in the UK. While welfare purchased through the market remains small in comparison to the traditional welfare state, its importance has risen in the last twenty years (Burchardt, Hills and Propper, 1999). During the years of Conservative administration between 1979 and 1997 there were a number of key initiatives designed to increase the role for private finance of welfare: these included withdrawal of entitlement to free dental and eye checks, the introduction of tax relief of private medical insurance for the over 60s, the right to buy scheme in housing, and tax reliefs to encourage individuals to opt out of the State Earnings Related Pension Scheme (SERPS). As pressures on tax-financed services seem set to remain, both policy-makers and consumers have an interest in the role of private alternatives. All the indications are that the current Labour administration will continue to promote self-provision and the involvement of the private sector. In the April 1998 Green Paper on welfare reform (DSS 1998), the Labour government argued that its policy reforms will follow a 'third way', but although this statement rules out the most radical forms of privatisation or simply pumping more money into the system, it does little to narrow down the numerous policy options between these two poles.

Against this backdrop, relatively little is known about users of private welfare and almost nothing is known about how use of different private services is linked. Is there now in the UK a private welfare class: a distinct group of users of private services who regularly use a range of private welfare services? The existence of such a class would have implications for the role of the state in provision of these services. Private sector use may be associated with different political attitudes about the role of the state in welfare provision: in particular, private users may favour a smaller role for the state. If attitudes are affected by use, then an expansion of private welfare use may mean less support for public provision, which may have knock-on effects on the level of support for taxes and the quality of the public sector. This article seeks to addresses these issues.

It examines privately-provided welfare services purchased by individuals to identify whether there is such a class and whether attitudes to the role of the state in financing welfare are linked to membership of this class. In contrast to all earlier studies, the article uses longitudinal data: the newly-available British Household Panel Survey for the period 1990 to 1995. This is complemented with analysis of the 1994 British Social Attitudes Survey (BSAS). The BSAS identifies different service usage from that recorded in the BHPS, as well as providing a check on the reliability of the BHPS

data. In addition, the BSAS has been used extensively to examine attitudes and service usage.

Non-state welfare can take a number of forms (Titmuss 1958). The services examined here are all privately provided, and are purchased by individuals (or in some cases by their employers), although there may some element of public finance (for example, tax reliefs, state benefits, or payments under the Assisted Places Scheme)[1]. Specifically, the services examined are private medical insurance, private health care, private schooling, owner-occupation and private renting, and private and occupational pensions. The focus is on health and education, as these are perhaps the most politically sensitive elements of government welfare spending and where the debate about the role of the private sector has been intense.

The analysis presented here indicates private welfare use has increased, and private welfare users have a clear social and demographic profile. The private use of one service is associated with private use of another, both in one time period and across time. However, the evidence does not suggest that the users of private welfare are a separate and distinct part of the population, or that there is a sizeable group who use only private services. Private users also make considerable use of state services and if a private welfare class is defined in terms of exclusive use of the private sector, it is very small. While private welfare users appear to differ in terms of attitudes to the role for the state in provision of services, there is evidence which suggests that it is use of any health services - public or private - that affects attitudes on the role of the state in the finance of welfare services, rather than use of private health care per se.

The article begins with a brief outline of the main policy changes in private welfare in the last decade and a description of private welfare users. In Section 2 the links between use of private services, both over time and across services, are examined. Section 3 explores the relationship between use of private welfare and attitudes towards state provision. Both satisfaction with, and support for, state services are investigated, taking into account where possible the intensity and range of use of private services. The final section concludes.

1. POLICY CONTEXT AND PRIVATE USE

1.1 Policy change

The Conservative administration of 1979 to 1997 sought to 'roll back the frontiers of the state'. In the area of welfare, many changes were not directly aimed at increasing private finance, but at increasing the role for the private sector in provision (for example, the quasi-market changes in health, social services and education). However, there have also been a more limited set of policy changes on the finance side. In health, the National Health Service (NHS) remains the dominant financier and provider, but there have been changes in eligibility and extensions of co-payments in dental and eye care, as well as increases in prescription charges. In 1985, free sight tests and dental check-ups were limited to children, those on low income and special groups, while charges for other services continued to rise. Tax relief on the purchase of private medical insurance was given in 1990, though withdrawn in 1998. Other changes have not been the result of direct policy but a by-product of changes to the way in which providers of NHS services are reimbursed by the government. Renegotiation of dental contracts in 1990 resulted in anecdotal evidence of a decrease in availability of NHS dental services, with many dentists declining to take on new NHS patients altogether. During the period of these changes there has been an increase in the numbers using private care, and a slow growth in the number of people covered by private medical insurance (which stood in 1996 at around 6.2 million, about half of which was employer-purchased (Laing and Buisson 1996)).

In education, the vast majority of schooling takes place in state-run institutions. The Assisted Places Scheme, introduced in 1981 and being phased out, was an attempt to encourage private education by providing financial assistance. The number of places available under the scheme grew from 5,300 initially to 34,000 in 1995/6, but many awards went to siblings of children already at private school (DfEE, 1996; Edwards, Fitz and Whitty, 1989). During the 1990s a steady proportion of pupils - around 7 per cent - attended a private school (DfEE, 1997).

