



# Patient Choice and the Organisation and Delivery of Health Services: Scoping Review

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

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*Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO)*

*December 2005*

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Authors of the report bear sole responsibility for the views expressed in this document and for any remaining errors.

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Professor Kieran Walshe and Dr Rod Sheaff acted as Advisory Group members.

## ***Executive summary***

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

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

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

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

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

The key points we found here were as follows.

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

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



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

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

### ***Evidence from primary care***

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

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

### ***Evidence from secondary care***

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

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

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

## The impact of choice on efficiency

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

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

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## The impact of choice on equity

The main findings from the literature follow below.

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

## The impact of choice on quality of care

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

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

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## Choice and individual treatment decisions

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

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

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## Information about choice

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

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

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

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## Important lessons

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

### ***In terms of efficiency***

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

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

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

### ***In terms of equity***

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

### ***In terms of quality***

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

### ***Choice in individual treatment***

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

### ***To improve information and enable choice***

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

### ***Evidence from other sectors***

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

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

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

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

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

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

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## Structure of this report

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

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

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

# ***The Report***

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## **Section 1 Background and methods**

### ***1.1 Aims and objectives of the project***

The main aim of this study is to assess the evidence available on patient choice, to guide future SDO research in this area. The second aim is to provide evidence to inform current policy-making and to assist policy implementation, and the third aim is to benefit patients by highlighting research areas that are relevant to their concerns.

We achieve these aims in two ways. Firstly, we explain the extent to which theories relevant to choice underpin choice policies in health care and other public sectors. Secondly, we summarise key findings from research on the impact of choice on the organisation and delivery of health services, drawn from both the academic and grey literature. This synthesis is structured around objectives identified in key policy documents and includes consideration of the following impact measures:

- health care effectiveness (quality of care; outcomes of care),
- efficiency (technical and allocative efficiency; value for money),
- equity in provision of health care,
- quality (access to care measured as waiting times and outcomes of care).

These impacts are analysed both within different sectors (primary and secondary care) and at different levels:

- system level (e.g. configuration of service providers, impact on services and providers that do not offer choice at present),
- organisation level (e.g. services offered by individual providers, mergers of providers, providers' response to choice incentives),
- micro level (e.g. relationships between patients and staff, choices of individual treatments).

We also considered particular issues already identified as likely to affect impact:

- the role of information in the exercise of choice, and differences among different groups in access and use of it;
- the way patients trade off different aspects of choice and different choices including constraints and limitations involved in these processes.

This work was informed by UK and international experience from implementing choice in health care, social care and education. This



helped to elucidate the issues and dynamics involved in choice in wider public sectors inside and outside the UK that might inform policy implementation in the NHS.

## **1.2 Methods**

We proceeded as follows<sup>1</sup>.

- We analysed choice-related public policies, to identify intended impacts and any other issues likely to affect impact.
- We identified theories relevant to choice.
- We analysed what the theories imply about policy impacts.
- We gathered evidence regarding the impact of choice on the organisation and delivery of services.
- We considered the potential impact of relevant NHS policies, and the likely implications for future policy.
- We identified gaps in knowledge in relation to relevant NHS policy areas.

The main methods we used in this process were:

- literature search and review,
- consultation with key experts, primarily through workshops,
- knowledge of team members.

### **1.2.1 Analysis of choice-related public policies**

First we gathered information about relevant policies. Existing knowledge of team members was supplemented by a rapid review of the literature, gathering policy documents published on the World Wide Web, together with recent articles published in practitioner journals. These documents were analysed as follows.

- Breaking down the rationale for each main policy programme to tease out what effects policy-makers are hoping to achieve.
- Summarising what the concrete and stated ends of policy are, as far as they can be read from policy documents.
- Defining 'values' that are stated or implied in different subcomponents of policies.

Subsequently we consulted key experts to test and refine our analytical framework. The research team organised a participative expert panel workshop, the first of two held during the project, to which SDO customers, academic opinion leaders, stakeholders from the NHS and other organisations, and members of our project Advisory Group were invited (see below). Team members also

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<sup>1</sup> Although the work was done largely in the order presented, there was some iteration between different stages as they informed each other, and some work was done in parallel.

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organised or attended other meetings relevant to patient choice (see Appendix 2):

- meeting with the Audit Commission,
- conference on Anglo–Dutch experiences of patient choice, organised by the King’s Fund,
- conference organised by the Institute for Public Policy and Research.

### ***First Expert Panel Workshop***

The workshop (see Appendix 2) comprised presentations and discussions related to:

- learning from the London Patient Choice Project,
- learning from the Liverpool and South Sefton Choice programme,
- service users’ views on choice,
- thinking through underlying national policy development,
- findings from the research team’s literature search so far.

These presentations and discussions were recorded and analysed to extract key issues. This confirmed that the main impacts of choice policies are intended to be on efficiency, quality, equity and responsiveness, so we focused on these impact measures in the rest of the project. This approach formed the core of our analytical framework, which is expanded on in Section 2.6.

### **1.2.2 Identifying theories relevant to choice**

The first part of the project focused on identifying major theories that have influenced the introduction of choice in public policies. A pilot search was undertaken first, partly in order to get a ‘feel’ for the literature and partly to set up systems of working among team members. This was then followed by the search ‘proper’. Details of both searches are given in Appendix 1.

#### ***Pilot search on theories of choice***

This search produced 525 references. However, the references were insufficiently focused on the literature of interest. A higher proportion (25%) of articles which contained the terms review, meta-analysis or critique in their title, abstract or keywords appeared to be relevant when compared to articles not containing these words (of which 9% were relevant), so we decided to restrict our subsequent search to such review-type articles.

We also decided to restrict the next search to the theories that appeared to be the most relevant to, and influential over, policy development in health care. Appropriate keywords were specified based on the articles found by this pilot search, thesauri provided by some of the databases and existing knowledge within the research team.

The pilot search, through discussion and independent peer review of articles, also proved useful in helping us to refine our ways of working as a team, how to judge whether articles were relevant, in how much detail we should record comments on the articles and how to manage data across a team of people based in different locations and with different preferred styles of working.

***Second search on theories of choice***

Keywords and other details of this search are presented in Appendix 1. This search produced 1422 references. These were allocated to team members according to their interests as specified by keywords used in the search, and then assessed individually for relevance using the team's expert knowledge on theories dealing with the concept of choice. The relevance of references was judged on the basis of their contribution to understanding the influence of different theories on current patient-choice policies. A total of 232 articles were judged probably (149) or possibly (83) relevant, based on the title, abstract and keywords. These articles were then obtained where possible, and if still judged relevant, used to supplement team members' knowledge of relevant theories so that summaries of these theories could be written. We did not review papers that dealt with theories of choice, and therefore they do not figure explicitly in any table; instead, we used them to complement our understanding of ideas that might influence the conception of patient choice in health care. In retrospect, it might have been appropriate to do less searching, as the search found little that was not already known to team members.

Although we did not follow the stages and exact methods of the realist inquiry, our approach was informed by insights that this new pioneering method of synthesis of evidence advances (Pawson and Tilley, 1997). The major contribution of realist inquiry to our study was its reliance on judgment to adjudicate between different theories as to their explanatory power in relation to evidence, its use of multiple sources of evidence to test the same theory, and its iterative approach to looking at data (Pawson *et al.*, 2005).

We found that it was therefore essential to first unearth theories of potential relevance to the current Patient Choice policy. Secondly, we sifted through all potential contributions that different theories could make to arrive at the conceptual synthesis. This process of theory mapping enabled us to construct an analytic framework comprising theories with higher impact on policy formulation and highest explanatory power for illuminating the likely consequences of choice policy on its own proclaimed objectives of efficiency, equity, quality and responsiveness (see Table 2, Section 2). The analytical framework was then applied in searching for evidence which was judged in terms of its fitness for purpose, and the extent to which the evidence could be used to populate our analytic framework (see Table 3, Section 2).

### **1.2.3 Analysis of the theoretical impact of choice**

We then analysed how the identified theories would best predict the effects of choice on our chosen measures (efficiency, equity and quality) by considering the following.

- To what values, besides choice, does the theory explicitly or implicitly appeal? In other words, is choice a means to achieve other goals such as equity or efficiency or is it a good of its own value, or is it both?
- At what points do the theories perceive conflicts (i.e. tensions, trade-offs, contradictions or inconsistency) between choice and these other values?
- What practical constraints on the exercise of choice are implied (e.g. limits on the amount of complex technical knowledge patients can be expected to process)?

The way in which we developed our analytical framework and applied it to the empirical findings is summarised in Table 3. Although this framework was largely devised a priori we tested it with practitioners and other experts who conferred on our First Panel Expert Workshop, convened in March 2005. This assured us that the framework fitted the purpose of our synthesis of evidence and enabled us to use it for:

- juxtaposing the evidence base deriving from variety of sources with theoretical standpoints and the stated policy goals as presented in the policy documents,
- identifying necessary preconditions of choice and policy implications resulting from uncertainties and constraints involved in implementing patient choice in public health systems.

### **1.2.4 Gathering evidence regarding the impact of choice**

The details of the initial search for impact are given in Appendix 1. A total of 5495 unique references were found. Of these, 1027 were judged to be relevant, either probably (748) or possibly (279), based on their title, keywords and abstract. Of the references on impact of choice that were obtained following all the searches, a total of 295 were found to be relevant. These are summarised in Tables A1–A5 (Appendix 8).

A small number of further references were also identified subsequently through automatic e-mail alerts that reflected the search terms, and a later search for dissertations.

Considering the results of this initial search helped us to clarify how choice ought to be interpreted for the purposes of this project (see Section 2). Bearing in mind the project aims and the time available, we also decided to limit further literature searching as follows.

- Decisions about end-of-life care, such as turning off life-support systems, and decisions about premature babies and abortion were

excluded. Patient-choice policy in its present form is primarily concerned with choice of secondary provider and is therefore unlikely to have major impact on these choices.

- We did not search explicitly for literature on agency, autonomy, empowerment or patient and public involvement, while recognising that these can be either related to choice or underpin some of the theoretical frameworks dealing with choice such as moral philosophy or ethics (see Appendix 3). Although we did not exclude papers that dealt both with choice and some of these concepts, we did define out all references that dealt mostly or exclusively with ethical and/or moral considerations and issues around patients' or users' autonomy.
- We limited our search to health care, choice of residential care home, direct payments, and markets in social care and in primary and secondary education. Choice of residential care home is analogous in some respects to choice of hospital for elective admission, and also has a substantial literature to draw on; the extension of direct payments to cover some health care of people with chronic conditions is being mooted; markets in social care and primary and secondary education have been in place for many years, so there is a good quantity of evidence to draw on while looking at positive and negative outcomes of choice. We carefully evaluated lessons from residential care, education and the use of direct payments in social care as they might signal the direction that patient choice takes if it is fully implemented.
- We limited our search for international experience to health systems with similar structure, philosophy policy objectives and organisation to the NHS in the UK.
  - a These were predominantly the integrated publicly planned, financed and delivered systems of Sweden, Denmark and New Zealand, which have introduced choice and competition in recent decades via quasi-markets or similar reforms.
  - b Other national health systems where choice is well established via social health insurance and plural providers such as for example The Netherlands, Germany and France, were largely excluded from the review because of limited transferability of this experience to the NHS implied by their different funding and organisational arrangements. However, pertinent evidence was occasionally used to illustrate the potential consequences and policy implications for the NHS in Section 3.3.2.
  - c Similarly, the vast evidence from the USA was used judiciously to inform our synthesis with emphasis on the issues of most relevance to the NHS. Choice, competition and the impact of public release of performance data are well researched areas that are also relevant to the philosophy of health systems per se. This literature is quite often concerned with issues of indirect relevance to the NHS user, manager or policy-maker (e.g. availability of information for providers rather than

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patients or limitations to choice in several respects including Health Maintenance Organisations such as Kaiser Permanente). Given the importance of information as precondition of choice we reviewed evidence on the effects of release of performance data on patients' decisions in Section 3.8.

We decided that we would focus on several key issues that seemed particularly relevant to the impact of patient-choice policy in health care. These resulted from our approach that involved several stages of framework building through analysis of theory, followed by testing conceptual frameworks against evidence to further refine our research questions. The search for choice impact was based on the literature review and the knowledge of the team and other experts, while unearthing of limitations was also assisted by participants during Second Panel Expert Workshop.

We looked at limitations of choice at both theoretical and empirical levels, including personal, institutional, cultural and other social factors that influence decisions made by individuals. In identifying these we combined theoretical predictions concerning factors that enable or are closely linked to choice, hence our focus on information and competition in relation to choice. Finally, we used the experience of policies from other sectors by focusing on direct payments, choice of residential homes and primary and secondary education to draw lessons that maybe of relevance to choice.

As a result the key overarching themes in our study identified are the following.

- What is the effect of the public release of health-services performance data in the context of choice?
- What is the relationship between choice, competition and performance?
- What are the factors that affect individual choices in health?
- What is the relevance and difference between patient choice and choice in other public sectors including direct payments in social care, choice of residential homes and choice of primary and secondary education?

One member of the research team took responsibility for scoping the literature within each of the key issue areas, supplementing the initial search as appropriate with searches using different keywords, searches for articles citing seminal papers, and direct communication with researchers active in the field. A purposive sampling technique was applied in selecting issues using snowballing to lead from one source to another. This process continued until the researcher judged that a 'saturation point' had been reached, with no new information being generated. Searches of literature from non-health care sectors and from countries outside England were not done in as much depth, bearing in mind the in-built limitations on relating the findings to

patient-choice policies in England (see above). Details of these searches are given in Appendix 1.

### **1.2.5 Considering the potential impact of relevant NHS policies**

Evidence about impact of choice was extracted from relevant publications found by our literature search and related to the primary and secondary care sectors, and to the system, organisation and micro levels.

We also gathered together documents of other policies likely to affect the impact of choice policies, such as Payment by Results, Foundation Trusts and Practice-Based Commissioning. We then considered how the different policies might influence patient choice, and how patient choice might influence them, drawing out possible policy implications (see Section 4).

The main question we asked was in what sense or senses of 'choice' are these policies about choice? A number of further questions underlying the main question were also considered.

- Who will have these choices?
- What will the choices be about (i.e. from what menu of possibilities)?
- How can the 'choice' policy be implemented?
- What effects will implementation produce?
- What other values will choice promote and/or be constrained by?

This work was done in conjunction with a panel of experts invited to the second workshop, who encompassed a variety of practitioner, patient, organisation and research perspectives (see below and also Appendix 2).

#### ***Second Expert Panel Workshop***

The aim of this workshop was to identify necessary pre-conditions for realising choice, and the implications of choice for the organisation and delivery of primary and secondary care services at the macro, meso and micro levels under various scenarios. These scenarios were performed by attendants during second workshop. Following presentations and discussions of summaries of findings from the project, participants used cognitive mapping (Eden *et al.*, 1983) to elucidate and develop their views about the likely impact of patient choice and other related policies that are being introduced simultaneously. Different scenarios were considered based on different levels of choice-policy implementation, modelling likely outcomes with regard to different scenarios (high, medium and low diffusion of choice). The maps produced were then used to refine the project findings and particularly to tease out policy implications.

### **1.2.6 Identifying gaps in knowledge in relation to relevant NHS policy areas**

Our analysis of the impacts of choice, based on theoretical considerations (Figure 1, Section 2), highlights impact measures where:

- different theories conflict in their predictions,
- theories do not support the impacts policy-makers desire,
- theories have little to say.

Similarly, our analysis based on the empirical evidence highlights impact measures and key issues where:

- the evidence conflicts,
- the evidence does not support the impacts policy-makers desire,
- there is a lack of evidence (little research has been done, or the research is not sufficiently robust).

### **1.3 Implications of methods used for our findings**

Our methodological approach implied several constraints, which are discussed in more detail below, which related to:

- limitations implied by the breadth and multi-sidedness of the subject which meant that some aspects of choice are not included,
- limitations of the theory-driven approach,
- limitations by diversity of the literature identified,
- limitations related to the small sample of key stakeholders against whose views we tested our hypothesis, although they represented NHS managers, policy-makers and users' representatives.

The variety of conceptions of choice, the large number of concepts closely related to choice, the large number of theoretical approaches and the wide variety of practical situations in which choice has been of interest from a policy or research point of view meant that the literature to be examined was potentially vast. We therefore identified and focused on particular topics and issues that seemed to be most relevant to policy (see Section 1.2.4).

Our adopted method of conceptual synthesis does not attempt to review all relevant publications in the field but rather aims to outline the key ideas to review the significance of these in terms of their implications for implementation of choice policies (Nutley *et al.*, 2002a, 2002b). Theory-driven approaches moreover reject the hierarchy of evidence because multiple methods are needed to illuminate a richer picture (Pawson *et al.*, 2005). In view of the diversity of literature on choice, it was not appropriate to apply standards of evidence to individual papers (e.g. as in a Cochrane



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Review). Instead, we decided to focus on providing a narrative description that would explain the nature of the evidence, and its implications for choice in health care.

## Section 2 Theoretical concepts of choice in health care

Like every policy, patient choice contains a programme theory; that is, assumptions about how the policy will achieve the intended outcomes, and about the value of those outcomes. In order to establish what evidence is relevant to the policy, a first step is to reveal what programme theory the policy contains. Being the product of a political process, a programme theory is not necessarily complete, consistent or well-formulated, but careful analysis can still reveal much. One has to say what patient choice means in this context, what policy outcomes the policy is intended to produce, by what processes and in which contexts. In this section we analyse the concept of choice by considering the following in turn.

- 1 What the term patient choice means and implies when used in contemporary English, including how the idea of choice differs from and overlaps with related concepts such as autonomy and demand. This will help define more sharply the limits of our review. That is, which aspects of choice are included and which are excluded?
- 2 Selected theories of choice.
  - a Descriptive theories describe how people actually exercise choice. Such theories identify the possible outcomes that policies aimed at promoting patient choice might be expected to produce, the mechanisms which would produce those outcomes and the conditions which these mechanisms require to work effectively. This will help define our framework for analysing the empirical evidence on the impact of choice.
  - b Normative theories assert how people would exercise choice if they chose rationally, and may have a bearing on policy. Such theories also guide us to empirical evidence that can be used to help assess the practical feasibility of policy.

For more details on theories of choice see Section 2.3 and Figure 1.

- 3 What the term patient choice means and implies when used in national public policy documents. The previous two steps enable us, by analysing the text of these documents, to identify the theories which implicitly underpin NHS patient-choice policies, and hence the programme theory. They also indicate what evidence appears to be most pertinent to policy, and what the impact of the policy is likely to be. Relevance to policy and its potential impacts, together with practical concerns about resources available for the review, could then be used to determine which bodies of literature will be covered by the review.

## **2.1 Logical analysis: what the term patient choice implies**

Choice is a many-sided, diffuse and value-laden concept. Any use of the term choice invokes assumptions about the following:

- who chooses?
- by what process do they choose?
- what scope do they have for choice?
- what do they choose?
- what effects do their choices have?

### **2.1.1 Who chooses?**

In the context of patient choice it seems obvious that patients do the choosing. But this idea has limits.

- Certain patients are not physically competent to choose, in the sense of either going through the mental processes or applying the criteria noted below. Obvious examples are neonates and very young children, unconscious patients and conscious patients whose illness leaves them no way of signalling their choices.
- Other patients are capable of choice but for policy or ethical reasons policy-makers insist that health systems must disregard their choices, for instance when patients' choices would harm themselves or others. Similarly, policy-makers do not usually permit patients to choose what treatment other people will receive, although there are exceptions: the parents or guardians of young children, and the partners, relatives or friends of adults who cannot exercise choice can act as proxies for these people.
- Competent adults often prefer to delegate their choice of treatment to someone, typically a health professional, whom they regard as better informed and trustworthy to take the decision on their behalf. But then choice may amount to no more than passive consent; that is, acquiescence in what the professional proxy suggests (Coulter, 2001). A paradox may arise: the patient chooses not to choose.
- As explained below (see Section 2.3.2), socially 'embedded' accounts of choice emphasise that anyone who chooses is embedded in a set of social relationships and a social culture. This raises the question of how meaningful it is to speak of individual choice, when the parameters and rules for choosing are largely pre-defined by marketers, the mass media and similar institutions.

A large literature debates the first three of the above points from ethical and legal standpoints, but this is of limited use for our review. Of greater relevance is the question of what evidence exists about how far patient-choice policies can be extended to cover the more

problematic categories of patient noted above, and what other arrangements can be made in lieu of such an extension.

Similarly, literature on the desirability of choices being made independently of wider forces is of little value to our purpose. But the question of the extent to which patient choices are managed, and by whom, is relevant to the impact of patient-choice policy on demand for services, and hence on goals such as efficiency. Evidence related to individual patients choosing for themselves would seem to be of greatest relevance, while the moderating effects of interactions with advisors in this process (such as general practitioners (GPs) and Patient Care Advisors) should also be considered.

### **2.1.2 By what process do patients choose?**

The term choice is usually taken to refer to a conscious, deliberative mental process whose endpoint is a person's action, belief or speech. The process of choice is also a motivational, emotional or attitudinal process as well as being constrained by the agent's knowledge, mental capacities and scope for choice. Uncertainties and limitations in individuals' capacity to choose are therefore examined from the perspectives of biological limitations and psychological conditioning.

A fundamental part of understanding patient choice is to review the theories which describe how this deliberation occurs, in particular whether choice is *purely* a consciously deliberative process or whether it is also coloured by non-rational processes (e.g. habit, information overload) or even irrational processes (e.g. unconscious compulsions).

In so far as choice is a conscious, deliberative activity, it is often assumed (e.g. in some branches of economics; see Section 2.3.2) that the process of choice consists of applying one or more criteria to a set of options: criteria reflecting one or more intended outcomes that the chooser wishes to either obtain (or maximise) or avoid (or minimise). We therefore need also to understand, among the processes of choice, what substantive criteria choosers apply (e.g. do they all, as the utilitarians argued, seek to maximise pleasure and avoid pain?).

So we distinguish three different empirical questions about the process of patient choice.

- 1 What mental processes occur when patients choose? This includes how far the choice is conscious and deliberative, and in that descriptive sense, rational.
- 2 What substantive criteria do patients apply during the process of choice?
- 3 What conditions facilitate the process of choice or are necessary for it? Most obvious of these is adequate, usable and accessible information about what options are available and their characteristics. Institutional conditions under which choice is feasible, including barriers to implementation, are also identified using, in particular, theories of institutional economics.

Regarding these questions our review has to identify both the most relevant and valid theories, and the assumptions that the policy rests upon (which may be the same, or different); and thus the corresponding bodies of evidence.

### **2.1.3 What scope do patients have for choice?**

Choice implies the presence of two or more options. The scope of choice can be understood in terms of the following.

- The range of options available:
  - how many dimensions (service provider, place, time, treatments, etc.) of choice are being offered?
  - how many options are available within each dimension?
- Feasible options which are not made available.
- Who, or what, determines which options are available and which are not.

With regard to the range of options both current policy and the extent of existing evidence suggest that the review should focus primarily on the following areas.

- *Choice of primary care provider* or setting because of its implications for individual patient choice and possible future importance and also because some evidence exists about patient willingness, or the lack of, to exercise choice in this area.
- *Choice of secondary care provider* for elective services (including choice of hospital site or health professional) because this is the main plank of the government policy at present.
- *Choice of treatment or different forms of treatment* (including trading off different aspects of treatment involved in discrete choice experiments) because it responds to the request specified in the call for proposals and because of the evidence that emerges in this area.

Evidence from other health systems and other public sectors may suggest the possible scope of patient choice by showing the feasibility of offering other options. It may also indicate the organisational conditions that produce or constrain the scope of choice, and the effects that the different scopes of choice produce.

### **2.1.4 What do patients choose?**

The notion of choice also implies that in the end one of the available options is chosen. It would be easy to slip into the normative presumption that, for the patient's purposes, this was the 'best' option. After the event, one can distinguish the following possibilities.

- The chosen option was after all the best available option for the patient's purposes.

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- The chooser would have preferred another feasible option but it was not available so the least bad available one was chosen.
- The chooser was under-informed about the option chosen, an important consideration in health care (considering risks, side effects, need for compliance, etc.).
- The chooser was misinformed about at least one option, or about what options were available.
- The chooser's preferences were unstable.
- There is so little difference between the options that the chooser vacillated.

These possibilities suggest a need for our review to consider in what circumstances people make bad choices, how health systems might either prevent this happening or reduce adverse consequences for the chooser or for others, and what choices different patients and other stakeholders make. Given current NHS policy, we should also consider evidence about how far different systems of patient choice produce desired outcomes such as effectiveness, efficiency, equity and quality.

### **2.1.5 What effects do patients' choices have?**

The practical effects of patients' choices are produced by a complex of interactions between patients, their relatives and carers, and health care providers (Elwyn *et al.*, 2000). The institutional settings which realise patient choices (or fail to) can be classified by *sector* or *level*, as follows.

- *Sector*, such as primary care, secondary care and some other selected public sectors. We argue that these sectors play different roles with regard to choice policies, and that the impact of choice policies on different sectors is likely to be different. They are used as units of analysis in this review, to which theories and empirical evidence are related.
- *Level* (system, organisation, individual): we argue that implications for the NHS should be considered at these three levels, both in response to the call for proposals but also to allow for separation and better clarification of its different effects. Impacts at the system and organisation levels will depend on the extent to which people exercise choice of provider and, conversely, NHS organisational arrangements also influence the individual patient-choice process.

