



A REVIEW OF PATIENT CHOICE IN THE NHS

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Executive Summary

By December 2005 National Health Service (NHS) patients who may require elective surgery will be offered a choice of four to five hospitals at the referral stage, as part of the government's vision for a responsive, patient-centric health service. The Healthcare Management Research Group of Cranfield Postgraduate Medical School has been working with Bedford Hospital NHS Trust to evaluate the possible implications of patient choice, and this document provides an overview of the current situation and predicted changes.

During February and March 2004 a number of meetings were held with key NHS stakeholders, including Strategic Health Authorities (SHAs), Primary Care Trusts (PCTs) and General Practitioners (GPs) in Bedfordshire, Hertfordshire, Cambridgeshire, Huntingdonshire and Northamptonshire, and also the Department of Health in London. Conclusions from these interviews form the core of the research and are reinforced by a literature review of academic papers, news articles, books, government guidelines and opinion surveys. In particular, the process by which PCTs commission secondary care providers is assessed and the nine pilot schemes are evaluated. The Department of Health's report on pilots also provides a valuable insight into the practicalities of offering choice. Lessons learned from healthcare systems around the world are compared with current policy in the NHS, and finally there is critique of the challenges to the implementation of choice.

Summary of major findings:

- Traditionally patients' choice of secondary care provider has been restricted by referral from their GP. The patient choice initiative today is still fairly limited, pertaining to elective surgery patients only and a choice of time and location for surgery from a predefined list. GPs will still act as gatekeepers for patients to access consultants and specialists and patients will be further constrained by the list of providers allocated by their local PCT.
- Evidence from the pilot schemes is incomplete and conclusions are drawn from two evaluations, one for choice at the point of referral and one for choice at six months. Ease of access was the priority for patients in the pilot scheme at

referral stage, followed by the reputation of hospital. In the Cardiac Heart Disease (CHD) pilot the reputation of the hospital was patients' main concern, then waiting time.

- Evidence also points towards patients choosing to stay in their local hospital as they felt they lacked sufficient information on alternative providers. The quality and level of detail in the information provided to patients will be instrumental in the uptake of choice.
- There is still the need to address long-term capacity; many solutions offered have been short-term, such as using overseas teams and the private sector.
- The two main opportunities for hospitals under choice are to increase activity through taking on patients from PCTs struggling with choice at six months and to find areas to improve efficiency and cost-effectiveness to maximise the benefit from tariffs.
- Excessive change in the NHS during the last 20 years has resulted in disillusionment and scepticism towards any new initiative, and the choice agenda is seen to be politically motivated, suggesting that the cultural barrier to an effective implementation of choice will be great.
- Patients value the offer of choice even if they opted for treatment in their local hospital so satisfaction with the NHS may improve as patients feel they are being involved in decisions.

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Glossary

CHD	Coronary Heart Disease
CHAI	Commission for Healthcare Audit and Inspection
CPPIH	Commission for Patient and Public Involvement in Health
EBS	Electronic Booking System
ECR	Extra-Contractual Referral
FSO	Forum Support Organisation
GMS	General Medical Services
GP	General Practitioner
GPSI	General Practitioner with a Special Interest
ICAS	Independent Complaints and Advocacy Service
ISTC	Independent Sector Treatment Centre
LDP	Local Delivery Plan
MFF	Market Forces Factor
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NSF	National Service Framework
OATs	Out-of-Area Treatments
OECD	Organisation for Economic Co-operation and Development
PALS	Patient Advice and Liaison Services
PCA	Patient Care Advisor
PCG	Primary Care Group
PCT	Primary Care Trust
PPI	Public Patient Involvement
PPIF	Public Patient Involvement Forums
SLA	Service Level Agreement
SHA	Strategic Health Authority
TCI	To Come In (<i>confirmation of a date for procedure</i>)

Contents

1. Introduction	1
2. Background to recent reforms	3
3. Current policy on choice	7
3.1 Overview	7
3.2 Funding	8
3.3 Commissioning	10
3.4 Performance measurement and accountability	12
3.5 Capacity	15
3.6 Competition and marketing	17
4. Pilot schemes	19
4.1 Overview	19
4.2 Dr Foster referral pilot	20
4.3 CHD choice at 6 months pilot	24
4.4 Other pilots for choice at 6 months	26
4.5 Shorter waits to see a GP	30
4.6 Keeping inpatient waits under 12 months	31
4.7 Shorter waits to see a consultant	32
4.8 Summary	33
5. Literature review	35
5.1 Impetus for change	35
5.2 Decentralisation	36
5.3 Quality	38
5.4 Restrictions on choice	40
5.5 Competition	42
5.6 Patient choice in other countries	43
5.7 Summary	44
6. Alternative healthcare systems	45
7. Conclusion	49

Figures

Figure 1: Structure of the NHS	5
Figure 2: Patient choice website	14
Figure 3: An overview of the main patient choice pilot schemes	20
Figure 4: Public and private expenditure on healthcare as a percentage of GDP	46
Figure 5: Total healthcare spending as a percentage of GDP	47

1 *Introduction*

The NHS was founded on the value of an equitable service that is free to everyone at the point of delivery and funded by the tax payer, costing £57 billion a year to run at the end of 2003 and expected to rise to £76 billion by 2005 [Department of Health, 2003]. The level of resources allocated to the NHS in national plans from 2003 to 2005 is at record levels, with high growth promised for 2006-2008. In the budget announced on the 17th March 2004, Gordon Brown reaffirmed his pledge to an increase in health spending of 7.2%. However, spending on healthcare is outpacing economic growth: from 2000 to 2001 spending in OECD countries increased on average by 4%, whereas real GDP growth was around 2.3% [OECD, 2003].

The final Wanless Report, published in February 2004, concluded that “the UK must expect to devote a significantly larger share of its national income to health care over the next 20 years ... to catch up with the standards of care seen in other countries ... success or failure will ultimately depend on how effectively the health service uses its resources” [Wanless, 2004]. The main challenges to governments today are increasingly expensive drugs and technology, the progressively ageing population and a rise in chronic conditions, while health policy, in particular the financing and provision of health care, is the most high profile item on the political agenda [Dixon and Robinson, 2003] so any reforms are subject to intense scrutiny.

The public is more likely to be willing to pay for a properly funded healthcare if it feels that the money is being invested in line with its needs, therefore public opinion often steers policy decisions. Surveys highlight waiting times for elective surgery and specialist assessment as the two most important perceived failings of the NHS [Jowell *et al.*, 2000], while in a worldwide 2001 survey the vast majority interviewed agreed that “fundamental changes” to their health system were required [Blendon *et*

al., 2002]. These are therefore the issues the Government has chosen to address as priorities.

Today there are 450,000 more NHS operations and 860,000 more elective admissions than in 1997 [EFRS, 2004]. Similarly in this time waiting list numbers have reduced by more than 15%, with a current goal of choice to cut the amount of time patients spend waiting for surgery [Appelby, 2003]. In addition, the rise of consumerism and the service sector have led to heightened expectations among a more informed and demanding public; the Government therefore has strong incentives to make the NHS more responsive. “The largely intervention-based understanding of medicine, focusing on acute services and the expertise of consultants, is being replaced by one based on preventative, holistic and patient-owned treatment” [Bosanquet and Kruger, 2003].

Tony Blair first raised the issue of choice in his party conference speech in 1999, echoing Margaret Thatcher when he said “I want to go to the hospital of my choice, on the day I want, at the time I want. And I want it to be on the NHS” [Blair, 1999]. However the NHS Plan published in 2000 admitted that the NHS was ill-equipped to offer choice as it was “a 1940s system operating in a 21st century world, encumbered by over-centralisation, disempowered patients and no real incentives to improve performance”. Choice is currently at its lowest point in the history of the NHS [Bromley *et al.*, 2003]. A degree of choice has been available in the past but only to those who are articulate and informed enough to demand it or can afford private healthcare (currently around 10% of the population). It has been a long-standing tradition in Britain that patients have to be referred to a consultant by their GP. The Patients Charter of 1991 declared that as a patient you should “be referred to a consultant, acceptable to you when your GP thinks it is necessary” [Lilley, 2000]. NHS (General Medical Services) regulations in 1992 also state that “general practitioners may arrange for the referral of patients, as appropriate, for the provision of services”. The Patients Charter was abolished in 2000, but the status of GPs as gatekeepers to consultants has not changed, due to the efficiency gains and cost savings in limiting access to specialists. Patients today have a wider range of primary care options to choose from, including walk-in centres and NHS Direct, and in theory can choose their GP. However in reality many practices are oversubscribed and choice of hospital is essentially restricted to those with whom the Primary Care Trust (PCT) has a contract.

2 *Background to recent reforms*

During the last twenty years there have been regular upheavals in the infrastructure of the NHS. In 1989 NHS trusts, GP fundholders and the NHS Executive were established under the 'internal market', separating the function of purchasing healthcare from the function of providing it [Propper, Burgess and Gossard, 2003]. This meant that local health authorities and larger GP practices had the power to purchase healthcare for their patients. Fundholders negotiated a contract with each hospital, giving fundholders real clout but meaning that trusts were inundated with contracts. GPs could make extra-contractual referrals (ECRs), but these only accounted for 2% of hospital expenditure and the majority were for emergency or tertiary services [Lilley, 2000]. Fundholding ended in 1997 and in 1999 ECRs were abolished and primary care groups (PCGs) were established. PCGs negotiated Service Level Agreements (SLAs) on the basis of the forecast needs of all patients in their area for at least three years ahead, so choice was restricted as patients now had to follow the money.

The NHS Plan in 2000 set out ambitious ten year targets for reform, including shorter waits for hospitals and GPs, more doctors, nurses and beds, modern IT systems, cleaner wards with better food and greater power for patients [NHS Plan, 2000]. This was partly in response to criticism that spending has been without adequate reforms to ensure the funding is used effectively. Peter Lilley MP is one of these critics: "a key feature of the March 2000 budget was setting targets to spend more money on health. But spending more money as an end in itself is bizarre – it needs to be used more efficiently and in ways which satisfy patients' desires rather than bureaucratic needs" [Lilley, 2000]. Even with the record level of funding at the end of the 1990s

the standard in the NHS was still well below the European average [Walker, 2001]. In 2001 the Chancellor of the Exchequer concurred that “alongside the extra resources must come more reform and modernisation”, and subsequently commissioned Derek Wanless, former CEO of NatWest Bank, to “undertake a review of the long-term trends affecting the health service in the UK” [Wanless, 2002].

Prior to receiving the Wanless Report, the Government published ‘*Shifting the Balance of Power*’ (July 2001), defining a programme of structural and cultural change to empower frontline staff and patients to attain the targets laid out in the NHS Plan. The Modernisation Agency was established in April 2001 to lead the changes, with an advisory role to translate the NHS Plan into reality. It is also a centre of excellence, identifying and disseminating best practice. The National Institute for Clinical Excellence (NICE) is a Special Health Authority to channel funding into the most cost-effective treatments and to advocate equal access to these treatments. Strategic Health Authorities (SHAs) were created in place of the Regional Health Authorities, reporting directly to the Department of Health. SHAs are responsible for developing strategies within the NHS in line with government initiatives, ensuring that hospital trusts and PCTs plan and deliver on projects such as implementing patient choice. PCTs control 75% of the NHS budget and oversee the health services in their local area to ensure that the local community has the care it requires. This devolving of power was the first stage in meeting the aims laid out in *Shifting the Balance of Power* and achieving a primary care-led service. Figure 1 shows the current structure of the NHS since 2002.

