

» Briefing

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Patient choice

Introduction

Attempts to give more choice to users of public sector services has been a major theme of the Labour government's public sector modernisation programme. Policies have been developed in health care, education and social housing that aim to give users a greater choice of publicly or privately owned providers, and to ensure that a proportion of the funding to providers follows those choices. The government believes that this will put pressure on providers to improve their services and make them more responsive to users' needs. Although the scope of 'choice' in health care is potentially large (including choice of treatment) this briefing looks at the development and impact of reforms to give patients a choice of provider for their planned hospital care. It is this aspect of choice that has received the most attention so far and has been a key part of the government's wider reform programme for improving quality and efficiency in the NHS in England.

How did choice policy develop?

Choices for patients have always existed in the NHS (patients have always been able to choose their GP, for example), but the idea that well-informed 'consumers' of health care can and should shape services by making choices is relatively recent. The related notion that the NHS should be 'responsive' to individual or local needs did not emerge in government policy documents until the 1970s, while the idea that 'responsiveness' could be shaped by the decisions of informed consumers, in addition to top-down decisions by clinicians or planners, began to be articulated from the late 1980s (Greener et al 2006).

The Conservative government first explicitly promoted the idea of patient choice as part of their 'internal market' reforms. The White Paper, *Working for Patients* (Secretaries of State for Health, Wales, Northern Ireland and Scotland 1989), set out a programme of action designed to 'give patients, wherever they live in the UK, better health care and greater choice of the services available'. The White Paper set out plans to give patients more information to facilitate a 'real choice' between GPs and proposed a reform, known as 'GP fundholding', which devolved budgets to GPs in order to 'allow practices and hospitals which attract the most custom [to] receive the most money'. In practice, under fundholding the choice of hospital lay largely with the GP (rather than directly with

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the consumer), whose choices on behalf of their patients were intended to facilitate competition among hospitals for elective (non-urgent) services. Research into the impact of fundholding on one clinical area (cataracts) has suggested that choice did not, in fact, increase during this period for either purchasers or consumers (Fotaki 1999).

Choice was not a priority when Labour first came to power in 1997. The NHS Plan, the main blueprint for NHS reform published in Labour's first term in office, rejected competition as a lever to bring improvement in the hospital sector and contained only limited references to 'patient choice' (Department of Health 2000). The document reiterated patients' rights to choose a GP (which had, in fact, always existed in the NHS), but also promised patients more information about GPs to help them make 'informed choices'. On choice of hospital care, the NHS Plan offered patients new choices over the date and time of their hospital appointment. However, it left the choice about the location of best hospital in the hands of the referring GP (Department of Health 2000).

The consultation process underpinning the NHS Plan had revealed widespread public concern over lengthy waiting times, and initially patient choice of hospital was further developed as a strategy to shorten queues for elective (non-urgent) treatment. In *Delivering the NHS Plan* (Department of Health 2002) plans were unveiled to offer patients, already on waiting lists, opportunities to choose 'alternative' hospital providers that had shorter waiting times in a series of pilots that began from 2002. Importantly, the same document also referred to 'patient choice' as a value in its own right; its absence in the past was described as a weakness of the 'old' NHS and patients were referred to as 'consumers'. *Delivering the NHS Plan* also unveiled plans to change the system of hospital payment, mainly to support the policy of patient choice. Under this new system called Payment by Results hospitals would be paid a fixed tariff per case treated. This would create, in theory, strong incentives for some hospitals to raise income by attracting and treating more patients.

In the patient choice pilots, patients with coronary heart disease across England, and some elective surgery patients in London, who were likely to wait more than six months (coronary heart disease patients) or eight months (London patients) for treatment, were offered faster care from an alternative provider in the NHS or independent sector. In the London pilots, funds were made available to help providers expand to treat more patients, and providers were paid for each extra case treated. Patients were supported by a patient choice adviser who helped them to decide where to receive treatment; free transport was provided to and from the alternative hospital and this form of patient choice was found to be popular with patients (Coulter *et al* 2005, Le Maistre *et al* 2003).

