

What benefits will choice bring to patients?

Literature review and assessment of implications

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Objectives: To assess the demand for, and likely impact of increasing patient choice in health care. The study examined whether patients would like to exercise choice of hospital, primary care provider and treatment and investigated the likely impact of policies designed to increase choice on equity of access, and on the efficiency and quality of service delivery.

Method: Theory-based literature review including an analysis of the intended and unintended impact of choice-related policies in health care in the UK, rest of the European Union and USA. Selected papers focused not only on offering choice to individual patients but also evidence of the impact of choice by patients' agents such as GPs, and on the impact of introducing choice in education and social services.

Results: Choosing between hospitals or primary care providers is not currently a high priority for the public, except where local services are poor, e.g. have long waiting times and where individual patients' circumstances do not limit their ability to travel. When patients become ill, they are increasingly likely to wish to rely on a trusted health practitioner to choose their treatment. Better educated populations make greater use of information and are more likely to exercise choice in health care. The increase in inequality which this could produce might be reduced by specific provision of information and help, enabling less advantaged populations to make choices about health care. There was little evidence in the literature that providing greater choice will in itself improve efficiency or quality of care.

Conclusion: Although patients may themselves make limited use of choices, the existence of choice may in theory, stimulate providers to improve quality of care. Patients do however want to be more involved in individual decisions about their own treatment, and generally participate much less in these decisions than they would wish.

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Introduction

The British National Health Service (NHS) was originally designed in 1948 to give priority to collective needs rather than individual wants. Patient choice was not on the policy agenda in the United Kingdom until the market-oriented reforms in the 1990s.¹ Even then it was not vigorously pursued² and was mostly concerned with decisions made by general practitioner (GP) fund holders contracting services from hospitals on behalf of their patients. With the concept of citizen as consumer, occupying a central position in New Labour's approach to 'modernizing' public services,³

the current re-introduction of patient choice in England differs in its ambition and the scope of intended outcomes. Offering a direct choice to users, is expected to create the threat of exit causing the threat of loss of income to health care providers ('contestability' to economists), triggering improvements in efficiency, quality and responsiveness in the NHS. The other aim is to increase equity by extending choice, regarded as a good thing in its own right,⁴ beyond the affluent and articulate.⁵ There are also proposals to expand patient choice to primary care providers, treatment options and to diagnostic procedures.⁶

The purpose of this literature review carried out in 2004–2005 was to assess the demand for, and likely impact of increasing patient choice in the English NHS, including the intended and unintended consequences of choice-related policies. The study examined whether patients would like to exercise choice of hospital, primary care provider and treatment, and on the impact of introducing choice in education, social services and in informal payments. The synthesis of

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research findings was structured around the policy outcomes of quality of care and responsiveness (defined as reduction in waiting times), efficiency and equity.

Methods

We chose a theory driven approach to the literature review, as this type of evaluation is most relevant to understanding the results of policy interventions.⁷ This approach explores the theoretical assumptions underpinning a given policy as its 'programme theory', involving the stated and implicit policy assumptions and testing them against the published evidence.⁸ Policy documents concerned with patient choice have expressly stated their assumptions about what effects the policy will produce and through what mechanisms.³⁻⁵ In the present case we have also identified the relevant assumptions from a spectrum of normative theories, including market libertarianism, social rights of citizenship and rational choice theory, and descriptive theories concerned with decision making such as prospect theory and social judgement theory. The study design was therefore theory-based in the sense that our inclusion criteria for empirical studies were relevance to the assumptions ('programme theory') underlying patient choice policy rather than traditional standards or hierarchy of evidence (as in a Cochrane Review). These criteria, and the programme theory itself, implied what search terms (see below) were relevant to this study. Specific topics were identified and covered subsequently including: international experience of choice in health care, direct payments, choice of residential care home and the impact of release of performance information on choice. We have produced a critical synthesis of this literature by providing a narrative description of the nature and strength of the evidence, and its implications for choice in health care. The search for relevant evidence took the form of an extensive literature review drawing on research from the UK, European Union and USA, and on the knowledge of experts representing NHS managers, policy-makers and user organizations who took part in two panel workshops held in March and June 2005. Databases and key words searched in the review of the literature are presented in Box 1. A total of 5495 references were identified of which 295 were judged to be relevant on the basis of their title, keywords and abstract. These papers were fully reviewed. Full details of the selection of studies and of the data analysis are presented elsewhere.⁸