It is therefore important to consider theories and evidence regarding the relationship between organisational, institutional and other conditions and whether patient choices tend to produce the effects that the patient intended. This will highlight potential risks, and the conditions in which these risks are most likely to materialise.

To evidence the effects of choice requires operationalising such policy goals as efficiency, quality, equity and responsiveness into measurable indicators to ascertain whether anticipated outcomes are happening in

reality and also to identify the unforeseen impact (if any) of patient choice on those goals.

## ***2.2 Concepts related to choice***

Choice is related to a number of other concepts. In order to focus our review appropriately, we needed to decide which of these concepts we should consider, in terms of both theory and evidence. Here we briefly discuss the most closely related concepts, and our reasons for including or excluding them. Because policy relevance is one of our key criteria for inclusion, we identified related concepts chiefly from the policy literature (see also Section 2.3).

In current UK policy debates, the idea of choice is most extensively discussed in the context of *competition, contestability* and *'exit'* (Hirschman, 1970) as drivers of choice, with the implicit and usually unquestioned assumption that these are essentially market mechanisms. This derives from conceptualisation of choice as associated with transactions in a competitive or at least contestable environment (operating under the real or perceived threat of competition), and usually these conditions too are conflated with markets.

In so far as the term choice is used as an oblique reference to market or market-like mechanisms, we justify the inclusion of an empirical focus on competition and the quasi-market experience. Evidence of choice is also examined in the context of markets including quasi-markets and GP fundholding in the UK and in other comparable health systems as they provide the most recent and relevant experience to understanding the effects of current policies. At the same time differences between the present and previous sets of reforms and country-specific context where experience of the quasi-market reforms is relied upon (such as, for example, in Scandinavia) are also acknowledged.

Another set of policy concepts related to, indeed sometimes cited to justify, patient choice are those of *empowerment, agency* and *autonomy*. Patient empowerment has been analysed in theories of participation (Arnstein, 1966) and Hirschman's conceptualisation of 'voice' as a mechanism of changing the system from within, which he contrasted with 'exit' which that choice implies (Hirschman, 1970). Different categories of empowerment range from the moral persuasion expressed in complaint procedures and appeals, gradually increasing to freedom of choice of the physician and the insurer and choice over the modalities of treatment given to users. Empowerment is at its strongest when users have control, either delegated or direct, over the resources spent on health (Saltman, 1994).

The expansion of patients' rights in choosing the providers of services could also be used to empower citizens, if properly linked to their direct participation in the decision-making processes (Winkler, 1987;

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Saltman, 1994). As elaborated by Saltman, this extension of choice could involve influence over modalities of treatment and higher accountability by providers and by those acting on the patients' behalf for budgetary allocation. It may also extend to their participation in election of health-related politicians (Saltman, 1992, 1994). We reviewed the literature on the citizen as consumer or customer, because of its centrality in New Labour approaches to modernising public services (Clarke, 2004a, 2004b; Needham, 2003), and, particularly, because of its relevance to the changing role of the user of health services, as articulated in the context of patient-choice policy in the English NHS (Greener, 2003a, 2003b, 2005).

For the reasons already stated, we did not review in any depth the ethical and moral philosophy perspectives on patient rights, empowerment and autonomy. For the same reasons we only consider the concept of agency in relation to choice in health care as it is understood in economic terms, when for example GPs act on behalf of their patients (e.g. Le Grand, 2003). We decided not to consider it in reference to human agency as conceptualised by sociologists or social policy analysts (e.g. Archer, 2000; Hoggett, 2001). This because it is seen as an individual attribute closely linked to autonomy although we acknowledge that there is an increased interest in developing concepts of autonomy relevant to health (e.g. Coulter, 2002) alongside critiques of the application of rational choice theory to understanding agency in health care (e.g. Pescosolido, 1992). However, we decided to exclude these from our review because of the limited resources and their peripheral relevance to the purpose of this scoping exercise.

Needs are often contrasted to demands, and to that extent choices. There are three ways of understanding the term need. One is to take need as a moral concept (Doyal and Gough, 1991; Ramsay, 1992), meaning something like a morally justifiable or necessary demand or choice. Economists often regard needs as meaning ineffective demand; that is, things that patients might wish for but do not have the money to buy, contrasted with the effective demand of a patient who has the money to buy what he or she chooses (Mooney, 1986). A third approach is to define needs as informed demands or choices, in contrast with patients' actual demands and choices (Sheaff 1996; and arguably Daniels 1985). The ethical sense of the term lies largely beyond the remit of the present review, whereas the economic sense of the term is largely inapplicable to systems like the NHS, where state spending guarantees that all patients have an effective demand for at least a guaranteed minimum level of health care. The third approach again raises the question of whether choices can ever be irrational bad choices, which is also outside the scope of this review (see Table 1).



**Table 1 Concepts linked to choice considered in the review**

<b>Concepts linked or related to choice</b>	<b>Examined theoretically</b>	<b>Examined empirically</b>
Quasi-markets	Examined	Examined
Competition	Examined	Examined
Contestability	Examined	Examined
Information/communication	Examined	Examined
Decision-making in health care	Examined	Examined
Demand	Examined	Examined
Needs	Examined	Examined
Agency	Examined	Examined
Consumerism/citizenship	Examined	Examined
Autonomy	Not examined	Not examined
Empowerment	Not examined	Not examined
Patient and public involvement	Not examined	Not examined
Alternatives to choice/limited choice	Not examined	Not examined
Choices from an ethical and moral perspective	Not examined	Not examined
Patients' rights	Not examined	Not examined

### ***2.3 Theories relevant to patient choice***

In reviewing theories of choice we make a fundamental distinction between normative and descriptive theories, because empirical evidence plays a different role with regard to normative and descriptive theories. Descriptive theories describe what criteria of choice a person actually uses. An individual patient's choices may affect others, however, such as other patients who have a claim upon scarce health resources, or health care professionals whose codes of ethics such choices may conflict with. So normative theories suggest ways of choosing that are better from some point of view (e.g. maximising benefit to society).

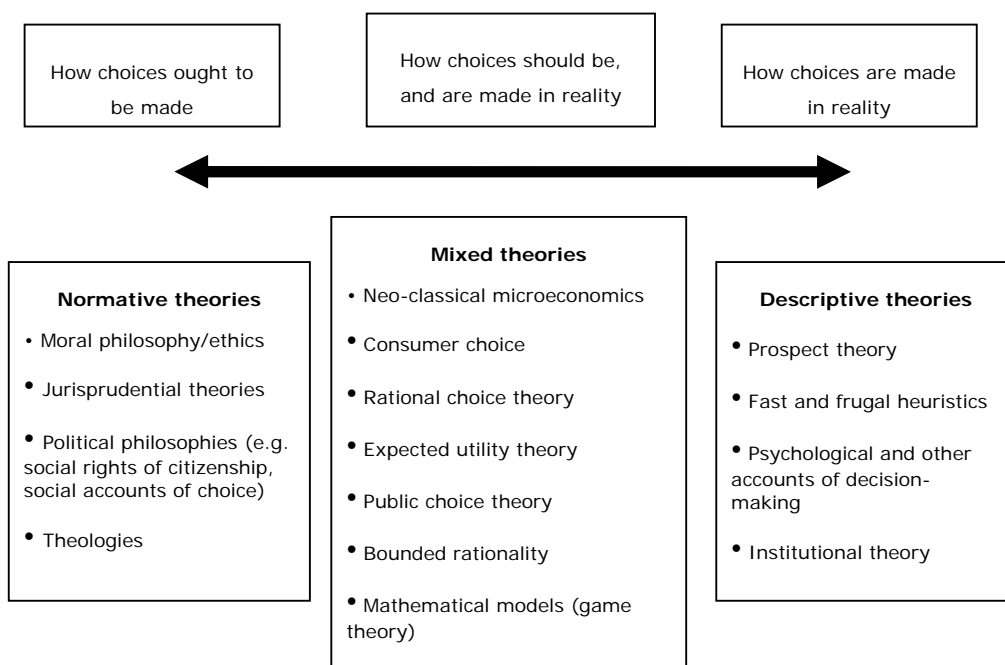
This section discusses normative and descriptive theories to provide a background for those particular theories that formed the basis for our analytical framework. Both are important for understanding patient-choice policies. Normative assumptions that underpin economics for example tell us about their relevance to health policy-making and particularly policy on individual patient choice, which originates from this thinking. In reviewing normative theories, the role of evidence is limited to assessing these value-laden recommendations, where studies exist, and to examining their feasibility for health policy.

Descriptive theories, on the other hand, provide an understanding of how choices and decisions are made in real-life settings. They are entirely susceptible to evidence-basing and can be evaluated accordingly, allowing for the fact that the methods for doing so are less developed and more difficult for qualitative research than for randomised control trials. There are also mixed theories which are neither purely descriptive causal nor purely normative, and entail a degree of ambivalence between empirical and normative content.

Theories of choice are better represented in a continuum ranging from purely normative to purely descriptive ones (see Figure 1). In this continuum normative theories (presented on the left of Figure 1) are constructed by a-priori reasoning departing from premises about rationality, rather than by observing behaviour and building a theory to fit these observations (Hargreaves-Heap *et al.*, 1992), as in descriptive theories (at the opposite end of the continuum).

Descriptive theories, discuss how choices happen in reality. Mixed theories are positioned in between the two, as they vary according to the context and the degree that they formalise descriptive or normative material in their models.

**Figure 1 Normative, descriptive and mixed theories of choice**



The continuum also reflects significant evolution in thinking about choice that occurred in recent decades. It has moved from rational choice theories and normative assumptions of how choices should be made (on the left side of our continuum) towards bounded rationality (Simon, 1956, 1978), which pointed out limitations to rationality in decision-making (in the middle of the continuum), towards simple heuristics of prospect theory (Kahneman and Tversky, 1979) and more recently to fast and frugal heuristics (Gigerenzer and Todd, 1999; on the right side of the continuum).

Below we present only those theories that in our view have either influenced policy-making (some normative theories or their assumptions present in mixed theories such as neo-classical microeconomics for example), or those descriptive theories that serve as a basis to provide an account of choices in health care. Additional information on mixed theories including rational choice theory, expected utility theory, public choice theory and game theory is given in Appendix 3. Appendix 3 also provides a more detailed exposition of decision-making theory and approaches including social judgement theory, the problem-solving approach and some additional information of simple heuristics and fast and frugal heuristics.

### **2.3.1 Normative theories of choice**

Purely normative theories of choice are noted here partly for completeness, but also because as explained above a policy such as patient choice always involves normative assumptions. These theories fall mainly within the domains of ethics (moral philosophy), jurisprudence, political philosophy and theology. Of these, the ethical and political theories that are concerned with diverse, indeed often conflicting, assumptions ranging from contractarianism to neo-conservative forms of libertarianism, theories of the social rights of citizenship and personal responsabilisation, and utilitarianism are the most relevant to the policy of patient choice.

#### ***Ethics and moral philosophy***

In brief, recent ethical perspectives tend to strongly favour choice as a manifestation of personal autonomy, and sees behaviours that are based on strict adherence to the rules determined by others as being sub-optimal from an ethical point of view (Beauchamp and Childress, 1995). Thus Childress and Beauchamp argued that from the perspective of medical ethics each situation where an individual patient is involved 'calls for a set of responses outside any generalisations' (Beauchamp and Childress, 2001: 373). Moral philosophers ranging from neo-Aristotelians (e.g. McIntyre, 1999) to contractarian theorists (e.g. Rawls, 1971) regard choice as a manifestation of personal autonomy. However, there is a substantial difference between specific a 'standpoint of detached fairness' as theorised in the notion of impartiality and universality implied in the Traditional Liberal Theory of justice (e.g. those reviewed by

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MacPherson, 1962). Neo-Kantian ethics also emphasise respect for autonomy alongside beneficence, non-maleficence and justice as one of the four moral principles on which moral thinkers are likely to agree.

These are also adopted as the foundation of medical ethics where autonomy is countervailed by the principle of non-maleficence, thus curtailing it by imposing an externality (Beauchamp and Childress, 2001). These concepts of the 'ethics of rights' have been criticised and juxtaposed to the 'ethics of care' from medical ethics and also from feminist perspectives (Gilligan, 1982; Baier, 1985). They stress the moral role of interdependence that care implies and the emotional response that plays an important role in human moral lives, providing 'a cognitive role' in grasping a situation which could not be available by arguing solely from a 'justice' position.

### ***Choice in market libertarianism and social rights of citizenship***

Choice is also the ultimate objective in the set of reforms promoted by libertarians whose theories profoundly influenced the policies that were adopted by conservative governments in many countries during the 1990s. The prominent features of this philosophy are property rights, individual freedom and personal responsibility, which are manifested in a strong reliance on the private provision of services, competition and freedom of choice as opposed by collectivist values of equity and the supremacy of community-defined needs.

Libertarian values were relied upon as a broad policy framework in quasi-markets reforms across the public sector in the late 1980s and early 1990s in publicly planned and delivered health care systems in industrial economies in Europe, New Zealand and economies in transition. The introduction of market features into the wider public sector (Glennerster and Le Grand, 1995) and, in this case, into integrated health care systems publicly planned and provided, was viewed by many (Garpenby, 1992; Gustafsson, 1995; Øvreitveit, 1994) as the result of a resurgence of conservative ideology.

However, the notion of users' autonomy, which underpins the market philosophy, is also considered from different perspectives in the theory of the social rights of citizenship (Marshall, 1950; Alinsky, 1960). According to the latter theory, policy imperatives aimed at the promotion of the concept of the well-informed patient who is able to choose from a range of available alternatives, are not necessarily bound to serve the individualistic attributes of an increasingly business-minded society (Gustafsson, 1995; Øvreitveit, 1994).

Choice has been traditionally opposed by libertarians and neo-conservatives to collectivist values such as equity and the supremacy of community-defined needs and values such as solidarity (Hirschman, 1970; Titmuss, 1970), Hirschman argued that choice (i.e. exit) in publicly financed and provided services was possible only at the margins of the system for those who could pay. Choice if fully

exercised could lead to diminishing the elements of voice in the system and disable the ability of users' to change it from within (Hirschman, 1970). Against this, New Labour policy-makers argue that collectivist values reflected only the traditional political concepts underpinning public health care systems and failed to take into account the changing expectations of users in recent years (Blair, 2003; Reid, 2003; Le Grand, 1995, 2004). More recently the contrast between citizens' participation as a means of democratising the health system, which is regarded as a public utility and is driven by users' needs, and choice being a manifestation of the consumers' wants, has been questioned (Calnan, 1997; Calnan *et al.*, 1998).

The current policy direction of introducing patient choice is compatible with the proposition put forward by Saltman (1992; see also Øvreitveit, 1996), who regarded choice not as a necessary expression of consumerism but as a means for increasing the democratic participation by the users. He therefore argues that citizen participation (voice) and individual choice (exit) are complementary, rather than alternative modes of ensuring citizens' influence over health services. Accordingly, market elements can be used to strengthen the voice element in the system and, through enhancing direct participation in decision-making at an individual level, to increase the accountability of elected politicians, which was hoped would ultimately provide more democratic legitimacy to the governance processes in health care systems. Market freedoms seem to fit well with the idea, conceived by post-modern sociologists (Beck, 1994; Giddens, 1994), of the autonomous user of public services who has evolved beyond being a passive recipient and has a critical capacity to appraise the welfare options that are on offer. Therefore there is congruence between the notions of the 'consumerist' patient advocated by libertarian economists and the post-modern 'reflexive' actor (Lupton, 1997).

However, these consumerist approaches that the Labour government has incorporated into policies aimed at modernisation of health and public services have been criticised with regard to both their appropriateness and effectiveness. Clarke argues that they are fraught with internal inconsistencies and are in effect subordinating any alternative concepts of citizenship to the neo-liberal ideas of producer and consumer (Clarke, 2004a, 2004b). Needham contends that consumerising citizenship for economic rather than political reasons is shallow and flimsy (Needham, 2003), while Greener criticises this privileging of pro-consumerist discourse in current health-policy documents as being detached from users' needs and the specificity of public good (Greener, 2003a, 2003b, 2005). Marquand critiques the approach of saturating ministerial speeches with consumerist rhetoric as leading 'to narrowing the frontiers of the public domain in the process' (Marquand, 2004: 118). Keaney (1999) examines the rationale for these developments, placing them in wide historical context, and arguing that far from being a passive consumer of pre-

packed health care, patients ought to be considered as partners in a continuing process of inquiry, in accordance with John Dewey's philosophy of instrumentalism.

***Choice and individual responsibilities***

A parallel but separate body of theory concerns entitlements and obligations in relation to patient choice (Wanless, 2004). According to these theories we are free to exercise choice but we are also supposed to choose responsibly. This means a shift from notions of citizenship, which are about the state providing goods and services, to notions, which advocate individuals and communities taking on responsibilities for things that were previously seen as the State's role. Several authors describe how governments have attempted to shift what have traditionally been seen as their responsibilities onto other agencies and onto citizens themselves, citing such normative values as, partnerships, community 'empowerment' initiatives, 'responsible' citizens (Barnes, 1997; Barnes *et al.*, 2004; Newman *et al.*, 2004) and, of course, choice. The second Wanless report places great emphasis on individuals choosing healthy lifestyles (Wanless, 2004) and uses a discourse of responsabilisation.

This policy discourse reflects a blurring of the frontiers between policies aimed at fulfilling personal autonomy and individual wants, and those aimed at meeting community defined needs. The idea that these goals are simultaneously achievable via market means such as choice and competition produces an illusion that there is no differentiation and therefore no difference between these goals, although they might have different implications for user and providers of services (Fotaki, 2005). The concept of consumer and choice in this debate stands for much wider social, political and philosophical conditions (Clarke and Newman, 2005).

In regard to their purely normative element these theories are a largely evidence-free domain. The only way in which they are susceptible to evidence-basing is in respect of the feasibility of their normative recommendations. It has long been argued that a normative claim that cannot be realised through human action can have no practical bearing on the choice of conduct. For human choice would make no difference as to whether that norm would ever be realised. As Hare (1951) put it, 'ought' implies 'can. What humans can and cannot do, including the question of what processes constitute and therefore constrain our psychological power to choose, is however an empirical matter. This is the only element of normative theory to which evidence is relevant. Consequently, the only aspect of purely normative theories of patient choice that the present review will cover is the evidence about which institutions for patient choice and what scope of patient choice it is feasible to establish. The institutional conditions necessary to realise effectual patient choice are discussed below.

### **2.3.2 Mixed theories**

#### ***Neo-classical microeconomics***

Neo-classical microeconomics is the archetypal normative economic theory underlying many of the grand narratives that dominate public policy discourse, including much of the New Public Management. Choice is central to both neo-classical economics and market liberalism, given the latter's focus on property rights, individual freedom and personal responsibility manifested in a strong reliance on the private provision of services, competition and freedom of choice (Friedman and Friedman, 1980; Snower, 1993). The importance of appropriate information as the precondition for effective choice systems is emphasised in both neo-classical economics (see below), and in the Austrian school (Hayek, 1944; von Mises, 1949; Kirzner, 1973). According to these beliefs, choice is best served through the development of the active, critical consumer who in some strand of liberal economics is considered to be a more (neo-classical economics) or a less (Austrian school) knowledgeable agent.

Neo-classical microeconomics claims to separate descriptive and normative theory, but in reality combines them almost inseparably. It rests upon an essentially normative theory of choice which bears little resemblance to most of the empirical findings of biology, neurology or even the descriptive psychology outlined below, but whose origins are easily traceable directly to the great English utilitarian ethicists of the eighteenth and early nineteenth centuries.

In neo-classical microeconomics the core theory of choice is consumer choice theory. Derived from early twentieth century theories of consumer demand which regard consumers as utility-maximisers, the core theory has subsequently acquired various additional nuances, in particular those which re-interpret utility maximisation in terms of revealed preference, maximisation of benefits over costs, and discounted maximisation of benefits over costs. Public choice theory attempts to apply the same analytical framework to political – in particular electoral – choices, and politicians' choices of public spending programmes. In regard to consumer choice, more radical departures are analyses based upon game theory, leading to the self-styled rational choice theory, theories of criterion-related (ranked) choice and satisficing theory.

#### ***Satisficing and bounded rationality***

As noted, the foregoing theories combine normative and empirical elements but with a strong bias towards the former. Simon's theory of bounded rationality has the opposite bias (Simon, 1956, 1978). It describes models of decision-making in which the limitations of the human mind are integrated with the limitations of the environment in which the individual makes their decision. Simon criticised neo-classical models of the process of consumer choice for ignoring

situational and personal constraints, such as time and information-processing capacity.

Neo-classical consumer choice does not consider in any depth the imperfections of the human mind in processing information (Kahneman and Tversky, 1979), as Simon recognised in his theory of bounded rationality. In this, Simon was not alone. Keen, for example, argues that the neo-classical model of consumer choice includes a requirement for 'perfect information' which stipulates so vast a volume of data as to be humanly impossible to handle; millions of pieces of data would be required even to select a single commodity from a supermarket shelf (Keen, 2001). Similar arguments have been made in regard to patient choice.

- *Limited information on the patient's side.* Gafni *et al.* (1998) explore whether patients can ever be decision-makers to conclude that, in order to make decisions, patients need the knowledge of outcomes and their probabilities, which as non-professionals by definition they cannot have, whereas possibly professionals (if they are assumed to have the knowledge!) need the knowledge about both utilities (preferences, values, opinions) and outcomes to be in a position to act for the patient (for details see Section 3.7 and Appendix 7).
- *The time-consuming nature of decision analysis* renders it virtually impossible to envisage it having any significant role in policies to promote patient involvement in decision-making. Furthermore, the decision is essentially prescribed by the decision-analytical process, so it is questionable whether this has any place at all in efforts to enhance or promote patient choice, in the sense of discretion, in health care services (Elwyn *et al.*, 2001a, 2001b).
- *Decision-making is carried out under conditions of uncertainty.* We may be able to assess the probability of a range of possible outcomes but the specific outcome for that individual cannot be predicted. In some situations the decision can be revisited and modified in the light of future events (chronic disease management) but at other times the decision is final and may have significant implications in terms of both morbidity and mortality for the individual (e.g. aortic aneurysm screening and surgery).

As an alternative, Simon proposed that humans choose rationally within the bounds of their limited time and information-processing capacity (Simon, 1956). Individuals do not attempt to find the one utility-maximising choice out of the millions conceivable, but settle for making a choice that is 'good enough' to meet a pre-defined level of satisfaction. He argued that the human mind had evolved short-cut strategies that delivered reasonable solutions to real-world problems. In choosing, a person behaves in a manner that is as nearly optimal with respect to its goals as its resources will allow. Our bounded rationality (limited knowledge of probabilities and perhaps of our value



systems) obliges us to use rough and ready rules of thumb (heuristics; see Section 2.3.3). Elements of the theory of bounded rationality, now widely accepted and corroborated by experimental evidence, have made their way into the descriptive psychological theories of choice outlined below (see Section 2.3.3 and Appendix 3).

***Socially 'embedded' accounts of choice***

Neo-classical economics and many of its variants, even bounded rationality theory, assume that in choosing, individuals process information in isolation, rather atomistically. That assumption has been questioned by political scientists, sociologists and psychologists, indeed also by economists who note that (say) public choice theory is incompatible with the health care ethos, the so-called 'caring externality' of benefits accruing from altruistic action that extend beyond the individual or narrowly defined group. For the political domain, the account of public participation and collaborative governance by Barnes *et al.* (2004) points to the importance of context in which individual choice and interactions occur not only at the point of entry but also during the course when determining objectives and strategies to achieve them (Melucci, 1996). Many commentators reply that neo-classical economic theory presents a rather undersocialised account of how people make choices. It has difficulty, for instance, explaining the origins of social norms, especially those of altruism, reciprocity and trust. Collective action poses equal difficulties for neo-classical economic accounts of choice and their descendants, for they have difficulty explaining why individuals join many kinds of groups and associations.

Such limitations to neo-classical microeconomic theory are especially evident in health care because of the importance of altruism that is involved in the 'disinterested' caring attitude of strangers and the 'gift relationship' explained by Titmuss (1970) that forms part of social solidarity. These difficulties for rational choice and similar theories result from seeing social interaction as an exchange analogous to market dealings. Two related solutions have been offered to solve this problem. One is to examine the way in which consumer, and in particular patient, choices are made by people who are embedded in wider social institutions. The other is to examine the unintended consequences of individual choices.

Granovetter's classic article (Granovetter, 1985; cited 1824 times according to the databases we searched) deals both with this issue and the counter-argument that institutionalist theory has the opposite fault of an over-socialised account of choice. One way of looking at *Homo sociologicus* as opposed to *Homo economicus* is to investigate how individual freedom of action is constrained by the existence of others, but also by rules, roles and relations in the society. Sociological and social anthropological studies, particularly by Mary Douglas, examine the impact of wider social factors on our behaviours

and preferences, in particular consumer choices (Douglas, 1937, 1992).

Duesenberry (1960) suggests that people are not just concerned about absolute levels of possession but are in fact more preoccupied with possessions in relation to others. His relative income theory contradicted microeconomic theories of human behaviour that relied on universalistic principles and took no account of personal circumstances. This approach gave rise to theory about relative poverty, and the importance context has on influencing human decisions and choices (Duesenberry, 1960:231–243). The famous phrase by Duesenberry that 'economics is all about how people make choices while sociology is about how they don't have any choices to make' encapsulates these theories.