The final Wanless Report followed in April 2002 and concluded that “the UK has fallen behind other countries in health outcomes. We have achieved less because we have spent very much less and not spent it well” [Wanless, 2002]. Other key points raised include the goal of a population ‘fully engaged’ in improving its health, with faster access, a personalised service and high quality care and informed choice. ‘*Delivering the NHS Plan*’, published in April 2002, sets out the goal of a more responsive healthcare system that allows patients to choose the hospital they receive treatment in, along the lines of the system in Scandinavia where patients who have waited for too long can opt for treatment elsewhere, and are provided with information on waiting times and the various options for treatment. ‘*Choice of hospitals: Guidance for PCTs, NHS Trusts and SHAs*’, July 2003, is the main policy guidance document, setting out the next steps to deliver the NHS Plan. The ‘*Fair for*

all and personal to you’ consultation was launched in August 2003 to debate questions around choice and equality. ‘*Building on the best - choice, responsiveness and equity*’ (December 2003) followed in reaction to this consultation, building on the NHS Plan and outlining the next steps in patient-centred care.

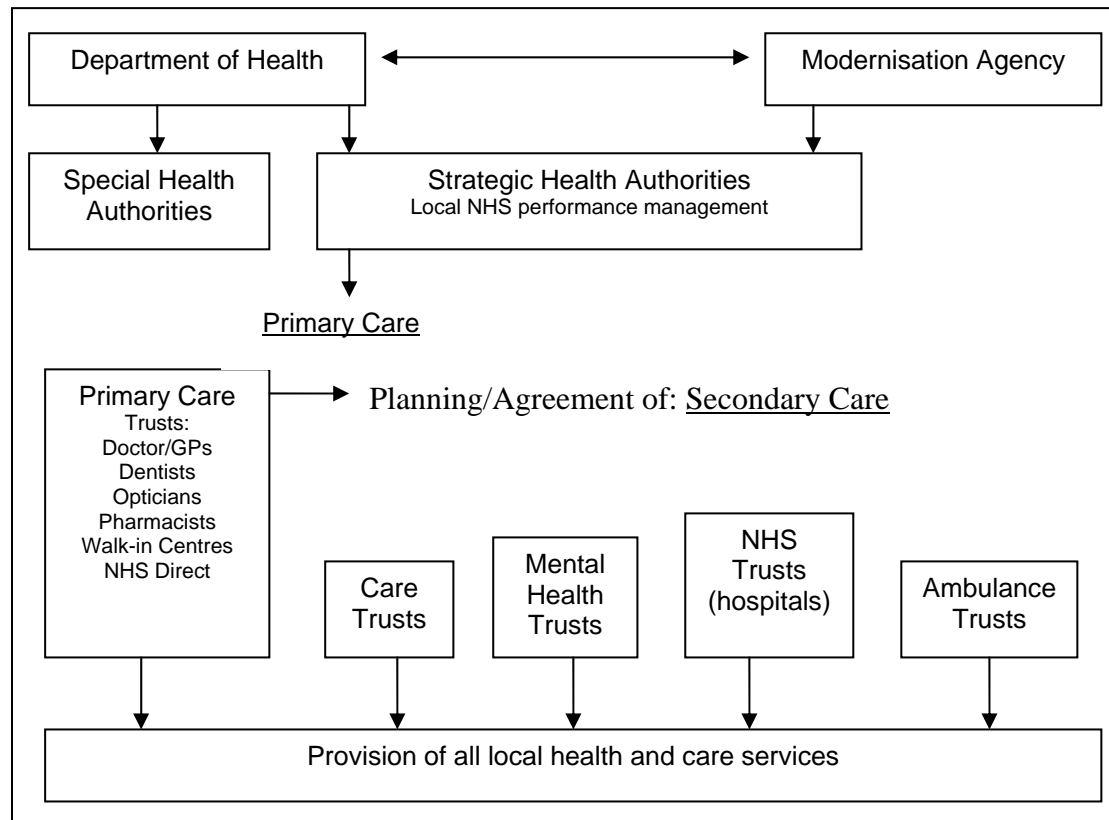


Figure 1: Structure of the NHS [<http://www.nhs.uk/thenhsexplained/howthenhsworks>]

3 *Current policy on choice*

3.1 *Overview*

Waiting, Booking and Choice is part of the wider strategy to give all patients fast and convenient access to health and social care services, including emergency and primary care. [NHS Modernisation Agency, 2003]. There are four major goals to *Waiting, Booking and Choice*. By the end of 2004, patients will be able to see a GP within two working days or another primary care professional within one working day; in addition, patients will wait no more than four hours in A&E. From 30th April 2004, choice at six months means that patients who have been on a waiting list for elective surgery for more than six months will be offered the opportunity to move to another provider for faster treatment. By December 2005 patients who may require elective surgery will be offered a choice of four to five hospitals at the referral stage, with waiting lists being replaced by booked appointments, underpinned by the roll-out of a national Electronic Booking System (EBS).

The technology to support choice will therefore be instrumental in the success or failure of the scheme, so that GPs and their patients can book a convenient appointment on the spot. GPs will only be able to access information on the four to five providers chosen by the PCT. Government guidelines for choice at six months state that each patient will be supported in their choice by a combination of the GP, primary care team, practice staff and a booking management service [Department of Health, 2003]. Patient Care Advisors (PCAs) have proved indispensable in the pilot schemes, but whether they will be retained under choice at the point of referral, or

amalgamated into call centres, has yet to be decided, and is likely to depend on each PCT. Transport must be provided by the PCT for patients, and possibly relatives and carers, if this would prevent them from otherwise choosing an alternative provider.

Subsequent sections of this report will now look at the fundamental aspects of the choice agenda in more depth, firstly focusing on the new funding system to facilitate patient movement between providers, followed by the process for PCT commissioning. The new performance measures are assessed along with the information requirements for patients, and then there is an outline of the plans for expanding capacity. Finally, the likelihood of a market arising for elective surgery and the idea of trusts advertising for patients are discussed.

3.2 Funding

“The key to making choice effective within a public service like the NHS is to make the taxpayers’ money follow the patient’s choice to fund the hospital they select” [Lilley, 2000]. The use of stronger market incentives has emerged as a dominant theme in the Government’s reforms [Lewis, Dixon and Gillam, 2003]. The Department of Health is overhauling the financial flows of the NHS, in particular the way in which hospitals are funded. As patients move around the system, hospitals need to be reimbursed for the work they do; from April 2003, phased implementation of ‘*Payment by Results*’ was introduced, based on similar schemes operating in the US, Australia, France and Scandinavia [Harrison and Appelby, 2004].

Payment by results incorporates three key themes. Firstly, there will be the introduction of national tariffs, developed using national Healthcare Resource Group analysis of treatments and costs, adjusted by a market forces factor (MFF) for geographical differences in cost. The aim of tariffs is to standardise the cost of treatments across the whole of the NHS in order to eradicate price discrepancies and price competition within the health service. Commissioners (PCTs) will be able to focus on the quality and volume of the services that they are obtaining from the trusts without the need to enter into lengthy price negotiations. This in turn will encourage trusts to improve the efficiency of their services whilst allowing them to keep track of

their costs. Cost and volume are the second factors in payment by results, steering the commissioning process away from traditional historically-based budgets, as payment to the trusts will be based on the volume of work that they carry out. This will provide an incentive for trusts to increase their activity in order to achieve realistic reductions in patient waiting times. The third factor concerns case mix. Case mix refers to different patients requiring a variety of differing treatments, e.g. a mix of routine treatments to more complicated surgery, so in short, case mix refers to varying amounts of complexity in the cases that a trust or specialties within a trust deal with. It is for this case mix, along with the amount of cases that they see, that trusts will be financially rewarded.

The current system for out of area treatments (OATs) will also be overhauled as part of the financial reforms. There is a payment system of two years unless agreed up front with the originating PCT that the receiving trust will be paid within one year. Extra-contractual referrals also led to disputes over who paid, and similar problems exist with OATs. For 2004-5, OATs will continue, adjusted in line with national tariffs based on data from 2003-03. Then from April 2005 OATs will be replaced, probably by direct payments for each activity outside of Service Level Agreements (SLAs), supported by risk sharing with the PCT based on historical levels of activity [Department of Health, 2004].

Through the new measures outlined above, payment by results will play a crucial role in the implementation of patient choice as the money will follow the patient and it will increase the accountability and efficiency within the trusts. As trusts are being paid by each activity this should drive efficiency and productivity as hospitals that can carry out more procedures will bring in more funding. The changes to the NHS financial system are being introduced gradually; between 2003 and 2005 a limited number of tariffs and commissioning by cost and volume are being implemented. These will be applied to most activities within the trusts between 2005 and 2008 with full implementation of payment by results scheduled for 2008. By 2005 the system will account for around 60% of hospitals' total incomes with the goal that by 2005-6 all services will be covered by a national tariff.

3.3 Commissioning

When PCTs were founded it was the intention that they “have a great deal of flexibility in commissioning in line with their patients’ and populations’ needs ... they will be able to choose the best way and place to deliver services for their patients, knowing that funding can follow” [Department of Health, 2003]. *Shifting the Balance of Power in the NHS* was clear in its intention to put the planning, commissioning and delivery of services closer to frontline NHS staff. The result was recognition that PCTs would have to take on significant extra responsibility [<http://www.natpact.nhs.uk>]. PCTs are therefore pivotal in the NHS, forming a link between the Department of Health and secondary care whilst also working closely with primary care providers such as doctors, dentists, pharmacists and social care. Part of their role will be in ensuring equity, through “articulating marginalised interests” [Lewis, 2003].

“Commissioning is the process by which PCTs identify the health needs of their population and make prioritised decisions to secure care to meet those needs within available resources. It includes longer term strategic planning, medium term planning (3 year local delivery plans) and the shorter term agreement and performance management of Service Level Agreements” [<http://www.natpact.nhs.uk>, 2004]. PCTs are effectively a replacement for fundholding [Butler, 2002], as their remit and purchasing power are comparable. Each PCT has an overall budget as specified by the Department of Health. With this budget it commissions work from a variety of trusts, usually within the local area, negotiating a contract with each trust and entering into a SLA. The amount of funding that is agreed between the two is largely based on historical levels – the budget from previous years adjusted for inflation. There is no real account of where the money is actually going and what precise activities it is spent on. It seems to be enough for the PCT and trust to agree on the funding figure and the hospital then uses the money in which ever way it sees fit to ensure that there is enough capacity to enable access and treatment for the local population. This type of system is known as a block agreement or contract. Bedford Hospital receives annual funding of around £100 million. Bedford PCT is the lead commissioner, as it accounts for 68%; Bedfordshire Heartlands contributes 31% and the remaining 1% is from Luton PCT. Therefore, each PCT has a portfolio of SLAs to manage with the Lead responsible for monitoring quality, attending regular

meetings with the trust and reporting back to the other commissioners. The PCT has a database of all the trusts they have SLAs with and the specialties they offer.