As the pilots were being rolled out, the government also completed a large public consultation on choice, which widened the discussion to include choices about treatment as well as provider and reflected public demands for more choice in end-of-life or maternity services (Department of Health 2003). In practice, choice of hospital provider for elective surgery has remained the main focus of patient choice policy. In 2004, the Department of Health promised a further expansion of choice of hospital to include a choice of 'four or five' providers at the point of GP referral, which would be expanded to include any provider by the end of 2008 (Department of Health 2004b). By this point, choice policy had evolved in government publications beyond a mechanism to shorten waiting times to becoming a driver of quality more generally and a means to improve the efficiency, responsiveness and equitable access to NHS services (Department of Health 2004b). Extending patient choice, it was argued, would correct two existing inequities. It would expand the right to choose a shorter waiting time for treatment, which had previously been enjoyed by a minority able to switch to the private sector (that had traditionally shorter waiting times). Furthermore, it would correct the bias within the NHS, where better informed (and more demanding) middle-class patients had been able to push for quicker or alternative treatments (Department of Health 2003).

How does choice currently work?

Since January 2006, patients needing a hospital appointment should have been offered, at the point of referral, a choice of four or five providers from a local menu commissioned by the primary care trust in consultation with local patient groups (Department of Health 2004a). Where clinically appropriate, the options should include local NHS trusts and foundation trusts, services provided by GPs within their surgeries (GPs with specialist interests), new treatment centres (NHS and private) and some existing independent sector providers. In May 2006, these local options were expanded to include an 'extended choice network' of providers from across England including foundation trusts, independent sector treatment centres and, since August 2006, approved independent sector hospitals (Department of Health 2006d, 2007a). Patients should be able to make appointments through the new 'choose and book' computerised system by using the internet or telephone. Printed and electronic information on providers has also been made available to support choice.

In orthopaedics, and all specialties by April 2008, an even wider choice should be available – any provider who meets Healthcare Commission standards, and agrees to provide care at the national price set under Payment by Results, can be added to the national choice list. From 2008/9 all choices should be made from the national menu, and primary care trusts (PCTs) will no longer be required to commission local options (Department of Health 2007a).

Who won't be given a choice of provider?

Military personnel and prisoners are excluded from the government's choice policy, and for some patients the full range of choices may not be available for clinical reasons (Department of Health 2007a). For example, if a patient needs access to intensive care services as part of their treatment there may be just one or two organisations in the local area that provide these (Department of Health 2004b). Referrals made within a hospital (consultant-to-consultant referrals) or from specialist tertiary care providers such as neonatal units are also exempt, although it is recommended that patients are given choice if possible (Department of Health 2007a). Because health policy is devolved to the administrations in Scotland, Wales and Northern Ireland, the UK government's choice policy does not apply there – only to patients residing and treated in England.

Progress with implementation

The latest findings of the regular national patient choice survey show that 44 per cent of patients referred for treatment in May 2007 (and eligible for patient choice) recalled being offered a choice by their GP (an increase from 30 per cent when monitoring began in May 2006 (Department of Health 2007f)). This compares poorly to the target of 80 per cent set by the Department of Health for April 2007 (Department of Health 2006g). However, the survey is administered at the time of the outpatient appointment, which could be several weeks after the initial GP appointment, raising the risk that those who don't report being given a choice might have simply forgotten. For those who remember being offered a choice, 79 per cent were satisfied with the process and 5 per cent were dissatisfied (Department of Health 2007f). The main negative comments were concerned with appointments taking a long time to come through, difficulties accessing the choice appointments phone line and dissatisfaction with long waiting times.

The Choose and Book electronic appointments system was introduced to support patient choice and allows appointments to be booked online in the GP consulting room, by reception staff, or later, using a password over the internet. Many appointments

are, however, still booked via paper referral due to implementation problems with the Choose and Book system. According to the latest official figures 'over 40 per cent' of NHS activity from GP surgery to first outpatient appointment is through Choose and Book (Connecting for Health 2007), against a target of 90 per cent for March 2007 (Department of Health 2006b). Additional guidance has been published with the aim of convincing more GPs and consultants to use the system (Choose and Book 2007).

