
4 Patient choice of hospital

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Patient choice is not new to the National Health Service (NHS). The nationalisation of hospitals at the founding of the NHS made it possible for a patient to go to any NHS hospital with a referral from a general practitioner (GP). In practice, however, GPs made these decisions on behalf of their patients and, for the majority of the 60-odd years since the inception of the NHS, patient flows to hospital have reflected the referral behaviour of GPs rather than patient demand.

There was a brief period under the earlier internal market (1991–7) when GPs were limited to referring patients to hospitals with which the health authority purchasers had contracts. So-called out-of-area referrals were possible, but required approval from the health authority. In contrast, GP fundholders had the freedom to refer patients wherever they liked, but for only a limited range of treatments.

Despite the avowed intent in the White Paper *Working for Patients* ‘to give patients, wherever they live in the UK, better health care and greater choice of the services available’ (Department of Health 1989, p 3), GPs did not consistently involve patients in decisions about where they were referred to. For more than 70 per cent of patients, the choice of hospital was made by the GP, despite claims that they offered their patients a choice (Mason *et al* 1994). The evidence from this earlier period of market reforms was that professional judgement took precedence over patient preferences. The standard of clinical care, proximity and convenience were most frequently mentioned by GPs as the most important factors affecting their choices (Mason *et al* 1994).

In 2002, the Labour government detailed its plans to strengthen patient choice: ‘Hospitals will no longer choose patients. Patients will choose hospitals’ (Department of Health 2002a, p 22). This document outlined plans to offer patients on long waiting lists the choice of faster treatment from an alternative hospital. The programme was piloted for coronary heart disease patients and those living in London, and was intended to make more efficient use of NHS capacity and to reduce waiting times. At the time, a quarter of a million people were waiting longer than six months for inpatient treatment (Department of Health 2004d). The use of patient choice as a policy tool to address waiting times followed similar initiatives in Sweden, Denmark and The Netherlands (Thomson and Dixon 2006).

Evaluations of the early choice pilots in England found it was popular with patients, although this is hardly surprising given that these were patients who were having to wait up to six months. The majority of the cardiac surgery patients offered treatment more quickly at an alternative hospital took up the choice (57 per cent), and the majority of those said they would recommend the scheme (89 per cent). Patients received support from a patient choice adviser, and travel and accommodation for an accompanying person, although some patients found this aspect of the scheme less satisfactory (Le Maistre *et al* 2003).

The London choice pilot offered the opportunity to be treated more quickly at an alternative hospital to patients who were likely to have longer than six months to wait for one of a number of elective surgical procedures. The majority of the extra capacity was in new NHS treatment centres (separate units dedicated to elective surgery at NHS hospitals) and other NHS hospitals, with only 5 per cent going to private hospitals. Only one-third of eligible patients were offered a choice, but the majority of those did take it up (67 per cent). The evaluation found no difference in uptake between socio-economic groups and, again, the majority were happy with their choice (85 per cent) (Coulter *et al* 2005).

The impact of choice on organisations was less clear-cut, largely because of the incentives and structural capacity issues they faced. Another component of the London evaluation found a convergence in waiting times between hospitals, and that the waiting times for participating hospitals that exported patients because they were not able to offer them sufficiently fast treatment, fell more quickly in comparison with the rest of England in ophthalmology and orthopaedics, but not in general surgery (Dawson *et al* 2004). The evaluation also found resistance from clinicians. Although there was no financial penalty for hospitals that exported patients, hospitals seemed reluctant to lose them (Ferlie *et al* 2005).

The majority of the additional capacity in participating hospitals that received patients came as a result of investment in treatment centres. In 2000, the government announced its intention also to set up diagnostic and treatment centres. In the first wave, 25 fixed-site centres and two mobile units were procured from the private sector to provide additional capacity for routine elective surgical procedures, with the first opening in 2003 (*see* Chapter 2).