The main change in commissioning with the onset of payment by results will be the shift from the present system of block contracts to a more targeted approach. Initially, therefore, the volumes agreed with providers are likely to be lower than historic levels to allow for the uncertainty inherent in choice, and this may be disturbing for trusts. Commissioning is intended to be dynamic so that PCTs can change the volumes purchased from individual providers during the year, and may need to be a collaborative effort between PCTs to help spread the risk. As the basic foundation is to pay a hospital by each activity, providers will be paid according to what they deliver and when they do not the PCT has adequate funding to find an alternative provider. PCTs must offer a choice of four providers as a minimum, with five the ideal and no maximum number of providers.

Originally the Government intended to include both a private sector and an overseas provider on every PCT list for choice, but has since withdrawn this proviso; PCTs can still use the private sector if the cost is equivalent to national tariff. An issue PCTs face is that local services have grown up over time and according to demand, so are essentially reactive and based on historical data. With changing demographics, such as population increases in certain areas (Milton Keynes for example), the needs of local populations have changed and PCTs are now struggling to align supply and demand. Rather than offer a greater choice under the new system, some PCTs see this as an opportunity to reduce their portfolio and reorganise local services more effectively. PCTs and GPs also hope patient choice will eliminate the need for OATs, since patients will all be offered a choice as standard so the PCT has better grounds to refuse.

“The new general medical services contract will increase the commissioning power of PCTs, as they will be able to create a market for enhanced and additional services and to develop new forms of out-of-hours care” [Lewis, Dixon and Gillam, 2003]. The new GMS is a “quality-based contract” [NHS Plan, 2000] paying GPs a basic retainer and they can earn more by providing services over and above this; one example being specialist care for drug addicts. The goal is that increasingly GPs will specialise and the routine work will be done by nurses and healthcare practitioners with the expansion of their roles through additional training.

3.4 Performance measurement and accountability

The UK has one of the worst rates of hospital-acquired infections in the developed world with approximately 9% of hospital beds being occupied by patients who have caught an infection since arrival [Lilley, 2000]. If choice succeeds in driving up quality then this would be a major advantage of the policy. From April 2004, the new Commission for Healthcare Audit and Inspection (CHAI) will take on the role of independent inspection across all healthcare providers, both in the NHS and the private sector. National Service Frameworks (NSF) set standards and put in place strategies for policy implementation and performance measures.

The trend towards accountability has been widespread and most countries are now running initiatives to publish information on the performance of providers as part of ongoing measurement and improvement cycles [Hurst, 2002]. Death rates and life expectancies have traditionally been used as measures for a nation's progress, and mortality rates are used commonly for assessing hospitals. However, actual performance measurement is far more complex than this [Donnison, 1994]. The NHS Information Authority has an overall remit to "improve patient care and achieve best value for money by working with NHS professionals, suppliers and academics and others to provide national products, services and standards, which support the sharing and most efficient and effective use of information" [<http://www.nhsia.nhs.uk>].

The Department of Health has also worked with focus groups and pilot projects to determine the information requirements for patients and GPs to make an informed choice. Four main areas have been defined - waiting times, convenience, patient experience and clinical quality/reputation. The nhs.uk website already provides the first two, and there are plans to add clinical quality and patient experiences. Waiting times will be linked to the EBS system anyway as the patient will be receiving a booked appointment.

A new website, www.makingthechoice.org, went live in April 2004: "This website tells you which hospitals are available in your area and gives you information about their location, facilities and performance. It also gives you detailed information about the specialists who work in each hospital, their qualifications, special interests and the

likely time you will have to wait to see them for an appointment. Comparator tools enable you to compare a hospital or specialist's performance with others in areas such as clinical excellence and waiting times" [www.makingthechoice.org].

Patients can search for the information under their SHA in four different ways:

1. Looking up a doctor by name, with more information on where they work, their qualifications, special interests and waiting times.
2. Finding the doctors with the shortest waiting lists that treat a particular condition:
 - a. by specialty
 - b. by illness or the type of operation required
3. Location of each hospital
4. A comparison of hospitals in the area

Figure 2 illustrates the patient interface, with a summary of performance information on a trust.

The Wanless Report recommends the ideal state of a population 'fully engaged' in healthcare to make the service more responsive, determine the needs of the local population, reduce the costs of healthcare through prevention and eventually improve outcomes. The Government is embarking on this by setting up forums and 'expert patient' schemes, and these support the choice policy by determining patients' views and needs while enhancing accountability. The Commission for Patient and Public Involvement in Health (CPPIH) is responsible for 552 Public Patient Involvement Forums (PPIF) across the country, to deliver the promise of more public participation in healthcare. Each PPIF is supported by a not-for-profit Forum Support Organisation (FSO) and aims to share information between patients, public and decision-makers. [http://www.cppih.org.uk]. Patient Advice and Liaison Services (PALS) are a central part of the new system of PPI in England, offering confidential advice and support, information on the NHS and health related matters, explanations of NHS complaints procedures and a focal point for feedback from patients to inform service developments and an early warning system for NHS trusts, Primary Care Trusts and Patient and Public Involvement Forums by monitoring trends and gaps in services and reporting these to the trust management for action. PALS act independently. Also under CPPIH is the Independent Complaints and Advocacy Service (ICAS).

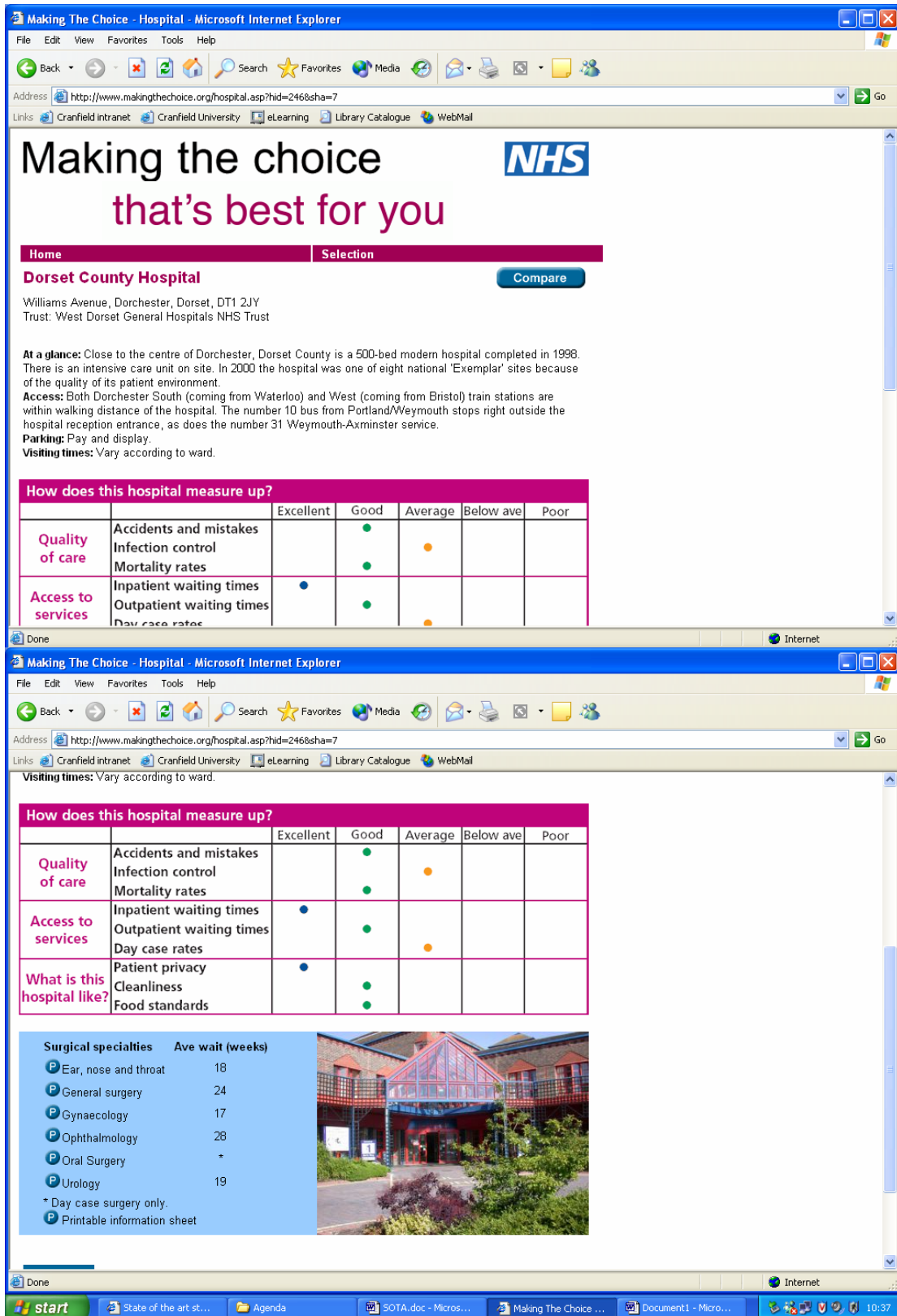


Figure 2: Patient choice website [http://www.makingthechoice.org]

'Expert patient' schemes for chronic conditions are to be rolled out to every PCT, allowing patients a more active role in their treatment. The Department of Health report '*A New Approach to Chronic Disease Management for the 21st Century*' summarises the aims: "an observation often made by health professionals who undertake long-term care of people with particular chronic diseases ... is "my patient understands their disease better than I do." This knowledge and experience held by the patient has for too long been an untapped resource. Research and practical experience in North America and Britain are showing that today's patients with chronic diseases need not be mere recipients of care. They can become key decision-makers in the treatment process" [Department of Health, 2002]. In a speech to New National Health Network in July 2003, John Reid, Secretary of State for Health, outlined the intention to extend choice beyond elective care into services for chronic conditions, primary care and maternity services. The manner in which this will be achieved is still under consideration.

3.5 Capacity

Patient choice is dependent on increased capacity and diversity, as patients exercising choice will require a broader range of services to meet their respective needs. The NHS Plan recognises that the NHS cannot expand fast enough to meet choice at six months by December 2005, so independent provision is being used where there are bottlenecks. Capacity could be met by NHS trusts, Foundation Trusts, treatment centres, private hospitals and possibly overseas, with the last three fundamental to meeting capacity requirements [Department of Health, 2003]. One aim in the Wanless Report is for more work to be carried out in primary care and in the community, which will free up capacity in secondary care. By 2005, 75% of elective surgery is to be performed by day surgery [NHS Plan, 2000]. In most OECD countries there has been a decline in acute beds per capita, on average from 5.7 in 1980 to 4 in 2000 per 1,000 population [OECD, 2003] due to an increase in day surgery. Australia, for example, is currently working to achieve 50% of elective surgery as day procedures, with a longer-term goal of 85% [Hurst and Siciliani, 2003].

Treatment centres are instrumental in achieving day surgery targets in the UK. They are new, stand-alone units for specialties that have traditionally had the longest waiting times, offering fast, pre-booked day surgery and diagnostic procedures [NHS Modernisation Agency, 2003]. As they are specialist units there is no pressure from A&E, so patients are unlikely to face cancellations and delays. Treatment centres are designed to process a relatively small number of procedures at high volume and, as the majority of procedures will be day cases, there is no requirement for friends and family to visit so the NHS hopes that more patients will be prepared to travel to them. It can be more cost-effective to carry out procedures in primary care; however there will need to be a balance, as economies of scale can often be achieved in secondary care [Docteur and Oxley, 2003].

