Choice? Bah! Humbug!

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Emergency services and choice

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Choice in health is the current shibboleth of the government. Choice is what people want. Choice is good for you. Choice will solve all your health problems. Choice will make you happy. Even health ministers with a tendency to speak in patronising and condescending sound bites talk up choice with a conviction not heard in all their utterances. Choice is what the market demands.

The National Health Service (NHS), whether we like it or not, **is** now a market. Private business is competing for work in primary care trusts (PCTs) and independent treatment centres. Many general practitioners now work out of premises which are leased from private business. Private investment in private finance initiative (PFI) hospitals is a well established fact. Foundation trusts (not the panacea that politicians and management think they are) will develop a corporate mentality similar to that of private enterprise.

Various agencies and opinion polls question the fervour and desire that the public have for choice in health. Most people surveyed by the King's Fund just want a good, local, reliable, and flexible health service that is there when they or their dependents need it, but acknowledging that a minority will find a practical benefit from choice in where, when, and from whom they get their treatment. Only 14% people will consider travelling away from their locality for treatment. The Fund does not comment on other core services such as education, utilities, and transport, as it is outside its bailiwick.

It is logical to see an adumbration here with respect to emergency work; will true choice extend into the prehospital area and the emergency department (ED)?

For choice to work in the way that the government is driving it there needs to be a choice of services available at the time of need, whether publicly or privately funded. A private company can readily provide a public service if the contracting is set up for them in the way they want.

The problem to solve for those who champion choice in emergency work is the time element. For choice to be available when a person experiences a severe life threatening illness planning and forethought will have been necessary. For those demanding unscheduled care for more benign conditions they will have time to consider their choices if they do not panic as to some extent choice is available already for acute unscheduled care: NHS Direct, walk-in centres, general practice, and EDs are there, but to suggest this is real choice is naïve. Private sports injury clinics and private practice for discrete and circumscribed problems are an option for a minority.

Privatisation of prehospital care (transport and paramedic) is feasible. The cost effectiveness of investing in prehospital care and the ability to raise revenue will vary in different parts of the country. For true choice the patient needs to be able to choose what they want at the actual moment of need as they decide to call an ambulance. This can work in two ways. Firstly, the patient can choose ambulance service A or B, details having been garnered from *Yellow Pages*; this is unrealistic for those with life threatening problems. Patients can be directly billed, in addition to or similar to any tariffs they pay now. Secondly, they can have an insurance policy and contract to a private provider. Impossible I hear you say? Maybe, maybe not.

People who live in major urban conurbations may have several NHS EDs to choose from; they can exercise a degree of choice using their local knowledge of quality, waiting times (yes! waiting times), parking facilities, and reputation. True choice for ED work, however, means private departments in a private hospital or an independent treatment centre.

A functioning ED with most of the bells and whistles is an option for private provision; contracted properly with guaranteed admission or follow up for their attending patients it can probably be financially viable. Such departments exist in parts of Australia. Alternatively discrete problems, such as sports injuries, ophthalmology, and ENT, can be mopped up with minimal infrastructure or investment needed and without having to have a fully equipped and staffed ED. It is not beyond imagination to even believe that foundation trusts will subcontract out some of their acute work.

When it comes to choice of who actually offers the treatment there are limitations in the NHS. The lottery of the roster will determine who is on duty on any one day. A woman with a pelvic problem will (and should ideally) see a female doctor or nurse if they want to, just as a man with a genitourinary problem may wish to see a male doctor; a patient may demand to see a consultant in ED rather than a junior doctor; a patient may be asked if they want to see a nurse practitioner or a doctor.

There are treatment options. Patients can choose to some extent between a local anaesthetic, procedural sedation, and a general anaesthetic; they may be well enough to refuse to receive alteplase for their acute cerebrovascular thrombosis; they may decline an antidote to a drug they have poisoned themselves with, decline analgesia, or refuse a blood transfusion. The list goes on. In essence, however, these are problems of informed consent and are not just choice per se. One day goodnatured but misguided and deluded management in a foundation trust may even try telling us to offer alternative therapies to our clientele.

Choice is a crucial implement of the free market; we live in a country and continent which espouses and supports the free market. Choice is available in virtually every decision we make in our lives. The downside is that if there is a surfeit of choice we poison ourselves. Too much choice and we risk undermining our wellbeing. It does not make you happier. Choice is a chimera. It has its limitations and must stop somewhere.

The way ahead for emergency care must surely be to maintain investment in existing acute services. Provide consistent properly resourced emergency care based on existing models. Consolidate what we already have. If this sounds like a threnody for what once was and what may be, perhaps it is.

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