

Patient Choice and the Organisation and Delivery of Health Services: Scoping review

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Executive summary

The goal of this scoping exercise on *Patient Choice and the Organisation and Delivery of Health Services* was to identify and assess the extent and nature of the evidence available on patient choice to guide National Co-ordinating Centre for NHS Service Delivery and Organisation R&D's (SDO's) commissioning of future research in this area. The other aims were to guide current policy-making and to benefit patients by highlighting research areas that are relevant to their concerns.

The process of scoping was built around literature review, expert panel workshops and the knowledge of team members. We initially reviewed the literature on different theories of choice and consulted key experts to build our analytical framework. We used a two-pronged conceptual framework deriving from economic theory and psychological accounts of how choices are made in reality. We focused primarily on individual choice, which forms the main plank of the current government policy in England. However, we also included literature on choice made by patients' agents (e.g. in quasi-markets by general practitioner (GP) fundholders), because choice as a market tool may bring contestability into health and other public services to influence providers' behaviour through the mere threat of economic incentives. Choice is also an essential precondition of an effective market.

We synthesised our review of the literature around three key indicators, which were efficiency, equity and quality, and we addressed these for health care in the UK (separating primary and secondary care where appropriate), health care in other countries, and experience from social care, residential care and education. We also looked separately at choice of health services (e.g. choice of hospital) and choice of treatment in the individual doctor–patient encounter. Our review is organised under several key themes, which are:

- do patients want to be able to choose their health care provider?
- how do they respond to choice of provider when choice is available?
- the impact of choice on efficiency,
- the impact of choice on equity,
- the impact of choice on quality of care,
- choice and individual treatment decisions,
- information and choice.

Do patients want to be able to choose their health care provider?

The key points we found here were as follows.

- Patient choice of health care is not currently a high priority for NHS patients. However, this has to be seen against a background of a service which has traditionally offered very little choice. Some recent experiments suggest that, when real choice is offered, it will be attractive to some groups of patients.
- Early studies from the early 1990s and the NHS internal market showed the dominant influence of providers over choice. Characteristics such as age, class, ethnicity and life circumstances affected patients' ability to travel to get treatment, and supply-side constraints such as the availability of providers and a perverse incentive structure for both commissioners and providers often operated to prevent greater choice.
- Primary care in the UK has not attracted much interest in terms of choice and there are very few studies specifically investigating choice in this sector.
- By contrast, there is substantial interest in patients choosing hospital for an elective surgical procedure where they face a very poor service at their local hospital (e.g. the London Patient Choice Pilots). Patients in these pilots expressed considerable interest in using choice of hospital if it meant a substantial reduction of waiting time and where support was provided to enact these choices.
- The latest studies suggest that the ability to exercise choice of hospital is strongly dependent on age, gender, family obligations, socio-economic status, and the nature of the health procedure involved. Those who are less mobile are less willing to travel.
- Evidence from health systems that share similar features with the NHS suggest there is relatively little enthusiasm by patients in other countries to take up choice of provider. It should be noted that most of these studies did not take place against a background of excessive waiting lists, as in the London Patient Choice Pilots.
- Choice of hospital in particular is more likely to be important to patients where the existing service is very poor, where there are long waiting times and where support is offered.

We conclude that there is not a strong groundswell of opinion asking for choice of provider, especially as some issues such as very long waiting times have been, in large part, addressed by other reforms to the health service in the UK. Although there maybe other reasons for introducing choice into the NHS – for example as a means of introducing contestability to improve quality – there is no empirical or

theoretical evidence about patients adopting or desiring a consumerist approach to health care.

How do patients respond to choice of provider when choice is available?

Evidence from primary care

There is little evidence that patients in the UK wish to change their primary care provider. In one experiment abroad (the quasi-market reforms in Sweden in the early 1990s), substantial numbers of patients changed primary care provider when given the opportunity but this probably influenced by the severe catchment-area restrictions to choice of primary care provider that existed before the reforms were introduced.

It is difficult to assess patients' willingness to choose primary care provider under conditions of insufficient capacity and with the existing disincentives that include boundary restrictions within tightly defined catchment areas as they currently operate in the UK. Choice is limited at present by such system-related barriers; some practices still have closed GP lists in many parts of the country. However, the impact of the 2003 GP Contract made it easier for patients to choose and change practice and data on the numbers of people doing so after the implementation of the Contract could be captured from Primary Care Trusts in the near future.

Evidence from secondary care

More recent evidence is based on the London Patient Choice Project and some other small pilots implemented during 2002–2003. These suggest that, in an environment of long waiting lists, patients respond to choice with enthusiasm. Uptake is reported as being as high as 65–75% in some cases, though more cautious estimates are lower when the data are disaggregated to account for uptake for different procedures. All London Patient Choice Project evaluations also imply lack of clarity in selection criteria applied for patients who were offered choice in pilots, which might in turn have influenced the uptake.