The shift away from social housing towards owner occupation is well-documented (Booth and Crook, 1986; Forrest, Lansley and Murie, 1984; Power, 1993); over two-thirds of dwellings are now owner-occupied. At the same time, attempts have been made to reverse the long-term decline in the private rented sector by providing incentives for private landlords and through rent deregulation, with some success

(Kleinman, Whitehead and Scanlon, 1996), although the sector still caters for only a small proportion of households.

Finally, in the area of pensions, contracting out of the state earnings-related scheme (SERPS) into occupational and personal pensions has been encouraged since the late 1980s. The incentives proved more effective than the Government anticipated and sale of personal pensions expanded rapidly, before falling off in 1993 (ABI, 1996).

1.2 The users of private welfare

This section builds on earlier work on private welfare usage (for example Besley et al, 1996; Johnson, 1987; MORI, 1993). The sources of data used here are the BHPS and the BSAS. The BHPS has detailed information on use of health services, both public and private, and is the first national UK survey that allows an examination of patterns of use across different private health services. It also asks individuals about their attitudes to equity in the delivery of health care. The BHPS re-interviews the same people each year, thereby allowing analysis of changes in individuals' attitudes and service use. The first five years of data (1990/1-1994/5) are used here. The BSAS has more detailed attitudinal information, asking both about respondents' satisfaction with the NHS and state schools, and about their support for those institutions in terms of government spending priorities and the principles on which they operate. It identifies people who have Private Medical Insurance (PMI) or have had recent private treatment, and those who themselves attended private school or have ever sent any of their children to private school, and hence allows cross-service comparisons. The data used here are from the 1994 BSAS[2].

Private Medical Care and Insurance

The BHPS differentiates between public and private use of a range of different health services. This article focuses on those services where there is significant public (NHS) provision: inpatient care, dental services, ophthalmic services, and community health services (physiotherapy, chiropody and health visitors or nurses). The variable "private health use", includes all these services plus outpatient care (for the one year in which data on outpatient services was collected). This article does not examine use of alternative health services which are not generally provided within the NHS (e.g. acupuncture).

The BHPS allows a distinction to be made between privately financed use (which this article focuses on) and publicly financed use of private services (e.g. having a hip replacement in a private hospital paid for by the NHS under the waiting lists initiative and treated here as public sector use since it is not purchased by the respondent)[3]. All the questions refer to health service use in the last year. Where the respondent reports using a mixture of NHS and private services, they are included in the "private use" category. Unfortunately the BHPS does not identify respondents who have PMI, so private health care paid for through insurance cannot be differentiated from out-of-pocket payments. However, most PMI plans do not cover dental or eye care, chiropody or health visitors or nurses, and only cover physiotherapy if it is the result of an inpatient stay, so these services are likely to have been paid for directly. In addition, the Office of Fair Trading (OFT, 1996) estimates that around 20 per cent of private patients pay directly for the sorts of treatment covered by PMI.

Table 1 shows there has been a general increase in the use of these private health services, particularly for dental and eye care. On the other hand, the proportion of respondents receiving private inpatient care each year has remained low and fairly constant. Table 2 shows the characteristics of BHPS respondents who report some private health service use in the last year, compared to users of NHS services only and to those who used no health services at all. (The sample is pooled across all five years: in other words, each individual appears for each year in which they were interviewed). Private users are slightly older on average than either NHS-only users or non-users, and have fewer children in the household. Private users are more likely than NHS-users to be male, although in general a higher proportion of women report health service use than men do. Private users are very much more likely to be homeowners than either NHS users or non-users, to have a high household income and to be employed. A higher proportion live in the South East, have qualifications at 'A' level or higher and identify with the Conservative Party. Propper (1998) confirms that these characteristics remain significantly associated with private use in multivariate analyses.

While these characteristics are much as we would expect, the users of one private service are not necessarily the same individuals as users of other services. Users of private dental care are younger on average than users of private health services in general, while users of private community health services (physiotherapy, chiropody and health visitors or nurses) are considerably older (with an average age of 56). Possibly related to this difference in age, users of private community health services are much less likely to be male. There are marked differences in the income of different service users. 55 per cent of private inpatients are in the top two-fifths of the income

distribution, compared to 53 per cent of private dentistry users, 46 per cent of private eye care users, and only 41 per cent of private community health service users. Respondents who report a private inpatient stay are a highly select group: much more likely to be Conservative Party identifiers (67 per cent as opposed to 52 per cent for private health users in general), to be homeowners (89 per cent), to be in a social class I or II (58 per cent), and to live in the South East (51 per cent).

One would expect users of both private and NHS services to be less healthy than non-users, since people use health services when they are unwell. This is true for the NHS services considered here, and for private community health services, but for private dental and eye care, users are on average healthier than non-users[4]. In addition, across all the health services, private users on average assess themselves as healthier than do their NHS-only user counterparts. Within private users, the users of private dental and eye care users are most healthy, while private inpatient care users are the least well. This suggests that those in the private sector are in better health on average, but inpatients - whether cared for in the private or public sector - suffer poorer health.