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Results

Assessment of the database

We found little literature on the direct impact of patient choice in the NHS internal market in the early 1990s. Most of the evaluations of the effects of introducing competition showed that health care providers – in particular, GPs – were the ones who actually made choices – they acted as 'agents' for patients rather than patients making choices themselves.^{2,9} More recent empirical studies on patients' attitudes to choice and the effects of choice are based on the findings from the London Patient Choice Project,¹⁰⁻¹³ a number of smaller studies and recent working papers reviewing the impact of choice and competition in English health care (for full details refer to the project report⁸). We also looked at reviews of the evidence of patient choice in health care and education,^{14,15} and other public services^{16,17} in the UK and internationally. Surveys by Which?,¹⁸ Health Link¹⁹ and MORI²⁰ were also used to inform our analysis. Findings from empirical research published after the completion of our literature review²¹⁻²³ generally support the results presented in this paper.

Do patients want choice?

We drew a distinction between patient choice of provider (in primary and secondary care), on which there was limited research evidence, and patient choice of treatment, where the evidence base was considerably larger. Primary care in the UK has not attracted much interest in terms of patient choice but in research conducted by Which?, patients appeared to value availability of a good GPs in their neighbourhood over the opportunity to choose providers.¹⁸ However, in the London Patient Choice Project, patients expressed great interest in choosing their hospital if it meant substantial reduction of waiting time and where support for making choices was provided in form of trained advisers and subsidised transport.^{10,11} Satisfaction with these pilot schemes also depended on patients' perception of hospitals' reputations, referral patterns and the difference in length of waiting times, between local and alternative hospitals.^{11,12} In a survey of patients carried out by MORI²⁰ in 2004, patients rated choice of 'where and when they were treated' as the 11th most important aspect of their health care among 16 items, below car parking but above hospital food. Patients' ability to exercise choice of hospital was found to be influenced by age, gender, family

Box 1 Search terms used and databases searched

- (1) Keywords: words beginning 'choice' or 'choos' or 'judg' or 'decision' or 'market' or 'consumer'
- (2) Who makes the choice: words beginning 'patient' or 'user' or 'client' or 'parent' or 'child' or 'young people'
- (3) Service/professional area: words beginning 'care' or ('health' and 'service') or 'NHS' or 'hospital' or ('health' and 'maintenance' and 'organization'/'organisation') or ('general' and 'practice') or ('health' and 'profession') or 'doctor' or 'treatment'
- (4) Time period: 1985 onwards unless stated otherwise; language: English only
- (5) Databases: CINAHL, HMIC, ASSIA, Sociological Abstracts, Medline (1993–current), IBSS (restricted to words in the title), PAIS International, SIGLE, Philosophers Index, Social Science Index

obligations, socioeconomic status in a study that examined patients' hypothetical preferences.¹⁰ Patients over 60 years old, with an income below £10,000 and family obligations were less likely to travel to an alternative hospital. Limited evidence from health systems that share similar features with the NHS (e.g. Sweden), suggest relatively little enthusiasm by patients to take up choices, but that middle class, relatively young and urban patients were more likely to exercise choice.^{24,25} In one study from the Netherlands patients showed limited willingness for cross-border travelling to a neighbouring country even if it meant much faster treatment in high quality settings.²⁶