Many normative theories hold that unless such conditions as independence, autonomy and free will obtain a person's choice then it is in some sense invalid, not a 'true' expression of the chooser's will. Taking that assumption at face value, critics of choice policies then raise a more radical question as to whether a competent adult is ever an independent, autonomous chooser. For all adults are embedded in social relations and, in modern societies, are subjective to massive, continuous management by advertisers, policy-makers and other institutions. Then it is not so much that it is the individual who is choosing as the marketers and others who are choosing. Through framing the choices of the individuals whose choices they so pervasively influence, the marketers, media and others effectively choose what people will do, consume or think. On the more subtle variants of this view, the individual who chooses does so as the proxy for institutions surrounding him. This individual becomes then the bearer of *their* choices.

### **2.3.3 Descriptive theories**

Two groups of descriptive theories of choice are especially relevant to understanding what evidence might be relevant to the policy of patient choice. As explained, a theory of the process by which people exercise choice is crucial, for it explains how far patient choice can be managed and what conditions are required for it to occur. Psychological accounts highlight biological constraints in processing information and how this affects the choices made. Equally crucial is a theory describing the institutional conditions necessary for choice to produce the effects which patients and (speaking of possibly different effects) policy-makers intend. We first describe the nature of choice as a biological process, and then outline institutional constraints to choice in health care environments.

#### ***Processes of choice***

Descriptive theories of choice explain how choice decisions are really made, whether seemingly rational or irrational. Descriptive accounts

are based on the observation which tells us that in reality decisions are not usually made purely to maximise utility. Here we focus on descriptive theories of decision-making – choice – which are of highest relevance to health care settings. Most psychological accounts of decision-making that are described below or expanded on in Appendix 3 (i.e. prospect theory, decision theory, problem-solving approach, social judgement theory, fast and frugal, and others) fall into this category. These include:

- prospect theory and simple heuristics (Kahneman and Tversky 1979),
- the decision theory approach (Edwards and Newmann, 1982; Fishbein and Ajzen, 1975),
- the problem-solving approach (Newell and Simon, 1972),
- social judgement theory (Brunswik, 1952, 1956; Hammond *et al.*, 1975),
- fast and frugal heuristics (Gigerenzer and Todd, 1999).

### ***Prospect theory***

In their prospect theory Kahneman and Tversky describe decision-making under uncertainty (Kahneman and Tversky, 1979, 1982). It has verified empirically Simon's concepts and has proved effective in taking into account the many factors that influence individual decision-making. Into prospect theory Kahneman and Tversky introduced the concepts of simple heuristics as mental short cuts or rules of thumb applied by an individual and used to simplify decision-making processes. These are used because of capacity limitations and to reduce mental effort in decision-making but may introduce bias by allowing individuals to make decisions which are acceptable to them but which may not be entirely rational.

Prospect theory also introduces the concept of *framing effects* in which the reference point may be affected by extraneous factors leading us to make different decisions depending on how the information required to make a decision is presented. It proposes that decisions are first framed and are then evaluated. Framing effects in health care were demonstrated when phrasing a question around saving lives shifted choices towards risk-taking while re-phrasing the same around lives lost induced risk-averse choices (Tversky and Kahneman, 1981).

The effect of framing on the decision-making has been seen in the medical domain. McNeil *et al.* (1982) presented participants with statistical information about two treatments for cancer. Preferences for the two treatments were changed radically by the way in which the information was presented in terms of mortality (losses) or survival (gains). Prospect theory has been used in the medical domain, but mostly used with clearly defined gambles and decision-making in general practice, a domain inundated with uncertainty as well as risk.

Like some varieties of microeconomic theories of consumer choice, prospect theory separates the seriousness of the consequences of a decision from the likelihood of those consequences. In clinical situations for example, both clinicians and patients are found to accept high risks with low probability of success when the payoff from success is high, such as in head surgery for example (Redelmeier *et al.*, 1993).

***Simple heuristics***

Heuristics describe mental short cuts. Among the reasons people use heuristics is that they have experience of them working successfully. In that sense the behaviour is not irrational and is often upheld by 'confirmation bias'. For example, if people are expecting a long delay, or a sympathetic hearing, and this happens, then people feel they were right in their hypothesis. Curiously, if not confirmed they may still retain the heuristic but there are exceptions to this approach. Gigerenzer and Selten (2001) suggest that these simple heuristics described in Appendix 3 may lead to results as accurate as those achieved using formal statistical models. However, empirical studies of heuristics also include evidence of erroneous heuristics including the overweighing placed on low probabilities and 'severe' or drastic risks (Tversky and Kahneman, 1983; Kahneman, 1991).

We also decided to categorise the numerous theories of decision-making by looking at the approaches used to research health and medical decision-making. The number of theories used is huge and far beyond the scope of this short section so three traditional approaches will be outlined here and discussed further in Appendix 3, according to common features of theories used and the suitability of approaches to analyse decisions made in the patient-choice arena. These are the *decision theory approach*, *problem-solving approach* and *social judgement theory*.

The three approaches to decision-making discussed in Appendix 3 differ in terms of their original motivation.

- Decision theory has its roots in the principles of economics.
- Problem-solving work came out of the fields of cognitive science, psychology and artificial intelligence. It looks at decisions as problems and uses process-tracing techniques to get at the underlying cognitive processes involved in the making of a decision or judgement.
- Social judgement theory has its roots exclusively in the domain of psychology (Hammond *et al.*, 1975), and looks at the information used to make the decisions or judgement and uses judgement analysis to do this.

***Fast and frugal heuristics***

Fast and frugal heuristics models take an approach that is also derived from Simon's idea of bounded rationality resulting from the limited

amount of information that humans can process at any one time. Following social judgement theory, Gigerenzer and Todd (1999) attempt to model the environment as well as the decision or judgement in terms of the available information. In contrast to the decision theory approach, which tends to measure human judgement against a normative standard and assume that decision-makers are fully rational and fully informed, and in contrast to social judgement theory, which proposes that decision-making requires much mental effort, fast and frugal heuristics models suggest that usually a person makes a decision by using the minimum number of cues. The book *Simple Heuristics that Make us Smart* (Gigerenzer and Todd, 1999) propose two requirements for rational decision-making. One is that decision rules are bounded in their rationality. Rules are frugal in what they take into account and therefore fast in their operation. Second, the rules are ecologically adapted to the environment, which means that they 'fit to reality'. These models stress trying to find the smallest number of cues that would be used in making a rational decision (Gigerenzer and Todd, 1999). For more details on this issue see Appendix 3.

### ***Institutional conditions for enacting choice***

In reviewing theories describing what institutional conditions are necessary for choice to produce the effects which patients and policy-makers intend, we come full circle back to neo-classical microeconomics. One of its branches, institutional economics, has dominated much recent research analysing how health systems function. This section therefore examines the institutional preconditions that according to neo-classical microeconomics must exist in the market or environment to enable competition to work effectively in health care systems as a mechanism for realising patients' choices. These preconditions are necessary in pure private markets and in planned quasi-markets (positioned in the midpoint on the continuum between pure market and planned economy) that were adopted in the UK or Scandinavian countries and elsewhere in the early 1990s.

These institutional conditions would, according to that theory, enable markets to fulfil the function of realising patients' rational choices, in the sense of the choices that patients would make if they wanted to maximise their personal utility and maximise global utility through a market economy, and were perfectly informed. That is, neo-classical microeconomics describes the institutional conditions that produce Pareto-optimal general equilibria. These are not, it should be noted, the only possible institutions which do so (Lange 1938), but a set of institutions which are sufficient to do so. Neo-classical microeconomics focus upon the institutions of perfect competition, arguing that they are more allocatively efficient ('optimal') than other kinds of market. Theories of quasi-markets tend to assume that the closer quasi-markets come to this model of perfect markets, the more fully they

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would enable the realisation of patient choices. The foci of these theories are usually:

- competition,
- free exit and entry from the market,
- information about prices and specifications of the service,
- low transaction costs,
- how agents become motivated to respond to market 'signals'.

*Competition* Patient choice presupposes alternative health care providers. Competition must exist on both the demand and supply sides. It is secured either by a sufficient number of providers and purchasers, or through contestability; that is, by at least posing the threat of competition (Roberts, 1989; Le Grand and Bartlett, Section 2, 1993; Roberts, 1994). The requirement for contestability creates the problem of regulating entry to health care provision markets (Arrow 1963; see below). Oliver and Evans (2005) argue that extending patient choice produces not only competition between providers, but between patients competing for scarce services, because integrated centrally planned health systems operate under budgetary cash limits. Thus competition between patients may bring higher benefits to one group of patients while at the same time implying harm to others. Satisfaction of individual wants will not be possible without limiting someone else's access to resources and therefore to options contravening collectivist principles of offering equal access to all according to need, and not on the basis of individual personal circumstance which underlies the NHS from its inception (Oliver and Evans, 2005).

*Free exit and entry to the market* Barriers to entry are regarded, in these theories, as unduly restricting competition. Barriers to entry are related to the size of the incumbent providers and the high capital costs that are required to initiate service provision, with resulting economies of scale and 'first mover advantages'. Relatively small, geographically isolated health systems are particularly liable to be exposed to 'natural monopoly' conditions, in which only one health care provider, if that, is more than sufficient to provide all needed services. In this way, monopoly or oligopoly conditions are created on the providers' (supply) side of the market. If these are coupled with monopsony or oligopsony on the purchaser's side, as they are in health systems where the funds of the state or sick purchase most health care, these conditions can lead to bilateral agreements between health care organisations at the expense of Pareto-optimal allocative efficiency and quality (Roberts, 1989; Propper, 1992).

*Information about service prices and specifications* Perfect markets, including the choice processes within them, require a supply of information about the cost and outcomes of services; information that must be accessible to all the parties involved: patients, purchasers and decision-makers. Securing a free flow of information, on the basis of which patients can make informed choices, is especially problematic

in health-service provision. This is due to the peculiarities of health care as a commodity and to the asymmetry of information between purchaser and provider, which operates to the disadvantage of the former (Arrow, 1963; Evans, 1974).

*Transaction costs* The lower that transaction costs are the greater the proportion of health sector resources that is actually used to provide the services which patients choose. Using Williamson's (1975, 1985) analysis of the effects of transaction costs, Le Grand and Bartlett (Section 2, 1993) argue that GPs usually have high ex-ante- and low ex-post-transaction costs. However the ratio of ex-ante to ex-post costs is most likely to be the reverse for collective purchasers such as health authorities. Because of the contracting and commissioning procedures, which by their nature are not cheap, reforms based on competition, contestation or, therefore, patient choice are likely to increase transaction costs (Hutton, 1993), especially during the initial implementation of the reforms, but a permanent increase in the transaction costs of operating the system can also be expected.

*Motivation* While the relevant agents must be motivated to respond to market signals, in particular user choices must be converted into incentives for other actors in the health system to provide what the patients have chosen. This motivation may cause problems if other conditions for a successful market are not fulfilled (Roberts, 1994).

Health care is not a typical market commodity as it possesses peculiar attributes of public good that are well known to economists, since Grossman's model of demand in health care (Grossman, 1972). Health care is not consumed for its own sake, has positive and negative externalities on those who consume and those who do not consume it (immunisation is a classic example of externality but for this very reason is not a classic example of health care). Given the peculiarities of health care as a commodity (McGuire *et al.*, 1992), the impact of imperfect information and the ill-established criteria for quality control pose the risk that unscrupulous providers may engage in opportunistic behaviour (Williamson, 1975) or gaming. This could then not only lead to greater and unintended inequalities, but also to allocative inefficiency, the opposite of the goals policy-makers originally intended.

Such are the main theories that appear relevant to patient choice in the NHS. This brings us to the question of which of these theories the policy of patient choice appears to rely upon as elements of its programme theory. For it is the evidence base of these theories that is most relevant to the empirical part of the present review.

## ***2.4 'Choice' in the NHS and other public sectors***

*...the ideas of economists...both when they are right and when they are wrong, are more powerful than is commonly understood. Indeed the world is ruled by little else. Practical men, who believe themselves to be*

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*quite exempt from any intellectual influence, are usually the slave of some defunct economist.... I am sure that the power of vested interest is vastly exaggerated compared with the gradual encroachment of ideas.*

John Maynard Keynes, *The General Theory of Employment, Interest and Money* 1936/1973, p. 383.

Having outlined what questions the concept of patient choice raises, and outlined the main theories that have been proposed in answer to these questions, we now turn to the programme theory on which patient-choice policy in the UK rests. That in turn defines what evidence is relevant to predicting the likely effects of the programme and whether, in its own terms, it is likely to succeed; that is, realise its stated aims. Where the relevant policy documents fail to state the policy's programme theory explicitly, it will be necessary to assume that the policy is resting upon whichever of the above theories appears the closest implicit fit. It bears repeating that a programme theory is not necessarily complete, consistent or well-formulated.

Historically the health care systems in the UK and other publicly financed and provided health care systems such as in Scandinavia, New Zealand or Canada were originally designed along egalitarian principles with primacy being given to collective needs and universality, and cost-effectiveness being actively pursued, particularly in the UK.

Elements of choice had already been seen in other areas of public service provision before their introduction into health care systems in the UK but they did not necessarily represent a coherent set of related policies, and were most likely a result of disjointed incrementalism (Higgins, 2004) or reflected diverse policy objectives (Perri 6, 2003). Choice was introduced into the provision of services such as old age community care, secondary education and prison services simultaneously in the framework of quasi-markets in the UK, which in the view of some represented an overhaul in the delivery of welfare akin to a revolution in social policy (Bartlett *et al.*, 1998).

In the NHS, patient choice of GP existed before the 1990s, although it was rarely exercised, whereas choice of specialist was needs-based and determined by the GP on behalf of the patient. As English case law confirms, patients had the right to choose whether to accept the consultant offered, although at the risk of a longer wait for treatment. Patients could not refer themselves to hospitals without prior approval from the gatekeepers – a role that GPs fulfilled in the UK. Wider choice existed only on the periphery of the system for those who decided to opt out of the NHS and obtain health care privately (Klein, 1995).

Patient choice was for the first time explicitly articulated as a health policy goal in the late 1980s under the quasi-market reforms introduced by the Conservative government in the UK (Secretaries of State, 1989a, 1989b), when an internal market was implemented following 'big bang' strategy in the UK (Ham, 1997). The British



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Government believed that the introduction of market elements into health care – competition and choice in particular – would enhance efficiency and would simultaneously tackle the main shortcomings of the former systems, such as rigidity, bureaucracy and unresponsiveness to patient choices and preferences (Le Grand, 1994). Competition among providers for contracts from purchasers and for patients who would freely choose among them were the chief means relied upon to achieve the reform goals.

During the same period similar reforms were introduced in other integrated, publicly planned and provided health systems such as Sweden, Denmark and Norway and also New Zealand. This reflected the zeitgeist and belief in the superiority of market arrangements in delivering better economic and welfare outcomes that was prevalent in the aftermath of the fall of communism (Fotaki, 2001), and the deep ideological conviction of the incumbent governments that state bureaucracy and planning alone were not able to deliver efficient and responsive public services of a quality that was increasingly desired by the users (Secretaries of State, 1989a, 1989b; Schwartz, 1994; Saltman and van Otter, 1995; Pedersen, 2002). In 1997 after the election of the Labour government to power in the UK, quasi-markets were nominally abolished as they were seen to be divisive, inequitable and expensive (Department of Health, 1997). However, choice in other public sectors reviewed here, such as primary and secondary education, residential care and direct payments in social care, was maintained.

Most recently choice in health care has made its come back and appears to be a popular policy in one form or another for all parties across the political spectrum in the UK (Burgess *et al.*, 2005). Current choice policies pursued in the NHS differ from earlier policies in many ways, but there are also many similarities. The first difference is that choice has been introduced as a whole-scale entitlement for all users of health care and not only for the patients of GP fundholders and that patients, and not their agents (the GPs), are the direct decision-makers for the first time, although support is provided by the commissioners of secondary care (the Primary Care Trusts) for those who need it (Department of Health, 2004a). Furthermore, competition among providers has been genuinely extended to include public, not-for-profit and private providers within or outside the country in the UK. Nonetheless, there are similarities in both language and the aims initiated by the pro-market reforms in the early 1990s.

The UK government has currently introduced policies to increase patient choice to enable users of the NHS services to participate directly in decisions about the place, time and way treatment is offered and provided to them (Department of Health, 2003a–d, 2004a). Patient choice based on appropriate information is central to Government plans to achieve greater responsiveness to patient needs, to increase technical and allocative efficiency, to enhance quality of services and, most contentious of all, to improve equity (Reid, 2003;

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Department of Health, 2001). Patient choice together with two other major Government policies – Payment by Results and practice-based commissioning – are aimed at introducing a market-type competitive environment in health care provision.

However, patient choice is confined to England, as the governments of other countries of the UK such as Wales and Scotland were not in favour of introducing what they consider as the consumer market approach, although this may be changing in Scotland. In England, choice considered here derives primarily from current Patient Choice policy as defined in *Building on the Best: Choice, Responsiveness and Equity in the NHS* (Department of Health, 2003a) and *Choose and Book* (Department of Health, 2004a). The focus of the current Government policy is primarily on choice of the secondary care setting made by individuals, although choice of provider can be further differentiated into choice of:

- GP,
- other primary care provider (midwife, dentist, optician or provider of alternative medical services such as chiropody, homeopathy and acupuncture, some of which are paid for by the NHS),
- different treatments or non-treatment options,
- choice of diagnostic procedure,
- medicines and prescriptions,
- the form of consultation (whether face-to-face or via telephone as in NHS Direct or by using telemedicine).

Elements of choice exist already in England too in areas such as NHS Direct and walk-in centres (e.g. Lang *et al.*, 2004a). Also in primary care there is a rather extensive choice of pharmacists and dentists, and complementary and alternative medicine, some of which is funded on the NHS (Peckham, 2004). Some of these also exist in other countries of the UK.

In England, developing patient choice is planned as a gradual process starting with choice of hospital for elective surgery (Department of Health, 2004a). Patients waiting for 6 months had a choice of at least one alternative provider for selected elective surgery procedures from April to August 2004. From January 2005 choice at GP referral was initially offered for cataract surgery and from December 2005 it was to be a reality for most procedures. The choice offer will be for faster treatment and for a certain date, and Primary Care Trusts will support the patient in choosing and will commission and fund the choice activity.

However, more initiatives are aimed at embedding choice, with patients being able to choose from four to five potential providers including independent providers and hospitals outside the UK in 2 year's time (Department of Health, 2004a). A large-scale introduction of patient choice is planned initially to reduce long waiting times for elective surgery and to give patients the possibility of getting faster

treatment in hospitals within, or outside, their Primary Care Trust's area or the NHS in the UK or abroad. There was an ambitious target to offer choice for most specialties at the point of referral by December 2005 (Department of Health, 2003d), while plans are being made for choice to be freely available after 2006.

Alongside the rhetoric of patient choice as a good in its own right (Milburn, 2002, 2003; Blair, 2003; Department of Health, 2003a), current policy-makers also see patient choice as a means to achieve other public health systems which they desire such as efficiency, quality and equity in the secondary care settings. At the same time an attempt is being made to maintain NHS allegiance to the core values of a public health system, such as universality and equity (Department of Health, 2003a). This creates a remarkable tension that is yet to be resolved. Two consultation documents issued by the Government attempt to address the dual nature involved in patient-choice policies: one concerned with efficiency and financial flows (Department of Health, 2003b), and the other with factors influencing provision of personalised services such as patient experience, information needs and participation (Department of Health, 2003c).

## ***2.5 Linking policy to its theoretical base***

We can therefore summarise the programme theory and tacit normative assumptions of patient-choice policy as follows. Choice is to be exercised above all by adults of sound mind choosing non-urgent hospital care. All this presupposes that patients want to exercise choice in these ways and not abdicate choice entirely to a GP or another professional proxy. In any event, however, GPs will be proxy choosers to some extent, which places them in an ambiguous role. On the one hand GPs are to present to patients the information on the basis of which the patient will choose a secondary provider, and a menu of providers. The GP will offer, record and execute the administration of that choice. However, the GP also selects which clinical, and possibly other, knowledge to frame and guide the patient's choice. Furthermore the GP still acts as gatekeeper. The GP chooses whether the patient is to be offered secondary care in the first place.

Thus the process of patient choice occurs within the constraint of a prior GP choice. It is the GP as clinical gatekeeper who chooses the treatment, subject to the legal constraint (which pre-dated the Patient Choice policy) of informed, freely given patient consent. This applies to the substantive criteria for the patient's choice as well as the process of choice.

The policy appears to assume that the patient will know how the different potential providers compare with his or her criteria of choice, and will select the provider that most closely matches them. Government pre-defines the scope of patient choice as four to five providers, preferably including one or more private ones, but the

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criteria by which patient selects them (say, by location or promptness of access) are left open, within the prior constraint of the GP's decision

The policy documents make quite definite, although sometimes tacit, assumptions about the institutional conditions that will realise patient choices; that is, cause patient choices to have their intended effects. Provider contestability of payment combined with payment per patient treated ('by results') to providers is assumed to provide the incentive for providers to compete to attract patients, thereby responding to patient and GP preferences about quality of care; the tariff system of payment removes price competition for GP referrals.

This mechanism is also seen as the means to produce both technical efficiency (low unit costs) within hospitals and allocative efficiency across the NHS as a whole. The policy makes many of the assumptions of neo-classical consumer choice theory; for example that patients can and should be informed when making their choices, that patients know best what services (in this case, health services) they need, especially in regard to the non-clinical aspects of services. This is why, implicitly, consumer choice is assumed likely to improve health-service quality in the sense of giving consumers the kind of services they want. Freer market entry and competition are assumed.

Therefore, the 'principle' of the NHS is now stated to be public funding of health care and free health care at the point of use, not exclusively public provision of health care. The policy assumes that bureaucratic management of the NHS is not an effective means of making these services user-responsive. These assumptions, and the intention to widen the scope of choice to other providers, approximates to the institutional assumptions of neo-classical microeconomic theory outlined above.

In regard to the process by which patients choose, the policy appears to assume that patients will choose in a way similar to that suggested by the theory of reasoned action. As the role of the GP proxy suggests, these assumptions are akin to bounded rationality theory about patients' capacity to choose rationally. The policy also appears to assume that GPs, and indeed government, will play a large role in framing the choices which patients are offered; prospect theory is a way of conceptualising that process. The policy also tacitly assumes that if patient choice is universally available, no objectionable inequalities of access to health care will arise, and there will be no adverse effects of patient competition.

A negative way to define the remit of the empirical element of the present review is to consider also which theories and assumptions do not enter into the programme theory of patient-choice policies. Among the normative assumptions of patient-choice policies, collectivist values (citizenship, solidarity, individual responsibility) are noticeable largely by their absence. Policy documents occasionally give them rhetorical acknowledgement, but little more. Given its long centrality in UK health policy rhetoric, it is striking how slight a role is played by

the idea that the NHS exists to meet health care needs, for example in the sense of informed rather than actual patient demands. As in neo-classical economics the possibility of irrational patient choice is not seriously entertained.

Neither, concomitantly, is any use made of theories suggesting a hierarchical ordering of goods and services, with health care distinguished from others by any special importance. Rather, the implicit emphasis is on parallels between health care and other consumer services. Institutional or socially embedded accounts of consumer choice are disregarded and so, in the tacit assumption that there will be no adverse effect of competition between patients, are game theory assumptions about choice. Assumptions about the process of patient choice in the policy documents are far simpler than those of the theories of social judgement, fast and frugal heuristics or even simple heuristics. Evidence pertaining to these theories is therefore of limited relevance to the present review and has therefore been set aside.

As for the normative assumptions of patient-choice policy, Oliver and Evans (2005) argue that patient choice features high on the policy agenda because it taps into the notion of autonomy that features highly in ethical theories of the good. These normative beliefs are widely held and rarely challenged, but also beyond the present review's remit.

The next section discusses theories of most relevance to the current Patient Choice policy that were used to construct our analytical framework.

## ***2.6 Analysing the impact of choice***

The foregoing analysis about the nature of choice and its relevance in the context of the NHS reforms has enabled us to identify which bodies of theory and empirical evidence are relevant to predicting the impact of choice (see Tables 2 and 3), and which impacts to consider, in terms of:

- the content and scope of choice policies,
- the likely effects of choice policies,
- the preconditions and limitations of choice.

The most important bodies of evidence are those concerning:

- whether patients want to exercise choice,
- factors which influence the responsiveness of health care organisations to patients' choices,
- the impact of patient choice upon health system efficiency,
- the impact of patient choice upon health system equity,
- the impact of patient choice upon health care quality.

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It follows then that the most relevant impacts to consider are effectiveness, equity, quality and responsiveness and these should be considered in relation to primary and secondary care, at the system, organisation and individual levels. We do this in Section 3. The impact on those policies will depend on the extent to which people exercise choice of provider, which links to factors that influence individual choices. Outlining the conceptually possible answers to these questions delimited the range of possible theories and evidence sets that are relevant to patient choice (represented as theory implications 1–5 in Table 2). It also generated an analytical framework summarised in Table 3 for the present review, one that shows where useful evidence is absent as well as guiding the selection of existing evidence to include.

In addition to reviewing the empirical evidence, we can also consider directly what different theories imply will be the impact of choice on effectiveness, equity, quality and responsiveness, and this is summarised in Table 2.

We then compared and contrasted theoretical predictions with evidence to identify uncertainties and gaps in both, leading to identification of key themes and issues, policy implications and research gaps.