The Healthcare Commission's most recent 'annual health check' of the NHS combined data from the national patient survey and uptake of Choose and Book to create a 'choice' target against which to measure PCT performance. They report that 70 per cent of PCTs had failed to meet this target and concluded that 'this is by far the worst level of performance for any of the existing national targets' (Healthcare Commission 2007).

It is not clear how much information is being accessed by patients to help support patient choice. GPs are supposed to give patients a 'Choosing your hospital' booklet to help their decision, although only 29 per cent of those who remember being offered a choice say they received the booklet (Department of Health 2007f). The Department of Health has announced an initiative to improve the targeting of information: under the Partnership for Patients Pilot Programme (that aims to improve support for patients when choosing a hospital and that runs from March to August 2007) patients can either book an appointment in the surgery, or be referred to a local library, who will direct them to appropriate information, answer questions and help book appointments online (Department of Health 2006a).

The NHS Choices website (www.nhs.uk), launched in June 2007, provides detailed information on NHS and independent sector providers to help patients compare options. It also includes a facility for patients to post their views on services. Routine data is not yet available on the rate of access by patients to the site or on the overall number (or nature) of comments left on providers.

What is the evidence on the impact of choice?

Patient choice of hospital at the point of GP referral is a relatively recent policy and there is as yet no formal academic evaluation published of what impact it has had on the NHS. A number of studies have been commissioned by the Department of Health, but they are in the very early stages of implementation (National Institute of Health Research 2007a, 2007b).

Impact on providers

A government-commissioned review of the existing evidence about the impact of user choice (drawing on the patient choice pilots, historical evidence from the NHS, the experience of choice in other countries and other public sectors) concluded that despite its popularity as an idea with the public, more choice on its own was unlikely to improve quality (Fotaki *et al* 2005). Evaluation of the London patient choice pilot concluded that the policy appeared to contribute to improved waiting times in the capital (Dawson *et al* 2004), but it is too early to say whether choice at the point of referral has led to real improvements in clinical quality of services in areas such as clinical outcomes, complication rates or rates of hospital-acquired infections.

The likelihood of patient choice driving improvements in quality appears to depend on two factors: the publication of evidence about the quality of providers and the use of that evidence by consumers to make decisions about where to be treated. As outlined above, the government has invested in the NHS Choices website, which allows patients to compare measures of quality across different hospital trusts. Research based on

analysis of people's responses to hypothetical choices suggests that there is an appetite for information about quality: the researchers found that quality measures such as health outcomes, waiting times and GPs' opinion were the most important factors for people when making a choice (Burge *et al* 2006). However, evidence about what is driving patients' choices in reality is currently limited. The Department of Health's national patient choice survey shows patients reporting that location and transport were the most important influence on choices in the current choice scheme (cited by 64 per cent of patients as important). Also important, but less so, are waiting times (21 per cent), reputation of the hospital (20 per cent), cleanliness (18 per cent) and quality of care (17 per cent) (Department of Health 2007f). The survey does not ask where patients get their information from in relation to the quality measures they refer to.

There is some evidence from early implementers of choice that suggests GPs make choices on behalf of their patients and use their own perceptions of quality to guide patients to (what they consider to be) the best providers (Rosen *et al* 2007). A poll of 1,000 adults by the think tank Policy Exchange found that although a majority of patients said they would welcome a 'scorecard' containing detailed information about the performance of hospitals (or GPs), only a minority said they would use the information to actually choose (16 per cent) or change their hospital (13 per cent) (Policy Exchange 2007). Some evidence from the United States suggests that the public release of performance data can lead to improved quality (Hannan *et al* 1994). Some studies have suggested that this improvement in quality is not driven by patients actually switching provider (Schneider and Lieberman 2001), but more by the impact on hospital managers concerned about the public image of their organisation (Hibbard *et al* 2003). The implication for the NHS is that choice may have an impact even if few patients actually use the information to switch hospitals in practice. In other words, the publication of performance information and the possibility that patients might act on this information could have the desired (positive) effect on the behaviour of NHS staff, without large numbers of patients switching in practice.