As the government rolled out the choice pilots nationally, it announced that from January 2006 all patients would be offered a choice of provider when they were referred for their first outpatient appointment (Department of Health 2004d). The initial phase of implementation required that patients were offered a choice of four or five hospitals at the point of referral. This was extended from April 2008 to include any provider on a national list – NHS or private – that had agreed to provide care to NHS standards at the national tariff price. This shifted the policy from being one focused on waiting times, where the main objective was to make more efficient use of capacity, to one with a broader set of objectives. Specifically, the government hoped that choice at the point of referral would, as part of a set of market-related policies:

- improve efficiency in the NHS by reducing waiting times and streamlining administrative processes
- make hospitals more responsive to patients' needs
- improve the quality of the service provided
- improve equity by opening choice to all.

The remainder of this chapter will review the evidence on the implementation and impact of patient choice at the point of referral.

Implementation

The Department of Health tracked the implementation of patient choice through a national patient survey. Six months after the launch of choice at the point of referral, this showed that less than one-third (30 per cent) of patients recalled being offered a choice (Department of Health 2007b). This rose steadily to 47 per cent in March 2009, and then stalled, with the number recalling being offered a choice in February 2010 standing at 49 per cent (Department of Health 2010h). The same survey showed that the number of patients who were aware of their right to choose before visiting the GP had gradually risen from 29 per cent in May/June 2006, to 54 per cent by February 2010.

A more detailed evaluation of patient choice in four areas of England found that, by January 2009, although now entitled to a choice of any NHS or registered non-NHS provider, most patients who were offered a choice said they had been given between two and five options, with the inclusion of a privately run hospital in only 8 per cent of choices (Dixon *et al* 2010a). Interviews with GPs and patients in the same study revealed that GPs often offered choice in a tokenistic way, rarely initiating a discussion of the merits (or otherwise) of the options available.

Although many GPs could see the benefits of the choice programme in theory, they often resisted the routine offering of choice as they felt that most patients were not interested in making one, preferring the GP to decide on their behalf, and that, in addition, they did not have time to discuss the options with patients (Dixon *et al* 2010a). In a qualitative study, Barnett *et al* (2008) found that patients did want a choice, but did not want to be active choosers, preferring their GP to choose on their behalf.

We do not know how many patients used the offer of choice actively to choose a provider that met with their preferences. Some indication of this is given in the evaluation by Dixon *et al* (2010a), which showed that 5–8 per cent more of the patients offered a choice travelled to a non-local hospital than those who were not offered a choice. However, some patients will actively choose their local hospital, and others will be referred beyond the local hospital without that being their choice,

and so the authors noted that this figure did not quantify the total number of active choosers. It did, however, give an indication that offering a choice led at least some patients to attend a hospital other than the nearest one.

At the beginning of 2006, an electronic appointment booking system called Choose and Book was installed in hospitals and GP surgeries to allow GPs and patients to book their appointments online in the GP surgery or from home. Even before the Choose and Book system began, it generated a negative response from GPs: just over three-quarters (78 per cent) described themselves as feeling 'a little negative' or 'very negative' (Doctors.net 2005, p 7) about the idea of it, and 93 per cent felt that there had been inadequate consultation on the system (Doctors.net 2005, p 6).

Initial technical difficulties frustrated GPs who, under time pressure in their consultations, found they were often unable to log on to the system or that it crashed during a booking (Rosen *et al* 2007; British Medical Association 2009). They also complained that a lack of training made it difficult to keep up to date with the regular modifications to the system, and that the inability to refer to a named consultant (unlike in a traditional paper-based referral) broke the links they had established with hospital clinicians (Rosen *et al* 2007; British Medical Association 2009; Dixon *et al* 2010b).

The technical problems not only made GPs reluctant to use the system, but also damaged their opinion of the choice programme in general. Despite a target of 90 per cent of appointments to be booked through Choose and Book by March 2007 (Department of Health 2006c), and the inclusion of incentive payments to encourage its use, only half of first outpatient appointments were being booked through the system by 2010 (NHS Connecting for Health 2010). GPs were key to the implementation of this policy, and their lack of enthusiasm for the programme and reluctance to use the Choose and Book system meant implementation stalled.