**Table 2 Theory mapping against underlying policy objectives and assumptions**

<b>Theory implications for choice policy</b>	<b>Choice improves efficiency (yes/no justification)</b>	<b>Choice improves quality (yes/no justification)</b>	<b>Choice improves equity (yes/no justification)</b>	<b>Choice improves responsiveness (yes/no justification)</b>
1 Market libertarianism	Yes, because market incentives reward actors that provide services users want and can choose from.	Yes, because market rewards quality that is demanded by the users.	No, because individual liberty and autonomy overrides equity considerations.	Yes, because the individuals are the best judges of their own welfare.
2 Consumer choice theory	Yes, because individuals express their preferences and are perfectly informed.	Yes, because consumer choice creates incentives for providers to improve quality.	No, because consumer sovereignty overrides equity consideration.	Yes, because consumers express their preferences.
3 Social theory of choice (collective choice)	Yes, if efficiency is defined in societal terms (as allocative efficiency).	Not necessarily, because quality may be implicitly relegated to lower priority and sacrificed to achieve equity and efficiency.	Yes, pursuit of equity defined as either horizontal or vertical equity is an objective which may not be perfectly realised.	No, because responsiveness to individual wants might be sacrificed to promote equity and community needs.
4 Psychological accounts: prospect theory and heuristics	No firm conclusions can be drawn but there are likely to be limitations; see cells on the right.	Not necessarily, because of framing effects and imperfections in processing information.	No firm conclusions can be drawn but there are likely to be limitations; see cell on the right.	Not necessarily, because of framing effects and imperfections in processing information.
5 Institutional economics	Not necessarily, because of social and institutional constraints (see Section 2.3.3).	Not necessarily, because of social and institutional constraints (see Section 2.3.3).	No consideration is given to the issue of equity.	Not necessarily, because of the imperfect information (see Section 2.3.3).
6 Rational choice theory	Yes, because individuals choose consistently, are well informed and will opt for	Yes, because individuals choose consistently, are well informed and will opt	Don't know: no specific consideration is given to	Yes, because individuals express their personal wants and personally

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	most efficient services if they face the cost.	for quality if there is no cost constraint.	the issue of equity.	defined needs.
7 Expected utility theory	Yes, because individuals are utility maximisers and make rational decisions.	Yes, because individuals are rational judges of the quality and are able to pursue it.	Uncertain but possibly yes, if it is an objective that is pursued on the systemic level.	Yes, because rational actors are able to pursue services that fulfil their needs and wants.
8 Game theory	Uncertain, as each player has well-defined preferences among the possible outcomes but the outcomes depend on the strategy choices of all the players.	Uncertain, because the players rationally pursue the best outcomes but they depend on the strategy choices of all the players.	Possibly yes, if this is the set outcome and players can be motivated to achieve it through their strategic decisions.	Probably, because players attempt to achieve the best outcomes for themselves.
9 Public choice theory	Not in publicly provided systems as government interference is seen as a source of inefficiency.	Not in publicly provided systems as government interference is seen as a source of inferior quality.	No, because equity considerations contravene the principles of self interest.	Yes, because the dominant motive in people's actions in the marketplace is a concern for themselves.

*For more details on theories 6–9 see Appendix 1.*

**Table 3 Overview of the analytical framework, methods and findings**

	<b>Policy analysis</b>	<b>Theory analysis</b>	<b>Analysis of empirical research</b>
Coverage	Choice in the English health care system 1990–2005	Theories related to aspects of choice from economics, psychology, political science, mathematics, moral philosophy, ethics and management (see Appendix 3 and Table 2).	Initial search: choice, consumerism, markets, decision-making and information needs; with regard to service users in the health care, social care and education sectors. Specific topics identified and covered subsequently: international experiences of choice in health care, direct payments, choice of residential care home and the impact of release of performance information on choice.



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Methods	Rapid literature review; extraction of stated ends and values from policy documents; consultation with key experts.	Pilot literature search and review; full literature search of online databases of academic and grey literature; identification and summarising of main theories; consideration of how theories relate to policy aims of efficiency, quality, equity and responsiveness.	Literature search of online databases of academic and grey literature; extraction from each study of its subjects and methods, and key findings; mapping of information extracted to the impact measures, on macro, meso and micro levels, to primary/secondary health care sectors, and to specific topics identified; consultation with key experts.
Rationale	<p>English health care choice policies are the main interest for the funders.</p> <p>There was a need to do policy analysis first so that project findings are policy-relevant, but there was insufficient time to cover policies from other countries or sectors, or to do a full discourse analysis.</p> <p>Consultation with key experts acted as a check on findings from the document analysis.</p>	<p>Theories from other disciplines such as ethics and moral philosophy were judged not to be relevant because they relate more to the issue of choice as an end in itself, which has not been a policy emphasis in the arena we are considering.</p> <p>As this was the first major search conducted as part of the project, it was important to pilot ways of working.</p> <p>The policy impact measures identified are sufficiently general to provide a means of relating literature from policy, theory and empirical research.</p>	<p>Research on empowerment, agency and end-of-life decisions (for details see Table 1) was excluded as not being sufficiently relevant to policy.</p> <p>Specific topics identified were also based on policy relevance, on 'distance' from the health care situation, and on key issues either stated in the project brief or identified during the project.</p> <p>The framework for mapping the information extracted was based primarily on the requirements stated in the project brief.</p>
Findings	<p>English health care choice policies aim to impact on efficiency, quality, equity and responsiveness.</p> <p>They do not emphasise choice as an end in itself (though policies in sectors such as social care do).</p>	<p>Theories can be categorised as normative or descriptive.</p> <p>English health care choice policies are most closely related to normative theories from economics.</p> <p>They are less closely related to descriptive theories from psychology and decision theory.</p>	<p>For description of impacts on choice, quality and extent of evidence; all with regard to the macro, meso and micro levels and with regard to primary and secondary care, and with regard to particular specific topics/issues.</p>

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## Section 3 Synthesis of evidence

This section reports and synthesises evidence found in the literature on the impact of choice. In our inquiry we adopted a theory-driven approach to explore broader policy questions by illuminating their theoretical underpinnings and testing them against the evidence (see Table 3). Our conceptual framework drew on the Patient Choice policy programme and used the most relevant theories to derive our indicators of impact of choice in terms of efficiency, equity and quality. These are described in relation to primary care, secondary care, evidence from other countries and evidence from other sectors, answering questions about:

- the nature of choice (what kind), content and scope (choice of what and who will have it), when, and in what kind of settings;
- the impact of choice on policy-derived indicators (see Section 2.6);
- preconditions for patients to be able to exercise choice, derived from our theoretical framework, as well as conditions necessary for implementing and managing the Patient Choice policy;
- the limitations of choice which are due to the nature of choice as a psychological process but also to a number of social and institutional constraints which are reflected on a system, organisational and individual levels.

In addition to looking at choices made by patients, we also looked at the experience of choice made by GPs' fundholders acting on behalf of their patients during the market-oriented reforms in the UK in the 1990s. Here again, we examined its impact on efficiency, equity and quality of care. Fundholders, at least in theory, were able to offer their patients both choice and the ability to exercise the power of exit over providers. In the absence of sufficient research on the effects of individual direct patient choice, we felt it was important to include the existing literature on the effects of fundholding as a proxy for predicting the consequences of introducing choice into integrated and centralised public health systems. Furthermore, this was decided because of the influence that GPs have on individual patient choices, as is identified in recent studies (Isroliwala *et al.*, 2004; Lang *et al.*, 2004b; MORI, 2004; Which?, 2005).

The structure of the section is determined by the above and sources that include:

- evidence from the UK literature on patient choice including recent evidence from choice pilots in England;
- international evidence of patients' experience with choice in health care systems that are similar to the NHS in their design or content (e.g. Scandinavia), but also the USA health care market, where

most of the evidence on choice in relation to competition and quality comes from;

- evidence from the quasi-market reforms of the 1990s in the UK and elsewhere;
- evidence of the effects of choice from other public sectors such as direct payments in social care, choice of residential homes and choice in primary and secondary education mostly from the UK.

Section 3 is structured as follows. Section 3.1 refers to key sources we used to examine different aspects of choice that form the sections of Section 3. This critical appraisal enables us to limit the basis for drawing our conclusions and recommendations. Section 3.2 reviews the evidence to see whether patients want a choice of providers. Section 3.3 describes how people respond to choice when it is offered. Sections 3.4–3.6 describe the impact choice makes under the headings of efficiency, equity and quality. Section 3.7 discusses choice in relation to individual treatments and highlights constraints and limitations, which relate to the nature of the choice process and its biological, social and institutional constraints. Section 3.8 discusses the importance of information in making choices, which is one of the essential preconditions enabling choice. In all these sections we present evidence from UK health care, from health systems overseas, and then from social care (especially direct payment schemes), residential care and education.

### ***3.1 Strength of the available evidence and implications for our findings***

The body of evidence about implementing patient choice of either hospital or primary care providers in the UK comes mostly from the following sources. For details of the findings of individual studies, see Appendix 8, which lists the main papers and summarises their findings.

- Two reviews of the evidence of patient choice in health care and education conducted by the Social Market Foundation (Williams and Rossiter, 2004) and the Centre for Public and Market Organisation (CPMO) by the University of Bristol (Burgess *et al.*, 2005), and three other reviews of evidence in health and several other public sectors by the University of Birmingham (Hughes, 2004) and a single researcher (Perri 6, 2003), in addition to a review by Lang *et al.* (2004a). Evidence presented in another more recent working paper by the CPMO, reviewing the impact of choice in the English health care (Propper *et al.*, 2005), was used to inform our analysis.
- Evaluations of the London Patient Choice Project implemented in 2002–2003, some of which were published in 2004 with full evaluation reports available only in summer 2005 (Dawson *et al.*, 2004; Fergie *et al.*, 2004; Coulter *et al.*, 2005), and the first

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report of London Choice Project Pilot looking at the experience of patients with coronary heart disease (Le Maistre *et al.*, 2003).

- A few more recent and smaller empirical studies conducted between 2003 and 2004 that included a MORI study in the Birmingham area (MORI, 2003), a study in Bedford and the Black Country (Isroliwala *et al.*, 2004; Lang *et al.*, 2004b) and a study in three Strategic Health Authorities (Taylor *et al.*, 2004).
- Research on the effects of the quasi-market reforms that operated between 1991 and 1997 in the UK, and also in Sweden, Denmark and New Zealand.
- The most recent reports and surveys produced by the National Audit Office (2005), the Audit Commission (2004), MORI (2004), Policy Unit (2004), the Policy Commission on Public Services (2004), the Public Administration Select Committee (2005) and consumer associations such as Health Link (2004) and Which? (2005).

There are several key messages to be drawn from evaluating this literature.

- 1 The overall conclusion is that there is little empirical evidence to rely upon in drawing conclusions about the likely impact of patient choice in primary or secondary care in the NHS.
- 2 Most evaluations concern the effects of competition introduced via quasi-market mechanisms where choice does not feature as a subject of evaluations but is nevertheless an implicit feature of the quasi-market (Robinson and Le Grand, 1994; Gosden and Torgerson, 1997; Le Grand *et al.*, 1998; Mannion, 2005). This required us to separate analysis of information on choice from the effects of other related policies, although often the effects of the policies on choice could not be disentangled from the effect of related policies including competition, even in the most recent reviews (e.g. Burgess *et al.*, 2005).
- 3 Newer empirical evidence on patients' attitudes to choice and the effects of choice are mostly from two sources: the London Patient Choice Project and a number of smaller studies. The methodological problems of the former relate to the lack of clarity about the criteria used in the selection of the sample and the controlled nature of the pilot experiments (Le Maistre *et al.*, 2003; Dawson *et al.*, 2004; Coulter *et al.*, 2005; Ferlie *et al.*, 2006), although the evaluations concerned large samples of patients and were rigorously conducted.
- 4 However, as pointed out by many researchers involved in evaluating the London Patient Choice Project, results of pilots cannot be used as a reliable guide to predict the demand, uptake and the effects or even satisfaction rates of the users, when they are rolled out on a national scale (Dawson *et al.*, 2004; Coulter *et al.*, 2005; Ferlie *et al.*, 2006). Coulter *et al.* (2005) for example pointed that satisfaction rates will depend on various subjective

factors such as perception of reputation, referral patterns and length of waiting times. Furthermore, the context of the London Patient Choice Project study has also changed as the long waiting times that formed the principal recruitment criterion for the study no longer exist in most parts of the NHS.

- 5 Evidence also came from small studies that examined limited numbers of sites (MORI, 2003; Isroliwala *et al.*, 2004; Lang *et al.*, 2004b) with their attendant problems of generalisation. There are also concerns about small pilots regarding the extent to which some of their findings could be replicated at a whole-system level.
- 6 A significant proportion of evidence comes from opinion surveys conducted on the behalf of polling agencies (e.g. MORI, 2004) and research foundations such as the College of Health (e.g. Rigge, 2001) and consumer associations (British Cardiac Patients' Association, 2001; Health Link, 2004; Which?, 2005) or from research that was being commissioned by specific institutions (National Consumer Council, 2003; Audit Commission, 2004; National Audit Office, 2005) or reviews of evidence by the Public Administration Select Committee (2005), Institute for Public Policy Research (Rankin, 2005) and the Policy Unit (2004). We included a number of these research reports and some surveys that were well designed and executed, and raised important policy issues and concerns of diverse groups.
- 7 The CPMO's report marshals a wealth of evidence on the effects of choice in primary and secondary education and a less comprehensive review of evidence in health care (Burgess *et al.*, 2005). It is a well-written and well-presented report with an exclusive focus on evaluating choice from an economic perspective where the terms of choice and competition are almost used interchangeably. It lacks clarification that competition, which is a necessary precondition of choice, might be used as a proxy for understanding its effects in an absence of literature dealing specifically with this issue. This report draws heavily on the recent synthesis of evidence in health from the Social Market Foundation report (Williams and Rossiter, 2004).
- 8 Another more recent working paper from the CPMO by Propper *et al.* (2005) focuses exclusively on the economic evidence of effects of choice in health care. The review considers several interlocking aspects of the current English choice policy: competition between hospitals, the responsiveness of patients to greater choice, the provision of information and the use of fixed prices, but it again uses competition and choice interchangeably rather than as interrelated but distinct concepts. The review aims to analyse evidence primarily from the UK and USA, with a view to critically appraising its implications for patient choice and competition policy being pursued in the English NHS at present.
- 9 The Social Market Foundation report (Williams and Rossiter, 2004) is much more comprehensive than the former, dealing with the

individual choice of hospital providers in a thorough and exhaustive way. It quotes a wide range of evidence from the UK and international literature although some important references from Scandinavia, for example, are missing. Its key weakness is its rather tendentious presentation of evidence in support of patients' acceptance and willingness to exercise choice, which seems to repeat Government's current policy pronouncements about the desirability and feasibility of choice. However, in terms of the wealth of material presented and clarity of argument it is one of the best syntheses of evidence on choice of hospitals and some aspects of education available.

- 10 Review of evidence by the University of Birmingham (Hughes, 2004) adopts a different angle by looking at preconditions of choice and attempts critically to appraise the effects of choice in several sectors (education, direct payments and housing). It uses a common analytical framework including the purpose of service, the range of choice, the exercise of choice, the framework of choice, support for choice, the values of choice, the costs of choice and the judgment of choice. It quotes a wide range of evidence, particularly in health care, but the quality of the material presented in different sectors is uneven. By contrast, the review of choice across the UK public sector by Perri 6 provides a good and comprehensive analysis of lessons to be drawn from implementing choice in the same sectors and offers a conceptual synthesis of evidence to inform public policy (Perri 6, 2003).
- 11 Lang *et al.* (2004b) use peer-reviewed and grey sources to provide an up-to-date but rather superficial literature review of findings. It also provides a brief overview of the results from 11 pilots implemented in 2003 in different parts of the country (Lang *et al.*, 2004b). However, this report reflects a snapshot of the situation at a particular point in time and the conclusions are based on two evaluations of pilot schemes: one for choice at the point of referral and the other for choice at 6 months, recounting the evidence that is more meticulously presented elsewhere (e.g. Le Maistre *et al.*, 2003; Taylor *et al.*, 2004).
- 12 There is very little international evidence published in English that looks into the results of introducing individual patient choice into planned and publicly provided health systems such as Sweden and Denmark. On the other hand, more abundant literature from social insurance-based systems such as those in France, the Netherlands or Germany was predominantly concerned with the choice of insurer or insurance scheme and was therefore only peripherally referred to in this report (Beusekom *et al.*, 2004; Council for Public Health and Health Care, 2004).
- 13 The biggest section of international literature on choice in health care comes from the USA. However, this is even more context-specific and refers to the peculiarities of the North American health care market which is largely concerned with choice (or the

lack of it) between Health Maintenance Organisations and between the Health Maintenance Organisation-provided packages. This on its own is of limited applicability to the NHS, which is a predominantly publicly financed and provided system based on principles of universal coverage and equality of access. Arguably, significant limitations apply for drawing inferences about merits or demerits of the markets in health care using the US example also because of the imperfections present, as defined in neo-classic institutional theory (see Section 2.3.3).

- 14 We restricted our review to studies from the USA that were focused on the use of information by users and the impact of release of performance data on their behaviour, in addition to the effects of competition (as a proxy and precondition for choice) on efficiency and quality of health care provision.
- 15 The existing evidence evaluating the effects of introducing public competition models in Sweden is not concerned with choice *per se* with an exception of a few small studies that examine attitude and views on choice of small samples of users. This makes the findings context-specific and difficult to generalise (Saltman, 1990; Anell *et al.*, 1997; Fotaki, 1999; Rosén *et al.*, 2001).
- 16 Another area reviewed in this project included editorials and discussion papers in peer-reviewed journals (e.g. Appleby *et al.*, 2003a; Appleby and Dixon, 2004; Oliver and Evans, 2005), and expert opinions about the likely consequences of choice in professional journals (e.g. Maynard, 2003; Forrest, 2004; Mythen and Coffey, 2004; Page, 2004; Peckham, 2004, Rosen, 2004) or published reports evaluating limited evidence of patient choice against theoretical predictions (e.g. Appleby *et al.*, 2003b). These were an important source for identifying policy issues and implications for policy, and also served as occasional sources for identifying additional references.

For more details of individual studies see Appendix 8, which summarises the findings and conclusions of individual studies.

By contrast with the literature on choice of primary or secondary provider that users of health services may or may not want to act upon, we identified many papers that discuss the extent to which patients want to make choices about their individual treatments and the role of different factors in this process. The individual and personal factors that influence patient choice and patient well-being in this context are discussed in more detail in Section 3.7.

We also looked at the evidence of the extent of choice, and its impact in other public services, to guide our understanding of how patient choice might develop. In this context we also considered some of the most recent theoretical and empirical research examining the changing attitudes of users of health and public services, which could be typified as ranging from citizen, through customer, and shifting

towards the consumerist approach of a marketplace (see Section 3.3.3).

### **3.1.1 Evidence base on direct payments in social care**

A comprehensive search of literature from the UK was conducted, covering not only academic journals but also reports of studies commissioned by key funders of social care research, such as the Joseph Rowntree Foundation. Precursors to direct payments such as the Independent Living Fund, and related schemes such as service brokerage, were not covered.

There is little research specifically on the extension of direct payments into health care, with only two studies (Glendinning *et al.*, 2000b; Glasby and Hasler, 2004) considering this in any detail. The research on direct payments itself comprises largely a mixture of interview-based case studies and of surveys. Most of the research is of a good standard, and there are few contradictory findings, giving a good picture of the key findings and issues. However, there are limitations in what has been studied: there is little consideration of equity, and the evidence on cost-effectiveness is limited to one, fairly old, study.

### **3.1.2 Evidence base on choice of residential homes**

A review of the literature on consumer behaviour and care homes has recently been published (Williams, 2005), which specifically considers the context in which older people and their representatives make choices about a care home and how this affects competition in the market. This review is of a high quality, and we used it extensively, but also reviewed key studies independently. Williams (2005) did not cover research from the USA in any depth, so we also reviewed some of this literature, which differs from the UK literature, including some large quantitative studies, and studies from a marketing perspective.

Williams notes that there are numerous, mainly small-scale, qualitative studies in this field, and that there is a marked lack of research on the experiences of minority ethnic communities, and a lack of longitudinal studies (Williams, 2005). There does however appear to be consensus about a number of features of the context in which older people and their relatives make choices about care homes.

### **3.1.3 Evidence base on primary and secondary education**

Evidence on education is comprehensive in both the UK and other countries including the USA, New Zealand, Sweden and even Chile. As an extensive review of literature was beyond the scope of this project, we relied mostly on peer-reviewed publications identified by our search strategy (see Appendix 1) and four reviews that looked at choice in several public sectors which are described above (Perri 6,



2003; Hughes, 2004; Williams and Rossiter, 2004; Burgess *et al.*, 2005).

Burgess *et al.* (2005) provide an incisive, in-depth and balanced analysis of the effects of choice in education, and examine a wide range of sources from the UK and particularly the USA. Williams and Rossiter (2004) also present rich evidence from a unique comparative perspective that includes Sweden and Chile in addition to the former, but does not avoid political colouring when drawing conclusions. The third review offers a good analysis of lessons to be learned from implementing choice in education in the UK drawing on key US evidence (Perri 6, 2003). By contrast Hughes' (2004) section on education has almost no literature review while the quality of argument is more likely to be found in grey rather than academic publications.

The implications of the evidence base used in this review alerts us to the contextual specificity of the findings, which relates to both methods and the samples of the studies reviewed but also to the wider institutional, national and cultural contexts.

- Most studies and reviews of evidence relied on *qualitative methods* designed to explore issues in depth, to illustrate the phenomena and underlying dynamics rather than being statistically representative, which does not allow inference about the extent to which views are being held in the wider population.
- In addition, most studies looked at supposed choices, and it is important to differentiate between *perceptions* and *facts*, which most of the studies are concerned with when examining stated (hypothetical) rather than revealed (acted-out) preferences. A notable exception here is the study by Burge *et al.* (2004, 2005).
- Studies conducted outside the UK refer to *different organisational and funding structures* in addition to *different cultural traditions* that shape the outcomes and attitudes to health and health care. Such are the examples of pluralist provision of health services by not-for-profit and private providers and less so by public providers in social and private insurance systems in many countries of the European Union and the USA respectively, or the long history of decentralised funding and provision in Sweden and Denmark. All these differences may to a certain degree limit the applicability of findings coming from outside the NHS in predicting likely developments in England.
- Similar limitations apply to making inferences and *transposing the experience of choice from other sectors* to understand developments in health care. For example, choice in social care (e.g. in residential care home) is closely related to means testing while health care is still regarded as a universal benefit, which raises obvious limitations to its transferability. Similarly, undesirable effects on social segregation resulting from choice in primary and secondary education are of rather limited applicability

to health care as there is more scope for 'selecting by mortgage' and choosing to live in a more desirable residential area for the mobile middle class in education than in health care. However, according to many the experience of direct payments in social care might be relevant for chronic or mental care patients. On the whole, evaluation of lessons from residential care, primary and secondary education and the use of direct payments in social care provide an indication of how patient choice could develop if it is fully implemented (for details see Section 4.7).

### ***3.2 Do patients want choice of providers?***

Patient choice was introduced into the NHS to provide more responsive and personalised services (Department of Health, 2003a). It is widely accepted that patients want more choice about different aspects of their treatment that may be concerned with place, time and form of treatment (National Consumer Council, 2003; MORI, 2004; Policy Unit, 2004; Public Administration Select Committee, 2005). Below we examine different forms of evidence to conclude whether, and to what degree, research findings support or disprove this claim.

#### ***3.2.1 Do patients want choice of provider in health care?***

In this section, we look at the evidence that patients want choice of provider in their health care. We then examine the ways in which they make choices in primary and secondary care in the UK, and the way in which they make choices in other countries. We also examine choices made by GP fundholders on behalf of patients, as an increase in choice of treatments was one of the mechanisms behind the UK quasi-market of the 1990s but also because GPs play a crucial role in influencing patients' individual choices today. We look at the factors that may affect patients' choices, and choices made outside the health sector. The overall messages to be drawn from looking at the evidence in respect of choice as outlined above are:

- Patient choice of health care is not a high priority for NHS patients. However, this relative disinterest has to be seen against a background of a service, which has traditionally offered very little choice. Some recent experiments suggest that, when real choice is offered, it will be attractive to some groups of patients.
- Early studies from the early 1990s and the NHS internal market showed the dominant influence of providers over choice. Characteristics such as age, class, ethnicity, and life circumstances affected patients' ability to travel to get treatment, and supply side constraints such as availability of providers for example and perverse incentive structure for both commissioners and providers often operated to prevent greater choice.

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- Primary care in the UK has not attracted much interest in terms of choice and there are very few studies specifically investigating choice in this sector.
- By contrast there appears to be substantially higher interest in patients choosing hospital for an elective surgery procedure where they face a long wait at their local hospital (e.g. the London Patient Choice Pilots). Patients in these pilots expressed great interest in using choice of hospital if it meant substantial reduction of waiting time and where support was provided to enact these choices provided.
- The latest studies suggest that the ability to exercise choice of hospital is strongly dependent on age, gender, family obligations, socio-economic status, and the nature of the health procedure involved. Those who are less mobile are less willing to travel.

Evidence from health systems that share similar features with the NHS, suggest relatively little enthusiasm by patients to take up choices. However, these studies have not been carried out under controlled conditions or with the level of support comparable to that of the London Patient Choice Pilots in England. Nonetheless, a few international studies suggest that choice is related to personal characteristics and patients' individual life circumstances.