The few empirical studies that look at patients' and doctors' attitudes to choice and factors affecting patients' choice of hospital suggest that ease of access, reputation of the hospital, quality of care and waiting time matter most for patients while locality is the most important factor for GPs. GPs play a fundamental role in affecting patient choice.

In the quasi-market reforms associated with fundholding, GP fundholders made limited use of choice. Although they were willing to offer choice in theory, changes in secondary care providers were relatively uncommon.

The impact of choice on efficiency

There are a few studies that deal specifically with the impact of choice on efficiency. However, there is more research looking at efficiency in relation to competition and quasi-market reforms, in which increased choice is one of the elements of reform. Even this evidence was not conclusive as different studies use different methods and different practical and conceptual approaches to measuring efficiency. Our main findings were as follows.

- Variations in unit costs in empirical studies may reflect contextual factors rather than inefficiency.
- There are many factors which influence hospital performance in addition to competition that include pricing of services, payment methods to providers, internal organisation and pre-existing culture.
- Hospital efficiency improved slightly under the quasi-market fundholding reforms in the UK.
- In Sweden evidence from quasi-market reforms was mixed as higher productivity was associated with increased costs, and efficiency gains were found in some cases only.
- Managed care introduced in the mid-1980s in the USA reduced costs, but this was mostly achieved at the expense of user choice, and in some cases at the expense of quality.
- Direct empirical comparisons among countries are difficult to interpret due to a range of methodological issues and contextual differences and there very few analytic as opposed to descriptive comparative studies.

The impact of choice on equity

The main findings from the literature follow below.

- The impact of choice of GP fundholders on equity under quasi-market reforms in the UK was mixed. Some studies suggested that no inequalities occurred while other studies point to fundholders' patients received preferential treatment, implying inequalities of treatment.
- Evaluations of the London Patient Choice Project did not provide evidence of inequity but the evaluations did not consider patients who were not offered choice in the pilots, who were generally disadvantaged in terms of being older, sicker and poorer.
- Evidence from the USA suggests that relatively advantaged populations benefit from efforts to promote active choice and benefit disproportionately from better access to information.

The impact of choice on quality of care

There is very limited evidence on the impact of choice on quality of care. Some of the evidence again comes from quasi-market reforms where increased choice was one part of those reforms. Here are our broad conclusions from this literature.

- There are individual examples where increasing patient choice has been associated with increases in quality of care. This includes small reductions in waiting times experienced by patients in fundholding practices in the 1990s.
- Looking at health systems more broadly, and looking at international as well as UK experience, there is no consistent effect of choice on quality of care. However, the review did not identify any controlled study to ascertain whether any changes in quality of care happened in reality.
- Choice provided through quasi-market mechanisms may be associated with improvement in quality of care, reduction in quality of care, or no change.
- Increasing choice does increase the awareness among providers of the importance of quality of care. This may have beneficial effects, which have been difficult to demonstrate in empirical research.

Choice and individual treatment decisions

There is a more extensive literature on individual choices of treatment. This research that looks at different factors that affect choice identifies the barriers, which currently prevent patients from taking part in decisions about their health care. In contrast to the literature on choice of provider, a number of experimental studies have been conducted to identify ways of giving patients more meaningful choice. A number of key messages to emerged from this literature:

- patients are not currently sufficiently informed to make choices,
- patients benefit from participating in choices about their treatment,
- patients want information about choices of treatment, but they do not always want responsibility for choosing their treatment or care.

Information about choice

As in choice about individual treatment options, providing good and accessible information is central to giving patients the ability to make choices between providers. Much of the research in this area relates to

the ways in which patients, purchasers and providers make use of information on comparative performance of health care providers, and most of this evidence comes from the USA.

- In the USA the public release of information appears to have had little impact on consumer choice. The limited research from the UK echoes these findings. By contrast providers seem to be very responsive to this information (see below). Some later studies suggest that consumers may be becoming more interested in performance data from health care organisations.
- There is some evidence that information on provider performance influences purchasers' decisions, but the results are mixed and the effects generally small.
- Making data on performance publicly available increases efforts by providers to improve quality of care. However, poor performers withdrawing from the reporting process may in part explain some of the observed improvements in performance.
- Performance data is often poorly understood by consumers. Consumers choose providers on the basis of other characteristics not included in performance data (e.g. personal knowledge, geographical proximity).
- Recent research has been carried out in the UK to identify how to provide information to patients in ways that they would find meaningful.
- Evidence suggests that the existing differential use of information by more affluent consumers will lead to inequalities in access to care and might also have an impact on patients' ability to exercise choice.
- Other undesirable consequences of making performance data public include incentives to providers to avoid treating sicker, high-risk patients to improve performance ratings.