Only 22 per cent of patients booked their appointment with a GP or practice staff on screen in the surgery. They more often received a letter with their appointment (34 per cent) or telephoned the booking centre (27 per cent), as some hospitals do not offer appointments online, due to technical compatibility problems between systems (Department of Health 2010h, p 17). The new system put more onus on patients to book their own hospital appointments, which inevitably heightened the risk of some referrals never being converted into outpatient appointments.

Two online information sources were available to help patients select their preferred hospital. The Choose and Book system listed providers by distance from the patient's home and gave an indicative waiting time for each. A government-run website called NHS Choices (www.nhs.uk) provided additional information for more detailed comparison of the facilities at different hospitals (car parking, accessibility, etc) and their performance on, for example, readmission rates, infection rates and patient survey results.

In addition, information booklets were produced by primary care trusts with information on the performance of local providers. However, much of the information available to patients was not necessarily relevant or presented in the most accessible format – for example, information on the performance of hospitals on the NHS Choices website was mainly presented at trust level, and might include four or five hospital sites. Furthermore, there was little information about specific conditions or treatments: other than for cardiac surgery, for which risk-adjusted survival rates for individual consultants are published online, there was no information available on the performance of individual consultants, although patients often said they would like such information (Boyce *et al* 2010).

Perhaps as a result of this, only 6 per cent of patients offered a choice reported that the booklet was the most important source of information in helping them in that choice, with only 4 per cent citing the NHS Choices website (4 per cent) (Department of Health 2010h, p 18). Most patients identified their GP as the most important information source when choosing (43 per cent of those offered a choice), followed by their friends and family (29 per cent) (Department of Health 2010h, p 18).

GPs reported that they distrusted the official performance statistics that were available to help patients choose, preferring to base advice on their patients' past experience at local hospitals and their relationships with individual consultants (Magee *et al* 2003; Rosen *et al* 2007; British Medical Association 2009; Dixon *et al* 2010a).

Taken together, this evidence shows that four years after patients were first entitled to a choice of provider in England, and despite the fact that half had ostensibly been offered a choice, few had had a meaningful discussion with their GP about the merits of the different options. A very small percentage had been given a choice of any willing provider, and only a tiny proportion had consulted performance information to help them choose. Nevertheless, there is some indication that a small number of patients did use choice to seek out care from a non-local provider. It could be that, either the threat alone of patients choosing an alternative provider, or a small number of active choosers, is enough to provoke a positive response in providers.

In the next section, we consider whether, despite implementation being incomplete, patient choice had an impact on the equity, effectiveness, efficiency and responsiveness of health service provision.

Impact

Equity

The Labour government promoted patient choice as a means of achieving greater equity in the NHS. Previously, the ability to access care more quickly than that available in the NHS had been restricted to those able to pay for private treatment, but, it was argued, giving NHS patients a choice of provider would, 'make the best available to all' (Department of Health 2003a, p 13). There were concerns that choice would, in fact, exacerbate inequities as more educated patients with the money to travel would reap the benefits of choice, leaving more deprived populations with poorer quality hospital services (Appleby *et al* 2003). However, Cooper *et al* (2009) found that the variation in waiting times across socio-economic groups reduced from 1997 to 2007, although they were not able to isolate the impact of patient choice from that of other reforms.

Policy-makers hoped that patient choice would improve equity by increasing taxpayers' support for the NHS and stopping the better-off from migrating to the private sector (Alan Milburn, cited in Barr *et al* 2008). Evidence from the British Social Attitudes Survey (Appleby and Robertson 2010) shows that public satisfaction with the NHS has been steadily increasing since 1997, and is currently at an all-time high of 64 per cent. These increases can be seen across all population groups. However, it does not appear that choice is a significant factor in explaining satisfaction, although waiting times, which choice was designed to improve, do have some association with satisfaction.

Finally, it was expected that competition for patients would motivate quality improvements in poor providers, benefiting patients in deprived areas where poor performance was often concentrated. Evidence on whether choice provoked quality improvement in providers will be considered in the following sections of this chapter.

So what evidence is there that the awareness and experience of patient choice differed between groups? Data from the national patient choice survey found that white patients and those aged 35–64 years were more likely to be offered a choice, and white patients were more likely to be aware of their right to choose and to get to the hospital they wanted (Department of Health 2010h).