The impact of choice on health service delivery

There is little recent evidence from which to draw policy conclusions about the impact of choice on *efficiency* in England with an exception of one recent study, which suggests that the London Patient Choice Project introduced strong incentives for hospitals to treat more patients, although their uptake depended on providers' culture and capacity to implement them.¹³ The evidence from fund-holding experiments in the 1990s suggested that hospitals contracted by GP fund holders, acting as patients' agents, offered better prices and faster access to them.²⁷ Evidence of competition on efficiency in managed care introduced in the mid-1980s in the USA shows that reduced prices and costs, were mostly achieved through competition between payers (employers offering health plans) and not as result of direct user choice of provider.^{28,29} In Sweden, competition and choice introduced in several regions in the 1990s produced efficiency gains in the larger county councils but had mixed results for small local health economies.³⁰ Overall, there are many factors which influence hospital performance in addition to competition: they include pricing of services, payment methods to providers, internal organization and pre-existing culture.⁸

With regard to *quality* there is evidence that GP fund holders operating under the quasi-market reforms in England managed to improve care for their patients by reducing long waits and attracting on-site services from specialists.^{31,32} However, there is little evidence that fund-holding had much impact on other aspects of quality.³³ One study examining large data-sets concluded that the introduction of the internal market was associated with an increased mortality for patients admitted with myocardial infarction.³⁴ A review of the impact of competition on quality in the UK and USA concluded that it has been studied very little but pointed out that, overall in the USA, competition among hospitals tends to increase quality, more than in the internal market in the UK.¹⁴ Looking at international as well as UK experience, there is no consistent effect of choice on quality of care. However, our review did not identify any controlled study reporting whether any changes in quality of care happened in reality.⁸

Whatever the small gains in quality achieved under quasi-markets in the UK, they applied only to patients of GP fund holders' and that system of choice had negative implications for *equity*.³⁵ It was therefore rejected in 1997 upon New Labour's ascent to power. The London Patient Choice Project revealed no inequalities in access to choice offered for different patient groups,^{11,12} with reductions in waiting times reported for all patients, including those who did not participate in the project.¹² However, it also showed that only 32% of all patients eligible for the scheme were actually offered a choice of hospital.¹² The evaluation of an earlier pilot survey on coronary heart disease reported similar levels of exclusion but contained little data on the characteristics of excluded patients.^{36,37} A RAND¹¹ study concluded that different patient groups including elderly, female, or those with a lower education and low income, guardians of minors and family carers, place a different value on choice and are consequently less likely to select an alternative hospital to have their treatment. Evidence from choice policies implemented over longer time in primary and secondary education and social care in the UK and elsewhere, points to serious limitations in terms of the impact of choice on efficiency, quality and equity. The overall conclusion for the education sector is that it is the middle class users who are disproportionately more likely to benefit from choice because their higher income enables them to move into desirable areas, they are able to travel further and have better access to information although there are some exceptions to this (e.g. some improvements in education outcomes were revealed in inner cities in the USA after implementing voucher schemes).³⁸ The market has led to more socioeconomic and educational polarization,^{9,14,39,40} and a very few and rather limited benefits for pupils from less privileged backgrounds.^{9,14} In social care of older people we found that choice of provider has tended to reduce for a variety of reasons⁸ and does not appear to have produced any significant overall gains in quality and efficiency.⁴¹ The choice offered by direct payments is popular with some users,^{42,43} but may have adversely affected disadvantaged groups.^{41,44}

Choice and information

The introduction of patient choice in the NHS is premised on neo-classical micro-economic theory and presupposes the importance of information in making choices happen. A review of the impact that disclosure of hospital performance data had on users of services and purchasers concluded that hospitals (as opposed to consumers, physicians or purchasers) appeared to be the most responsive.⁴⁵ While information provision is a key element of choice, people appear to use published information only in certain circumstances – for instance when there is a single outcome of major importance and the data can be easily understood,⁴⁶ or in an absence of a meaningful and trusting doctor–patient relationship.²² The research from the USA

showed that relatively socially advantaged groups were significantly more likely to use performance data to make health care choices.^{47,48} A number of studies looking into the information about treatments found that a substantial proportion of patients appear to be insufficiently informed to be able to exercise choice effectively.⁴⁹