In 2000 the Government signed a concordat with the private sector for acquiring spare capacity, overseas medical teams and to take over the management of failing NHS trusts. Private companies can therefore operate services within the NHS, and around half of the treatment centres are operated by private companies. The Government is running an Independent Sector Treatment Centre Programme (ISTC), which allows PCTs to bid for a number of procedures in the private sector (funded by the Department of Health so not from the PCT's budget). Overseas treatment has also been trialled as another temporary measure to alleviate waiting lists. Patients were first treated overseas through the NHS in 2001, with pilots run by five health authorities for routine surgery, using spare capacity in France and Germany. Often this proved to be more cost-effective: an eye operation that cost £6,000 in the UK cost £2,000 in Germany [Timmins, 2001]. In a recent pilot scheme, Nottingham Trent PCT secured funding from the Department of Health to bring in an overseas team for cataract surgery. As the team were concentrating purely on one procedure, with no interruptions from A&E, it proved extremely efficient. A South African team is now coming to Nottingham under the ISTC scheme for five years to cover orthopaedic surgery.

There will be no penalties for hospitals with waiting times of over six months under choice as the Department of Health has planned for 'dynamic management'. The EBS will be instrumental in managing demand. Although the Government has not yet decided the exact procedure, it seems likely that an oversubscribed hospital will be removed from all but the local PCT's menu as the waiting time limit approaches, to allow access for the local population until the waiting times drop again. An

alternative idea was to allow patients to choose, so that if they want to wait longer than they can; however, this creates a conflict with the guarantee that patients can always choose their local hospital within the maximum waiting time. The EBS will be therefore be crucial in managing demand.

3.6 Competition and marketing

There have been suggestions that the Government is keen to create more of a market for elective surgery in the NHS [Timmins, 2003], and that choice will lead to greater competition [Appleby, Harrison and Devlin, 2003]. Confidential findings from one-day simulations in East Anglia and Manchester, set out in a document from the Department of Health's strategy unit, mentioned that NHS hospitals are likely to start advertising for business, marketing either their waits or innovative ways of treatment [Timmins, 2003]. Payment by Results is an incentive for hospitals to seek more work and attract patients from outside the local area, but the Department of Health does not think this will be a major challenge for trusts. Hospitals already use the media for good news stories and can promote themselves through their forums.

Evidence of marketing and the quality of information provided to patients is covered in more detail in the following section.

4 *Pilot schemes*

4.1 *Overview*

The advent of the patient choice initiative marks a significant cultural change in the long history of the NHS. Although the need to modernise the NHS in a way that is responsive to the needs of the local population is widely accepted as a natural way forward, how this should be done remains a cause for debate. Best practice has been adopted from other health organisations around the world and there is the intention to incorporate learning from the UK pilot schemes. Figure 3, provides a summary of the main pilot schemes.

There are 10 pilot schemes being run in conjunction with the Department of Health (Figure 3), in addition to a number of smaller independent projects at various PCTs and SHAs around the country. Most of these are concerned with choice for long waiters and have not yet been evaluated so few conclusions have been drawn. However two reports have been published; one assessing the Dr Foster website's pilot for choice at the point of referral, and the second concerning the CHD pilot for choice at six months.

The pilot schemes currently offering choice can be differentiated in the following ways:

- Choice at the point of referral
- Choice for long waiters
- Shorter waits to see a GP
- Keeping inpatient waits under 12 months

- Shorter waits to see a consultant

This section will look at each of these themes in turn, beginning with a discussion of the two evaluation reports and followed by a summary of the other pilot schemes.

Name of pilot	Choice for long waiters	Choice at referral	Comments	Report
Dr Foster	No	Yes	For all electives, run with 3 SHAs and 116 GPs	Yes
CHD	6 months	Reevaluating the choice offered as 6 month waiters eliminated	CHD patients across the country	Yes
Berkshire	6 months	No	Plastic surgery, general surgery, ENT and dermatology surgery	No
Cataracts South	6 months	Yes, from GP or optometrist	Initially 2 choices rising to 4 in 2004	No
Dorset & Somerset	6 months	No	All specialties	No
Greater Manchester	6 months	Moving to choice at the point of referral	ENT, orthopaedics and general surgery	No
London Patient Choice Project	6 months	No	Firstly for cataract patients extending to most elective care	No
Surrey & Sussex	6 months	No	General and urology operations	No
Trent	3 months	Some work with choice at the point of referral	All specialties	No
West Yorkshire	6 months	Yes	Cataracts	No

Figure 3: An overview of the main patient choice pilot schemes

4.2 *Dr Foster referral pilot*

4.2.1 *Overview*

In October 2003 a four month pilot scheme was run in collaboration with the Department of Health and the Dr Foster website for choice at the point of referral. 116 GPs from 38 practices in three Strategic Health Authorities (SHAs) – Trent; Norfolk, Suffolk & Cambridgeshire; and Dorset & Somerset – took part.

Patients received a 16-page A5 booklet explaining choice, with information on the five local hospitals. This included a brief description, details of transport and parking, comparison ratings on clinical quality, access and the environment. A website, www.makingthechoice.org, was set up with wider range of performance measures than in the booklet, including details of surgeons' special interests. There was also a 24-hour telephone helpline, staffed by call centre operators with knowledge of quality indicators

A summary and analysis of the findings follows.

4. 2. 2 Factors influencing patients

The final report confirms that patients value being able to exercise choice over when and where they are treated, but without raised expectations of being able to travel outside the local area. Only 15% of patients chose not to go to their local hospital. The dominant influencing factor in this decision was ease of access, affecting 56% of respondents, followed by reputation of hospital (47%) and quality of care (43%). Waiting time was the fourth factor, influencing 34% of patients. Information on quality of care was therefore a key consideration and in this instance was more important than waiting times. Under quality of care patients cited knowing people unhappy with a local hospital or recommendations from friends or family as important.

Although the main reason for choosing the local hospital was convenience, trust was also important. The main deterrents from choosing the local hospital were clinical issues; if a hospital elsewhere specialised in their condition; if the local hospital could not provide their particular specialty; or the local hospital had a bad reputation or performance rating, then patients were likely to travel elsewhere. Some patients also opted for private treatment. Patients did not reject their GP's recommendation and many asked their GP's advice.

4. 2. 3 GP feedback

Choice was less complicated for GPs to implement than feared, with the average consultation time only increasing by 36 seconds. Rise in delayed referral rose from 1% to 14%, so there will be administrative costs associated with this. Concerns were

raised about the implications for GPs as it is easier for GPs to write a referral letter when it is fresh in their mind.

65% of GPs had a positive attitude towards offering choice, but these practices had agreed to participate in the pilot so it is not necessarily representative of GPs as a whole. Some expressed concern at the requirement to offer all patients choice, due to the potential to confuse some patients.

4. 2. 4 *Information*

Patients and GPs indicated a desire for more information, as in absence of clear indicators of quality elsewhere most patients chose the local hospital on grounds of convenience, while for GPs this was the safest option of referring to the hospital and consultants they knew best.

Only 8% of participants used the website, though 17% stated that they would have done if they knew about it, and only 4% contacted the call centre. In spite of this 63% of patients stated that they had questions they wanted or needed to ask their GP; 23% said there was something that would have made them decide to go elsewhere (what this might be was not specified); and 21% said they would like to have known more about the doctor or hospital they were being sent to. In contrast only 2% felt that the consultation time was not long enough and a minority of 10% 'Agreed' or 'Agreed Strongly' that they would like to have had more information, as opposed to 35% who 'Disagreed' or 'Disagreed Strongly'. Both patients and GPs felt that there was a requirement for more information related to specific consultants or treatments, although this was available on the website. These figures suggest that any additional questions the patients had could have been answered by more detailed information in the packs or greater awareness of the website and call centre where this information could be found.

4. 2. 5 *Travel*

There was no effect on the referral pathway as most patients still opted for their local hospital; the report concludes that limited numbers of patients will make use of the opportunity to access more distant services. This contradicts the pilots for choice at six months and also opinion surveys, in which patients have said they would travel

further for better services. Cost of travel was an issue only for a minority of patients (10%), but aftercare was a deterrent to travel. GPs suggested that PCAs could be used effectively to provide support concerning travel arrangements for patients wishing to go further afield, where GPs knowledge is limited, and this would also support the co-ordination of aftercare and communication between parties. One GP commented that ultimately patients will go locally unless there is a problem with the service. Locality therefore has three important reasons for influencing patients: ease of access; familiarity and GP recommendation; and aftercare/follow-up.

4. 2. 6 *Recommendations*

GPs requested that they have the option not to offer some patients choice; in reality, however, they should be able to use their judgement on this when referring. Practices will need to set up choice well in advance of the December 2005 deadline and this could create extra administrative pressure. A public awareness campaign will be important, so patients have some familiarity before GP appointment, as there was some confusion among patients and GPs wasted time explaining the initiative. A distinction between choice at the point of referral and choice for long waiters is that in the latter patients receive a definite offer of quicker treatment, which most take up, whereas at referral there is more uncertainty and the GP may be unwilling to recommend the alternative.

Lack of personal contact between GPs and consultants at more distant hospitals could be a barrier to GPs and patients choosing hospitals further away. The report suggests open days for consultants to present to GPs, which is a good idea in theory but in reality might be difficult to manage. It does however support the idea of trusts marketing themselves to raise awareness of surgeons' special interests and skills. Over time this situation may well change, as GPs will increasingly identify better services outside their local area through feedback, word-of-mouth and receiving promotional literature from trusts. This suggests that eventually more patients may take up the offer of travelling to a hospital further away; however, evidence from Europe contradicts this, as locality is still the dominant influencing factor [Hanning and Spangberg, 2000; <http://www.nhs.uk/magazine>, 2002]

4.3 *CHD choice at six months pilot*

4.3.1 *Overview*

The Coronary Heart Disease (CHD) pilot was set up in July 2003 to offer patients the choice of moving to an alternative hospital for faster treatment if they had waited for more than six months for heart surgery. Patients were contacted by the originating trust and sent a booklet explaining choice and 57% of patients opted for treatment elsewhere. At the outset patients were only offered one alternative, but this increased during the scheme until eventually 25% of patients were offered three or more choices.

An evaluation report has been written by the Picker Institute Europe for the Department of Health, based on the feedback from 3,431 patients who responded to a postal questionnaire.

4.3.2 *Influencing factors*

Younger patients were more prone to take up the offer of choice (61%, as opposed to 55% for over 60s), and the reputation of the hospital was the most important factor in their decision. Waiting time was the second most important consideration. For patients who chose to remain at their local hospital, the reputation of the hospital was even more important than for those who decided to travel to an alternative (78% for the former and 65% for the latter). This difference could be attributed to word of mouth or prior experience of local services, or less information being available on the alternative providers.