Historically, the concept of choice has not featured prominently in the NHS, until the market-oriented reforms in the 1990s when it was for the first time articulated as an explicit policy goal even though it was not actively pursued in reality (Mulligan, 1998; Le Grand, 1999; Calnan and Gabe, 2001; Fotaki, 2001; Perri 6, 2003). Furthermore, where choice was offered, it was not generally accompanied by information to help patients choose, which probably limited the uptake of choice (Mays and Dixon, 1996; Le Grand *et al.*, 1998; Fotaki, 1999).

With this background, it is not surprising that there is not a strong groundswell demanding choice. For example, in a survey of patients carried out by MORI for the Department of Health in late 2004, patients rated choice of 'when and where they were treated' as the eleventh most important aspect of their health care out of 16, below car parking, but above hospital food (MORI, 2004). Indeed, in qualitative research, Which? found that consumers were reluctant to make choices about their health care, and even felt intimidated by the prospect. Few were aware of government proposals to increase choice in health care (Which? 2005). However, research findings presented in the same report give an account of 85% and 89% of respondents opting in favour of access to a good GP or hospital rather than more GPs or hospitals to choose from.

Despite this, in a survey of a representative sample of 1744 adults conducted by Which? in 2005, nine out of ten respondents said that they wanted to be able to choose their GP, and 69% agreed with the statement '*I want to be able to choose which health care service I*

use'. In another study, Coulter and Magee carried out a telephone survey of patients' willingness to make decisions about their health in several European countries and found that 79% of patients in the UK thought they should have free choice of hospital specialist and 87% thought they should be able to choose their GP (Coulter and Magee, 2003). Recent surveys therefore suggest that there is considerable interest by patients in having choice of a secondary care provider, and of a GP or nurse in primary care practice.

Smaller telephone surveys by the College of Health (Rigge, 2001) and British Cardiac Patient Association (2001) confirmed patients' willingness to have choice of hospital, reporting a very high percentage of respondents in favour of choice. A postal survey that focused specifically on the stated trade-offs by patients, found they were willing to travel if it meant substantial reduction of waiting times (Ryan *et al.*, 2000). In the same time however, many patients in the above survey expressed reservations as to the continuity of care (British Cardiac Patient Association, 2001), accessibility to friends and family in the alternative hospital (MORI, 2001) and travelling distance (Ryan *et al.*, 2000). Le Maistre *et al.* in their report of patients' experience of coronary heart disease choice quote a finding from 130 participants of diverse focus groups expressing their fears that no adequate support to recover might be provided to them in an alternative hospital (Silkap, 2002, quoted in Le Maistre *et al.*, 2003).

Other recent studies also indicate that patients are interested in choosing hospitals if this is explicitly offered to them and means a reduction in waiting times (Taylor *et al.*, 2004; MORI, 2004; Coulter and Magee, 2003). A MORI study of patient choice in Birmingham, Solihull and the Black Country that used quantitative and qualitative methods concluded that 43% of patients would be prepared to travel for more rapid treatment (MORI, 2003).

In the primary care reforms of the 1990s where choice of GP was a policy objective, the freedom which patients were given to choose a GP already existed but was rarely enacted (Salisbury, 1989; Billingshurst and Whitfield, 1993). In the 1990s, GPs (both fundholders and non-fundholders) acted as agents on behalf of their patients choosing hospitals for their referral (Glennerster *et al.*, 1994), though many at the time thought of fundholding as a means of increasing efficiency rather than as a means of giving patients choice (Coulter, 2004:87, quoted in Williams and Rossiter, 2004). However, this could be because the availability of choice of GPs in the UK, though always existing in theory, was rather muted. Many concluded that these limited choices were likely to be curtailed even further after the Labour government decided to abolish the quasi-market in the late 1990s (Goodwin, 1998; Gage and Rickman, 2000; Lilly, 2000).

In contrast, in the London Patient Choice Project in 2002–2003, which preceded the roll-out of choice policy for England, patients were for the first time given the opportunity to choose a hospital for having

their elective operation although the choice was limited to one alternative (Dawson *et al.*, 2004; Coulter *et al.*, 2005). Furthermore, newer evidence suggests that patients do want to be able to choose which GP they see, and they want to be able to choose whether to see a GP or a nurse when they consult in primary care (Baker *et al.*, 2005). The current policy builds on these pilots and is mostly concerned with the choice of hospital made by individuals (Burgess *et al.*, 2005; Perri 6, 2004) although different forms of choice and contestability may be introduced into primary care in a White Paper, which is expected early in 2006.

These studies all relate to choice of health-service providers – e.g. GP practice or hospital. There is a separate literature, which shows that patients want to be involved in choices about their individual treatments, or at least to have information about treatments available. We expand on this important area in Section 3.8, with a fuller review of the literature on individual treatment choices in Appendix 7.

### **3.2.2 Do patients want choice in other sectors?**

#### ***Direct payments in social care***

Direct payments were introduced in the UK in 1996 as a means of enabling local authorities to make cash payments to social service users in lieu of directly provided services (Glasby and Littlechild, 2002). Recipients of direct payments typically employ a personal assistant, either directly or through an agency, giving the service user greater choice over which individual supports them, at what times the service is provided and what the service comprises. The earlier Independent Living Fund (ILF), which was similar to direct payments in many ways, had proved popular with users, fundamentally shifting power away from professionals, but was too costly for a government wanting to limit public expenditure.

Direct payments are generally well regarded by users because of the flexibility, choice and control they offer (Dawson, 2000; Glendinning *et al.*, 2000a; Witcher *et al.*, 2000; Carmichael and Brown, 2002; Commission for Social Care Inspection, 2004; HASCAS, 2004; Stainton and Boyce, 2004; Lundsgaard, 2005). But direct payments are not the best option for everyone. Some people will still want to use directly provided services as long as they are of good quality (Joseph Rowntree Foundation, 2000). In the context of younger disabled people, where care is complex and care managers are responsive to users' needs, then neither user nor staff see a need for a direct payment (Social Services Inspectorate, 2000).

The take up of direct payments has been slow among groups outside of the initial focus on younger disabled people; for example, with older people, people with mental health problems and people with learning difficulties (Zarb and Nadash, 1994; Social Services Inspectorate, 2000; Bainbridge and Ricketts, 2003; Ridley and Jones, 2003; Jordan,

2004; Riddell *et al.*, 2005). Direct payments have been particularly under-utilized by minority ethnic users (Vernon, 2002, cited by Pearson, 2004), and by economically deprived populations (Clark *et al.*, 2004; Leece, 2004a, cited by Leece, 2004b), perhaps due to access having been at the discretion of care managers (Perri 6, 2003), or, in Sweden, individuals having to positively ask for a direct payment (Askheim, 2005).

For selected groups, it is clear that the opportunity to choose between direct payments or directly provided services is welcome. Take up of direct payments would appear to be restricted more by organisational barriers than by service users not wanting choice of service provider. A recent survey suggests that almost three-quarters of the general public believe that people needing social care should be given money, which is then used to choose which care they receive (Commission for Social Care Inspection, 2004), although this figure would appear likely to be sensitive to the form of words used. For more detailed discussion of direct payments in social care see Appendix 5.

### ***Choice of residential care home***

Older people whose care is being arranged by local authorities have had the statutory right to be placed in a care home of their choice in the UK since April 1993, subject to certain conditions (Department of Health, 1992).

The literature about the decision whether or not to enter residential care is significant, but studies are usually small in size. The literature suggests that (Williams 2005, Jenkins and Gibson 2005):

- older people and their relatives are rarely involved in the decision,
- the choice is often 'expert-driven',
- older people may prefer others to make choices on their behalf,
- most people moving into a care home have not considered alternatives, such as care at home.

There is a consensus that a significant proportion of older people who move to care homes have no choice about the home they move to. Often, the choice is made by a relative or carer (Williams, 2005), and this is often a relief to the older person. An Office of Fair Trading (1998) study found that among residents who reported having had no choice of home, 54% said a relative and 20% said a social worker, the hospital or a consultant had made the selection. However, choice of home is hampered by lack of information, and in one study 65% of carers said they had not been given the information they needed to help choose a home for their relative (Nolan and Dellasega, 2000). Relatives exercising choice on behalf of older people act as agents on their behalf, which is similar to the experience of GP fundholders who exercised choice on behalf of patients in the late 1990s. For more detailed discussion of choice in residential care see Appendix 4.

***Primary and secondary education***

In 1988 the UK Education Reform Act was explicitly aimed at enabling open enrolment and greater choice for families to choose schools outside their catchment areas.

Proponents of choice argue that choice enables patients to select schools with better academic outcomes which would provide not only benefits to individual pupils (Hoxby, 2000, 2003), but also collective benefits for the wider population (Hughes, 2004). School choice is popular with parents, local education authorities, schools and the general public (Flatley *et al.*, 2001; Gorard *et al.*, 2002; Parsons *et al.*, 2000), even though the effects in terms of pupil movement are marginal, with the great majority of parents choosing local schools. As a result both the negative results measured in terms of social stratification and also the positive effects in improving access to all that could benefit from choice were less than expected (Taylor, 2001b, 2002; Taylor and Gorard, 2001), possibly because of the pre-existing inequities, although this view is not uniformly supported either (Bradley *et al.*, 2000; Burgess *et al.*, 2004). Taylor (2001a) argues that on the whole geography of education remains an under-researched area, particularly in light of major transformations in education provision over the last two decades. Greener (2003a, 2005) compares parents' attitudes to school choice with their choice of GP to conclude that in the former case they were able to display a degree of calculativeness while in the latter they relied on trust rather than their reflexive rationality to make their decisions.

However, Burgess *et al.* (2005), in their review of economic evidence on choice of education cite Ladd (2002), who argues that parents' perception of school quality is partly dependent on the socio-economic status of the school body, which in turn affects choices by creating an 'uneven playing field' of school choice (Ladd, 2002, cited in Burgess *et al.*, 2005). They also identify a number of preconditions and constraints determining the exercise and outcomes of choice. Choice of schools was found to be dependent on the flexibility of supply and the nature of vouchers where they were used (e.g. the USA). For more details see Appendix 5.

With regard to the nature of schools, particularly local schools, selective, fee-paying, voluntary-aided and grant-maintained schools are all strongly associated with choice in the UK and elsewhere (Williams and Rossiter, 2004). Gorard *et al.* (2002) argue that schools in the UK have introduced wide variations in their admission criteria after different re-organisation and rationalisation programmes, thus having a consequence for increased segregation in the situation where demand frequently outstrips supply. Gorard (1998) compares no-choice regime in Wales with the opposite developments in England and Scotland, concluding that pulling schools towards similarity rather than diversity in the former represents a move towards a lesser social segregation. Burgess *et al.* (2005), on the other hand, suggest that

supply has been subject to strict government regulations creating conditions that impede rather than facilitate choice. The study contrasts this evidence with the USA where choice seems to have improved access for certain groups of less-advantaged children through the introduction of pro-active policies in the form of well-designed targeted vouchers (Hoxby, 2003).

### ***3.3 How do people respond to choice of provider when they have the opportunity?***

This section examines patients' and users' reactions to choice when it was offered and looks at studies researching actual choices made as opposed to stated preferences. It also examines the attitudes to choice by patients' agents (fundholders in the UK, or in a more limited way at choices made by patients' carers where relevant). The section is concluded with an outline of research on factors that facilitate or impede choice of providers (GPs and hospitals) and among individual treatments.

#### **3.3.1 Evidence from UK health care**

##### ***Evidence from primary care***

The factors that influence patients' choice of primary care provider are important because of the key role that GPs play in the UK's health system (Charny *et al.*, 1990). GPs in the NHS traditionally assume a double and somewhat contradictory role, acting both as agents or 'advocates' on the patients' behalf and also as the gatekeepers of the system. After examining the evidence on patients' attitudes to choice the key messages to be drawn from this sample are as follows.

- Studies evaluating patients' willingness to choose primary care providers under quasi-market reforms in the UK provide little evidence of patients wishing to change their primary care provider. This is also confirmed by other studies both before and after the quasi-market reforms.
- By contrast during similar reforms in Sweden in the early 1990s, approximately 30% of patients in the Stockholm county councils were reported to have changed their primary care doctor. Other studies from Sweden suggest that this willingness to exercise choice in primary care settings is dependent on age, socio-economic status and gender.
- The effects of quasi-markets on choice of GP practice in the 1990s were rather muted, possibly because no sufficient information existed. Overall, patients' awareness of existing choices and also their actual availability was subject to significant regional variations and depended essentially on the density of population and on the concentration of facilities.



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- Later studies suggest that it is difficult to assess patients' willingness to choose a primary care provider under conditions of insufficient capacity and with the existing dis-incentives that include boundary restrictions within tightly defined catchment areas. Choice is severely limited at present by the widespread prevalence of closed GP lists in many parts of the country.

Research findings from studies conducted in the early 1990s reflect the uncertainties related to patients' willingness and ability to choose a primary care provider (Shackley and Ryan, 1994). Mahon *et al.* (1994) evaluated patient choice of GP under the quasi-market reforms and found that respondents were not inclined to travel to pursue their choices and were generally rather uninterested in this aspect of care. These findings were supported by another study which examined patients' willingness to exercise choices of primary care in outer London and Stockholm; in the latter, choice was found to be much higher, possibly because patients could exercise it directly and because travel costs were reimbursed (Fotaki, 1999).

Recent study by Baker *et al.* (2005) points at the trade-offs between speed of access and type of health professional accessed. These studies need to be seen as a background in which patients in the UK rarely change their GPs for reasons other than moving home; dissatisfaction with clinical care and the attitude of doctors are less important factors prompting patients to change their GP practice (Thomas *et al.*, 1995; Gandhi *et al.*, 1997; Wearne, 1998).

First attempts at evaluating the impact of fundholding on choice under quasi-markets produced contradictory results. One group of researchers claimed that there was evidence of improvements in choice and information, not only for the agents (GPs) but also for their patients (Glennerster *et al.*, 1994; Glennerster, 1996) while other authors were less convinced (Audit Commission, 1996; Mays and Dixon, 1996). Another study, conducted at the early stage of the introduction of the reforms reviewed the practice patterns of 19 GPs in ten fundholding practices in the northern region of the UK and found no changes in the choice given to patients (Newton *et al.*, 1993).

Studies evaluating the change in patients' and GPs' choices that resulted from the fundholding reforms also pointed out that there was potential for conflict between the differing objectives of reforms. The increased choice given to GP fundholders in the market environment may have been chiefly driven by efficiency considerations, which did not necessarily take patient preferences fully into account (Mahon *et al.*, 1994).

Later studies looking at benefits of fundholding suggested that the only significant increase in choice was the availability of a more accessible secondary care service in the form of outreach clinics located in GP surgeries (Gillam *et al.*, 1995; Kerrison and Corney, 1998) and also some increased access to providers with shorter waiting times (Dowling, 1997; Goodwin, 1998; Dusheiko *et al.*, 2004).

There is also evidence from related research which demonstrated that, while fundholders were more willing to offer choices to their patients, a change of secondary providers rarely took place in reality (Ellwood, 1997).

***Evidence from secondary care***

Choice of secondary provider is the most prominent feature of current Patient Choice policy, described by Which? as 'the jewel in the crown' of the Government's Patient Choice policy (Which?, 2005).

Understandably, this policy component attracts high attention in terms of policy polemic and, reflecting its importance for the Government policy, this is also an area where some recent evaluations exist. We looked at the limited experience of choice of the secondary providers from quasi-market reforms and at the newer evidence assessing the effects of the pilots in choosing alternative hospitals for elective procedures. The key messages arising after reviewing available sources of evidence are the following.

- There are very few studies from the secondary sector referring specifically to the implementation of patient choice under the quasi-market-oriented reforms in the UK, and only two evaluations that are specifically concerned with patient choice during this period.
- These studies suggest that there were limitations to choice, possibly because there were trade-offs involved in the simultaneous pursuit of choice and efficiency for both commissioners (with a partial exception of GP fundholders who could choose among hospitals on the basis of quality and price of services provided) and providers.
- The few studies that exist suggest that GP fundholders made limited use of choice. Although they were willing to offer choice in theory, changes in secondary care providers were relatively uncommon. There is evidence that GP fundholders had shorter waiting times for elective procedures, but this did not necessarily imply a change of provider.
- More recent evidence is based on evaluations of the London Patient Choice Project and other pilots implemented during 2002–2003. These suggest that, in an environment of long waiting lists, patients respond to choice with considerable enthusiasm. Uptake is reported as being as high as 65–75% in some cases, though more cautious estimates are lower when they show disaggregated uptake for different procedures.
- A few empirical studies which look at patients' and doctors' attitudes to choice and factors affecting their choice of hospital suggest that ease of access, reputation of the hospital, quality of care and waiting time matter most for patients, while locality is the most important factor for GPs. GPs play a fundamental role in affecting patient choices.

There are very few empirical studies examining the impact of the fundholding reforms on different aspects of choice and their relation with quality and/or efficiency. The evaluations conducted in the early stages of the market reforms (Jones *et al.*, 1994; Mahon *et al.*, 1994; Mays and Dixon, 1996) provided some indications of their likely implications. One of the first studies conducted in the UK which investigated the choice of hospital by patients and GPs for four specialties (Mahon *et al.*, 1994) found that, at the early stages of the implementation of the reforms, there was very little change in the choices exercised by either patients or GPs. This view was also supported by the results of another study, which looked at the choice of the hospital, involving a sample of older patients. Here again, no visible difference in patients' choice between 1990 and 1992 was observed, although some improvements in information provision were reported (Jones *et al.*, 1994).

These studies of fundholding suggested that choice was in potential conflict with the other objectives of the reforms (Mahon *et al.*, 1994), a finding that was confirmed by later evaluations (Fotaki, 2001) and reviews (Williams and Rossiter, 2004). More importantly, quasi-markets in the UK had a negative effect on choice for some specialist care, despite this being one of the proclaimed goals of the market reforms (Fotaki, 1999). This comparative case study of cataract surgery in outer London and Stockholm has shown that quasi-markets had an adverse impact on choice of specialist provider in the UK, because in London GPs followed their own rather than patients' preferences and because referrals out of the GP's catchment area became more difficult as money would flow out of the health authority's purse. This study also found that older patients expressed little interest in having choice over hospital, primary care provider or the form of their treatment (Fotaki, 1999).

However, the newer evidence coming from a study that looked at random samples of patients' attitudes and GPs' views on choice found that patients who were offered choice of referral reported that patients themselves made choices in 81% of the cases as compared to 37% of the control group (Taylor *et al.*, 2004). They also found that of participating GP practices only 22% offered choice to patients 'most of the time' and 75% 'some of the time', and that 65% of them had a positive attitude to choice. Implausibly, the study also estimated that GP consultation time in cases where choice of referral was offered increased by only 36 seconds, which was not statistically significant as explained by the authors (Taylor *et al.*, 2004).

The authors also found that there was a statistically significant difference of 1.6 minutes in the mean time of the consultation in the intervention compared to the control group. However, these findings may not be representative of the population of general practices in the areas studied, because of the 48 general practices and 166 GPs that were originally recruited, only 38 practices and 116 GPs (less than 70%) eventually agreed to participate in the study. This might have

introduced a self-selection bias as those with a more positive attitude to choice reforms might have been keener to be part of the research.

The results of a second study of choice at the point of referral for electives in Bedford and adjacent areas at 4 months starting in October 2003 suggest that ease of access was a major influence on choice (56%), followed by reputation of hospital (47%) and quality of care (43%). Waiting time was the fourth factor, which influenced 34% of patients. When judging quality of care people cited factors such as knowing people who were unhappy with a provider or information from family and/or friends. Most patients chose their local hospital (Lang *et al.*, 2004b). When evaluating a pilot study of coronary heart disease choice at 6 months in the same report younger patients were reportedly more likely to take up choice (61 compared with 55% for over 60s).

However, a study of a larger sample of patients ( $n=4330$ ) that underwent heart surgery in a London pilot project, which preceded the introduction of London Patient Choice Project for other specialities, found that only about 50% of those offered choice of treatment at an alternative hospital opted for it (Le Maistre *et al.*, 2003). Le Maistre *et al.* also found that older patients were more likely to remain on the waiting list and that the reputation of the hospital and also the speed of treatment influenced patients' decisions. Also, only one-third of patients made choices on their own while others sought the advice of their primary care advisers, families and friends (Le Maistre *et al.*, 2003).

The second report by the Cranfield team (Isroliwala *et al.*, 2004) examined stated preference (hypothetical answers) in the same area to tease out factors influencing patient choice but there are no empirical data on revealed preferences (actual choices made). It found that GPs had a strong preference for local hospitals, even when choice of other providers was offered. Predictably the report concludes that GP advice has a big influence on patient choice (Isroliwala *et al.*, 2004). This latter finding is important when compared to the rather unenthusiastic attitude of the GPs to choice, with 61% of them feeling a little or downright negative about *Choose and Book*, as reported in a recent study by the National Audit Office (2005).

### ***Factors influencing patients' choice of hospital***

Patients in the UK tend not to behave as consumers, shopping around for better services or providers (Charny *et al.*, 1990; Shackley and Ryan, 1994). They even make very limited use of choice when opting for private health care (Cant and Calnan, 1992; Wiles and Higgins, 1996). Choice is constrained by a number of systemic, practical and context-specific barriers, which include:

- supply-side constraints manifested in an insufficient capacity (Cant and Calnan, 1992; Gage and Rickman, 2000);

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- lack of appropriate information on a system level about existing options (Mays and Dixon, 1996) and specifications of service (Goddard and Smith, 2000);
- influence of GP advice on the choice of consultant and choice of hospital even when private care treatments are concerned (Higgins and Wiles, 1992).

Evidence from the London Patient Choice Pilots suggests that patients are willing to make use of choices offered (Dawson *et al.*, 2004, 2005; Burge *et al.*, 2004, 2005; Coulter *et al.*, 2005). Choice was only offered to a minority of patients in the pilots (e.g. excluding older and sicker patients) so it is difficult to use the results to predict patients' behaviour more widely. However, these studies did look at characteristics of patients that made them more or less likely to use choice. Burge *et al.* performed conjoint analysis using two sets of data: stated-preference data elicited from London Patient Choice Project participants and revealed-preference data that indicates choices actually made by patients. They conclude that patients were less likely to opt for an alternative provider if they were older (particularly over 60 years of age), had low education levels, had family commitments or if their income was less than £10 000 (Burge *et al.*, 2005). These results were confirmed for both stated (hypothetical choices) and revealed preferences (actual choices).

Men were more likely to opt for an alternative provider than women, and ophthalmology procedures attracted the highest willingness to travel to an alternative provider compared to gynaecology, which had the lowest. This finding is also confirmed by Dawson *et al.* (2004), who found that the use of choice varied substantially between specialities. For example, 65% of patients who were offered choice for ophthalmology made use of it while only 28% of patients accepted choice of an alternative provider for gynaecology (Dawson *et al.*, 2004).

In contrast Coulter *et al.* (2005) found no difference in the uptake of choices offered by patient groups in relation to class, education, income or ethnicity except for unemployed patients who were less likely to exercise choice. Patients' decisions to choose an alternative provider were however influenced by the level of pain, length of waiting time and a poor reputation of the home hospital (Coulter *et al.*, 2005). These authors report a very high satisfaction level, with 97% of patients keen to recommend the scheme to others. However, they also point at the popularity of free transport, which attracted high satisfaction ratings (Coulter *et al.*, 2005).

### **3.3.2 Evidence on choice of provider from other health systems**

The evidence on patients' willingness to exercise their choice of doctor or hospital from other comparable systems is mixed. There are few evaluations looking into actual patient choices but there is some

evidence of patients' potential willingness to choose and of higher satisfaction when this occurs.

Two studies from Sweden that examined hypothetical choices (stated preferences) in primary and secondary care found that the responses were dependent on the age of respondents, their socio-economic status and gender (Anell *et al.*, 1997; Rosén *et al.*, 2001). The first study reported the results of a postal questionnaire survey to 2000 randomly selected respondents which found that two-thirds of respondents wanted choice of primary care and secondary care setting and doctor, with women twice as likely to want to exercise choice compared to men and older patients less willing to make choices (Anell *et al.*, 1997). The second study carried out by the same team of researchers with a larger sample of respondents confirmed the findings of the former, adding a dimension about preferences of well-educated older people being more similar to the preferences of the younger respondents as opposed to choices of less educated older people (Rosén *et al.*, 2001). A study from Estonia looking at responses of almost 1000 randomly selected patients also found that patients wanted to be able to choose their personal doctor (Kalda *et al.*, 2003).

As in the UK, reforms to increase competition in Sweden may have had conflicting aims in terms of trying to increase both choice and efficiency (Anell, 1995, 1996; Rhenberg, 1997). However, the outcomes of the Swedish reforms were different from those in the UK, in that many more patients exercised choice by changing primary care provider as well as exercising choice of specialist (Anell, 1996; , 2002).

Patients were most likely to exercise choice in areas with a high concentration of specialist facilities, where there was an excess capacity. In some cases this even extended across county council boundaries, for example in Western Sweden (Rhenberg, 1997). However, in other parts of the country, patients seemed to be making little use of choice, preferring to be referred within their neighbourhood (Anell and Svarvår, 1993), and to wait a bit longer instead of moving elsewhere for treatment (Hanning, 1996; Hanning and Spånberg, 2000).