Analysis of the 1994 BSAS shows that around 15 per cent of individuals had PMI, of whom just over half had premiums paid by their employer[5]. The analyses indicate that those with PMI are more likely to be male, to own their own homes, to have a household income of £15,000 per year or more, to have educational qualifications at 'A' level or higher, to be in a higher social class, more likely to be working, and working full-time, to live in the South East, and to support the Conservative Party than those without PMI. Those with employer-purchase PMI tend to have more extreme characteristics than those with own-purchase PMI - even more likely to be a homeowner, have high income and be Conservative Party identifiers - and they are particularly likely to work in the financial sector. Besley, Hall and Preston (1996), using BSAS for the years 1986-1991, confirm that income, owner-occupation, age, educational qualifications, and party identification remain significant even when other characteristics are controlled for.

Private education

The BSAS provides information on whether the respondent attended private school in the UK and also whether any child of theirs is currently at, or ever attended, private school[6]. In 1994, 11 per cent of the sample answered that they had been to private school. Of those who had ever had children, 12 per cent had sent a child to private school. Table 3 shows the characteristics of these groups. In interpreting this table, it

needs to be borne in mind that characteristics refer to the respondents' current circumstances, while the events in question (the respondents' schooling and that of their children) may have occurred some considerable time ago.

Respondents who went to private school are more likely to be home-owners, to have high household income, qualifications at 'A' level or above, and be in social class I or II, than are those who have not used private schooling for themselves or any of their children. They are more than twice as likely to be Conservative Party identifiers, and more likely to be living in the South East. Respondents who have ever had a child at private school are even more likely to be owner-occupiers, to have higher income, to be in a high social class and to be Conservative Party identifiers than respondents who themselves went to private school. The proportion who have qualifications at 'A' level or higher is slightly less than for respondents who themselves went to private school, although still considerably higher than the proportion of respondents who have never used private schooling. These characteristics remain significant in multivariate analyses[7].

2. IS THERE A PRIVATE WELFARE CLASS?

A private welfare class can be defined in terms of repeat use of a particular service (for example, individuals who opt for a private provider of dentistry and always use that service privately), in terms of whether use of one private service is associated with use of other private services (for example whether use of private dental services is associated with use of private inpatient services) and in terms of repeat use over time of one or more private services. Note that this meaning of a 'class' does not have the intergenerational meaning that might be appended to the term in a sociological context, though we do examine associated use by parents and children of private education.

Repeat use of a service

Table 4 shows that private use of a service one year is associated with use of the same service in another year. Of BHPS respondents who used a private dental service in the previous year, just over half use private dentistry again in the current year and just under a third (29 per cent) use NHS dentistry in the current year. Similarly, of those who used NHS dentistry last year, a high proportion use the NHS again this year (73 per cent) and a small proportion (just 8 per cent) use a private service this year. This suggests that both private users and NHS users are more likely to remain with the service they used the previous year than switch to the alternative; not surprising given

the search costs associated with medical care. So once the individual has used a private service they are much more likely to use private again. But private use does not mean the individual will not make further use of public health services. A higher proportion of people switch back to the NHS having used a private service than switch to private from NHS.

Use of other services show similar patterns. Of those using private eye care in one year, 27 per cent use again the following year, while only 9 per cent of those who used NHS eye care in one year use private eye care the next. Again, the proportion flowing out of private use into NHS use is larger than the proportion flowing in the opposite direction. The same applies to community health services and inpatient care.

These flows do not support the idea that service providers are encouraging individuals to use private services and then not allowing them to return to NHS care. If private providers are attempting to 'induce demand' their efforts seem to be thwarted by individuals who return to the NHS.

The BSAS provides some insight into repeat use of private education in the form of the relationship between parents' and children's schooling. There is a strong correlation between these two events: respondents who went to private school themselves are over six times as likely to send their child to private school (51 per cent compared to 8 per cent). This is increased to eleven times more likely if households in which both the respondent and his/her spouse went to private school are compared to households in which neither respondent nor spouse went to private school (66 per cent compared to 6 per cent)[8]. So as for healthcare, past use of private services increases the likelihood of use again in future, albeit in this case by other family members.

Use of different services

The second definition of a private welfare class is a group of individuals who use a range of private services. BHPS data indicate that individuals who use one private welfare service are considerably more likely to use another than those who use a public service. For example, 28 per cent of those who have private dental care in a year also have private eye care in that year, whereas only 6 per cent of those who have NHS dental care have private eye care in the same year. Use of private community health services appears to be associated with private inpatient care, but less with eye and dental care. These associations are stronger when service use over the entire 5-year window is considered. Of those who have some private dental care over the period, 48

per cent also have some private eye care in the period, as opposed to 17 per cent of those who have dental care under the NHS only.

The proportion of times a service used is private (within a five year period) is linked more strongly than use across services within the year[9]. The correlation between use of private dental and eye care within one year is 0.11, and rises to 0.43 for the proportion of times a private service was used. Similarly, the correlation between private community health services and private inpatient care is 0.20 and 0.36 respectively for association within a year, and the proportion of service use that is private over five years. Correlations between other combinations of private health services are all positive although weaker. It seems that *repeated* private use of one service has a greater effect on the likelihood of using another private service than one-off private use.