Choice and individual treatment decisions

In contrast to the relatively small literature on desirability and effect of choice of provider, there was substantial evidence of patients having strong preferences for being involved in individual treatment choices. Substantial gaps between patients' preferences for information and their actual involvement in decision-making during GP consultations have been identified, with up to one in three patients reporting that they received less information than they desired.⁵⁰ Moreover, patients in England are less likely to be offered these choices than patients in other countries.⁵¹ Yet these seem to be the aspects of choice that patients value well above the choice of provider.²³ Furthermore, patient choices about treatments involve decisions that are complicated and go far beyond the uncertainty of scientific evidence, also involving their beliefs about health and health care⁵² and their perception of risk.⁵³ Attitude to the medical profession affects patient choices too: patients are likely to leave treatment decisions to the doctor when they believe that the relationship with the consultant is important to their recovery or when they feel that the consultant cares for, respects and understands them.⁵⁴ Many patients may prefer to abdicate choice partly or entirely to their GP because they don't know that they can play an active role in decision-making, have a 'doctor knows best' attitude, wish to avoid regret or responsibility for possible failure of the chosen treatment or are reluctant to acknowledge the uncertainties of health care.⁴⁹ Actual choices also differ from hypothetical ones. In one study, six out of 10 patients compared to one in three members of the general public would prefer to leave treatment decision to doctors.⁵⁵

Discussion

Patient choice was introduced into the NHS to provide more responsive, personalized and efficient services while at the same time improving equity.⁴ It arguably represents an attempt to bring together the element of 'exit' as the tool of the market with the rights of citizenship conceptualized as 'voice' by Hirschman.⁵⁶ However, the consequences of a policy to introduce greater choice in health care are likely to differ depending on whether choice is used as a means to bring about increased efficiency, quality and responsiveness or whether its primary goal is about enabling large numbers of patients to exercise choice. In the first case, there will be no need for many patients to choose a different provider, only enough to signal to the

existing provider that something is wrong with their services. Achieving 'Choice for All'³ is a different matter altogether. In the market-orientated reforms of the early 1990s there was no information to help patients choose, which probably limited its uptake.⁵⁷ Yet, the support element of the London Patient Choice Project was an important aspect of its success, suggesting one way in which choice can be introduced to meet the needs of all population groups (e.g. providing an advice line for all who need it or paying for transport for the poor). Moreover, we used the evidence from other public sectors with longer experience of user choice such as social and residential services or education as guidance for what the long-term effects of choice in health might be. The findings of research suggested that providing choice may increase costs and that controlling such costs is liable to restrict choice as shown in the example of residential care in the UK and elsewhere.⁵⁸ Choosing a residential care home can be seen as analogous to choosing a hospital for a specialist consultation under the NHS 'Choose and Book' policy. The 'expert driven' nature of choices in both sectors is similar, but there are contextual differences which may affect the transferability of learning, including that social care choice is often made in a crisis situation, that a residential care home is likely to be the person's home for the rest of their life, and that financial issues are more likely to be a factor. There are several important points of comparison between education and health and therefore useful lessons to be learned. Education is in many ways different than health, because it is usually a much longer and continuous relationship and because selection made on the basis of academic ability is institutionalised in several education system including the UK.⁹ Also there is more scope for selection by mortgage and choosing to live in a more desirable residential area for the mobile middle class in education than it is in health care. However, research shows that it is difficult to examine and measure parents' willingness to exercise choice under various constraints imposed by the way choice is implemented, and by other constraints to access (i.e. purely geographical constraints in rural areas and the use of information by parents). Thus the experience of education is an important lesson for health, and it is easy to see how in an absence of supporting measures adverse selection procedures could operate in the NHS.

What choice (means) for patients?