However, this analysis did not control fully for respondent characteristics. A regression analysis conducted by Dixon *et al* (2010a) found that older, non-white patients and those with no educational qualifications were the most likely to think having a choice of hospital was important. There were no significant differences in who was offered a choice in terms of education, age or ethnicity. However, patients with degree-level education and those aged 51–65 years were more likely than younger patients and those with no qualifications to choose a non-local provider. Older patients and those educated to degree level were also more likely to be aware of their right to choose before visiting their GP.

Interestingly, patients who lived outside urban centres were also more likely to be offered a choice, and more likely to choose a non-local provider for treatment. This is consistent with the evidence in Chapter 6 showing that the largest increase in hospital competition in the 2000s took place outside the main urban areas.

When interviewed, GPs raised concerns that non-English speakers might be disenfranchised by the choice process (Dixon *et al* 2010a). Neither of these surveys was able adequately to capture views from patients with difficulties understanding English.

Discrete-choice experiments present patients with information on hypothetical hospitals and ask them to choose between them. This type of experiment was included in the evaluation by Dixon *et al*, in which one of the choices was labelled 'local'. Respondents who were more likely to stay at their local hospital irrespective of its other characteristics were those who:

- had no access to the internet
- had a low level of education (no formal qualifications or GCSE/O-level or equivalent)
- did not normally travel by car to their local hospital
- were living in cities and large towns
- were aware of their right to choose (Dixon *et al* 2010a).

This research confirms the findings of earlier discrete-choice experiments that found evidence of a social gradient in those prepared to travel to a non-local provider in hypothetical situations (Burge *et al* 2006).

Overall, there is mixed evidence on whether certain groups of patients were more likely to be offered a choice than others, although when controlling for other factors, less educated, older patients and those from black and minority ethnic groups appeared no less likely to be offered a choice than others. There is some indication of a social gradient in those exercising choice, and older patients and those living outside urban centres were more likely to do so.

Effectiveness

A core aim of the policy to increase patient choice was to improve the quality of services provided by the NHS. It was hoped that patients would seek out the 'best' hospitals, or at least choose the highest quality from among a set of options based on published data on quality such as hospital standardised mortality and readmission rates. In a market where prices were fixed, providers were expected to compete on quality.

A number of quantitative analyses considered the impact of competition on patient outcomes during the period (eg, Cooper *et al* 2011; Gaynor *et al* 2011), but these studies did not isolate the impact of patient choice from the impact of other elements of the NHS market that stimulated competition (*see* Chapter 6), such as per case reimbursement (Payment by Results, *see* Chapter 5), private-sector provision of NHS-funded care (*see* Chapter 2), and competitive tendering of services by commissioners (*see* Chapter 3). The question remains: did patient choice promote quality competition within the NHS?

As we cannot directly observe whether patient choices led to better outcomes, there are two main sources of evidence available to judge the impact of choice on quality. The first is whether patients said that quality was an important influence on their choices. The second is whether those running hospitals said that patient choice motivated quality improvements within their organisation. We consider this second point below under the section on responsiveness.

There is evidence from patient surveys that quality was important to patients, but it did not appear to be the most important influence on their choice of hospital. When patients were asked to name the single most important influence on their choice, being close to home or work was selected most often (by 38 per cent of those offered a choice), followed by personal experience of the hospital (12 per cent) and waiting times (10 per cent). Quality of care was the most important factor to only 5 per cent of respondents (Department of Health 2010h, p 10).

In a previous patient choice survey, patients were asked to select from a list as many factors as they felt to be important in their choice, rather than having to select just one as being the most important (Department of Health 2009b). In that survey, hospital cleanliness/infection rates was the factor most often cited as important (74 per cent of those offered a choice) followed by quality of care (64 per cent) and waiting times (62 per cent) (Department of Health 2009b, p 8).

Quality of care was also found to be important to patients in a more recent analysis of patient preferences in both real and hypothetical situations (Dixon *et al* 2010a). A choice experiment conducted in the north-east of England to look at older people's preferences for the time and location of cataract surgery found that whether or not a consultant performed the operation was the strongest determinant of whether patients accepted treatment at a particular provider (Lim and Edlin 2009). This could be seen as a proxy for the quality of the surgical procedure.