On the other hand, although associations between use of private health services are evident, they occur alongside considerable mixing of private and NHS use. Even within a given year and within the same service, some people use both NHS and private. For example, 5 per cent of those who use dental services in a year report both NHS and private use and 4 per cent of eye care users report use of both sectors. These proportions rise if a window of more than one year or a combination of services is examined.

Some of these links are because of the entitlement rules as only particular individuals are entitled to free dental and eye check- ups, and such entitlement may affect the rest of their dental and eye care. To examine the effect of entitlement, individuals over pensionable age were excluded from the analysis on the grounds this group are likely to use public care. The results still indicate considerable association between use of one private service with another. Some of the repeat use is because individuals have bought private medical insurance so that the cost of using private health services (primarily inpatient services) is small when care is needed. Links between private health treatment and PMI can be examined from the BSAS[10]. About half of those reporting some private medical treatment in the last two years currently have PMI which indicates a significant amount of private health use is not paid for through insurance. Nevertheless, those with insurance are much more likely to have had recent private medical treatment than those without: 43 per cent with PMI had private medical treatment as opposed to 7 per cent without. But again, those with PMI do not use private health services exclusively: the same proportion of those with PMI as the rest of the sample visited their GP in the last two years, and a similar proportion had been

an outpatient at an NHS hospital and in fact a slightly lower proportion of the insured than the uninsured reported having an inpatient stay in an NHS hospital (46 per cent as opposed to 52 per cent for uninsured)[11]. The reasons for this mixture are to do with both the nature of the service - GPs act as a gateway for access both to NHS and private treatment and in the case of outpatient visits, many outpatient treatments are not covered by PMI - and the nature of the uninsured compared to the insured, the latter being healthier.

There is also linked use across different areas of welfare. Table 5 shows that those who have ever sent a child to private school are much more likely to have PMI or to have had private medical treatment within the last two years. Respondents who went to private school themselves are also much more likely to have PMI or to have had private medical treatment. The first column of Table 6 shows the association between use of health, education and tenure. For this analysis, 'private health' is defined as having private medical insurance or having received private medical treatment in the last two years, 'private education' is defined as self, spouse or any child having attended private school, and 'private tenure' as private renting or owner-occupation. Just under half the sample have private tenure only, and they form the largest single group. About a quarter of the sample have neither private tenure, nor private health, nor private education. At the opposite extreme, 5 per cent of the sample have some private use in all three categories. The remainder of the sample has various combinations of private welfare, the largest groups being those with private tenure plus either private education (9 per cent) or private health (12 per cent).

Contributions to pensions is another important area of welfare provision that may be public or private. BHPS data provides information on the links between private tenure, health and pensions[12,13]. The second column of Table 6 reports the proportions of the sample with each possible combination of private welfare in the year. The largest group of respondents – 31 per cent – has private tenure but no other identifiable private welfare. The next largest group – 29 per cent – has private tenure and pension, followed by those who have no private welfare at all (14 per cent). Those with private tenure, health and pensions in the year form 11 per cent of the sample. So in summary, from the two data sets we get a similar picture: if a private welfare class is defined as those who use all private services within a year, only a small minority - between 1 in 10 and 1 in 20 individuals - fall into this class.

Not unexpectedly, income, education and political colour are all associated with use of several private services. Those with all three components of private welfare in BSAS

data are the most likely group to have household incomes of £15,000 per year or above; those with no private welfare are the least likely. Those with private tenure plus either private health or education are more likely to have high household incomes and high education than those who have just a single component of private welfare. Those who have all three components of private welfare are most likely to identify with the Conservative Party (62 per cent), followed by those with private education and private health (58 per cent), followed by private tenure plus either private education *or* health (47 and 43 per cent respectively). The proportion identifying with the Conservatives is considerably smaller in the groups who use only one component of private welfare, ranging from 36 per cent of those with private education only, to 25 per cent of those with private tenure only. Only 12 per cent of the 'no private welfare' group are Conservative identifiers. On top of these differences there are some which are functions of age rather than socio-economic position. Those who have private tenure, health and pension, or who have private tenure and private pension but no private health in the year, are less likely to have high household incomes – perhaps because these groups include higher numbers of retired people.

4. RELATIONSHIPS BETWEEN ATTITUDES AND USE

Groups differentiated by their consumption of private and public services may have distinctive attitudes and mark significant social divides (Dunleavy and Husbands, 1985; Saunders, 1986; Burrows and Marsh, 1992). Understanding the links between the use of private services and people's attitudes to public welfare is important for policy purposes. A number of links are possible. Users of private services may be less supportive of public services than others, either on ideological grounds or because they see little personal return from services they themselves do not use. Alternatively, users may be strong supporters of public welfare, either for reasons of altruism or ideology, or because they are 'frustrated' public users who would prefer higher state spending to achieve better collective provision, or because use of the sectors is complementary. Finally, use of either public or private services may itself change attitudes.