One of the hypotheses that is frequently being put forward to explain the limited exercise of choice in both the UK and Sweden under quasi-market reforms relates to the lack of information and knowledge about the new options (Bergman, 1998). It was argued in both countries that the limited information might have led to the underutilisation of choice (Anell, 1996; Mays and Dixon, 1996). Good quality, reliable and usable information is needed to make choices, which did not exist then (Coulter *et al.*, 1998; Entwistle *et al.*, 1998) and is far from being satisfactory and sufficient now. We discuss this issue further in Section 3.8.

In Denmark patients were given the option of receiving treatment outside their county area. This was initially launched as 'free choice' but later renamed to 'extended choice' with a number of constraints

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imposed (Vrangbæk and Bech, 2004). These included patients having to cover transportation costs themselves, the hospitals having to accept the patients, counties having an ability to retain money for 'incoming' patients, exclusion of the private hospitals from the scheme and other limitations to services. Not surprisingly these measures deterred patients from utilising choice and only 5% of the population received care outside their own county (Thompson, 2002; NHS Magazine, 2002).

A comparative study looking into perceptions of adults about primary care and health system performance using data from the Commonwealth Fund International Health Policy Survey in five countries, including Australia, Canada, New Zealand and the UK, compares patients' satisfaction with choice of doctor with the USA and between each other (Schoen *et al.*, 2004). It finds levels of satisfaction with choice highest in New Zealand and the UK and lowest in Canada when compared to the USA, with Australia positioned somewhat lower but still higher than the USA. A similar trend was observed for the values of least satisfied patients, with New Zealand and UK having the lowest and Canada the highest percentages (Schoen *et al.*, 2004).

In Germany and the Netherlands and many other countries that have adopted a social health insurance system, patients have many more choices. They can choose among primary care physicians, hospitals and also among insurers. Beusekom *et al.* (2004) carried out a literature review on consumer choice in health systems with the focus on social health insurance models. They cite research that deals primarily with choice of insurer where factors such as ability to choose provider as a part of the scheme, quality and benefits play an important role in choosing an insurance plan (McLaughlin, 1999). However, they also note that patients find the different health plans hard to compare (Beusekom *et al.*, 2004).

This is indirectly confirmed by recent research examining data of The Commonwealth Fund Biennial Health Insurance Survey, to conclude what type of 'choices' matter to patients who are insured in competitive insurance market. The analysis of the survey data finds that having a choice of provider matters more than choice of health plan, and that patients are happy overall with choices of health plans made by their employers (Lambrew, 2005). Ability to choose a personal physician within limited choice of the Health Maintenance Organisation was found to be closely linked to higher patient satisfaction in another study from the USA (Schmittiel *et al.*, 1997). By contrast, research from the Netherlands, which explores the likely impact of the European Court of Justice Regulation enabling cross-border transfers in the European Union, concludes that Dutch patients were not willing to make use of choice and travel across the border to get faster treatment (Brouwer *et al.*, 2003).

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The Council for Public Health and Health Care (2004) in the Netherlands conducted an international survey by telephone to explore patient preferences and the importance they attached to the choices that were available to them at different stages of their journey through their country's health system. Although it found no developed notion of consumer or customer in any of health care systems examined, there were clear differences between Belgian, French, German, Dutch and British respondents. British patients were found to be the least accustomed to greater choice: Dutch patients, for example, face similar waiting times and restrictions of specialist provider (via GP gate keepers), but attached greater importance to choice and expressed higher levels of dissatisfaction with access. French patients were the least dissatisfied with the level of choice available when compared with social health insurance systems for either German or Belgian patients, both of whom were prepared to pay for having more choice within their health systems, although they already enjoyed a great degree of choice of both primary and specialist health care providers. The way patients were able to approach health providers was correlated with the structure of health care system, the organisation of the services provided while values attached to choice were dependent on options offered (Council for Public Health and Health Care, 2004).

In other social health insurance systems there is also evidence that patients exercise choice by choosing insurance schemes, as in the private health market in the USA. However, in all health systems, even in the market-orientated ones such as the USA, there are limitations that are applied to contain costs (Lang *et al.*, 2004a; Burgess *et al.*, 2005). Where choice is apparently relatively unrestricted there is risk selection of patients by providers, especially where they operate under conditions of monopoly and insurance cartel (Mossialos and Dixon, 2002).

In private insurance markets there is also an issue of personal preferences expressed by customers, leading to moral hazard that leads to the overuse of services under insurance schemes where no cost falls on the user. This has led to the abandoning of full insurance schemes in the USA, and also to reductions in choice for patients and the use of competition that is driven by the payer rather than the user (Pauly, 1968; Cookson and Dawson, 2006). In the social insurance markets such as Germany and France, choice is also being curtailed to contain high costs resulting from inflationary reimbursement schemes and from policy capture by powerful professional interest groups (Rodwin and Le Pen, 2004; Allen and Riemer-Hommel, 2006).

### **3.3.3 Evidence of users' changing needs and shifting to consumerism?**

The overall evidence is that, contrary to policy pronouncements that justify health care and other public service reforms as a response to



users' changing expectations and shifts towards pro-market individualism, there is little empirical data to confirm this claim, although there are some differences in users' attitudes between sectors such as health and education (Greener, 2003a, 2005) and in users' expectations of improvements in different public services (National Consumer Council, 2003).

Recent ESRC-funded research on Cultures of Consumption in health services and the police found that the binary of the passive recipient versus the active and sovereign consumer of public services, which dominates contemporary policy discourse, is a simplistic and inadequate concept, particularly with regard to health services, but possibly also other public services too (Clarke and Newman, 2005; Westmarland and Smith, 2004). Specifically, users of health services display a much more nuanced approach to public services that goes beyond this dichotomy, as they identify in a very limited way with either 'consumer' or 'customer' notions, while having more affinity to 'service-specific terms' such as patient and service user. They also see themselves much more frequently as members of the public and members of the local community rather than citizens, and are well able to hold different identifications alongside each other, and to deploy them according to the context and the nature of each specific situation (Clarke and Newman, 2005).

These findings seem to indirectly confirm Needham's critique of consumerism as a one-off and transactional exchange that prioritises narrowly defined and temporary individual needs over long-standing needs of the individual as the community member, and her conclusion that it is therefore brittle and self-undermining (Needham, 2003: 33). Greener reiterates this message from a different critical perspective by arguing that the consumerist approach in health care is most relevant for simple and relatively insignificant choices where easy available alternatives exist. This leaves out the bulk of health care choices, where users need to form a meaningful and trustworthy relationship with health care provider. He concludes by arguing that the 'consumer model offered might be based on assumptions about human behaviour that that are unsustainable and possibly dangerous' (Greener, 2005: 233).

### ***3.4 The impact of choice on efficiency***

The concept of efficiency encompasses both technical and allocative efficiency. The former implies either the decrease of the cost of inputs for a given outcome or the increase of outputs produced at the same cost (this notion of efficiency derives its origins from the industrial production process). Allocative efficiency occurs when the benefits gained from the use of given resources are maximised. This is the approach used more often in the public policy domain.

There are several key messages emerging from the review of evidence on the impact of choice on efficiency. These are:

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- variations in unit costs may reflect contextual factors rather than inefficiency;
- there are many other factors influencing hospital performance in addition to competition;
- hospital performance slightly improved under the quasi-market-oriented reforms in the UK;
- in Scandinavia, evidence from quasi-market reforms was mixed as higher productivity was associated with increased costs, and efficiency gains were found in some cases only.

Choice is seen as a market tool, which should promote efficiency, by giving power of exit to patients and users. This will in turn stimulate competition and innovation among providers. Although choice is not synonymous with competition they are closely interlinked and quasi-market reforms are therefore included in this review of the potential impact of choice. A prerequisite of patient choice is the availability of a number of providers from which to choose. A key plank of Government policy is to increase competition between providers to facilitate choice. It is also assumed that competition between providers for patients will lead to increased responsiveness and greater efficiency. Implicit in this is the belief that existing NHS providers are inefficient.

Researchers have questioned this assumption, pointing to flaws in the calculation of efficiency estimates, which may understate hospital efficiency. Variations in unit costs may reflect contextual factors rather than inefficiency (Street and Jacobs, 2002).

### **3.4.1 Evidence on efficiency from health care in the UK**

The introduction of quasi-markets in the UK during the 1990s offers an opportunity to examine the impact of choice of GPs by patients and choice of hospitals by GPs (on behalf of patients). The drive for increased efficiency was one of the main reasons for the introduction of market mechanisms by the governments of the UK, Sweden and Denmark, among others, in the 1990s. These governments believed in the superior capacity of the market to deliver efficient treatment.

The introduction of quasi-markets in the UK during the 1990s offers an opportunity for examining the impact of choice of practices by patients and hospitals by GP fundholders and health authorities. The drive for increased efficiency was one of the main reasons for resorting to market mechanisms by the governments of the UK, Sweden, Denmark and several other countries in the 1990s, which believed in the superior capacity of the market to deliver this objective. Here a distinction has to be made among choices that were available under quasi-market into:

- patient choice of GP (and occasionally also other primary health care providers);
- GP choice of hospital on the patient's behalf;

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- health authority choice of hospital on the patient's behalf through GPs.

Below the evidence of choice-driven competition on efficiency is examined. This was looked at only in terms of the first two items on the above list.

The evidence about efficiency gains in the UK suggests at best that small efficiency gains occurred, and in many cases the findings of research are either conflicting or inconclusive. The evidence for efficiency gains achieved by GP fundholders is mixed. There is agreement that such gains were achieved with respect to the prescribing patterns (e.g. Glennerster *et al.*, 1994; Robinson, 1996, Glennerster, 1996; Mannion, 2005). Fundholders were more efficient in prescribing and more able to halt the pace of the rise in prescribing costs (National Audit Office, 1994; Gosden and Torgerson, 1997; Rafferty *et al.*, 1997). It was argued that this was because they were keener to prescribe generic drugs (National Audit Office, 1994; Wilson *et al.*, 1995; Gosden and Torgerson, 1997) or reduce the volume of prescriptions (Howie *et al.*, 1995), or were more cautious in adopting new and expensive drugs (Audit Commission, 1995).

A few claimed this to be proof of the market's success (Le Grand *et al.*, 1998). At the same time Dixon and Glennerster argued that efficiency in prescribing which had been achieved was perhaps due to more generous funding of fundholders' practices (Dixon and Glennerster, 1995). According to others, the gains, even where they appeared, were not maintained for a long time (Stewart-Brown *et al.*, 1995; Robinson, 1996) or associated with deliberate over-prescribing in the preparatory year. Keeley asserted that overall fundholding did not succeed in containing the rise in prescription costs over time in general practice and nor did it succeed in reducing the use of expensive specialist services (Keeley, 1997). For example, the cost of ophthalmology services provided on site at fundholders' premises in form of outreach clinics were found to be three times higher than when they were provided at a hospital's eye unit (Gillam *et al.*, 1995), but patients seemed to prefer these arrangements. Goodwin claimed that under quasi-markets modest efficiency gains were achieved in the primary care sector (Goodwin, 1998).

A similar picture emerges for the hospital sector where efficiency gains were also found to be modest (Le Grand *et al.*, 1998). In a study of the effects of NHS reforms on hospital efficiency, Söderlund *et al.* (1997) found real productivity gains during the period 1991–1994 for trusts when compared with directly managed units in England. However, the same study also showed that some hospitals became intentionally less productive shortly before obtaining trust status, so as to be able to look more efficient under the new arrangements (Söderlund *et al.*, 1997).

Newer evidence suggests that fundholding did have an impact on reducing hospital prices for non-emergency services (Propper, 1995;

Propper and Söderlund, 1998), reduced time for non-emergency service (Propper *et al.*, 2002) and reduced referral rates (Gravelle *et al.*, 2003; Dusheiko *et al.*, 2004). The evidence about impact of choice on efficiency comes also from the evaluation of the London Patient Choice Project in that it achieved reduced waiting lists by matching capacity to demand, thereby having an indirect impact on the efficiency of service provision on a system level (Dawson *et al.*, 2004).

There is little evidence from which to draw policy conclusions about the impact of choice on efficiency at the organisational level. Some indirect evidence is provided by Ferlie *et al.* (2004, 2006), who observed that although the London Patient Choice Project apparently introduced strong incentives for hospitals to treat more patients, whether organisations actually did treat more patients depended on their culture and capacity for change. In one of their studies they also questioned the results of incentives in expanding capacity and concluded that so far this has been patchy and narrow with primary focus based on diagnostic centres (Ferlie *et al.*, 2004).

A few enterprising providers captured 80% of the extra resources made available, and if a small number of providers come to dominate a market in this way, then this militates against competition, and hence against efficiency. Monopoly or oligopoly is known to affect efficiency negatively in the long run because the market is captured by a few providers who become price leaders when the pricing is flexible as they tend to compete on quality (Propper and Söderlund, 1998; Anell, 1996). On the other hand, in the fixed-price systems there may be disincentives to quality and if prices are fixed too low they may even negatively affect quality (see Section 3.6.2) or limit the number of providers and thus access to some user groups (see Section 3.6.3 on residential care).

### **3.4.2 Evidence on efficiency from other health care systems**

The evidence on the effects of choice-driven competition on efficiency comes primarily from the USA, although there is also some evidence from other countries. Key messages from the international literature are as follows.

- Managed care introduced in the mid-1980s in the USA reduced prices and costs, but this was mostly achieved at the expense of user choice.
- Direct empirical comparisons among countries are difficult to conduct and interpret due to a number of methodological issues and contextual differences which impede the valid comparisons of measurements.

Although direct comparisons between the UK NHS and other health systems are rare, there are some notable exceptions. In particular, recent studies have compared the costs and performance of the NHS

with those of an integrated system for financing and delivering health services (Kaiser Permanente) in California (Feacham *et al.*, 2002; Ham *et al.*, 2003). The analysis of Feacham *et al.* (2002) did not support the widely held belief that the NHS is efficient and that poor performance in certain areas was largely explained by under-investment. They suggested that Kaiser achieved better performance at roughly the same cost as the NHS because of better integration across the system, efficient management of hospital use, the benefits of competition and greater investment in information technology (Feacham *et al.*, 2002).

Critics pointed to a range of flaws in the study. Talbot-Smith *et al.* re-examined the data and methods used by Feacham *et al.* and considered the issues raised in the 82 letters sent by *British Medical Journal* readers in responding to the Feacham article (Talbot-Smith *et al.*, 2004). They highlighted errors in the costing methods, the selective use of performance measures and the inappropriateness of comparing universal with selective coverage systems. Additionally, since the US population was younger, healthier and more affluent, they expressed doubt about the extent to which Kaiser's performance could be compared to that of the NHS.

In another Kaiser/NHS comparison Ham *et al.* examined hospital-bed utilisation in the two systems, building on the observation of Feacham *et al.* that the NHS uses three times the number of acute bed days as Kaiser (Ham *et al.*, 2003). Focusing on the 11 leading causes of use of acute bed days, Ham and colleagues concluded that bed day use for the NHS is three and a half times that of Kaiser. Feacham *et al.* stressed the benefits of competition and choice, which enable Kaiser to drive a 'hard bargain' on quality and price (Feacham *et al.*, 2002). However, rather than focusing on competition as driving this increase efficiency Ham *et al.* stress the benefits of integrated care and the active management of patients to maintain their flow through the system and minimize their stay in hospital (Ham *et al.*, 2003). Therefore, although there is evidence of increased efficiency of Kaiser compared to the NHS, it is far from clear that it relates to competition with other providers, and better internal organisation is as likely to be the cause. The Kaiser papers do not therefore contribute in a major way to an argument about choice as a stimulus for increased efficiency.

Earlier evidence from Propper *et al.* referring to the US health care market indicated that health plans in competitive markets that do not face hard budget constraints tend to compete on quality rather than on price, and that this leads to higher costs (Propper and Söderlund, 1998). However, new research from the USA suggests that it was competition driven by purchaser choice, with limited choice for users that secured the substantial reduction in prices, costs and excess capacity that has occurred since managed care was introduced in the mid-1980s (Dranove and White, 1994; Keeler *et al.*, 1999; Cookson and Dawson, 2006). Zwazinger *et al.*, in their study of the Californian

health care market, report that for-profit plans are somewhat more effective in driving price competition than not-for-profit ones (Zwazinger *et al.*, 2000, quoted in Cookson and Dawson, 2006). However, a study assessing performance differences between private for-profit and non-for-profit US health care providers found that the latter were judged superior 59% of the time, compared to the former, which were found superior only 12% of the time (Rosenau and Linder, 2003).

In Sweden, evidence for the efficiency gains that might result from competition was also mixed, as competition and choice resulted in higher productivity but led also to higher costs (Bergman, 1998; Bruce and Jonsson, 1996) and had mixed results for small local health economies (Gerdtham *et al.*, 1999). In Italy, the introduction of greater competition has been accompanied by budget deficits and an increase in the cost of care leading to the scaling back of market mechanisms and attempts at a more cooperative relationship between purchasers and providers (Anessi-Pessina *et al.*, 2004). It appears that there are many other factors influencing hospital performance in addition to competition (Cellini *et al.*, 2000). The deficits are not attributable solely to increased levels of competition, but to factors such as more expensive private sector providers and an open-ended commitment to funding services using tariff-based, full-cost reimbursement systems (Cellini *et al.*, 2000). However, a study from Catalonia, Spain, found that the number of competitors in the market contributes positively to technical efficiency (Dalmau-Matarrodona and Puig-Junoy, 1998).

Many studies report the adverse consequences and perverse incentives associated with fixed-tariff funding systems, such as the one underpinning the NHS Payment by Results scheme which lies behind the planned increases in patient choice of hospital (Goldfarb and Coffey, 1992; Hsia *et al.*, 1992, 1998). Such systems create incentives to 'upcode' activity (i.e. shifting the classification of a patient's diagnostic group to yield higher payment from third-party payers) and to 'skim the cream' by treating less dependent patients within a diagnostic group and avoiding patients with higher dependency (Chuang *et al.*, 2003). There is also some evidence of a positive relationship between hospital ownership and the propensity to 'upcode', with one study finding that hospitals converting to for-profit status and for-profit hospitals were more likely to adopt this tactic than not-for-profit-hospitals (Silverman and Skinner, 2004).

The findings from the studies evaluating the public competition model in Sweden suggest that choice has not resulted in sustained efficiency at system and organisational levels, despite increases in hospital productivity (Bergman, 1998; Bruce and Jonsson, 1996). So, for example, in Stockholm there was a dramatic rise in activity, manifested in increases in the number of hip replacements and coronary bypass procedures by 50%, and the number of cataract operations increased by as much as 70% (Håkansson and Nordling,

1997). However, when 'reform' counties were compared with 'traditional' ones, no differences were found in terms of cost-effectiveness or increased productivity.

One plausible explanation, proposed by Brommels (1995), was that the economic recession that coincided with the reforms forced all counties to take drastic managerial action, regardless of their governance systems. Furthermore, as predicted by economic theory (Williamson, 1975; Le Grand and Bartlett, 1993), administrative costs also increased as a result of the contracting procedures of quasi-markets. In Stockholm these forced the county council to impose quantity-related ceilings on payments and to lower the prices of services. These changes in the rules and prices diminished the cost increases, but it did not save the county councils from running into serious deficits despite the higher productivity they manage to achieve (Håkansson, 2000).

In Denmark the approach has been to encourage extended choice and increased competition by switching to DRG-based funding and providing supply-side incentives to compete for patients (Vrangbæk and Bech, 2004). In a system that has traditionally emphasised budget control, cooperation and equity, as opposed to income generation and competition, it is perhaps not surprising that the relatively weak supply-side incentives have not transformed the system into a highly competitive environment. This demonstrates that not only do regimes of competition differ between countries in terms of their rules, but also that the cultural context in which those policies are introduced will have an impact on their implementation and consequences.

### **3.4.3 Evidence on efficiency from other public sectors**

#### ***Efficiency in direct payments in social care***

Direct payments for disabled people may be more cost-effective than direct service provision (Zarb and Nadash, 1994; Dawson, 2000), mainly due to lower administrative overheads, as much of the administration is done by the service users themselves. Zarb and Nadash (1994) also suggest that mixed arrangements combining services and payments are both more costly and less efficient than either the payments option or services on their own. However, there may also be a presumption among many that 'bulk' purchase is more efficient than individual purchasing (Commission for Social Care Inspection, 2004). The overall view in a review of direct payments in European countries was that direct payments are at least as expensive as directly provided services, although the response was mixed (Halloran, 1998). A more recent study suggests that they can give quality benefits at similar cost to other modes of service provision provided that they are suitably targeted (Lundsgaard, 2005).

***Efficiency in choice of residential care home***

We found little if any literature on individuals' choice of residential care home increasing the efficiency of the sector as a whole. One of the themes in the literature is the lack of real choice that most people have, due to supply shortages, local authority policies, pressure to make quick decisions, and 'cream skimming' by care homes (Knapp *et al.*, 1994; Perri 6, 2003; Williams, 2005). Cost is one of the factors considered by people when they choose a home, but it is only one among a number of other factors, and is likely to be less important, for example, than location. Overall, the literature indicates that the residential care 'market' is a long way from the free market, which in theory might suggest that efficiency would improve. Furthermore, individual choices currently have a relatively weak influence, compared to for example, that of social services departments.

***Efficiency in choice of primary and secondary education***

Efficiency in education is very difficult to assess because readily measurable outcomes such as results achieved in national examinations may not reflect efficiency while more substantive results such as equipment with life skills are long term and very difficult to measure. On the whole, however, results of studies of efficiency of the UK education system over time are either stable or show slight improvement. Schagen and Morrison, who measured GCSE results between 1994 and 1996, found that they improved between 1994 and 1996 and then in 1996 they decreased again (Schagen and Morrison, 1998, 1999).

Burgess *et al.* (2005) differentiate between raw score and value-added performance measures, arguing for the latter as the best indicators for schools' effectiveness. However, they also state that it is difficult to predict what might be the consequences for productivity, pointing at some gains from exercising choice, which are not uniform across different groups of students or choice programmes, and stressing rather the importance of contestability on increased productivity, particularly in the USA.

In the UK, although parents use performance indicators to inform their choices, this does not automatically translate in schools achieving better outcomes because schools are able to alter their raw intake and the results are also sensitive to measures used (Bradford, 1991; Propper and Wilson, 2003; Wilson, 2004). As a result they may seem to improve measured performance but not actual outcomes. Schools are also judged as more or less efficient depending on their attendance rate and their proportion of A\*–C grades in GCSE exams. Studies by Bradley *et al.* and Bradley and Taylor found a small positive relation between competition and relative efficiency (Bradley *et al.*, 2000; Bradley and Taylor, 2002), although some other studies use different measures to disprove it (Burgess *et al.*, 2005).



### **3.5 The impact of choice on equity**

The pursuit of equity is a goal of many health systems but differentiation between horizontal and vertical equity as put across by economists may not be sufficient for understanding the impact of choice on equity. Both concepts derive from Aristotle's notion of justice expressed in moral terms (Gillon, 2003). Thus horizontal equity implies equality of treatment for equals and vertical equity is concerned with unequal treatment reflecting unequal need. In public health policy equity is strongly linked to the concept of need that has been extensively debated in equity literature (Culyer *et al.*, 1992; Culyer, 1995; Goddard and Smith, 2001).

Attainment of distributive justice underpins the principle of treatment according to need as opposed to mere desire but it is often traded-off against the principle of maximisation of welfare per unit of resource or against respect for the autonomy of various stakeholders (Oliver *et al.*, 2001). Achieving horizontal equity might be easier largely because recognising equality of treatments for equal conditions is simpler, unlike in vertical equity where it entails measuring inequalities and determining accordingly how unequal treatment should be. One of the key considerations of many public health systems is securing geographical equity in terms of equal access (which is considered as equivalent to equal opportunity of use) for equal need.

#### **3.5.1 Evidence from primary and secondary health care in the UK**

The possible impact of certain types of choice within health care on equity (of access and health outcome) is a disputed area. Some (e.g. Appleby *et al.*, 2003a, 2003b; Oliver and Evans, 2005) draw on economic theory and moral philosophy, to suggest that it is not certain whether the exercising of choice will necessarily improve access and outcome inequalities; indeed, that it is entirely possible that exercising choice could exacerbate inequalities. Others, on the other hand, point out existing inequalities in access and health outcomes (Dixon *et al.*, 2003) and suggest that patient choice will alleviate these (Stevens, 2003; Le Grand, 2004).

Although there is a huge literature on health inequalities (e.g. Marmot *et al.*, 1997; Stanistreet *et al.*, 1999), the literature on the equity implications of policies to expand patient choice is sparse. The very few empirical studies that exist point to the following key messages.

- The impact of choice of GP fundholders on equity under quasi-market reforms in the UK is mixed. While it is clear that patients' choice of GP was negligent, GP fundholders' choice of hospital for patients was more uneven. Some studies suggest that no inequalities occurred whereas other studies point out that fundholders' patients received preferential treatment, implying inequalities of treatment.

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- Evaluations of the London Patient Choice Project did not provide evidence of inequalities but they did not consider patients who were not offered choice (and who may be older, sicker and poorer).
- Freedom of choice implemented through a public competition model in some county councils in Sweden resulted in geographical inequalities as only some counties where the reforms were implemented benefited from choice.
- Evidence from the USA suggests that relatively advantaged populations benefit from efforts to promote active choice – i.e. provision of performance information.