Surprisingly 37% of patients made up their own mind about where to be treated; the rest were influenced by their PCA (19%), doctor at home hospital (16%) or friends and relatives (15%). Only 7% said that their GP was influential in their decision. PCAs were crucial in the success of the CHD pilot, with 61% of patients who chose an alternative provider classing their PCA as excellent (in contrast with 38% who stayed at their local hospital).

4. 3. 3 *Information*

When asked about the information they received there was a noticeable difference in survey responses between patients who opted to stay at their local hospital and those who decided to travel. 75% of patients who travelled said they received enough information to make their choice, whereas only 47% of patients who remained at home said this was the case. Some patients may have felt that they lacked sufficient information to make an informed choice, and this discouraged them from taking up the offer so they decided to 'play safe' and remain at their local hospital. The role of the PCA could also have influenced these responses as there was a definite link between the answers to questions concerning information provision and those relating to standard of support received from the PCA.

4. 3. 4 *Travel*

38% of patients travelled less than one hour for treatment and 35% for two hours or longer, while the further the patient had to travel the greater the likelihood that transport was provided. A few patients experienced problems with travel after their operation, in terms of delay and discomfort and 20% felt adequate arrangements had not been made for their travelling companion. Aftercare was an issue for some, with inadequate communication between the receiving and originating trusts, or a relinquishing of responsibility by both.

4. 2. 4 *Recommendations*

The report has suggested that every patient offered choice should have access to a PCA, while lack of information appeared to inhibit the uptake of choice, especially when there was only limited information about each surgeon. Improvements need to be made with travel arrangements and communication between parties, as an uncomfortable return journey can mar the whole experience for a patient. More work also needs to be done on how patients assess each hospital's and surgeon's reputation and compare hospitals, as this was not within the scope of the CHD evaluation.

4.4 *Other pilots for long waiters*

4.4.1 *Pilot scheme advertising*

Advertising for patients waiting for surgery has been successful in a number of cases. The London Patient Choice Project placed adverts in South East London newspapers to raise awareness of the scheme, while in 2003 Cumbria and Lancashire SHA advertised faster treatment for cataracts. University College Hospital in London attracted patients from Devon, Cornwall and Birmingham after it publicised that it had spare capacity for NHS patients. PCTs from Birmingham and the south-west have been sending patients to London, and University College Hospital London is considering advertising directly to patients themselves. There was some advertising during the Trent pilot, in the Derby Telegraph and Nottingham Evening Post, but the SHA believes the impact of this was not great as most patients and GPs had already heard about the project through word of mouth.

The quality and level of detail in the marketing information provided to patients and GPs is important. A Luton GP highlighted the quality of the brochure received from Hammersmith hospital during the Luton and Dunstable orthopaedics pilot scheme, and believes this was influential in her patients' decision to go there for treatment. The information provided included a glossy brochure with photos, good maps and directions and a separate pamphlet explaining each procedure. 14 out of the 15 patients agreed to travel to Hammersmith instead of staying on the waiting list at Luton and Dunstable. In contrast, a pilot run by Huntingdonshire PCT offering patients choice used a basic A4 sheet showing limited information on each hospital, such as a photo and a few figures (such as mortality rate). Not one patient in this scheme, run in conjunction with five GP practices, took up the offer of moving to another hospital. Although there will be other factors at play in these cases, such as waiting times, the suggestion is that quality of information played an important role.

4. 4. 2 *Trent*

In the Nottingham pilot, choice was offered to patients waiting for cataract operations. This was undertaken through the provision of funding from the Department of Health to procure a team of overseas surgeons to conduct cataract surgery, using a theatre in the community hospital. Call centres was set up to contact patients and explain the choice, and transport was included in the offer. Patients were initially selected from six month waiters, and then when this had been successful patients were offered the opportunity at the point of referral. To achieve this, half the referral letters from the GPs were diverted from the mail room at the Queens medical centre direct to the call centre. The PCAs then phoned patients and offered then choice of going to the overseas team much sooner, or going onto the QMC waiting list.

A proper assessment is still to be completed but limited initial findings have been released. There was on average a 60% uptake and patients were happy with the service. The overseas team were extremely efficient; conducting 2,300 operations in 16 weeks; approximately 30 operations in one day, in contrast to 5 in the NHS. This was attributed to the fact that it was a specialist team who were used to working together and had no disturbances, from being on call for example. In the NHS the theatre team is different each time and there are often problems with theatre overrunning, poor quality instruments etc, all of which impede efficiency.

The first 100 patients were contacted after 30 days to evaluate the patient's experience throughout the referral pathway. Feedback received showed that only 16% of patients found the information leaflet helpful, 18% did not receive a leaflet and the majority, 66%, did not comment on the leaflet or indicate if they had received one. Not all patients were sent a leaflet as most were on hospital waiting lists. 51% reported that the Patient Care Advisor was helpful and 6% patients could not recall the initial conversation. The remaining patents did not make a comment on the Patient Care Advisor.

4. 4. 3 *London Patient Choice Project*

The London Patient Choice Project was carried out in collaboration with three NHS trusts; Barking, Havering and Redbridge and a number of PCTs. Under the scheme patients who have been waiting six months for treatment were given the option of

faster treatment at another NHS hospital, a diagnosis and treatment centre or an independent sector hospital. The scheme had managed to cut waiting times for those patients opting to go elsewhere from up to a year to less than seven months. Patients had to wait for up to a year for treatment in several specialities such as ophthalmology, orthopaedics, general surgery and ear, nose and throat (ENT) surgery. Additional capacity was developed in other NHS and independent sector hospitals and patients who would have waited for up to a year for admission were treated earlier. Having this extra capacity enabled the trust to improve on the waiting time of patients that remained on its own waiting list.

The process starts with the hospital telling the scheme when they have a patient who will soon have waited six months for treatment. The patient is then contacted and offered faster treatment by a number of providers and an appointment is agreed with the patient on the phone allowing patients to book a time and date that suits them. The scheme was initially introduced for ophthalmology patients, was then widened to orthopaedic, general surgery and ENT, urology, plastic surgery, oral surgery and gynaecology patients. Under the guidelines the PCT pays the same price for treatment wherever the patient goes.

The challenges faced by the pilot include: a) business planning was more complicated; b) the PCT was concerned with money leaving the local health economy; c) staff at the hospital needed reassurance that post-operative complications would be handled by the surgeon carrying out the procedure so that they won't be left with the most complicated treatments [Department of Health, 2003].

4.4.4 *Dorset & Somerset pilot*

NHS trusts within Dorset and Somerset faced a considerable challenge in achieving local waiting times targets. Through offering choice they were able to reduce waiting times and ensure that national and local waiting time targets were achieved. Within Dorset and Somerset waiting times at 31 March 2003 were a maximum of six months for inpatient treatment, except for orthopaedics at two trusts. At the time of writing (May 2004) choice at six months has been implemented in order to maintain these maximum waits and reduce orthopaedic waits and choice at the point of referral was developed.

The management of choice was through the existing performance management and planning structures, including the monthly meeting of Chief Executives and the regular performance management meetings held with organisations. Each PCT with long waiters, working with the relevant NHS trusts, has set up and managed systems for offering choice for patients waiting for treatment at the NHS trusts for which the PCT is lead commissioner. At the time of writing (May 2004) three PCTs were developing choice at the point of referral, each exploring a slightly different model, as part of the choice pilot. The monitoring of choice is done through regular reporting of maximum waiting times at the relevant trust, and by reporting of the numbers offered and accepting choice.

4. 4. 5 *Greater Manchester*

The scope of the Manchester pilot was to offer Choice at six months in three specialities – General surgery, Orthopaedics and ENT. Having undertaken an analysis of longer waiters and wanting to develop resources that were Greater Manchester related (for all patients offered choice) they opted for three treatment centres across Manchester. Choice is being offered initially in a new treatment centre, Greater Manchester Surgical Centre at Trafford General Hospital.

4. 4. 6 *West Yorkshire*

The West Yorkshire pilot focuses on choice for patients requiring cataract surgery. Focussing initially on long waiters, the target was that by April 2004 all West Yorkshire patients requiring cataract surgery will be offered the choice of at least one alternative provider at the point of referral. The pilot included the arrangement and subsequent management of a cataract service from Westwood Park, a primary care based Diagnostic and Treatment Centre, as well as ensuring the co-ordination of cataract activity and waiting times across all West Yorkshire within the choice framework. To accommodate the increased cataract activity – together with other service developments – the refurbishment and extension of Westwood Park was undertaken.

The project was phased as follows. In *Phase 1* current arrangements already in place at Westwood Park were used as building blocks where visiting clinical teams from some of the provider trusts in West Yorkshire provide a service on behalf of the

PCT. This has provided an opportunity for clinical teams to work together and experience Westwood Park for themselves. *Phase 2* was the planning of the clinical protocols and patient pathway to deliver choice at point of referral from December 2005. Once the pathways are agreed, they hope to be in a position to determine the most appropriate staffing model.

4.4.7 Berkshire pilot

There are two separate streams to the Berkshire Choice pilot. The first phase is offering timed choice for patients waiting six months. The two local hospitals for most of their referrals are Heatherwood and Wexham park hospital and Royal Berkshire and Battle Hospitals (RBBH).

The surgical specialties covered by the pilot include plastic surgery; general surgery; ENT, dermatology surgery and MRI scans. Although all patients waiting over six months at RBBH or Heatherwood and Wexham are offered choice, there are certain clinical criteria's which would make patients ineligible and the view of the originating and receiving consultants over the suitability for treatment. As contracts for the pilot are between the PCT's and the receiving trusts, money is not currently available for transport. Accommodation for carers accompanying patients would also not normally be provided unless made by receiving trusts.

The main challenges the pilot foresees when delivering choice would be one of communicating this new concept to patients and Payment by Results, which will create a certain amount of competition i.e. a fundamental cultural change in the way patient services are delivered.

4.5 Shorter waits to see a GP

Hopwood House Practice in Oldham has reduced the time patients wait to see a GP from around five days to less than one by improving the way it manages demand. It achieved the turnaround after taking part in the National Primary Care Collaborative [Department of Health, 2003]. In the past patients were waiting up to five days for a routine appointment with a GP and staff were under pressure because they were

dealing with frustrated patients and felt the workload was out of control. Through the national collaborative, patients are now encouraged to get telephone advice from a practice nurse before making a GP appointment saving between 55 and 80 GP appointments a month. Practice nurses were given responsibility for treatment changes for patients with hypertension. The receptionists undergo some of the health care assistant training modules so they now do many of the routine tasks previously done by the practice nurse. These include running the chronic disease register. Telephone consultations with GPs were introduced and these last an average of three minutes compared with the in-person consultations which last up to nine minutes. The duplication of work was stopped - for example keeping written records of tests - because the computer system can manage the process.

The above changes have created the flexibility so that for routine appointments, patients are seen within 24 hours and usually get an appointment on the same day. The challenges faced on this pilot were staff concerns that the changes might add additional pressure on them as well as the time required by the practice to monitor demand, test ideas, and draw up contingency plans.

4.6 Keeping inpatient waits under 12 months

Bradford Hospitals NHS Trust has ensured that, for the past three years, none of its patients have waited more than twelve months for inpatient or day case care. This is despite a significant increase in the number of patients seeking treatment. Unfortunately increasingly shorter waiting times for outpatient clinics further increased the numbers waiting for inpatient and day case care.