Evidence from previous studies is mixed. What is does indicate is that these relationships are likely to be complex and difficult to disentangle (Taylor-Gooby, 1989). Busfield (1990) argues that in the case of the UK system of medical care, the distinction between public and private users is too poorly defined to be useful. However, Calnan, Cant and Gabe (1993) find that people with PMI are more dissatisfied with the NHS and tend to emphasise individual responsibility for health and health care, although still believing in free health care for all. Propper (1993) considers

the possibility that political beliefs may affect the decision to purchase PMI, but it could equally be that purchase of PMI and other components of private welfare affect political beliefs. Besley, Hall and Preston (1996) show that having PMI is associated with a lower probability of supporting increases in spending on the NHS, and this is found to hold even when allowance is made for other characteristics (Brook, Hall and Preston,1997). No strong evidence is found for a link between the use of private schooling and attitudes towards public spending on education, however, either at the national or local level (Emmerson, Hall and Brook, 1998).

To probe the relationships between use of private welfare and attitudes towards state provision further, the article examines both satisfaction with, and support for, state services, taking into account the range - and where possible the intensity - of private services used. Using panel data it is possible to try to tease out causality by examining attitudes prior to, and after, use of services[14]. In contrast, most other studies have relied on cross-sectional data, where the direction of the relationship between attitudes and use is difficult to determine. In interpretation of the results, the caveats articulated by Taylor-Gooby (1982, 1985, 1986) and others (for example, Judge and Solomon, 1993; Judge *et al*, 1983, 1997) need to be borne in mind. They suggest an ambiguity in attitudes towards welfare, namely, a high level of satisfaction with and support for state services on the one hand, and a preference for the expansion of private alternatives on the other.

Use and current attitudes

First, cross-sectional evidence on the relationship between use and satisfaction with public services is considered. The 1994 BSAS contains one question about satisfaction with the NHS overall, subsidiary questions for each of GP, dental, inpatient and outpatient services, and one question about whether the respondent thinks the NHS is well run. This can be matched to PMI coverage and use of health services in the last two years. Table 7 indicates that those with PMI express less satisfaction with the NHS in general but the difference between the insured and the uninsured is not statistically significant[15]. In contrast, those who have had recent private medical treatment are slightly more likely to be satisfied with the NHS in general, but again this difference is not significant. Larger differences emerge in satisfaction with inpatient and outpatient services: both those with recent private treatment and those with PMI are less likely to be satisfied than their non-private use counterparts, and these differences are significant.

A general question about support for government spending on the NHS is also asked. While Brook, Hall and Preston (1997) found that having private health insurance is associated with a lower probability of supporting increases on public health spending, even when other characteristics of respondents are taken into account, having had private medical treatment in the last two years (as distinct from having PMI) appears to make no difference to the likelihood of putting health as first priority for government spending (45 per cent agree in both groups). Having PMI or private medical treatment is however associated with being less likely to think the government should spend more or much more on the NHS (82 per cent as opposed to 90 per cent). A possibly more revealing question asks whether the respondent agrees that the NHS should be available only to those on lower incomes[16]. Those who have had recent private treatment or have PMI are less likely to oppose such a restriction on the NHS than those who have been a NHS inpatient or outpatient in the last two years, or those who are non-users (Table 8). PMI, and to a lesser extent, private health use, therefore seem to be associated with reduced support for the principle of universal free health care.

This finding is given support from an analysis of the attitudinal questions in the BHPS. Respondents are asked in four of the five years to state how strongly they agree or disagree with two statements. These are (i) "It is not fair that some people can get medical treatment before others, just because they can afford to pay for it", and (ii)"All health care should be available free of charge to everyone regardless of their ability to pay"[17]. Unsurprisingly, private use is associated with less support for the principles of the NHS. For the data pooled for 1990-95, 70 per cent of those who used either no health services or only the NHS agreed with the first statement. For those who used some private health care, this percentage, while still a majority, is 64 per cent. On the other hand, 85 per cent of those not using health care agree to the second question, falling to 82 per cent for those using NHS services, and 80 per cent for those using some private health care that year.

For education, the BSAS provides data. In 1994, a sub-sample was asked whether they thought state schools were well run. Those who ever had a child attending private school are less likely to think schools are "very well" or "well" run (42 per cent compared to 54 per cent for those whose children did not attend private school), as are those who attended private school themselves (50 per cent compared to 53 per cent). However neither of these differences are significant at the 5 per cent level. Two questions in the BSAS relate to support for state education in general. Respondents are asked whether education should be the top spending priority, and whether the government should spend more on education, even if that means higher taxes. In 1994,

those who went to private school themselves were more likely than others to list education as the top spending priority (41 per cent compared to 29 per cent), but were slightly less likely to believe the government should spend more or much more on education (72 per cent as opposed to 76 per cent). Those who had a child who ever attended private school were less likely to put education as top priority (27 per cent as opposed to 34 per cent) *and* less likely to want more spending on state education (63 per cent as opposed to 75 per cent). But Brook, Hall and Preston (1997) controlling for other characteristics of respondents find no strong evidence for an association between having a child who ever attended private school and demand for public expenditure on education.

Attitudes and use over time

In the case of health care there is therefore evidence that use of private services (in particular having private insurance) is associated with less satisfaction with NHS hospitals and slightly lower support for greater spending on the NHS or its preservation as a universal service. This does not, however, give an indication of the direction of causality. Does use lead to attitude change, or do attitudes determine use?