The evidence suggests that patients think quality is important. Although many patients are loyal to their local provider, some are willing to travel to an alternative provider to get quicker access or a higher-quality service in both hypothetical and real situations. If a patient has had a previous bad experience of his or her local provider, he or she will choose to avoid it in future (Dixon *et al* 2010a). There also appear to be some differences depending on the speciality and seriousness of the treatment required.

Efficiency

Another explicit aim of the policy to increase patient choice, especially in the early stages of implementation, was to improve efficiency by lowering waiting times. It was expected that patients would choose providers with the shortest waiting time and so bring about a better use of capacity.

There is some evidence from discrete choice experiments that, in hypothetical situations, patients choose hospitals with shorter waits (eg, Burge *et al* 2006, Dixon *et al* 2010a), but there may be a threshold after which waiting time becomes less important. In one hypothetical experiment, when waiting times were less than 10 weeks, they did not influence a patient's choice of hospital (Burge 2006).

In the patient choice survey, 10 per cent of patients said that waiting time was the most important influence on their choice of hospital, but this was the third most popular answer overall (Department of Health 2010h). In an earlier survey with a different question format, 62 per cent of patients said that waiting times were one of the factors influencing their choice (Department of Health 2009b), and in another study patients ranked waiting times as a 'somewhat important' influence on their choice (Dixon *et al* 2010a). The more waiting times reduced, the less likely patients were to cite this as one of the reasons for exercising choice.

Waiting times have decreased dramatically since 1997 (Thorlby and Maybin 2010), but it is very difficult to isolate the factors that have contributed to this decline, although it is likely that the setting of targets and strong performance management were key drivers rather than patient choice (Alvarez-Rosete *et al* 2005; Harrison and Appleby 2009; Connolly *et al* 2010).

Further efficiency gains were expected from the implementation of Choose and Book. It was hoped that this electronic appointment booking system would remove the need for paper-based referrals and streamline administrative processes within GP surgeries and hospital outpatient departments. By allowing patients to choose the time and date of their appointment, it was also hoped the system would reduce the number of patients who did not turn up to their appointments (Department of Health 2004a).

Despite some accounts that patients processed through the Choose and Book system were more likely to turn up for their hospital appointment than those booked via a traditional referral, there is no firm published evidence of this (Dixon *et al* 2010b). More than half of patients were not offered a choice of time or date for their appointment (Department of Health 2010h). The Choose and Book system made the process of referral more transparent, and standardised some referral processes (Dixon *et al* 2010b), but it is yet to remove the need for a paper-based system of referral, which is still run alongside it. GPs have been reluctant to use the system, and in 2010 it booked only half the appointments eligible (NHS Connecting for Health 2010). Hospital administrators often print referral letters from the system, pass them to clinicians to annotate and return to the administrator, who updates

the system (British Medical Association 2009). This falls well short of the efficiency gains envisaged from a paperless system into which clinicians directly input and assess information.

Responsiveness

As discussed above, one of the main mechanisms by which choice was expected to lead to quality improvements was by prompting providers to pay more attention to what matters to patients, that is, to become more responsive.

While providers were gathering market information, such as on the waiting times and quality of other local hospitals, and undertaking analysis, such as of referral patterns, they did not perceive that there were significant changes in market share as a result of patient choice (Dixon *et al* 2010a). Any changes resulting from choice were likely to have been masked by the increasing volumes resulting from the requirement to meet the 18-week waiting-time target.

At least some of the service developments mentioned by providers were intended to make the hospital attractive to patients, particularly the upgrading of facilities, but very few were as a direct result of investigating changes in market share or market research with patients.

Dixon *et al* 2010a identified many other factors that drove quality improvements in providers (*see* Box 4 overleaf). Some, such as meeting national targets and the need to comply with legislation, were common to all providers. Other factors, such as achieving foundation trust status or mission-driven changes, varied by provider. The report concludes that patient choice had an indirect impact through reputation: a provider's reputation would be enhanced by taking action to improve services, and patients would therefore be happy to choose that provider or to recommend it to friends and family.