Several studies have demonstrated that, in theory at least, most people would like to choose their GP, hospital specialist and the service they use – and that this preference is greater when people face long waiting times or poor local services.^{18–20} However, these results may not replicate across the whole range of health care decisions, patient groups and health care settings.⁴⁹ In particular, patients appear less likely to want to exercise choice when they are in a state of uncertainty,

vulnerability or distress preferring then to delegate choices to a trusted medical advisor⁸ but it is important to take account of heterogeneity of patients and doctors.⁵⁹ Although patients are interested in a range of choices about their health care concerned with place, time and form of treatment, individual characteristics including age income and ability to travel might affect these decisions, and therefore their exercise of choices. Also some users (e.g. elderly, poor and carers) will need additional support in order to make meaningful choices about their health care. But what is needed to facilitate choice in the consulting room is different from what is needed in the management boardroom. Making decisions about health issues involves acting upon complex technical and scientific information at a time of stress and vulnerability as the prospect theory suggests.⁶⁰ This is different from the way other consumer choices are made, and may require support from a trusted professional.

In any case the GP, as the patients' primary care physician, will continue to make choices for patients (e.g. about the need for referral and place of referral). Current 'Choose and Book'⁶¹ policy also assumes that GPs and indeed, government (via the National Institute for Health and Clinical Excellence [NICE]), will play a role in framing the choices which patients are offered. Patient choice is limited to options which survive this prior framing process.

Does patient choice bring about improvements in the health care system?

Choice could in theory be a driver for improving quality of care by improving access and reducing long waiting lists. However, there appears to be a potential tension between the overall improvement in service quality and efficiency which greater choice may bring about, and equity primarily, because of the differential access to information by the affluent and educated.⁶² The evidence reviewed questions the assumption of the pro-market libertarian theories^{8,63} that extending choice will on its own improve fairness and will be free of adverse consequences. The negative impact that choice may have on equity is twofold: first, not all patients will use the choices on offer without additional support, and second there is an opportunity cost to providing sufficient choice to enable everyone to be able to make choices about their health care. Although the threat of competition together with increased number of providers may further reduce waiting lists,¹² maintaining this element of choice may lead to inefficiency if there is a need to keep the supply of services high enough to make choice of provider an ongoing option for patients. We found no study which quantified how much additional capacity would be required to produce this scope for choice but the evidence from education suggests that if this does not happen it might be the providers who will choose the users of services.^{9,14} However, there were indications from other

public services that by financially stretching the system, choice could create problems for sustaining a universal access to health care as shown in the case of residential homes.⁵⁸ On the other hand, policy rhetoric about patient choice could still put patients increasingly in conflict with organizations such as NICE which have the power to restrict the range of available treatments, for instance by prohibiting treatments of unproven effectiveness. Arguments about choice of provider should also not obscure patients' overwhelming desire to be more involved in individual decisions about their treatment.

Conclusions

Introducing choice to health care is a complex process with potentially unpredictable results. Choice may or may not increase efficiency, it is likely to increase costs, and is probably more likely to increase than decrease inequalities. There are both theoretical reasons and practically realized examples to suggest that choice of health care can be beneficial to patients under a range of circumstances. However, there is little evidence that patients want increased choice in health care except where local services are poor or have long waiting times. Although patients may themselves make limited use of choices, the existence of choice may in theory, stimulate providers to improve quality of care. The literature also suggests that improvements in access, efficiency and quality will not follow automatically from increasing choice of provider, and policies to increase choice need therefore to be carefully coordinated with other policies designed to improve health services. More importantly, patient choice could result in winners and losers, with the affluent and educated turning out to be the most likely beneficiaries unless specific measures are taken to support disadvantaged groups. Finally, patients want to be more involved in individual decisions about their own treatment, and generally participate much less in these decisions than they would wish.

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Q1	We have changed Table 1 in the text citation to Box 1 as per the Box provided. Please confirm whether this is ok.	