In England, geographical inequalities in access to choice have been observed following the introduction of patient-choice policies. In December 2004, the number of reported clinical exclusions as a percentage of eligible patients at Strategic Health Authority level ranged from under 1 to 70%, with the variation likely to be even greater at the level of individual organisations and specialties (Department of Health, 2005a).

Furthermore, the existence of clinical exclusions means that excluded patients are not offered choice. A recent evaluation of the London Patient Choice Project concluded that there was no difference in population characteristics between those patients who accepted the choice of an alternative provider and those who did not, suggesting that choice did not lead to greater inequalities in access (Coulter *et al.*, 2005). However, since this failed to consider excluded patients who are likely to be older and sicker and may be poorer, it is not possible to draw conclusions about the equity impact of the scheme. The same report states also that only 32% of patients of all whom were apparently eligible for the scheme were actually offered a choice of hospital (Coulter *et al.*, 2005). It continues by asserting that reasons for these exclusions were surprising and unclear.

By contrast, when evaluating the impact of the London Patient Choice Project on reducing waiting times in hospitals that were part of the scheme and those that were not, Dawson *et al.* (2004) concluded in their report that patient equity improved, because waiting times were reduced for all patients irrespective of their participation in the project. However, they caution against drawing conclusions on equity implications from this experiment for rolling out choice on a national level.

The evaluation of the former pilot on coronary heart disease under the London Patient Choice Pilot project reports similar levels of exclusion and contends that there is an absence of data on characteristics of excluded patients (Appleby *et al.*, 2003b; Le Maistre *et al.*, 2003; Coulter *et al.*, 2005). Although according to some there is no evidence that there is correlation between patients' characteristics and access to coronary heart disease care (Williams and Rossiter, 2004), this issue raises obvious concerns for equity.

Furthermore, the RAND study by Burge *et al.* (2005) suggests that different patient groups place a different value on choice in relation to their circumstances by pointing out that patients who are older, female, or with a lower education level and low income, and those who are guardians of minors, are less likely to select an alternative hospital to have their treatment (Burge *et al.*, 2005). The MORI study of Birmingham, Solihull and the Black Country confirms some of these results about the negative correlation of age and family commitment with attitude to choice. It also stresses the importance of distance and reputation when patients choose a hospital. It brings out a new dimension of ethnicity in relation to how patients value quality of care, which is highest for blacks when compared to whites and Asians (MORI, 2003). However, as pointed out by the report's authors these significant differences in perceptions of different groups, such as black and ethnic minorities, may be also related to factors other than ethnicity, such as lower age (MORI, 2003).

In a small study from Bedford and the adjacent Primary Care Trusts Isroliwala *et al.* (2004) compared patients' and GPs' views on the relative importance of factors influencing choice. They found that patients value most the reputation of the hospital whereas GPs see waiting times as the key issue (Isroliwala *et al.*, 2004). Also both studies note an age gradient in favour of younger patients when stated preferences (hypothetical choices) are taken into account (MORI, 2003; Isroliwala *et al.*, 2004).

As mentioned above (see Section 3.2.1) the evidence on the impact of choice incentives under GP fundholding schemes on equity is mixed, with some researchers suggesting no adverse impact (Glennerster *et al.*, 1994) and others demonstrating that indirect discrimination occurred for non-fundholders' patients as the former received preferential treatment in outreach clinics and had shorter waiting times, for example (Gillam *et al.*, 1995; Kerrison and Corney, 1998). These could also be 'zero-sum' arguments, although others give evidence that fundholders' patients gained but non-fundholders' patients lost nothing; that is, a 'positive sum' argument for choice, keeping in mind differences between individual patient choice and choice enacted by GPs as their agents (Dowling, 2000; Dusheiko *et al.*, 2004).

### **3.5.2 Evidence on equity from other health care systems**

We did not identify any published studies looking directly at the impact of choice on equity. One indirect analysis of the impact of choice introduced through public competition reforms comes from Sweden, which points out the differences in waiting times for elective procedures that developed between counties that followed reforms and those that did not (Burström, 2002). However, these differences may be also due to historical patterns in developing capacity. The

other indirect source of evidence comes from the USA, where the public release of provider performance information has been used as a vehicle to promote choice, and relatively advantaged populations appear to have been the beneficiaries of these efforts (see Section 3.8).

### **3.5.3 Evidence on equity from other public sectors**

#### ***Marketisation and equity in social care***

The 1990 NHS and Community Care Act aimed both to control costs by formally introducing a quasi-market, and to remove incentives favouring residential care over care at home (Weiner *et al.*, 2002). However, these changes did not appear to be based on a commitment to remove inequalities, and charges may have put off some vulnerable clients from taking up services and have led to some inequalities in the services provided (Wright, 2003; Johnson, 2002).

When the Commission on Long Term Care (1999) recommended that 'personal care' should be free, and not means tested, the Government rejected its proposals and instead made the boundary between health and social care clearer (Johnson, 2002). Indeed, it seems likely that inequalities will increase under Labour's policies (Rummery and Glendinning, 2000), and increased regulation and standards monitoring may lead to under-provision of services by private, for-profit operators, which is unlikely to be replaced by state provision (Knibb and Gage, 2004).

As a consequence of these changes, care services for older people were not invested in and there were greater trends towards market involvement. Resources were concentrated on people most in need, and fees were increased which related more strongly to income (Welfare Commission, 2001). Some have argued that this differential provision of care, which may disadvantage particular ethnic, social class or gender groups, is undermining the legitimacy of the welfare system (Blomberg *et al.*, 2000).

In Sweden, the Ädel reform (1992) transferred responsibility for long-term health care for older people from counties to local municipalities. This may have been economically advantageous for municipalities in the short term but it proved unduly expensive in the long run (Bergmark *et al.*, 2000). At the time of the reforms, the market ideology gained much support in local politics, with a view that communities should use their own resources (relatives, friends, community groups) rather than state services (Bergmark *et al.*, 2000).

As in the UK, many municipalities in Sweden introduced market-oriented systems of care, with an emphasis on economy and targeting of frail older people, rather than welfare for all (Johansson, 1997; Blom, 2001; Trydegard and Thorslund, 2001). Blomqvist (2004) argued that financial problems that local governments faced in Sweden were at the root of changes introduced into social care that

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resulted from demographic and funding pressures and that these led to the adoption of increasingly restrictive eligibility criteria. A summary follows.

- The organisational responses to quasi-markets in Sweden appear to parallel those in the UK, and so do the outcomes.
- During the 1980s and 1990s the proportion of older people receiving home help decreased markedly (Andersson, 1991; Sundström and Tortosa, 1999; Blomberg *et al.*, 2000; Welfare Commission, 2001).
- Local politicians tried to retain control in the light of concerns about equity and under-funding (Light, 2001).
- The market fragmented care. Some professionals lost a sense of identity and professional development became difficult in social care, with consequences for recruitment (Trydegard and Thörslund, 2001).
- Fees have put off some potential clients from taking up services, particularly those with low incomes (Blomberg *et al.*, 2000; Welfare Commission, 2001).
- Despite the reforms, public expenditure on care of older people did not fall. Indeed it increased slightly between 1990 and 1997 (Bergmark *et al.*, 2000).

### ***Direct payments and equity***

There is evidence that direct payments have been particularly under-utilized by minority ethnic users (Vernon, 2002; cited by Pearson, 2004). It may also be that the middle classes benefit disproportionately from direct payments (Clark *et al.*, 2004; Leece, 2004a). However, they do offer potential benefits to some groups traditionally poorly served by social care services. For example, direct payments enabled Somali older people to employ personal assistants who shared their language (Clark *et al.*, 2004). There are concerns, summarised by Spandler (2004), that direct payments, by virtue of being focused on the needs of individual clients, may distract from developing services to meet the needs of groups of people with similar difficulties, and developing culturally appropriate communal services.

The service users who are most dissatisfied with existing services are most likely to campaign for improvements and are more likely to take up direct payments, with potential loss of stimulus for service improvement. Thus direct payments may lead to inequalities, or perhaps heighten existing ones, between users who wish to pursue individual solutions, and those who want to use provided services (Lyon, 2005). There is also a danger that the availability of direct payments as an 'alternative' which people can choose may be used by local authorities to justify avoiding development of other services (Lyon, 2005).

***Choice and equity in residential care***

We found no literature specifically relating to choice and equity.

***Choice and equity in primary and secondary education***

Although reforms in education in the UK were aimed at reducing inequality of access to good public schooling (the Education Reform Act 1988), the view as to whether this has been achieved are at best mixed. The evidence available suggests that families from higher socio-economic groups are more likely to be knowledgeable and exercise choice, and several studies suggest that cultural and material resources are a clear advantage in the educational marketplace (Bradford, 1991; Carol and Walford, 1996; Reay and Lucey, 2003; Dustman, 2004). The ability of wealthier people to move into desirable areas, so-called selection by mortgage, has led to a paradox of wealthier parents in some places campaigning for 'so called comprehensive reform that never happened' (Ball, 1990). However, there is also an alternative view arguing that choice had resulted in relatively insignificant inequity because the education market was already inequitable (Gorard and Fitz, 1998; Gordon *et al.*, 2002), or highly stratified and inequitable before the introduction of the reforms (Taylor, 2001b).

Almost a decade after introduction of reforms in the UK (the Education Reform Act 1988) choice by catchment area for popular schools remained almost unchanged. If anything, social homogeneity was strengthened (Gewirtz *et al.*, 1995; Gibson and Asthana, 2000; Hatcher, 1998), and poorer families outside the catchment areas of popular schools did not want to risk rejection and settled for their own local schools (Carol and Walford, 1996). Also, Bagley and Woods (1998) found that children with special education needs were marginalised and devalued in the UK because of pressure on academic achievement.

The evidence from the USA seems to lend even stronger support to these findings. Thus a voucher system when coupled with an ability to choose from public and private schools is in effect seen as a public subsidy that may not necessarily benefit those who are less advantaged (Ladd, 2002). Under a private choice model public funds are transferred directly to the consumer to purchase education on the open private market (Lens and Gibelman, 2002). The evidence from the USA supports UK findings about children with learning disabilities where a voucher system is found to create inequities for those children, who usually end up in the bottom tier of the education system (Bagley and Woods, 1998).

However, there also findings from well-designed empirical studies in the USA that contradict these views. For example, Hoxby (2000, 2003) suggests that the less advantaged black pupils benefited from a targeted voucher system. She argues that flexibility of schools to respond to demand, and the availability of uniform and universal

vouchers, should prevent selection by ability, which is an equivalent to cream skimming or selection of low-risk patients in health care. There is also a study from the UK which argues that there is little evidence of further socio-economic segregation happening after the introduction of choice; if anything there is evidence of more equitable distribution of children living in poverty among secondary schools, particularly after the early 1990s (Taylor and Gorard, 2001).

Studies from other countries such as New Zealand seem to suggest that the market has led to more socio-economic and educational polarisation (Ladd and Fiske, 2001; Ladd, 2003), and choice has led to more social stratification in primary education in Sweden (Blomqvist, 2004). Similarly, Rossiter and Williams (2004) cite various studies from Chile to conclude that parental choice has resulted in reduced equity. This is because the uptake of choice of private schools by classes with lower socio-economic status was constrained by income, transportation costs and other factors, even when vouchers were introduced. There is also a negative effect of parental choice of state schools in non-metropolitan areas and segregation of pupils by both class and ability (Williams and Rossiter, 2004).

Nechyba (2003) examines the impact of income on school sorting that reaches counterintuitive conclusions, in that the pure state system results in higher sorting of pupils by ability than private schooling. On the other hand, various authors conclude that a range of vigorous reform efforts over the past decade and a half have, whatever their successes, failed to resolve some seemingly intractable problems in the schooling of disadvantaged groups and of schools in disadvantaged areas (OECD, 2001; Bell, 2003; Milliband, 2003).

### ***3.6 The impact of choice on quality***

We define quality of care for individual patients in terms of access to health care and the effectiveness of that care once it has been accessed. Quality of care for populations is defined additionally by efficiency and equity (Campbell *et al.*, 2000). The impact of choice on equity and efficiency is addressed in previous sections, so here we focus on the impact of choice on access to care and effectiveness. The main literature here relates to access to health care, and in particular reduction in waiting times for elective surgery. This has been an area of major concern in the NHS, and one where choice has been used as a lever to improve care.

There are a few key messages arising from the review of literature on quality defined in terms of access and outcomes:

- Under quasi-markets in the UK, GP fundholders reduced waiting times for their patients but these results were, in any case, temporary.

- Similar trends with modest and short-lived gains in reduction of waiting lists occurred under the same set of reforms in other comparable publicly funded and integrated health systems.
- In the UK there is only one study measuring quality of outcome in relation to organisational changes, which found higher mortality outcomes following heart attacks under quasi-market reforms.
- More numerous studies from the USA point to methodological flaws or limitations in published studies and a limited spectrum of outcome measures.

### **3.6.1 Evidence on quality from primary and secondary health care in the UK**

In this section we describe the impact of choice on quality in the internal market of the 1990s, followed by more recent experiments designed specifically to increase patient choice and improve access to health care by reducing excessive waiting times.

During the introduction of the market-oriented reforms a heated debate took place in the UK over whether fundholders would fulfil the expectations placed on them and become more responsive providers of services to their patients, which meant that they would also need to become effective purchasers. This was demonstrated in a few studies, most of which found that fundholders' patients, in fact, had shorter waiting times when they were compared with non fundholders' patients. Although Dowling demonstrated that GP fundholders were more effective purchasers and managed to achieve reductions in waiting times for their patients (Dowling, 1997; Mannion, 2005), these results were temporary and may have been related to the increases in funding provided to fundholding practices (Dixon and Glennerster, 1995).

However, changes in waiting times may be a relatively unreliable quality indicator because the Government uses them often as targets for assessing providers' performance (Mulligan, 1998). Therefore waiting lists under market reforms might have decreased as a result of introducing league tables, which had little to do with the market but more with the league tables, which were also abandoned when the Labour Government came to power in 1997.

Fundholders also proved to have a greater ability to attract on-site services from specialists (Consumer's Association, 1995; Gillam *et al.*, 1995). However, other researchers doubt whether fundholding had much impact on quality of care (Maynard and Bloor, 1995; Glennerster, 1996; Harris and Scrivener, 1996; Harris, 1997; Kerrison and Corney, 1998), despite one study in which the introduction of the internal market appeared to be associated with an increased mortality for patients admitted with myocardial infarction (Propper and Burgess, 2004).



Smith and Wilton (1998) conclude in relation to those reforms that although quality in terms of the procedural aspects of care improved there was very little evidence on the impact of the reforms on health outcomes. Nonetheless, the study by Propper and Burgess (2004) is an important one as it is the only one in the UK to measure quality of outcomes in relation to organisational change under market reforms using a previously unavailable large data-set. It concludes that the relationship between competition and quality of care appears to be negative, although the estimated impact of competition is small. Greater competition is associated with higher death rates, controlling for patient mix and other observed characteristics of the hospital and the catchment area for its patients (Propper and Burgess, 2004). The most recent review of economic evidence of choice in English health care and the implications of this literature for policies to promote competition in the English NHS concludes that there is neither strong theoretical nor empirical support for competition, but that there are cases where competition has improved outcomes (Propper *et al.*, 2005).

Newer evidence from London Patient Choice Project suggests that substantial reduction of waiting times occurred for participating and non-participating hospitals in the Greater London area, so the mere existence of incentives introduced via choice altered providers' behaviour, which is known to economists as the phenomenon of contestability (Dawson *et al.*, 2004, 2005). In the report to the London Patient Choice Project and a paper resulting from this work they present the results of a large-scale project offering 22 500 patients on waiting lists the choice of an alternative hospital.

Although there was high acceptance rate by 66% of patients there was only a small but significant reduction in waiting times for all three specialities for participating and non-participating hospitals alike, in periods before and after the introduction of choice scheme in London. This reduction for ophthalmology was by approximately 3 weeks relative to both comparator groups (other non-participating hospitals in London, and other trusts in England), and for orthopaedics it was approximately 1 week.

However, both acceptance rates by patients and reductions in waiting times differed across specialities; these were highest for ophthalmology and orthopaedics and lower for general surgery (Dawson *et al.*, 2004) or gynaecology (Burge *et al.*, 2005). More importantly however, London Patient Choice Project produced convergence in waiting times by bringing them down in hospitals with high waiting times to the levels which prevailed in hospitals with low waiting times (Dawson *et al.*, 2005). Waiting times were the commonest concern about the NHS in a survey conducted by MORI for the Department of Health in 2004 and previous telephone and postal surveys by MORI, the College of Health and other researchers (Ryan *et al.*, 2000; MORI, 2001, 2004; Rigge, 2001) and this initiative therefore addressed one of patients' key concerns.

### **3.6.2 Evidence on quality from other health care systems**

Siciliani and Hurst review the causes for waiting times in 12 OECD countries and evaluate the effectiveness of measures that are aimed at their reduction, including increase of supply, demand management and maximum waiting-time guarantee (Siciliani and Hurst, 2004). They consider unconditional time guarantees (offered to all patients) introduced in England and Sweden in the 1990s, buying additional service from the private sector as it happened in New Zealand and Spain or activity-based remuneration implemented in Denmark as possible measures in addressing the issue. Authors discuss positive sides and drawbacks of each measure

Thus, a maximum waiting-time guarantee works but often needs to be supplemented by additional resources as illustrated in the examples from Sweden and England in the 1990s. Under the Stockholm model the number of people appearing on waiting lists for elective procedures, for which a care guarantee was provided, decreased by 30% (Håkansson and Nordling, 1997; Håkansson, 1998) but these results were shortlived because they were dependent on concomitant increase in resources (Hanning 1996; Hanning and Lundström, 1998) and professional support, which was not forthcoming (Hanning and Spånberg, 2000). However, the importance of these actions is also shown by the fact that waiting lists have reappeared since the waiting-time guarantee was taken away (Bergman, 1998).

Policies introducing unconditional maximum waiting-time guarantees that were more recently implemented in England were effective but they might have been achieved at the expense of clinical prioritisation (Siciliani and Hurst, 2004). Siciliani, in another paper, also points out potentially perverse incentives that choice might have, by keeping waiting times growing because hospitals with relatively short waiting times could attract users from other providers (Siciliani, 2005).

On the other hand, the experience from other health care systems where patient choice was introduced with the sole purpose of reducing waiting times (Denmark) suggests that principal factors likely to moderate the pace of its implementation could deal with information, resources and incentives for providers (Thompson, 2002).

It is generally difficult to evaluate quality outcomes in relation to particular reforms as the causal link between the two cannot be easily established, not least because of many other organisational changes which occur simultaneously and confound the results. The evidence from the USA on the impact of choice and/or competition on quality is difficult to interpret because of other confounders. A recent review from the USA by Romano and Mutter concluded that it was difficult to draw clear conclusions because of problems relating to methodological flaws or limitations in published studies (Romano and Mutter, 2004). Studies tended to be subject to confounders and focused on a limited

spectrum of outcome measures. They also failed to use clinical data systems to overcome the problems associated with administrative data systems for risk-adjustment.

Some studies looked at patient-level data on costs and outcomes, concluding that hospital competition improved quality measured as 1-year mortality after myocardial infarction (Kessler and McCellan, 2000), but other studies contradict these findings by suggesting that outcomes may differ in relation to the method of payment (Gowrisankaran and Town, 2003). Burgess *et al.* reviewed the impact of competition on quality in the UK and USA and concluded that it has been studied very little but pointed out that, overall in the USA, competition among hospitals tends to increase quality, more than in the internal market in the UK (Burgess *et al.*, 2005).

At the same time Burgess *et al.* report neutral or even negative effects of fixed payments on outcomes in Medicare from the review of the US evidence, which they attribute to the lack of incentives to provide quality or the occasional presence of perverse incentives in higher payments for errors (Burgess *et al.*, 2005). However, Cookson and Dawson, while referring to the evidence from the USA (Gowrisankaran and Town, 2003) argue that the vigorous competition for fixed-price Medicare patients is associated with negative quality while increased competition for Health Maintenance Organisation patients (on negotiated contracts) may improve outcomes of care (Cookson and Dawson, 2006).

At the same time it is difficult to draw general conclusions about improvement or worsening in the quality of care under competitive regimes in countries that are easier to compare to the UK, such as Sweden, although these reforms are accompanied by an increased awareness of the importance of quality of care (Forsberg *et al.*, 2001a; Fotaki, 2001). Improvements in quality of care were found in one Swedish study (Garpenby, 1997) but not all agreed that there was evidence of improvement (Gustafsson, 1995), and in one study, providers had the impression that quality had got worse, even though there was no measurable change (Forsberg *et al.*, 2001b).

### **3.6.3 Evidence on quality from other public sectors**

#### ***Direct payments and quality in social care***

Direct payments are generally well regarded by individual service users because of the flexibility, choice and control they offer (Glendinning *et al.*, 2000a; Carmichael and Brown, 2002; Commission for Social Care Inspection, 2004; Stainton and Boyce, 2004).

Glendinning *et al.* (2000a) found that directly employing personal assistants provided greater continuity of care than either conventional home-care services or care agency staff, and this continuity was valued both by users and by the personal assistants they employed. Warm, friendly relationships developed (Leece, 2004a; cited by Leece,

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2004b), but this sometimes led to users developing a sense of obligation towards their personal assistants, and thus being less able to control the help they received.

Direct payments may also play a key role in improving assessments, making them more focused on needs rather than services (Lyon, 2005).

There is little evidence about whether direct payments act as a mechanism for improving services overall, partly because the scale take up of direct payments has been relatively small (see below). However, the development of direct payments enabled Gateshead council to significantly change the nature of its own services (Commission for Social Care Inspection, 2004), and another study felt that direct payments might drive up the general quality of community support (Joseph Rowntree Foundation, 2000). Growth of a new independent 'care market' appears to have been stimulated by direct-payment developments in Germany, Austria, the Netherlands and France and to a lesser extent in Sweden and Denmark, where local authority providers may be preferred because of a long-standing positive attitude towards public services (Halloran, 1998).

Personal assistants may feel isolated and lack development opportunities (Glendinning *et al.*, 2000a), although for a minority of personal assistants in one study the role was a stepping stone to other things (Keigher, 1999). However, concerns have been expressed in other European countries that there could be future dangers for both service users and personal assistants from an unregulated home-care market based on an untrained, fragmented and vulnerable work force (Halloran, 1998).

There are also problems with monitoring quality. Social workers have reported finding it more difficult to monitor the care packages of direct-payment users (Stainton, 2002), with much being taken on trust. This was viewed as positive by some social workers and negative by others. How the quality of services accessed through direct payments should be monitored is not an easy issue to resolve, given that a key purpose of direct payments is to promote the independence of service users (Halloran, 1998).

### ***Choice and quality in social care***

There is some limited evidence that contracts may incentivise service providers to reduce quality (Forder, 1997). Forder's study was based on statistical/econometric modelling of social care data on 52 homes. Their data suggested that, where they were not constrained by a fixed price, homes might exaggerate a client's level of dependency to the purchaser (social services) so as to secure increased revenue (the equivalent of 'DRG creep' in health care). Their data were also consistent with the possibility that homes, as an alternative to securing higher revenues for a client, might reduce quality.

The evidence from comparable systems in other countries suggests that market reforms do little to improve quality in social care. One of the most advanced and highly discussed market models is in the municipality of Linköping in Sweden, where there was a change from a traditional organisation to a purchaser–provider model in January 1992 (Blom, 2001). Evaluation of this reform suggested that quality did not improve because of organisational directives to cut costs and limit the choice of provider, uncertainty about future contracts for providers, increased bureaucracy and a lack of information for clients about different services (Blom, 2001).

***Choice and quality in primary and secondary education***

It is very difficult to ascertain whether choice improves quality in education because outcomes in education are notoriously difficult to evaluate as they are either long-term or poorly represented by existing performance indicators. In addition there are many other factors which may confound studies of the outcomes of reform, one of which may be more lenient marking (Gorard and Taylor, 2002), as well as deficiencies or changes in the assessment process (Williams and Rossiter, 2004).

The problem of quality measurement in education is that knowledge is not a static commodity and there are problems involved in comparability over time and among schools. The most commonly accepted proxy outcome would be to examine the results in terms of educational attainment. However, these are also used to determine performance and efficiency. Over the period choice was introduced in the UK it seems that the gap in educational attainment between different social groups measured as achievement in exams has narrowed slightly (Williams and Rossiter, 2004); however, it is uncertain whether it can be attributed to the working of the market or other factors (Bradley and Taylor, 1998; Gorard and Taylor, 2002; Le Grand, 2004).

***3.7 Choice in relation to individual treatment decisions***

This section looks at how individuals make individual treatment choices to draw conclusions on what might be the impact of patient choice on individuals' behaviour, but also how factors that influence individual decision-making may influence the outcome of the policy itself. This literature is richer in both volume and quality than some other aspects of choice, and a more detailed summary of the literature is available in Appendix 7. Appendix 7 includes a more detailed discussion of issues around specific decision aids that may help the patient to choose between treatments. There are two consistent messages that point out constraints and limitations relating to:

- the lack of appropriate information for patients on which to base decisions (Entwistle *et al.*, 1998; Elwyn and Edwards, 2001);

- distorting effects that illness has on decision-making (Entwistle *et al.*, 1998; Henman *et al.*, 2002).

For individual patients to exercise choice, people need information, and in Section 3.8 we consider some additional aspects of providing information to patients. Nevertheless, a significant proportion of the literature in this area relates to providing information about individual treatment options.