First, it should be noted that attitudes shift somewhat over the period, either due to real change or sampling variability. The overall majority in favour of the 'queue-jumping unfair' statement rises from 67 to 70 per cent between 1990 and 1995. On the other hand, the overall majority in favour of the 'free health care for all' statement falls from 84 to 81 per cent. Against this backdrop, Table 9 classifies the sample by attitudes at the beginning of the period and examines their subsequent use. It shows three groups: those who make no use of health care in the 5 year window, those who use only NHS services, and those who make use of private care at some point. The findings are instructive. First, at the start of the period those who go on later to use private services are somewhat less likely to agree with the 'queue-jumping unfair' statement than the other two groups. They are also slightly less likely than non-users (but not than the NHS-only users) to agree with the 'free health care for all' statement. This offers mild support for the idea that those using private services are slightly less favourable to the principles of the NHS than others.

By the end of the period those who do not use health care at all change their views little. Meanwhile, the support for the 'all health care free for all' by those who have used private services does fall - from 84 to 81 per cent. But looking at the rest of the table it cannot be inferred that private use leads to fall in support for the NHS, as

almost exactly the same fall occurs for users of NHS-only services. On the first question, the responses actually go the other way: both those using NHS-only services and private users increase their support for the idea that queue jumping is unfair. In other words, it is not only the NHS users, who have perhaps seen others jump ahead in the queue, who become increasingly egalitarian, but also the "queue-jumpers" themselves[18].

5. Conclusion

Use of private welfare has been growing in the last ten years. Alongside the well-publicised growth in home-ownership there has been an increase in the use of private health services, particularly dental and eye care, and of private pension provision. This article has used two major UK household surveys to examine the determinants of this use and to investigate whether there is evidence of a private welfare class.

In support of the idea, private welfare users are distinctive. They tend to have higher household incomes, to have higher educational qualifications, and to be Conservative supporters. There are a group who are repeat users of private services: these are richer, more likely to support the Conservative Party and have higher educational qualifications than individuals who use privately services rarely. There are strong links between private use, both within and between services. Previous private use of health services appears to make current private use much more likely. There are also links across generations: for education: respondents who went to private school are considerably more likely to send their children to private school than respondents who did not. Associations between private use of different services are evident within health between dental and eye care, but also between private education and private health care, and between private pensions and private health care. All are linked with owner occupation.

This private welfare class is not large. Roughly 1 in 10 individuals in the BHPS have private tenure, health and pensions, while in the BSAS, just 1 in 20 have three components of private welfare broadly defined (tenure, health and education). For most, consumption of private welfare services has not gone beyond private tenure. Very few who are not in private tenure use other private services, and even of those who are in private tenure, only a small minority go on to use other private services. Moreover, private welfare users do not live by private services alone: there is considerable movement within a year and over time between the NHS and private sector; likewise in education, parents may choose a private secondary school for their

children but use the state sector for prior and subsequent periods. Private welfare users benefit indirectly from public sector finance, for example from mortgage interest tax relief, from tax relief on PMI for the over-60s, from education funding through the Assisted Places Scheme and tax exemption for schools, and from funding for private and occupational pensions through tax reliefs and rebates.

Evidence on the relationship between attitudes towards public services and use of private services is complex. Use of private health care and education appears to be associated with lower support for the principles of free universal provision. But there appears to be little evidence that increasing private use undermines support for the NHS. Both public and private health care users maintained high levels of agreement with the principles of free health care and treatment according to clinical need, and their attitudes over the period 1990-95 moved in tandem rather than in opposite directions. This may in part be due to the high proportions of private service users who return to NHS use, or who use the NHS for other services. The most important distinction in the relationship between attitudes and use is between users and non-users, rather than between users in either sector: non-users tend to have more egalitarian views than either NHS or private sector healthcare users.

Private welfare is likely to be used by different people for different reasons. There will be some whose income and tastes are such that they buy the additional quality they feel is offered by the private sector whenever possible. There will be others who would like to use public services, but cannot, either because they are no longer eligible, or because the actions of the suppliers of the public service mean there is less service available (argued to be the case for NHS dentistry, for example). Even in the first group, the non-existence of some private services will limit the extent to which these users use only private services (for example, there is almost no private provision of accident and emergency health care). The data used here do not enable these different reasons for use to be identified, but the mixture of reasons perhaps accounts for the lack of a clear association between attitudes towards public services and private sector use.

The Labour Government in 1998 proposed a ‘third way’ for welfare reform, a path that was neither privatisation nor continued funding without change in the nature of public services (DSS 1998). To be successful, radical changes in health and education services require public support. The evidence presented here does not indicate that there is strong support for abandoning the principles of the NHS or for reducing public spending on health or education, even amongst users of private services - a group who

might be thought to be less sympathetic to state welfare. Those who consistently use a wide range of private welfare services do not constitute a large group and their attitudes to public provision are not strikingly different to others; most users of private welfare services continue to make use of the public sector. In addition, this article has found no evidence that over a 5 year period use of private healthcare services changes attitudes greatly. On the other hand, for services which are less strongly supported than the NHS the relationship between use and attitudes may be different. The results do show an identifiable group of between 1 in 10 and 1 in 20 persons who rely heavily on private services, and who - because of their higher incomes - will pay a large proportion of the taxes used to fund public services. Perhaps more worryingly for the public sector, it appears that it is use of the public, as much as use of the private services, that shifts attitudes away from support of a universal NHS.