Other reviews of the reforms have also suggested it was the threat of choice and not actual choice that influenced providers (Audit Commission and Healthcare Commission 2008).

What impact did this have on patients' experience of care? Patient-experience surveys have been conducted regularly since 2002 within the NHS, but there has been very little change in the overall scores and the NHS continues to perform comparatively badly on the extent to which patients are informed about and involved in their care (Thorlby and Maybin 2010). There appears to have been a slight increase in the proportion of patients who said they were asked for their views on the quality of their care while in hospital – from 6 per cent to 9 per cent between 2005 and 2008 (Garratt 2009, p 98). This suggests that more providers are recognising that, in order to keep patients loyal and to maintain their reputation, they need to ensure that every patient leaves having had a good experience. However, compared with other service sectors, this level of 'consumer' research is probably still relatively low.

Box 4 Drivers of quality improvement initiatives by providers

The study by Dixon *et al* (2010a) identified the following factors as key to driving quality improvement among providers:

- choice
- response to actual switching by patients
- response to anticipated or potential switching (a manifestation of a contestable market)

Other factors

External/national

- national targets/objectives
- National Institute for Health and Clinical Excellence guidance
- international directives
- legal/statutory requirements
- requirements of national regulators (Monitor, Care Quality Commission)
- relative performance on national indicators of quality

Internal/local

- capacity to change
- organisational prestige
- professionalism/intrinsic motivation
- commissioner/GP demands
- historic service configuration/quality
- patient feedback (through surveys, complaints).

Source: Dixon *et al* 2010a, p 134

Discussion

The implementation of patient choice in England during this period of reform followed several pilots and evaluations and was given significant support. The government invested in a new electronic booking system (Choose and Book), produced advertising and marketing brochures to promote choice directly to patients, published comparative information on providers (NHS Choices), and

provided incentives to GPs to offer choice. Despite these efforts, the evidence suggests that the overall impact on the NHS was limited.

As with the other market-related reforms discussed in this book, it is hard to untangle the impact of patient choice from the impact of Payment by Results (which was partly created so that money could follow patients, *see* Chapter 5) and competition (for which patient choice was seen as a key driver, *see* Chapter 6).

From the evidence presented here, it appears that patient choice has not, as some feared, led to greater inequities in access to care – indeed there is some (limited) evidence that differences in waiting times by socio-economic group reduced during this period. Despite concerns that better-off patients would be more likely to know about and exercise choice, those with the lowest levels of education valued choice more and were no less likely to be offered a choice. However, there is some evidence to suggest that older patients and those with no qualifications were less able to exercise their choice by travelling further to access care.

Consistent with previous research and the experience in other countries, although patients said that quality was an important factor in choosing, in fact few patients actually consulted published information about the quality of care when making their choice (Marshall and McLoughlin 2010). Patients continued to rely heavily on their personal experience, the advice of a trusted professional (usually the GP), and the reputation of a hospital – something that is constructed from a variety of ‘softer’ information sources.

The importance of the referring doctor has been shown to be critical in other systems with a longer history of choice of hospital. In one Dutch study, only one-third of patients had made their own decision about which hospital to be referred to, the rest had been referred by the GP and relied on their physician’s opinion (Lako and Rosenau 2009). Asked how they chose, 14 per cent indicated that reputation was the main factor, while 17 per cent mentioned other factors, including distance. Many patients said that quality was an important factor when choosing a hospital, and were in some cases willing to travel further or wait longer to access higher-quality care.

These findings are similar to those reported elsewhere. For example, a discrete-choice analysis of public preferences for surgical care in Germany found that the degree of specialisation and experience of the provider was the most important attribute, with patients willing to wait an additional four weeks to obtain surgery at a specialised institution (Schwappach and Strasmann 2007).

More easily observed factors such as waiting times are important to patients, but their impact on choice may be diminishing. Whereas during the choice pilots, a high proportion of patients was willing to travel to an alternative provider to be treated more quickly (Le Maistre *et al* 2003), under choice of referral, only an additional 7–8 per cent of patients travelled to a non-local hospital when offered

a choice, compared with those who were not offered a choice (Dixon *et al* 2010a). Waiting times were, by then, significantly lower than in the earlier pilot period, however, and the differences in waiting times between hospitals were smaller, with most achieving the target of 18 weeks from referral to treatment.