In order to tackle this problem the trust:

- Developed strong modelling and forecasting techniques to plot demand and a robust annual capacity plan. This was done in close collaboration with PCTs.
 - Recruited more staff. For example, during 2002/2003 it had recruited two more general surgeons, two more plastic surgeons, two more orthopaedic surgeons, plus additional theatre and support staff including nurses and anaesthetists.
-

- Encouraged Consultants to carry out more outreach work, establishing partnerships with the increasing number of GPs with a special interest (GPSIs). As a result, 15,000 minor operations which used to be done in hospital were carried out in primary care.
- The ophthalmology service was redesigned to improve the patient's care pathway and speed up the referral process. As a result, patients can now be referred for cataract surgery by an optometrist, which meant they no longer needed separate outpatient appointment. The service redesign work also showed additional capacity was needed to meet demand and an additional ophthalmic surgeon and team were recruited into the trust. Together, the reforms and additional investment had cut waits from more than twelve months to nine months.

The main challenges on this pilot were capital not being available to expand the number of theatres, wards and beds at the trust as well as the trust working hard to enable staff to understand the importance of change and encourage them to embrace new ways of working.

4.7 Shorter waits to see a consultant

In Bournemouth, the lengths of time patients have to wait to arrange for an appointment with a consultant has been reduced from six weeks to less than 15 minutes following the introduction of an electronic booking system (EBS). The system links 22 GP surgeries to Royal Bournemouth Hospital's computerised appointment system.

In the past patients were waiting up to six weeks to receive a letter confirming an appointment with a hospital consultant. It also used to take up to two weeks for GPs' referral letters to arrive at the hospital and a further four weeks for the consultants to prioritise the case and send out an appointment letter. By linking the 22 GP practices to the hospital appointment system via a computer and through developing 17 referral protocols in consultation with consultants and GPs the following results were achieved:

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- Patients could now arrange a time and date for an appointment that suits them while they are in the doctor's surgery. The process takes only 15 minutes instead of six weeks.
 - GPs no longer have to write referral letters or wait for the consultant to prioritise the case and send out an appointment letter.
 - Practice clerical staff do not need to write letters or chase up the hospital about appointments. The system prints off appointment information that can be given to the patient there and then.
 - The system shows appointment cancellations, which means some patients can be seen as quickly as the next day whereas in the past these slots were wasted.
 - Missing patient notes have become a thing of the past. GPs fill in the protocol electronically so the consultant has the relevant notes on their computer screen when the patient arrives.

The challenges faced include:

- GPs were sceptical about whether the system would work properly or take up more time during their consultations with patients.
- GPs needed to dedicate time to training, which varied depending on how computer literate they were.
- Setting up the 17 protocols for the system required detailed consultation with both consultants and GPs requiring a considerable amount of time from both.

4.8 Summary of pilot schemes

A major consideration in all these examples, excluding the Dr Foster pilot, is that they were offering faster treatment to patients waiting already on the waiting list, so there was a greater incentive for patients to travel and therefore the results are not necessarily representative of choice at the referral stage. This also applies to successful advertising initiatives, as these were attracting long waiters rather than patients at the point of referral.

Patients valued the offer of choice and the feeling of being involved in decisions about their health even when they chose to remain at their local hospital, so this is step towards the NHS aim of empowering patients. The local hospital is important to

patients for three reasons. Firstly, ease of access is a factor, not just for patients but also for friends and relatives who wish to visit. Secondly, the level of trust is higher; word-of-mouth and previous experience proved to be prime factors influencing patients' perception of quality, and in addition GPs' knowledge of and trust for local services is built up over time and from face-to-face contact with consultants. Thirdly, aftercare is easier at the local hospital and there will be continuity in the service provided, and since this was a concern for patients and GPs it provides another reason to choose the local hospital. There are therefore significant ties between local hospitals and their population.

An interesting point discovered in the CHD pilot was that 37% of patients made up their own mind and 19% were influenced by their PCA, with the GP playing a minor role.

Experience in the pilot scheme in Bradford suggested that although outpatient waiting times dropped, inpatient and day case times increased; therefore there may be a trade-off in meeting waiting time targets as waits elsewhere may rise.

5 *Literature review*

There follows a critical assessment of choice based on a literature review of think-tanks, academic papers and policy commentators, with evidence from choice in healthcare around the world.

5.1 *Impetus for change*

Cohen describes the NHS as “the bureaucratic equivalent of Mao’s China ... successive governments wait just long enough for a kind of order to be restored after each reorganisational crisis before reorganising again ... the logic of permanent revolution obliges another radical reform” [Cohen, 2003]. Kieran Walshe, a specialist in NHS bureaucracy and advisor to the Commons Health Select Committee, writes that the NHS has become “a shanty town in which structures and systems are cobbled together or thrown up hastily in the knowledge that they will be torn down in due course” [Walshe, 2003]. He documents changes in the NHS over last two decades, concluding that most are nothing but a repackaging of old ideas, driven by the political desire to be seen to be reforming the health service and using structural change as the most obvious way to do this. However these changes only scrape the surface with no real improvement, but instead consume valuable resources and instil in management a sense of change resistance and a short term outlook. “The Government is so obsessed with the need to achieve short-term results like reducing waiting times for non-urgent surgery that it is subjecting the NHS to counter-

productive top-down reorganisation imposed under the guise of modernisation and decentralisation” [Jones, 2003]. It has been suggested that choice is a ruse to retain middle class voters, who want to feel that they can exercise choice within the NHS rather than being driven to take out private health insurance, which would result in them losing interest in the state of the NHS and thus the Labour Party [Mohan, 2003].

Another criticism of reforms over the last two decades has been the speed of change, so that even if pilots have been run the results have not necessarily been properly assessed, if at all, or incorporated into the roll-out [Walshe, 2003; Kings Fund, 2003]. Sir Andrew Foster of the Audit Commission said in a recent interview: “I worry about the sheer mass of structural change there has been . . . and whether that will really bring the result that is needed . . . one of my experiences of 30 years in public service is that setting up these new institutions and getting them working well always takes two to three years, and longer than people hope. People become preoccupied with establishing them, and politicians very often then become impatient, and before you know it there are calls for further change. There is a danger of people getting slightly punch drunk about the amount of change . . . Some of the mechanisms being created are similar to those introduced a decade ago then scrapped” [Foster, 2003]. Others have said that spending has been politically motivated to grab the media’s attention by, for example, building new hospitals, rather than investing in the actual running of the service [Due, 2002].

5.2 Decentralisation

Walshe has also suggested that the UK cannot have a world class health service without transferring power to the frontline. “No other comparable European country has a health service run by central government, even in countries where the state plays just as large a role in funding healthcare through taxation” [Walshe, 2003]. The NHS Plan promised that investment will be accompanied by a restructuring of the NHS to meet user requirements and devolve power to local areas. Part of this has been attempted by the devolution of resources to PCTs; however, there are restrictions on their use of resources.

The Kings Fund has highlighted a number of weaknesses in the current structure of PCTs and “evidence suggests that PCTs are struggling to achieve all that is expected of them” [Lewis *et al.*, 2003]. The Kings Fund has found that central policy initiatives, from NSFs to NICE guidance, have absorbed most of the money allocated to developing local services. Nick Bromley from the Centre for Reform believes that PCTs are too small, and the budgets similarly too small, to absorb fluctuating demands for health care, especially for one-off expensive cases [Bromley *et al.*, 2003]. Financial pressure from emergent technology and new drugs will drive PCTs to demonstrate better value for money [Campbell, 2004] and patient needs could potentially suffer as a consequence. Strategic decisions are still made by the Department of Health, dictated to the SHAs and thence to the PCTs, so in reality the top-down autocracy remains, with central assessment and regulation. PCTs must juggle these conflicting priorities while ensuring equal access, especially as “encouraging patient choice runs the risk that the choices of the few rather than the needs of the many will determine the trajectory of hospital development” [Mohan, 2003]. The few are still likely to be middle-class, educated and the younger generations, so it is important that their needs do not dominate the development of local services.

“As consumers are increasingly offered choice ... the commissioning role of PCTs diminishes. For elective care, the commissioning will increasingly take place in the GP’s consulting room”. Although PCTs will have selected a list for GPs, the actual choice will reside with the GP and patient so this will further erode PCTs’ power. “The change to trust status seems to have reduced the influence of general practitioners on the governance of PCTs and therefore the priority attached to developing primary care” [Lewis *et al.*, 2003]. Therefore rather than the smooth integration of primary and secondary care under PCTs this may become more fragmented. Concern has also been expressed over how PCTs will arbitrate between different GP interests [OECD, 2003].

Foundation Trusts were a step towards offering hospitals greater autonomy and freedom from political dictates. “They represent an attempt to ‘internalise’ stakeholders and to shift the power from those that provide or commission services to those that receive them” [Lewis, 2003]. Foundation Trusts have a board of governors drawn from the local community and are responsible to an independent regulator. The Government is hoping that Foundation Trusts will empower local

communities in services where choice is hard to accommodate, such as emergency care, as services will be responsive to local needs [Reid, 2003]. However, it has been argued that there is friction between ruling party accountability to parliament, with its requirement to know every detail of the day-to-day running, and a locally-managed and independently regulated health service [Walshe, 2003]: "a pull from the centre tends to reassert itself when governments try to decentralise" [Roll, 2003].

GPs act as gatekeepers to secondary care and form the vital link between patients and specialist services. However, the traditional relationship between GP and patient is gradually being eroded by increasing usage of out-of-hours services, walk-in centres and NHS Direct. It has been argued that the authority of doctors is also in decline, due in part to wider availability of information for patients and the rise of consumerism [Gray and Rutter, 2003]. Unlike the rest of the NHS, where doctors are salaried, GPs have so far retained their independence, but the government is gradually breaking up their monopoly of primary care and estimates that by 2005 the majority of GPs will be salaried [UCL, 2003]. GPs are, inevitably, unenthusiastic about what they see as attempts to undermine their authority, and expressed concern that this will detract from the personal relationship they have with patients so that in the end it is the patients who will suffer. A recent survey by the Institute for Public Policy Research (Ippr) and the College of Health has found that patients today are on the whole "more willing to question their doctor and much less deferential, which can bring real benefits" [Ippr, 2001].

5.3 Quality

It has been suggested that CHAI will scrap the controversial star ratings system in 2006 when the deadline is reached for the current set of targets [Shifrin, 2004], abolishing the 62 targets and replacing them with 24 wider 'quality objectives'. This has been welcomed by healthcare professionals, who claim that the targets to achieve star ratings distort clinical priorities. The Chairman of the British Medical Association has said of star ratings "they are a system of measuring political targets rather than what patients want" [Johnson, 2004]. The Audit Commission proved that in most instances the star rating bears no resemblance to how good a hospital is from the point of view of patient care, as they are more concerned with internal processes. Other complaints revolve around the view that the targets for star ratings

present a crude, over-simplistic picture of performance. There has therefore been a positive reaction to the introduction of a common, more general set of healthcare standards: “independent sector hospitals work to transparent, detailed, national minimum standards, while NHS hospitals work to wide-ranging, less explicit principles and guidance. If all hospitals operate under the same set of minimum standards it will be clear to patients if a hospital fails to meet patient care and quality expectations” [Henson, 2004].