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[1] NHS care, even when provided under contract to the NHS - for example by dentists - is treated as public provision for the purposes of this article.
[2] The latest publicly-available year at time of writing.
[3] The question for inpatient stays in the BHPS asks whether they were "free under the NHS" or "paid for privately"; for health visitors, physiotherapy and chiropody, two questions are asked, one concerning public or private service use, and the other whether the service was free or charged for, and it is the first question which is used in this analysis. For dental and eye services, the question asks "Did you get this on the NHS or was it private?", which could be taken to refer to either finance or provision; It is possible that respondents who paid for their dental care will be inclined to answer that the service was private even where it was NHS with a user charge, in which case private dental care will be over-estimated in the BHPS.
[4] The variable used is 'hlstat', self-rated health over the last year on a scale of 1 ("excellent") to 5 ("very poor"). Similar results are obtained using other definitions of health status available in the BHPS.
[5] PMI pays for care in a private hospital or in a private NHS ward. It is designed mainly for short-term acute conditions, and does not usually cover dental or eye care, preventative health care, pregnancy, alternative medicine or long-term care. Limited outpatient care is covered under some policies.
[6] Opted-out, voluntary aided and direct grant schools are not included in the definition, nor is nursery education.
[7] Probit regressions using the variables in Table 3. Results available from the authors.
[8] There are no data from this source on how many of the respondents children attended private school, or for how many years. A survey carried out by MORI for the Independent Schools Information Service (MORI, 1993) found that 74 per cent of parents of children at private school used the independent sector for their other children. On the other hand, 45 per cent of children at senior private schools had not attended a private "prep" (junior) school. Johnson (1987) also found that many children in private secondary schools had been to a state primary school or went on to a state sixth form, so clearly many parents combine use of private and state education.
[9] Intensity of use is defined as the proportion of years in which any service was used that some private services was used.
[10] The question in BSAS about private health use is general: "Have you had any private medical treatment in the last two years?".
[11] Some of these stays may have been in private beds or wards in NHS hospitals.
[12] 'Private tenure' is defined (as in BSAS) as owner-occupation or private renting. "Private health" is defined by the "any private health service use" variable described in section 2, and does not include those who have PMI who did not make use of it in the years in question. "Private pension" includes both contributions to, and receipt of, private and occupational pensions. It is defined by the respondent reporting membership of an employer's pension scheme, contributions to a private personal pension, receipt of a pension from a previous employer or from a spouse's previous employer, or receipt of a private pension or annuity.

[13] The question about contributions to personal pensions was not asked in the first Wave. Information about membership of employers' pension schemes was collected at Wave One, and subsequently only if the respondent moved jobs. It is assumed that employees who do not move jobs do not leave or join an occupational pension scheme.
[14] We are unable to observe either health service use or attitudes before the start of the Panel, which may of course affect subsequent behaviour and beliefs.
[15] Difference between mean satisfaction scores not significant at 5 per cent level.
[16] BSAS variable "nhslimit". The question reads: "It has been suggested that the National Health Service should be available only to those with lower incomes. This would mean that contributions and taxes could be lower and most people would then take out medical insurance or pay for health care. Do you support or oppose this idea?".
[17] These correspond to variables 'ophlc' and 'ophla'. A third question, corresponding to variable 'ophlb', is not used here because no clear pattern could be found in the responses. 'ophlb' records agreement or disagreement with the statement: "People who can afford it should have to take out private health insurance rather than use the National Health Service". The complexity of the question may contribute to the erratic pattern of answers.
[18] Analysis by type of service reveals similar patterns (not tabled here). Analysis of the impact of attitudes held at the beginning of the period on subsequent use shows no very clear pattern.

Table 1: Changes in private health care use over time

	Percent of individuals using private health service				
	1990/1	1991/2	1992/3	1993/4	1994/5
Private dental care	9.0	8.5	11.1	11.6	12.7
Private eye care	8.6	8.4	10.5	10.0	10.7
Private physiotherapy, chiropody, or health visitor or nurse	4.0	4.2	4.9	5.2	5.0
Private inpatient stay	1.0	0.9	0.8	0.9	0.9
Any private health service use	18.4	17.5	20.9	21.3	22.4
Base (weighted)	*9911*	*9458*	*9021*	*9054*	*8816*

Source: BHPS 1990/1-1994/5, cross-sectional sample by year

Table 2: Characteristics of individuals by health service use in the last year

Characteristic	**Some private**	**NHS only**	**Non-user**
Average (mean) age	48.2	45.2	46.3
Average (mean) number of children in household	0.39	0.54	0.43
	%	%	%
Male	47.5	42.7	55.6
Homeowner	81.9	70.4	63.3
Equivalised household income in bottom fifth of sample	15.8	21.0	21.3
Equivalised household income in top two-fifths of sample	46.8	39.2	36.0
Employed or self-employed	63.7	50.3	55.4
Full-time (if employed/self-employed)	80.6	73.0	81.2
Works in public sector if working	23.8	25.6	20.3
Qualification 'A' level or higher	46.3	36.3	29.5
RG Social Class I or II	43.1	33.6	26.4
Conservative Party identifier	51.6	39.6	34.5
S.East including London	40.1	28.7	29.9
Base (weighted)	*9783*	*24633*	*11844*