Important lessons

There are several important lessons to be drawn from our literature review that policy-makers could reflectively use in the decision-making process.

In terms of efficiency

- A key question for policy-makers is how much choice should be available to patients. Should patients, for example, be given choice of treatments that are very popular but ineffective (and hence inefficient)?
- A second key issue for policy-makers is whether capacity in some areas needs to be increased significantly to make contestability

between providers meaningful. This will increase costs, with uncertain effects on efficiency.

- There is also the need for clarity between payer and user choice because of different consequences for efficiency.

In terms of equity

- Introducing choice into the NHS clearly brings a risk of having an adverse effect on equity. This is mainly because wealthy and articulate populations are better able to take advantage of choice. To avoid it, specific measures will be needed to enable disadvantaged populations to benefit from choices that become available.

In terms of quality

- The key message for policy-makers is not to assume that choice will improve quality of care. In particular, the NHS needs to guard against hidden adverse effects on quality that may arise from policies being introduced as part of the wider choice agenda; for example, adverse selection to avoid high-risk patients or hard-to-detect reductions in quality that may be associated with fixed tariffs.
- The latter may be able to be achieved without raising expectations of choice to levels that the NHS may find difficulty in meeting.

Choice in individual treatment

- Such choice necessitates substantial changes in the way health professionals conduct consultations if patients are to share meaningfully and participate in decisions about their health care. Alternatives include a number of experimental ways of providing patients with information on treatment choices outside the constrained context of a time-limited consultation.

To improve information and enable choice

- The NHS and the Healthcare Commission should identify ways of providing information to patients in ways that they can genuinely use to enhance choice.

Evidence from other sectors

Experience of other public sectors with longer experience of user choice might be used to understand possible consequences and developments in health care, if due limitations are acknowledged.

- *Choice of residential care* has resulted in a reduction in the number of homes and an increase in the number of residents

entitled to the state support, with variable effects on equity and efficiency. The principal lessons for the NHS from this experience is that there is a risk that providing choice may increase costs in a way that is difficult to control, and that controlling such costs inevitably restricts choice.

- *Direct payments in social care* indicate conditions under which users benefit from their different forms, the barriers to information experienced by others, and the issues involved in ensuring and monitoring quality. Their careful evaluation is essential before replicating them in chronic conditions or mental care.
- *Choice in primary and secondary education*, has demonstrated the overall negative consequences for equity which are determined by income, access to information and travel costs, and a very few and rather limited benefits for pupils from less privileged backgrounds. This experience cautions about the real possibility of adverse selection in health care particularly for chronic patients.

We identified gaps in research on choice to guide future commissioning activities of the SDO.

- Equity is a key issue since choice is likely to make equity worse. Therefore we propose evaluation of the introduction of choice in terms of its impact on equity (e.g. differential uptake by different social groups), and development and evaluation of interventions specifically designed to use choice to increase equity.
- The second most important issue is to identify the choices that different user groups wish to make, factors influencing different kinds of choice, and the value and meaning attached to choice by those groups.
- Research looking into adverse selection of patients and manipulation of diagnostic categories in relation to competitive incentives in the NHS, or through perverse behaviour of other contracted providers, is also important because of their implications for both equity and quality.
- In terms of efficiency it would be important to know whether the choice policy actually does lead to contestability in the long run and what are the conditions that best facilitate it.
- Another important area is how to manage patients wanting ineffective or socially inefficient treatments through research into trade-offs involved in individual choice and personal responsibility for health by different groups.

Structure of this report

The report is divided into five sections. Section 1 outlines the project's objectives and describes our methods. Section 2 discusses the theories that have influenced patient-choice policies and describes the

analytical framework adopted in this scoping review. Section 3 presents the evidence we found for the impact of choice in the headings used in this executive summary. Section 4 discusses the policy implications of our findings for the NHS and Section 5 identifies gaps in knowledge and recommendations for future research.

Information about search strategy and workshops is to be found in Appendices 1 and 2. Appendices provide supplementary information on theories of choice (Appendix 1), residential care (Appendix 2), direct payments in social care (Appendix 3), primary and secondary education (Appendix 4) and choice of individual treatments (Appendix 5). Details on the studies reviewed are given in Appendix 6.

Disclaimer

This report presents independent research commissioned by the National Institute for Health Research (NIHR). The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the NHS, the NIHR, the SDO programme or the Department of Health

Addendum

This document was published by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) research programme, managed by the London School of Hygiene and Tropical Medicine.

The management of the Service Delivery and Organisation (SDO) programme has now transferred to the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. Prior to April 2009, NETSCC had no involvement in the commissioning or production of this document and therefore we may not be able to comment on the background or technical detail of this document. Should you have any queries please contact sdo@southampton.ac.uk