The government has recognised that hospital trusts are likely to promote and advertise their services to patients in the future and last year issued, for consultation, a 'code of practice' to govern how providers should market their services (Department of Health 2006c). Although it is not yet known whether (or to what extent) NHS providers are marketing their services to patients, one independent sector provider has already begun to market their services directly to NHS patients (Timmins 2007).

Equity

There is limited evidence so far of the impact of patient choice on equity: the government-funded evaluation in this area has only recently begun (National Institute of Health Research 2007b). As the policy was being developed some commentators had raised theoretical concerns that not all individuals might have the same capacity to make choices or use information equally (Appleby *et al* 2003). The review of evidence from other sectors and countries concluded that the impact of choice on equity was 'consistently negative' (Fotaki *et al* 2005). In Scandinavia, where choice of provider was introduced in the 1990s and early 2000s, young, well-educated patients with clearly defined treatment needs were most likely to take up treatment from a provider outside their local administrative area (Vrangbaek *et al* 2007). Evaluation of the impact of choice in the NHS will be complicated by the evidence that access to services was inequitable prior to the introduction of choice. For example, recent research has demonstrated that patients living in affluent areas travelled further than those in deprived areas to access inpatient care prior to the introduction of choice (Propper *et al* 2007).

Interestingly, in the London patient choice pilots, there were no significant differences in the take-up of choice by socio-economic group (Coulter *et al* 2005). This may be because each patient was supported by a choice adviser, who provided individualised support, and because of the free travel offered to each eligible patient. The Department of Health has recognised that some individuals need extra support to access information and make choices and has recommended that PCTs put in place measures to support choice, including personal help and translated material (Department of Health 2007a). However, there is no routine information on what efforts PCTs are making to support choice. The early evidence suggested only limited activity in this area despite some examples of good practice (Thorlby and Turner 2007).

Data from 2006 implies some potential inequality in those currently being offered a choice in relation to equity: 30 per cent of respondents from the 'white' ethnic group recalled being offered choice compared to 25 per cent of patients from all other ethnic groups (Department of Health 2006f). However, more detailed analysis, taking socio-economic factors into account, would be needed to investigate this further. More recent patient choice surveys have not published the data broken down by ethnic group (Department of Health 2007g). Further research is needed to understand the impact of patient choice on equity of access to services.

Patient choice beyond hospital care

Choice of general practice

The focus of this briefing is on choice of provider for planned hospital care because it has received the most policy development by government. However, one of the original aims of the choice policy was giving patients a choice of general practice; this was mentioned in the NHS Plan (Department of Health 2000) and was also a key aim in the 2003 White Paper, *Building on the Best: Choice responsiveness and equity in the NHS* (Department of Health 2003). But until recently, policies aimed at improving patients' choice of GP practice have not attracted much interest within government.

Over the past two years the idea of giving patients more choice of GP practice has again become prominent in government policy documents. The 2006 White Paper, *Our Health, Our Care, Our Say*, acknowledged that patients currently have little choice over their GP practice. Although in theory patients can choose to register with any practice, boundary list restrictions and closed lists mean they often have to register with the nearest practice with an open list rather than with their preferred GP. The White Paper proposes increasing choice of GP practice by opening up GP practice lists, supporting surgeries who wish to expand, and providing incentives for GPs to set up practices in areas that are currently undersupplied with practitioners (Department of Health 2006e). To enable this they have promoted the use of Alternative Provider Medical Service contracts that encourage commercial and voluntary sector organisations and entrepreneurial GPs to provide new primary care services. However, take-up of these contracts has so far has been limited (Walsh *et al* 2007). More recently, the Department of Health launched the Primary Care Procurement programme in March 2007 to increase the numbers of GPs in the undersupplied areas of Hartlepool, County Durham, Ashfield and Great Yarmouth. GPs, social enterprises and independent sector providers can bid to run additional primary care services in these areas (Department of Health 2007e). The commitment to add to the supply of GPs in deprived areas was reconfirmed in the government's interim report on the NHS review, although the expressed aim was to deliver equity of provision rather than more choice of practice in general.