Source: BHPS, 1990/1-1994/5, pooled cross-section

Table 3: Characteristics of individuals who use or used private schooling

Characteristic	**Attended private school**	**Has/had child who attended private school**	**Neither self nor child ever at private school**
Average age	48	56	45
Average (mean) number of children in household	0.5	0.6	0.7
	%	%	%
Male	46	42	47
Homeowner	80	87	69
Household income less than £6,000pa	15	11	21
Household income £15,000 per year or more	61	70	47
Employed or self-employed	54	47	54
Full-time (if employed/self-employed)	81	72	67
Qualification 'A' level or higher	62	51	32
RG Social Class I or II	52	59	26
Conservative Party identifier	53	61	25
S. East including London	42	36	29
Base (weighted)	*396*	*239*	*2390*

Source: BSAS 1994

Table 4: Links between previous and current health service use

Dental *Of those who last year used:*	*This year percent who use:* None	NHS	Private	(% of all last year)
None	**77**	18	5	45
NHS only	19	**73**	8	45
Some private	20	29	**51**	10

Eye *Of those who last year used:*	*This year percent who use:* None	NHS	Private	(% of all last year)
None	**76**	16	8	69
NHS only	50	**42**	9	22
Some private	54	18	**27**	10

Physiotherapy, chiropody, health visitor or nurse *Of those who last year used:*	*This year percent who use:* None	NHS	Private	(% of all last year)
None	**90**	8	2	83
NHS only	43	**53**	4	12
Some private	37	12	**51**	5

Inpatient *Of those who last year used:*	*This year percent who use:* None	NHS	Private	(% of all last year)
None	**92**	7	0.8	89
NHS only	70	**29**	0.6	10
Some private	72	8	**21**	1

Source: BHPS 1990/1-1994/5, pooled cross-sectional sample of those in Waves 2-5 who were present at all five Waves.

Table 5: Relationship between respondent's and child's private education

	Percent who have child who attended private school
R attended private school	51
R did not attend private school	8
R and spouse attended private school	66
Neither R nor spouse attended private school	6

Source: BSAS 1994

Table 6: Private tenure, health, education and pensions

	Tenure, health and education (BSAS) %	**Tenure, health and pensions (BHPS)** %
None private	24.0	13.7
Private tenure only	44.0	30.6
Private health only	2.5	1.1
Private pension only	-	5.2
Private education only	2.3	-
Private tenure and health only	12.0	7.5
Private tenure and pension only	-	29.4
Private tenure and education only	9.0	-
Private health and pension only	-	1.2
Private health and education only	0.9	-
Private tenure, health and pension	-	11.4
Private tenure, health and education	5.3	-
Base (weighted)	100.0 *3469*	100.0 *46056*

Note: For BSAS, private tenure is owner-occupation or private renting; private health is PMI and/or private treatment in last 2 years; private education is self, spouse or child attended private school. For BHPS, private tenure is owner-occupation or private renting; private health is private health service use in the year; private pension is membership of occupational scheme or contributions to personal pension, or receipt of either occupational or private pension.
Sources: BSAS 1994; BHPS 1990/1-1994/5, pooled cross-section

Table 7*:* Private health use or PMI and satisfaction with NHS services

Percent "very" or "quite" satisfied with:	Private medical treatment in last two years		Private medical insurance	
	Yes	No	Yes	No
NHS in general	45	44	40	45 *
Inpatient services	58	64 *	56	65 *
Outpatient services	53	60 *	53	60 *
NHS dentists	66	59	61	59
Local doctor	81	80	79	80
Base (weighted)	*2480*	*366*	*2914*	*529*

Differences on rows marked * are statistically significant at the 95% level.
Source: BSAS 1994

Table 8: Private health use or PMI and opposition to restricting NHS to those with lower incomes

Health service use	Percent opposng restriction of NHS	*Base (weighted)*
PMI or private health treatment in last 2 years	75	*697*
NHS inpatient/outpatient in last 2 years and no PMI or private treatment	81	*1748*
Neither	83	*459*

See footnote in text for details of BSAS attitudinal question.
Source: BSAS 1994

Table 9: Health service use over time and attitudes at beginning and end of years in Panel

Health service use over years in Panel	Beginning of period	End of period
	Proportion agreeing or strongly agreeing with: *"Unfair that wealth buys medical priority"*	
None	71.7	71.7
NHS only	69.5	73.3 *
Some private	64.9	67.0
	"Free health care for all"	
None	85.5	84.1
NHS only	84.0	81.0 *
Some private	84.2	81.3 *

Differences on rows marked * are statistically significant at the 95% level.
"Beginning of period" is first year individual appears in Panel; "End of period" is last year individual appears. Unweighted, since comparison is between attitudes of the same individuals at beginning and end of period and no single set of weights applies.
Source: BHPS 1990/1-1994/5, longitudinal sample