Consumer health information was pioneered in the US, with organisations such as Planetree among the first to provide information services to support patient choice [Shepperd, Charnock and Gann, 1999]. In the US a combination of information, publication and choice has been a powerful weapon in improving clinical outcomes [Lilley, 2000]. Patients and GPs in Denmark were initially deterred from taking up choice due to the limited information available to them [<http://www.nhs.uk/magazine>, 2002]. GPs have stipulated that if any of the providers offered under choice are hospitals they are not familiar with then they will require details of all the consultants in a specialty, including particular interests of each, and GPs do not have the time or the inclination to research. For these reasons, the resources supplied to GPs and patients are vital to assist informed choices.

Patients are generally tolerant of short and moderate waits, and it is the general public who expresses more concern about waiting. [Hurst and Siciliani, 2003; Derrett *et al.*, 1997]. Six months has been classed as the approximate threshold before a wait is too long, depending on the severity of the symptoms [Derrett *et al.*, 1997]. Evidence also suggests that “once patient choice has been in place for two to three years and waiting times tend to even out, the incentive provided by shorter waits will be limited. It may even disappear if the Government does succeed in its aim of driving down waiting times across the board. In those circumstances, choice between hospitals will depend on other factors, particularly quality of care” [Harrison and Appelby, 2004]. Waiting times were a key factor influencing GPs during the fundholding days [Propper, Croxson and Shearer, 2002], so it is likely that this will be similar under patient choice, but there is also likely to be a trade-off between waiting time and continuity of care.

5.4 *Restrictions on choice*

Patient choice in its present form is extremely restricted, limited to a narrow range of hospitals for elective surgery only. “Where patients can exercise choice easily (for example, in elective surgery) the consumerist model will be adopted ... (whereby) health care users influence services by exercising choice rather than by ‘owning’ the provider itself ... The current patient choice initiative offers choice to consumers within a broad market framework although, to date, these choices are primarily focused on the location of treatment and its timing” [Lewis, 2003]. The Government has been accused of taking the easy way out in offering patients choice of hospital as “elective care is but a small part of total NHS provision” [Coulter, 2003], although it has always attracted a disproportionate amount of the Government’s attention.

There has been a shift since the nineteenth century from infectious to chronic diseases - CHD, respiratory diseases, cancer, diabetes - which are extremely costly to treat, and the UK performs poorly in comparison with other countries [Wanless, 2003]. The real challenge to choice will be its extension into these areas of chronic care, which is not just a case of offering patients a choice of hospital. “Emergency care and the management of patients with chronic diseases are less amenable to simple market-based solutions” [Lewis, Dixon and Gillam, 2003]. Patients could, for example, be offered a choice in the type of treatment or care they receive [Ippr, 2002], rather than an automatic appointment in secondary care, and this would also cut down on unnecessary referrals. It has been estimated that around 50% of GP referrals do not lead to surgery as there are a number of inefficiencies in the system, possibly by GPs referring to a consultant out of habit [Thames Valley SHA, 2004]. A pilot scheme is being undertaken with Somerset PCT to streamline the referral process: once a patient has seen their GP and been referred, they will be directed to a Referral Management Centre, a call centre managed by health professionals, who decide whether to refer the patient to therapy, a specialist nurse or a consultant. There are generally alternatives for ongoing care for non-urgent cases and these need to be identified.

“There is an irreconcilable conflict in the NHS between allowing individual patients unconstrained choice of treatments that are free at the point of use, and the allocation of resources in a cost-effective manner ... the benefits of extending choice

are almost always at the expense of other benefits ... greater choice may lead to reduced quality" (Appelby, 2003). It is vital for maintaining the principle of equity to guarantee a minimum standard across the board, rather than aim to drive up quality in some areas and risk a decline in others. It is probable that there will be excessive demand for elective surgery in a publicly insured health system [Hurst and Siciliani, 2003]. "The point of insurance is that the insured person does not bear the full cost of treatment received. The associated 'moral hazard' implies a propensity to consume beyond the social optimum" [Docteur and Oxley, 2003]. This is in opposition to the wish to improve efficiency in the NHS and make patients more responsible users of resources.

In all healthcare systems around the world there is restriction on individual choice for this reason. In the US, financial restrictions by a patient's insurer affect the choice of provider [Appleby, Harrison and Devlin, 2003]. Pilot schemes have been run successfully by Kaiser Permanente, the US healthcare provider, where patients accepted reduced choice, to prove the theory that unlimited choice is not necessarily positive [lppr, 2001]. In Denmark, choice is effectively limited as, although patients waiting over two months can choose to go privately or to travel overseas, no advice or support is offered and there is no help with travel costs [<http://www.nhs.uk/magazine>, 2002]. Free choice of hospital has been advocated in Norway since 2001, but patients cannot go to a hospital with a higher degree of specialisation than the one to which they were initially referred [OECD, 2003].

It has been argued that "real choice can only be provided if there is surplus provision, which may be OK for general goods and services but is inefficient and massively more costly when it comes to essential public services dependent on highly skilled staff and complex equipment" [Jones, 2003]. Although increased capacity, in terms of more beds and consultants, has been shown to be associated with shorter waiting times [Martin and Smith, 1999], it requires a commitment to build new units and recruit and train staff, which will take several years [Hurst and Siciliani, 2003]. There is still a shortage of frontline staff in the NHS. Last year figures for management increased by 60%, in contrast to 22% and 21% respectively for doctors and nurses; there are therefore fears that the record amount of funding is being siphoned off into bureaucracy [Hope, 2004]. A problem with introducing marketing mechanisms is that the scarce resource hospitals will want to compete for is trained and talented staff [Cohen, 2003].

5.5 Competition

There is very little evidence on the impact of competition in health care. The current Government has been criticised for a return to the Conservative's 'internal market' [Laurance, 2002], but tariffs will remove the price-based competition that existed in the 1990s. Activity-based payments have been recommended as a way of raising productivity because providers have an incentive to increase the volume of activity, with evidence from Norway showing a growth in hospital activity without any increase in expenditure [Biorn *et al.*, 2002]. Conflicting evidence from the fundholding days implies that competition resulted in little real improvement in waiting times, outcomes or quality [Smee, Mays *et al.*, 2000]; in fact Propper (2002) has shown that death rates were higher in hospitals where the potential for competition was strongest. This generally applied to cities, since competition in health care markets is geographically-based [Burgess *et al.*, 2003], so areas such as London will face greater competition than Bedfordshire. However, "a fall in quality should be matched by a fall in costs and research has shown that competition in the UK health care market has been associated with lower costs and prices" [Burgess *et al.*, 2003], showing that there are advantages. The British Medical Association also has fears that competition will discourage knowledge sharing of medical breakthroughs and best practice between trusts.

Unison has expressed doubts about a market for healthcare services because of the enticement of selecting only the profitable patients and services, therefore further reducing equity. "The problem is that fee-for-service creates opposing incentives among commissioners and providers – one seeking cost containment, the other income maximisation through competition and the careful selection of patients" [UCL, 2003]. The Government is considering adjusting tariffs for length of stay, and this would remove a potential obstacle to hospitals to taking on more complex cases as they would be adequately remunerated; however it must be ensured that trusts do not reject certain patients or procedures for financial reasons. In Germany, for example, insurance companies compete for patients and measures have to be put in place to avoid selection of the healthiest patients and refusal of the needy.

Some policy commentators are worried about tariffs because cost data is poor in the NHS so it is dangerous to base prices on this information and equally risky to force

hospitals to adhere to set national prices [Bromley *et al.*, 2003]. The next few years could be financially unsettling for trusts, as presently there are significant variations in each hospital's costs in relation to tariff, some as much as 20% above and some 20% below [Appleby, Harrison, Devlin, 2003]. There will be no measures to protect hospitals if there is a shift in patients' demands and the hospital loses business as the Government deemed this unnecessary. With the length of waiting lists at present, trusts already have several months' leeway, so if in the unlikely event that they receive no referrals under choice, then they have a few months to resolve this before the supply of patients runs out.

5.6 Patient choice in other countries

The OECD has compared waiting times for elective surgery across OECD countries and contrasted various policies for tackling excessive waits [Hurst and Siciliani, 2003]. This concludes that there is not necessarily a correlation between waiting lists and waiting times: it is possible for lists to increase while actual times reduce. Another point is that the achievement of maximum waiting time guarantees may be at the expense of increasing the outpatient waiting time. Failed initiatives in Sweden and Norway have brought to light inadequate prioritisation of the needy, while another scheme trialled in Norway attempted to reduce waiting times for patients on sick leave and therefore reduce the cost of sickness benefit; a figure estimated at 5-10% in the UK [Harrison and New, 2000]. "Constraints on capacity are desirable to achieve optimum surgery rates and prevent supply from matching this demand ... It can be cost-effective to maintain short queues of elective patients because the adverse health consequences of short delays are small and there are savings in hospital capacity from allowing queues to form". Measures to reduce waits by increasing activity will, over a period of time, lead to demand increasing and waiting times back to where they were before [Hurst and Siciliani, 2003]. Clinical prioritisation is not practiced under choice, but surgeons' and GPs' thresholds for admission can vary lists and therefore waiting times, as well as ensuring that the least needy wait the longest [Hurst and Siciliani, 2003].

Experience in other countries has been that the impact of patient choice has been negligible and it has been observed that patient mobility tends to be low: in Sweden, for example, few patients opted for private treatment when offered choice after waits of longer than three months [Hanning and Spangberg, 2000]. Choice has been available in the Netherlands for three years, but most patients choose to go to their local hospital. Norway has sent a number of patients abroad for treatment over the course of many years but with no obvious reduction in waiting times [Hurst and Siciliani, 2003]. Since 1993 patients in Denmark have been able to go to a private hospital or abroad if a public hospital cannot treat them within two to four months; however only 5% of patients have exercised their right of choice [<http://www.nhs.uk/magazine>, 2002].

5.7 Summary

The majority of commentators feel that patient choice is a repackaging of old ideas and therefore should not have much of an impact. Some have expressed concern that the pilot schemes will not be properly assessed or the findings not used to influence the choice agenda. Other comments relating to the short-term focus and change resistance endemic in the NHS culture imply that there will be significant obstacles to overcome for the choice initiative to be accepted. Even with recent reforms there has been no real decentralisation and PCTs' power is limited. Since there will no prioritisation of patients, it will be essential to provide adequate support for those who most require it or choice will be limited to the informed, educated and articulate patients.

There is also likely to be a trade-off, so increased choice may even reduce quality instead of improving it, with the added issue of competition discouraging collaboration amongst trusts. Elective surgery is only a small part of the work of the NHS yet is in the spotlight. If trusts are too focused on this area there is the danger that it will be at the expense of other services. The introduction of wider quality standards in place of star ratings should benefit trusts as they can be more clinically focused and patients if there are true measures of hospital performance.