Choice of treatment type

In addition to giving patients a choice of provider, the government plans to extend the choices patients have over the type of treatment they receive. Although the details have yet to be worked out, policy has emphasised the need for shared decision-making and allowing patients to tailor their treatment to their own preferences. For those with long-term conditions and users of mental health services, policy development will focus on choice of care setting as well as choice of treatment option (Department of Health 2006a). In maternity, by the end of 2009, all women will have choice in where they give birth (at home, in hospital or a midwife-led unit), the type of antenatal care they receive and the location of their postnatal care (Department of Health 2007d). The NHS End of Life Care Programme seeks to give patients the option to die at home (NHS End of Life Care Programme 2007). More recently, the government has published guidance on offering choice to patients with long-term conditions, but there are no details yet about how implementation of choice in this area is to be monitored.

The future of patient choice

Even though targets have been missed relating to the implementation of choice of hospital care, the architecture is in place for a substantial expansion of choice of hospital provider in 2008. From April 2008 patients needing elective surgery will be able to choose any hospital in England that 'meets NHS standards and price', including private sector providers, and the government has already reported that referrals are growing to this sector (Department of Health 2007c).

Nevertheless, as patient choice unfolds, there are still uncertainties surrounding the relationship between patient choice and other components of the NHS reform programme. For example, the recent government initiatives to strengthen the power of PCTs and GP practices as commissioners in relation to hospital providers include the use of tactics to intervene in the referrals between GPs and hospitals, mostly to keep the demand for hospital services within budgetary limits (Department of Health 2006d). These include the use of referral management centres, which add an extra stage to the referral process, whereby GP referrals are scrutinised by a third party for appropriateness. Choice guidance states that in these cases choice should be offered by the referral management centre clinician (Department of Health 2007a), but it is not known how effective this is or how it compares to the quality of choice being offered in the GP surgery.

Another example is the impact of practice-based commissioning (PBC) on patient choice. Practice-based commissioning is a system introduced across England by which participating GPs are given their own indicative budgets with which to purchase all their patients' care. This system provides incentives for GPs to carry out some procedures in their own surgeries that were previously undertaken in the hospital. Potential conflicts of interest have been recognised as the purchasers of services (GPs with their indicative budgets) may be the same as the providers (GPs providing, for example, an anticoagulation service in their surgery) (Audit Commission 2006), which might result in the reduction of choices on offer to patients as well as raising questions about the quality of care.

Beyond choice of hospital care, there is still a lot of detail to be worked out in order to deliver different kinds of choices, such as choice of treatment, or to enhance choice in different sectors, such as mental health, long-term conditions or palliative care. A big consultation on the future of the NHS has begun, entitled 'Our NHS, our future', which is being led by Lord Darzi of Denham, a minister from a senior clinical background. The interim report produced for the review emphasises improving quality for patients through clinician-led, evidence-based reforms to the design and configuration of

services locally. There appears to be less emphasis on patient choice as a 'mechanism' to lever up quality through consumer pressure, which was seen to be a characteristic of the reforms championed by Tony Blair. Indeed, Lord Darzi concedes, in an article about the review, that reforms such as patient choice and Payment by Results have been controversial and sat 'uncomfortably' with some NHS staff in the past (Darzi 2007). Nevertheless, the most recent speech by the Prime Minister, Gordon Brown, makes clear that the government has no intention of backing away from the choice agenda: choice of hospital provider (and the competition and financial incentives that come with it) is an important part of the 'forces for change' in the NHS. But, according to Gordon Brown, real change will come from taking choice to a new level 'moving beyond people being seen as simply consumers and empowering them to become genuine partners in their care' (Brown 2008). Much more detail is promised on how choice can be extended in the future, beyond hospital care to new sectors of the NHS and new groups of partners.

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