Despite the greater availability and promotion of information on differences in the quality of care between hospitals in the English NHS, patients are extremely loyal to local providers. This so-called stickiness has been observed in other studies, showing that convenience and distance may outweigh quality, reducing the likely impact of choice on the quality of care.

In Denmark, patients who refused the chance to be treated more quickly at a hospital outside their own county cited shorter distance, transport time and previous experience as reasons for being 'loyal' to the local provider (Birk and Onsberg Henriksen 2006).

In Canada, a survey of patients waiting for joint surgery found that the majority (63 per cent) were unlikely to consider changing surgeons to reduce their waiting time. Men, those with higher levels of education and those who had already undergone surgery were more likely to change. Those with a particular preference for a surgeon before referral, higher self-reported health status, and who thought the waiting times were acceptable were less likely to consider changing surgeons (Conner-Spady *et al* 2008).

There is little evidence to assess whether choice has had an impact on efficiency. The improvement in technical efficiency that was expected to be one of the potential benefits of the Choose and Book system was not realised, and although differences in waiting times were reduced, suggesting better use of capacity, these reductions cannot be attributed to the choice policy. Indeed, the additional capacity available in independent-sector treatment centres during this period (*see* Chapter 2) was not fully utilised, as many patients were not aware of the option to be treated by a private-sector provider and GPs appeared reluctant to refer patients to them.

Although providers were monitoring the demand for their services, they focused their efforts on attracting GP referrals rather than on promoting their services directly to patients. There is little evidence that the introduction of patient choice resulted in increased provider responsiveness to patients. A range of factors, including a desire to provide attractive services and ensure that the local population stays loyal, drove service improvements.

Perhaps most surprising was the geography of choice. Patients outside urban areas were more likely to be offered a choice and to attend a non-local provider. Providers were also focused on GPs and patients on the fringes of their catchment areas, recognising perhaps that patients and GPs in these areas were equidistant from several providers and were more amenable to switching their allegiances, whereas patients in towns and cities appeared more likely to stick with their

local providers, perhaps out of a sense of loyalty and identification and also their greater reliance on public transport (*see* Chapter 6 for more on the geography of competition and choice).

Policy implications

Patient choice of provider began as a policy to reduce waiting times, but by the time the Labour government had set out its market-based reforms in full, choice was seen as a key driver of competition between hospitals. The objective of efficiency, ie, making more effective use of spare capacity in the system, was superseded by the goal of responsiveness, ie, making services more patient-centred, with the underpinning philosophy being that hospitals would improve the quality of care as they sought to attract patients and the money that followed them.

The coalition government has again put choice at the centre of its English NHS reform proposals (Department of Health 2010d). The view is that a combination of greater information and transparency about the performance and quality of care, plus patient choice (now supported by GPs with real budgets and therefore with buying power), will result in a more efficient and higher-quality service (*see* Chapter 10 for a fuller discussion of the coalition's proposals to extend New Labour's market reforms). However, as long as GPs remain reluctant routinely to offer patients a choice, it is unlikely that policy commitments to expand patient choice will be realised. If patients remain loyal to local NHS providers despite the government's extension of the any willing provider market from elective care to other services, there are unlikely to be significant changes in market share and therefore few attractive opportunities for new entrants.

Under greater pressure to maintain financial viability, hospitals will be interested in maintaining activity levels and might therefore be keen to ensure that local GPs and patients view them positively. Guarding their reputation for quality may well act as a spur to improvement. It will certainly mean that hospitals will be eager to avoid scandals or public humiliation (such as by being listed towards the bottom of rankings and league tables). Given the evidence that patient loyalty is largely based on a positive personal experience, providers that want to thrive will make sure that every patient leaves having had a good experience and wanting to recommend their hospital.

While there is probably no going back on choice – the experience of other countries where patients are used to exercising choice suggests that they will not want it restricted – the evidence summarised here suggests that policy-makers should not rely on patients alone to drive quality improvement.