6 *Alternative healthcare systems*

Although all OECD countries rely heavily on both public provision of insurance and on public regulation of various aspects of healthcare [Docteur and Oxley, 2003], the UK is one of the only countries in the world to fund healthcare purely through taxation, although some services in the NHS incur charges – prescriptions, dentistry, orthodontics, fertility treatment and long-term care for example. The majority of European countries run their healthcare through social insurance and it has been argued that tax funding alone is insufficient to provide a quality service: “the UK should take note of the world’s experience and move towards a mixed funding model, adopting compulsory social insurance. This will preserve equity, the greatest strength of the NHS, and increase transparency, provide choice and empower users ... co-payments systems can encourage patients to be more responsible users of healthcare” [Adam Smith Institute, 2000].

However, the World Health Organisation has commended the UK for having one of the fairest systems in the world for funding healthcare [NHS Plan, 2000], and the way in which a health system is financed affects equity [Docteur and Oxley, 2003]. Figure 4 shows the differences in public and private expenditure on healthcare for European countries. There has been no realistic alternative to the NHS model if the ideal of free care for all is to be preserved. In the NHS Plan the Government specifically points out that “the systems used by other countries do not provide a route to better healthcare ... (we have) examined other forms of funding healthcare and found them

wanting” [The NHS Plan, Department of Health]. The 2002 budget also reaffirmed the commitment to central taxation for funding the NHS [Unison, 2003].

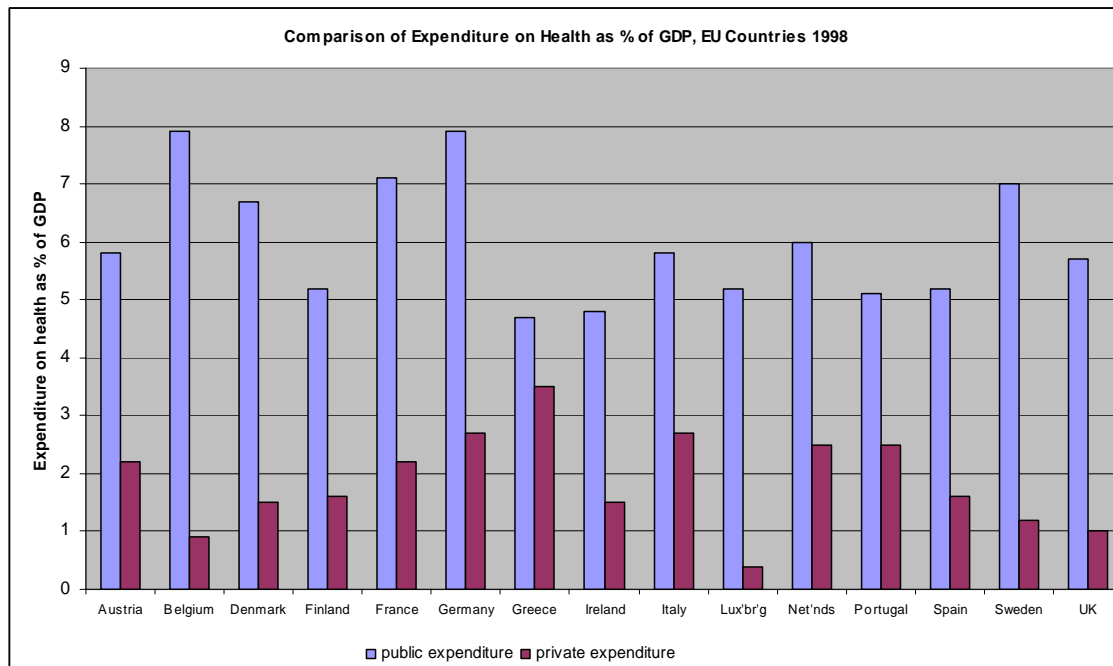


Figure 4: Public and private expenditure on healthcare as a percentage of GDP

The UK still contributes significantly less of GDP to healthcare than the average for OECD countries, as shown by Figure 5. The US spends the greatest percentage of GDP on healthcare, with a system dependent on social insurance (as in Switzerland, the second highest), and the service is efficient, fast and the level of quality high. However, the insurance companies go over every item with a fine toothcomb and rarely pay the full amount for any procedure. Research shows that medical expenses are the second most common cause of bankruptcy in the US [Warren, Westbrook and Sullivan, 2000]. In stark contrast, an American patient can be seen quickly in a medical centre in their local shopping mall - many of which even have the latest technology and x-ray machines on site. There is a huge divide between some patients receiving fast, quality care whereas approximately 45 million people, predominantly the working poor [Unison, 2003], are denied access.

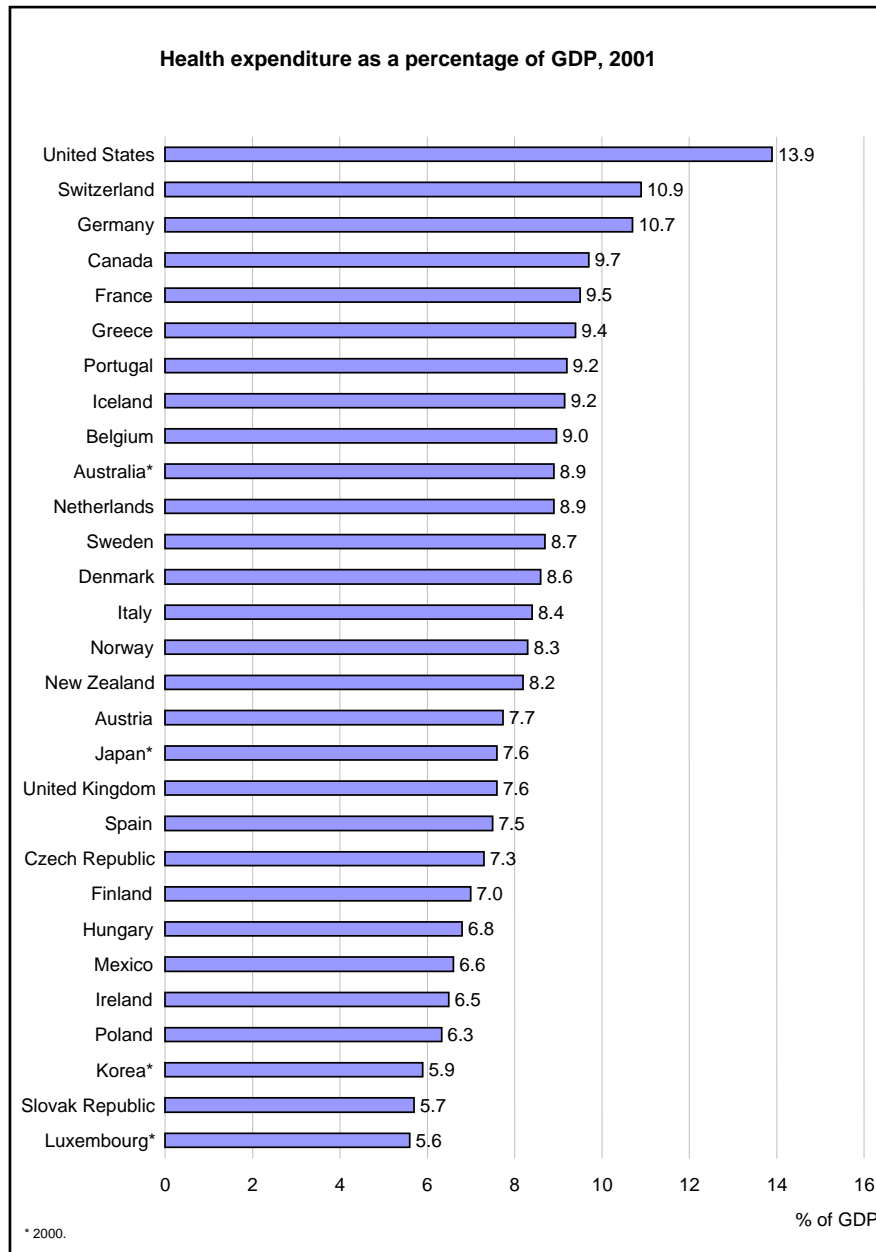


Figure 5: Total healthcare spending as a percentage of GDP [OECD Health Database 2003]

Germany spends more than the EU average on health, employing 12% of the entire workforce [Walker, 2001]. German governments have traditionally seen spending on public services as priority [Charter, 2001], and Germans tend to value social solidarity, even at the expense of high taxes [Walker, 2001]. However, the combination of an increasingly ageing population, expensive new technology and drugs means that state insurance funds are no longer adequate [Boyes, 2001]. There is an urgent need for more responsible use: German patients consult several

different doctors for the same condition, while millions of x-rays are taken each year without medical justification. Doctors, encouraged by the pharmaceutical companies, are over-prescribing expensive drugs, while some hospitals have to wait six months or more for bills to be settled by the state insurance [Boyes, 2001].

Lack of funding is not necessarily the problem, however, as even in Norway, one of the richest countries in the world, people have to wait months for serious treatment such as heart surgery [Ippr, 2001]. Inefficient distribution of money is the major issue in Germany [Boyes, 2001], and this is applicable to the UK. Inappropriate incentives have also been blamed by the OECD for existing problems with healthcare systems, and there is insufficient information about the impact of previous reform attempts by countries to guide new initiatives [OECD, 2003].

7 *Conclusion*

Patients' decisions not to travel have in many instances been attributed to insufficient information, as where this is lacking then the GP is more likely to recommend the local hospital. Although PCAs have proved to be influential in the pilots and helped to overcome this issue, in reality it will not be feasible to offer the same level of support when choice is available for all, so this will further limit the number of patients willing to travel.

Research has shown that patients value local services, therefore if waiting times are reduced then location will become the priority and patients are likely to opt for their local hospital. Evidence that patients will travel is from choice for long waiters, so not necessarily applicable to choice at the referral stage, and the little evidence for choice at referral is from Europe, where the impact has been small. Payment by Results is designed to be an incentive for trusts to increase activity and efficiency, but if most patients are unwilling to travel there is limit to the extra activity hospitals will be able to attract. The two main opportunities for hospitals under choice are therefore to increase activity through taking on patients from PCTs struggling with choice at six months and to find areas to improve efficiency and cost-effectiveness to maximise the benefit from tariffs. One way of improving efficiency could be to have dedicated teams performing specific operations on one day a week, as was trialled by Trent PCT using an overseas team. Another area for exploration is to increase day surgery and perform more work in the community and in primary care.

Patients valued the offer of choice even if they opted for treatment in their local hospital so satisfaction with the NHS may improve as patients feel they are being involved in decisions. The concept of a responsive, personalised health service with choice for patients is commendable in theory, but in reality there are a number of

insurmountable obstacles. There is a tension between choice and equity of access, as there will be no prioritisation of patients. Evidence points towards a possible drop in standards with increased competition, which is the opposite of the Government's intention to improve quality in the NHS. It is also possible that reducing waiting times to six months will be at the expense of waiting times elsewhere, as experience shows there will be a trade off.

For choice to be successful a cultural change is necessary, and this will only happen in the long-term, if at all, as due to the amount of change in the NHS in recent years patient choice will be seen as a short-term measure and possibly not given adequate time or attention before the next policy replaces it. There is still the need to address long-term capacity; many solutions offered have been short-term, such as using overseas teams and the private sector. Finally, NHS resources, particularly nursing staff, are limited in spite of the record levels of investment in recent years, and if the Government is serious about keeping the funding model that exists today then there is an urgent requirement for greater efficiency.

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