### **3.7.1 Four key messages**

There were four key messages to emerge from the papers on individual treatment choices:

- patients are not sufficiently informed to make choices;
- patients want information more than they want responsibility for choosing their treatment or care;
- patients can benefit from participating in choices about their treatment;
- people may not always wish to make choices about their treatment.

#### ***Patients are not sufficiently informed***

Many decisions by patients about their treatments can be seen as uninformed, as not enough information is available to them or sought by them. For example, Marteau *et al.* described over half of women deciding to undergo a prenatal screening test for Down's syndrome as making an uninformed decision (Marteau *et al.*, 2001). This is one example of a widespread problem of availability of information. Another example is provided by Coulter *et al.*, who found that written information provided to patients in a range of specialities was out of date, inappropriate and poor (Coulter *et al.*, 1998).

This study showed that the majority of patients wanted information about treatment options, even if they did not wish to be involved in decision-making about their treatment, and other studies have shown that patients in the UK frequently do not receive as much information as they would like from health professionals, which was also confirmed by other studies (Entwistle *et al.* 1998, Elwyn and Edwards, 2001). This problem occurs in both hospital and general practice settings. Ford *et al.*, who used qualitative methods to interview patients and health professionals, found that in general practice more than a quarter of patients reported receiving less information than they would like, particularly in relation to the risks and benefits of treatment options (Ford *et al.*, 2003a, 2003b).

#### ***Patients want information more than responsibility for decision-making about their treatment or care***

Although information provision is a key part of exercising choice, it is valued in its own right, even when the patient does not wish to make

choices about treatments. This emerges as a main theme from the literature on information, communication and relationships (Blanchard *et al.*, 1988; Beisecker and Beisecker, 1990). For example, in a study by Henman *et al.* (2002), women who did not necessarily want to participate in treatment decisions about their cancer still wanted as much information as possible. They felt that information would help them to be in control, feel less anxious, be able to take better care of themselves and plan for the future (Henman *et al.*, 2002).

***Patients benefit from participating in choices about their treatment***

There are some clear examples of benefits from participating in treatment decisions. For example, Guadagnoli and Ward found that some benefits were detected from patients making their own treatment choices (Guadagnoli and Ward, 1998). Guadagnoli and Ward provide examples that include weight loss in overweight children who choose their own treatment programme (Mendonca and Brehm, 1983), improved psychological well-being in patients with breast cancer (Ashcroft *et al.*, 1986), and less anxiety, depression and sexual dysfunction among breast cancer patients (Fallowfield *et al.*, 1994).

Davies *et al.*, in a literature review about the promotion of autonomy and independence for older people within nursing practice, argued that the ability to make quite small decisions about day-to-day activities can make a significant difference to older people's sense of control (Davies *et al.*, 1997). They argue that a wealth of research conducted over a wide range of settings has demonstrated the importance of adequate information in promoting patient recovery and that this should form a fundamental principle of care delivery.

However, the benefits of participating in decision-making about treatments are not universal. The review by Entwistle *et al.* (1998) of evidence-informed patient choice points out that relatively little is actually known about benefits. Some studies suggest that psychological outcomes are better among people given a choice about their treatment. But they argue that these results may not replicate across the whole range of health care decisions, patient groups, health care settings, and forms of evidence-informed patient choice (Entwistle *et al.*, 1998). An additional benefit is that patients may be more likely to comply with treatment when they have been involved in the decision to prescribe (Haynes *et al.* 1996).

***People may not always want to make choices about their treatment***

Entwistle *et al.* provide a good overview, pointing to several reasons why people may not want to get involved in decisions about their health care (Entwistle *et al.*, 1998). This may accordingly be due to:

- patients not knowing that they can play an active role in medical decision-making;

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- having a 'doctor knows best' attitude and fearing being a nuisance;
- preferring to let their doctor make treatment decisions to avoid regret or responsibility for possible failure of the chosen treatment;
- reluctance to acknowledge the uncertainties of health care;
- time pressures which stop them from considering information about the effectiveness of different health care options;
- concerns about their ability to understand technical information on deciding what treatment is best for them.

A patient's decision about becoming involved in choosing between treatments is a complex one, and their choices are influenced by a range of factors. These might include personal beliefs (Gordon, 2001; Howell-White, 1997), cultural values (Kravitz and Melnikow, 2001; Carrese and Rhodes, 1995 cited in Kravitz and Melnikow, 2001), individual and social characteristics (Kuiper *et al.*, 1997; Mastaglia and Kristjanson, 2001; Hudak *et al.*, 2002; Chen *et al.*, 2003), former experience of treatment or witnessing unsuccessful treatment (Charles *et al.*, 1998; Gordon, 2001) and life experiences of those who choose, such as racial discrimination (Di Caccavo *et al.*, 2000; Klassen *et al.*, 2002; Greiner *et al.*, 2003). Contextual factors also play a part. These include the severity of illness and type of procedures involved.

Patients facing a complex and life-threatening procedure tend to be less inclined to be involved in the decision (Luker *et al.*, 1995, 1996; Beaver and Luker, 1996; Fotaki, 1999; Donovan *et al.*, 2002). In these cases, the main criterion of choice was the perceived efficacy of a particular treatment (Divshali-Luft, 1991). Patients may also decide to devolve decision-making to doctors to avoid experiencing regret (Loomes and Sudgen, 1982; Ryan, 1994). Margalith and Shapiro (1997), for example, found that patients' anxiety declines when they perceive that they have received relevant information but it may increase when they are actually expected to take part in decision-making.

Therefore, trust that underpins the therapeutic relationship between patient and doctor (Balint, 1957) is also likely to have a moderating effect on patient choices. Trust plays an important role in business and public transactions (Zaheer *et al.*, 1998; Korczynski, 2000), and in socially embedded (Granovetter, 1985) health care service while doctors and health care organisations are still the most trusted institutions in the UK (Page, 2004) and elsewhere (Norris, 2002). As the experience of public competition reforms in Sweden suggests, introducing market tools did not necessarily result in improved efficiency, while at the same time, according to many, they had also 'drastically diminished the trust in the system' (Diederichsen, 1995; Whitehead *et al.*, 1997; Forsberg *et al.*, 2001b). Active support for choice reforms by physicians is also crucial in affecting their pace of



implementation and outcomes (Spänberg-Winbald, 2003; Spänberg, and Hanning, 2004).

### ***3.8 Providing information for choice***

There are two major areas in which information is key to choices in health care. The first is in relation to patients' choice of individual treatments, and the information that they need from their doctor or nurse in making such choices. This area is discussed in Section 3.7 with a more extensive review of the literature in Appendix 7. In this section we focus on the role that information plays for making choices about health services, for example practices and hospitals. In parallel with other sections in the report, we discuss information in relation to health services in the UK first, followed by evidence from health services in other countries, followed by evidence from social care and education. It is perhaps not surprising that US studies predominate in the area of choice of health care provider, given their more consumerist approach to health care; however, there are also some studies from the UK, which we review first before presenting more extensive evidence from the USA.

#### **3.8.1 How information affects choices in health care**

A particular focus of published research has been about the way in which information is made available to consumers, and in particular the impact of public release of performance data. There are some key messages from this literature.

- In the USA the public release of information appears to have had little impact on consumer choice. The limited research from the UK echoes these findings. Some later studies suggest that consumers may be becoming more interested in performance data from health care organisations.
- There is some evidence of impact in relation to third-party payers, but this is limited and results are mixed.
- The public availability of performance data has been associated with increased efforts by providers to improve quality.
- Observed positive relationships between performance may in part be explained by poor performers withdrawing from the reporting process.
- Performance data is often poorly understood by consumers and consumers choose on the basis of other characteristics not included in performance data (e.g. personal knowledge, geographical proximity).
- Reporting may have more impact if it identifies 'bad' rather than 'good' performers. Framing health plan or provider choice decisions using a risk message has a consistent and significant positive impact on how consumers comprehend, value and weight comparative performance information.

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- Evidence suggests that the differential use of information by consumers (i.e. more affluent younger patients are more likely to use publicly available performance information to make choices) leads to inequalities in access to care.
- Other undesirable consequences include incentives to avoid treating sicker, high-risk patients to improve performance ratings.

### ***Public release of performance data – evidence from the UK***

It has been suggested that in the UK members of the public do not want to view health care as a market commodity and that their strong sense of responsibility for local services providers leads them to distrust comparative information produced by external bodies (Marshall *et al.*, 2002). In their focus-group study, Marshall *et al.* found that service users distrusted what they saw as the political motivation driving initiatives to provide performance data on their practice, and expressed a desire to 'protect' their general practices from political and managerial interference. They were uneasy about practices being encouraged to compete against each other. This study focused on primary care, where continuity of care and close proximity to practices are likely to feature highly on patients' priorities.

Magee *et al.* conducted another focus-group study in England to investigate the views of patients and members of the public on the publication of information about the performance of health care providers (Magee *et al.*, 2003). Participants felt that independent monitoring of health care performance was necessary, but they were ambivalent about the value of performance indicators and hospital rankings. They tended to distrust Government information and preferred the presentational style of 'Dr Foster', a commercial information provider, because it gave more detailed locally relevant information. The authors concluded that if public access to performance information was to succeed in informing referral decisions and raising quality standards, the public and general practitioners would need education on how to interpret and use the data.

Mannion and Goddard conducted the first empirical evaluation of a national clinical reporting initiative outside the USA. They examined the impact of the publication of Scottish (CRAG) clinical outcome indicators on four key stakeholder groups: health care providers, regional government health care purchasers, GPs and consumer advocacy agencies (Mannion and Goddard, 2003). They found that CRAG indicators were rarely used by any of the stakeholder groups. Hospitals in Scotland also appeared less responsive than their US counterparts, although since Scottish hospitals face few incentives to act on performance data this is perhaps understandable.

In this study, consumer advocacy agencies reported that the major source of information on the quality and clinical performance of local hospitals was based on informal information provided by family and friends, the consumers'/patients' own experiences of local services and

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GPs' views. However, GPs in the study reported that CRAG data never, or rarely, featured in their discussions with patients. Mannion and Goddard conclude that those responsible for developing clinical reporting systems should not only pay close attention to developing technically valid and professionally credible data which are tailored to the information needs of different end users, but should also focus on developing a suitable incentive structure and organizational environment to foster the constructive use of such information (Mannion and Goddard, 2003).

### ***Public release of information – evidence from the US***

Most of the literature concerning information about provider performance draws on experience from the USA, where there has been an increasing trend towards the publication of quality report cards by governments and the private sector, giving information about health insurance plans, institutional providers (such as hospitals and nursing homes) and physicians (Hibbard *et al.*, 2003). The aim of these report cards is to provide consumers with information to enable them to make choices between competing health plans and providers on the basis of quality.

Studies of report cards suggest that they have at best only a small impact on consumers (Hibbard and Jewett, 1997; Chernew and Scanlon, 1998; Knutson *et al.*, 1998; Goldstein and Fyock, 2001; Farley *et al.*, 2002a, b; Chernew *et al.*, 2004), although some patients found them helpful in learning about plan quality and their decisions to switch among them (Fowles *et al.*, 2000) or selection of primary care providers (Hsu *et al.*, 2003). However, Marshall *et al.*'s review of the evidence on public disclosure of performance data in a US context found that consumers were not in the habit of searching out information, and neither did they understand or trust it (Marshall *et al.*, 2000). Evidence from descriptive studies suggests that consumers rate anecdotal evidence from friends and family more highly than performance reports (Mennemeyer *et al.*, 1997; Robinson and Brodie, 1997). Also, employers were not always aware of clinical-outcomes data while measures used did not meet their purchasing needs and acted as a barrier to effective decision-making (Hibbard *et al.*, 1997).

Similarly, Schaffler and Mordavsky's review of the evidence on report cards suggested that consumer report cards make little difference in decision-making, improvement of quality or competition (Schaffler and Mordavsky, 2001). They suggested that consumers desired information that was provider-specific and that they were more likely to use information on rates of errors and adverse outcomes. They also suggested that purchasers would be in a better position to understand and use information about health-plan quality to select high-quality plans to offer consumers and to design premium contributions to steer consumers, through price, to the highest-quality plans.

If the public shows little response to the publication of performance data, perhaps purchasers or providers respond to such information being available. Marshall *et al.* found that public disclosure had a small, though possibly increasing, end effect on purchaser behaviour (Marshall *et al.*, 2000). This review also concluded that hospitals (as opposed to consumers, physicians or purchasers) appeared to be the most responsive. Organisations whose performance is shown in a positive light are more likely to use the information (Bentley and Nash, 1998; Dziuban *et al.*, 1994; Rosenthal *et al.*, 1998), but poor performers are more likely to criticize the data and the resources implications of acting on it (Luce *et al.*, 1996).

Some studies in the review by Marshall *et al.* showed an association between public release of information and improved health outcomes, suggesting a significant shift in provider behaviour. However, the evidence that disclosure of performance data is associated with higher quality and health outcomes (Rosenthal *et al.*, 1998; Hannan *et al.*, 1994, 2003; Longo *et al.* 1997; Ito and Sugawara 2005) should be interpreted with care. Some evidence from the USA suggests that health plans with lower scores may withdraw from public disclosure, leading to selective non-disclosure, which undermines both informed consumer decision-making and public accountability (McCormick *et al.*, 2002). Publication of performance data might also lead providers to cream skim and hence avoid high-risk patients.

There is evidence from some recent studies that consumers suggest that report cards do have an impact on health-plan selection. Spranca *et al.* found that in the absence of plan ratings participants prefer plans that are more expensive and likely to provide more coverage (Spranca *et al.*, 2000). Those with access to plan ratings were more likely to choose less expensive plans covering fewer services, when these received favourable ratings. However, this study used hypothetical as opposed to actual choices. Since what consumers say may be different to what they do it may be preferable to look at studies examining actual choices (or revealed preference). Scanlon *et al.* found that consumers were willing to pay more to avoid a plan with below-average ratings (Scanlon *et al.*, 2002). This supports findings from other hypothetical-choice-based studies (Hibbard *et al.*, 2000).

Schulz *et al.* (2001) found that consumers did use information on quality of care provided to them, particularly if they were new to a health care market or changing care systems. They suggested that ratings based on physician performance were more useful to consumers than those based on health plans (Schultz *et al.*, 2001).

Some research suggests that consumers find information presented to them difficult to understand. However, these studies tend to focus on data-sets offering information on many dimensions (Jewett and Hibbard, 1996). In contrast, other studies suggest that consumers do make use of published information to make choices about health care options when they provide just one outcome that is of major

importance to patients and that can be easily understood (Mukamel *et al.*, 2004). Support for the view that the format of data presentation influences the extent and ways of its use comes from a number of studies assessing the impact of data formats, and there is a relatively large body of work reporting the characteristics of health plans and consumers that are important in health plan selection (Edgman-Levitan and Cleary 1996; Scanlon *et al.*, 1997).

In their review of the literature, Scanlon *et al.* present a framework for understanding how these variables affect the health plan choices which consumers make (Scanlon *et al.*, 1997). Primary variables, such as price, quality, choice of provider, benefit design, coverage and convenience are seen as directly impacting on choice. In addition, there are secondary variables (e.g. demographic and health status) that impact in a more indirect way by attenuating the effects of primary variables. However, there is relatively little research on the relationship between variables such as health status and plan attributes in the decision-making process, and the ways in which specific populations differ from one another in terms of the sensitivity of their health plan choices to these different variables.

Hibbard *et al.* used a controlled experimental design to assess the relationship between the way information is presented and interpreted, as well as the way it is weighted in decisions (Hibbard *et al.*, 2003). Presenting quality data in a format that was easier to evaluate increased the weight it carried in consumer decisions. They suggest that those who disseminate information have a responsibility to be aware of how they may influence decisions and to direct the information in productive and defensible ways.

#### ***Potential adverse effects of the public release of information***

A number of potential adverse and unintended effects resulting from the public release of performance data have been identified in the literature. Among providers, performance information may produce perverse incentives and dysfunctional behaviours (Smith, 1995). Among consumers there is the potential for vulnerable groups to be disadvantaged due to the exclusion of issues that matter to them. For example, many of the leading causes of death among minority and low-income groups (e.g. AIDS, strokes and unintentional injuries) are underrepresented in most report cards.

Additionally, since it has been easier for providers to collect data on outcomes in relation to short-term, acute interventions, provider performance in relation to the management of chronic disease is less readily available. Furthermore, whereas report cards and other published performance data formats focus on disease and clinical procedures, key concerns of low-income groups, such as physical proximity of services, the extent of financial barriers (Davies *et al.*, 2002) and the quality of communication between providers and patients (Stewart *et al.*, 1999), are largely neglected.

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Patients from black and minority ethnic communities, particularly those for whom English is not their first language, may be more likely to have comprehension difficulties and be disadvantaged by culturally insensitive care, but these issues are largely neglected by report cards. In addition, where quality reporting encompasses measures requiring voluntary reporting by patients (e.g. patient satisfaction), patients of lower socio-economic groups and some ethnic minorities are less likely to respond (Holt *et al.*, 1997), leading to an underrepresentation of their views in the published data.

Other commentators point to the potential for report cards to mislead rather than inform service users (Root and Stableford, 1999).

Empirical studies suggest that these fears are not unfounded. Jewett and Hibbard, for example, used focus groups to explore consumers' comprehension of quality indicators appearing in health care report cards (Jewett and Hibbard, 1996). They found that indicators are not well understood and are interpreted in unintended ways. For example, they equated high rates of admission for asthma (an indicator of poor care) with high quality of care on the assumption that this indicated that physicians would hospitalize patients whenever it was necessary.

Mukamel *et al.*'s evaluation of the effect of report cards on selection of cardiac surgeons found that patients residing in more affluent and more educated areas were more likely to select surgeons of higher quality (Mukamel *et al.*, 2004). Their study suggests a 'crowding out' effect, with poorer, less educated patients being turned away by the better surgeons whose schedules fill up with patients who use the information contained in the report cards.

Other studies also suggest that relatively socially advantaged groups are significantly more likely to use performance data to make health care choices (Schneider and Epstein, 1998; Romano and Zhou, 2004). Dranove *et al.* used national data on Medicare patients at risk for cardiac surgery to examine effects of cardiac surgery report cards in New York and Pennsylvania (Dranove *et al.*, 2003). They adopt an economic approach that assesses the benefits of report cards in terms of their effect on social welfare. They suggest that sick patients have more to gain from seeking out high-quality providers and high-quality providers have less incentive, than their lower-quality counterparts, to shun the sickest patients.

Report cards improved matching of patients with hospitals (i.e. enabling sicker patients to choose higher-quality hospitals), resulting in a gain in social welfare. However, the study also identified an impact in terms of selection behaviour of sicker patients by providers. Report cards led to a shift in the illness severity of patients receiving coronary artery bypass graft surgery, but not in illness severity of patients with acute myocardial infarction. In addition, relatively sicker patients experienced higher rates of readmission with heart failure and higher rates of acute myocardial infarction. Report cards were associated with increased expenditures for both healthy and sick

patients, marginal health benefits for healthy patients and major adverse consequences for sicker patients. Taking into account the positive gains from improved patient matching and the negative consequences, from providers shifting towards healthier patients, the net effect is higher levels of resource use and worse health outcomes, particularly for sicker patients. The authors conclude that, at least in the short run, these report cards decreased patient and social welfare.

With regard to the adverse effects of information on provider behaviour, Schneider and Epstein found that 59% of the Pennsylvania-based cardiologists surveyed in one study reported increased difficulty in finding surgeons willing to perform coronary artery bypass graft surgery in severely ill patients who required it and 63% of the cardiac surgeons reported that they were less willing to operate on such patients following the publication of the *Consumer Guide to Coronary Artery Bypass Graft Surgery*, which lists annual risk-adjusted mortality rates for all hospitals and surgeons providing such surgery in the state (Schneider and Epstein, 1996).

### **3.8.2 Evidence from other public sectors**

#### ***Information on direct payments in social care***

Information about direct payments is particularly important for people to be able to make choices. It needs to be personalised, address individual needs, be straightforward and be presented in a variety of formats (Maglajlic *et al.*, 2000). It also needs to use real-life examples to demonstrate how direct payments can be used, their potential impact and how to access support (Newbigging and Lowe, 2005).

People with learning difficulties need the same sort of information as other people, but may need this to be provided in different ways: for example, written information may be less useful (Joseph Rowntree Foundation, 2004b). Ways of helping people with learning difficulties make informed choices include providing accessible information in other formats (e.g. CD-ROM), giving people time, reducing the formalities, respecting the ways in which people communicate, lessening the pressures and enabling people to make decisions in their own, familiar environment (Joseph Rowntree Foundation, 1999a, b). People with learning difficulties can also play an important role in informing others with learning difficulties (Joseph Rowntree Foundation, 2004b).

#### ***Information and residential care***

Most care homes responding to a survey (Office of Fair Trading, 2005) said that the quality of brochures and information was important to them in attracting new residents. Nevertheless, concerns expressed since the Community Care reforms include (Williams, 2005):

- a lack of timely and helpful information about what services are available;

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- insufficient information about homes to support choice, often not provided within a useful timescale (Office of Fair Trading, 1998, 2005: 61).

A study of older people moving to care homes from hospital concluded that older people did not consider themselves to be informed consumers (Reed and Morgan, 1999). One study found that 65% of carers had not been given all the information they wanted and that 50% had not received all the help they would have liked (Nolan and Dellasega, 2000).

In terms of informing service users more generally, a survey of eight councils in 2001–2 concluded that the levels of information provided to social services staff in information-giving roles were 'alarmingly low' (Rhodes, 2003). In 1999 just over half of self-funded residents and their relatives surveyed reported having had no advice or guidance about the process of finding an appropriate home and arranging a place (Netten *et al.*, 2001).

Little is known about the degree and nature of communication between prospective residents and their representatives and prospective homes. An Office of Fair Trading survey (1998) found that only 35% of relatives/friends and 23% of residents had received written information from a leaflet or brochure prior to staying at the home. Recent evidence from the national regulator shows that although care homes are now required to make certain information available to prospective residents, only 25% of homes met or exceeded the information standards in 2002–3 (Unsworth *et al.*, 2004). Of the 75% who failed to meet it, 51% were said to have almost met it, but 24% to have definitely failed. The report concluded that the 'information currently provided by the care sector in England is often deficient' (Unsworth *et al.*, 2004).

A mystery shopping survey (Office of Fair Trading, 2005) found that it can be difficult to get clear, timely information about fees and services from care homes and under half were rated by the researchers as 'informative'. Homes that are part of a chain were more likely to give residents brochures, information and contracts than homes run by smaller providers. Furthermore, large homes (more often part of a chain) are more likely than small ones to provide such a range of information (Jenkins and Gibson, 2005). Most brochures relied on generalities, printing few specifics about the service that could be checked, such as staff/resident ratios, or staff training and qualifications, and in 1999 none of the 30 relatives who were interviewed were aware that they could look at inspection reports (Davies *et al.*, 2000). In the USA Lawrence *et al.* (1998) concluded that families selecting a nursing home found visits and personal investigation more helpful than printed materials.



***Information in primary and secondary education***

Burgess *et al.* define information about schools' performance as a prerequisite for parents to make informed choices about schools (Burgess *et al.*, 2005). However, choices made by parents are not constraint-free and information contained in performance measures is used by both parents and school teachers (Propper and Wilson, 2003) but the latter are slightly more sensitive in their responses (Wilson, 2004). Research suggests also that this does not necessarily lead to improvements in outcomes because schools can manipulate outcomes (Burgess *et al.*, 2005) by either increasing raw output or improving measured performance by altering their intake (Propper and Wilson, 2003; Wilson, 2004). Therefore the information on performance has to be seen in the context of what information it is trying to elicit and what objective it tries to fulfil (Burgess *et al.*, 2005). Bradford argues for a need to introduce adjustments to the performance indicators to account for the effects of the local environment and perhaps parental choice itself, as well as prior attainment and social class (Bradford, 1991).

## Section 4 Policy implications

The aim of introducing greater patient choice is central to Government plans to achieve greater responsiveness of the NHS to patient needs, to increase technical and allocative efficiency, to enhance quality of services, and most contentious of all, to improve equity by extending choice beyond the affluent and articulate (Blair, 2003; Reid, 2003). Two consultation documents issued by the Government address two broad aims in their patient-choice policies: one concerned with efficiency, effectiveness and financial flows (Department of Health, 2003b), and the other with the provision of personalised services to meet the needs of individual patients (Department of Health, 2003c).

The policy is also part of a broader shift that goes beyond improving health services to the improvement of health, with the 2004 White Paper arguing that this improvement depends on individuals taking more control over their health choices (Wanless, 2004). In addition, patient choice is a key part of the Government's strategy to enable the NHS to evolve into an organisation that is less dependent on central control, which is reflected in other related policies including the establishment of Foundation Trusts and Practice-Based Commissioning, and closer to what patients want in Payment by Results.

In this section, we draw out the policy implications of the findings of our literature review. We discuss whether the empirical evidence identified in our review is consistent with the theoretical predictions outlined in Section 2 and set out some of the practical implications for policy-makers. We first identify more general and important policy issues. The implications of the review are then discussed for each identified indicator of the impact of choice, namely efficiency, equity and quality. We also make specific reference to responsiveness, which was identified in Section 2 as an important element related to patient choice and system, organisational and individual levels. Finally, we draw lessons for health care from other relevant sectors.

The overall policy implications resulting from the implementation of choice are as follows.

### ***System level***

- A universal health care system may be difficult to sustain under a choice regime unless costs are contained. But mechanisms to do this, such as explicit rationing or co-payments, may have undesirable consequences (e.g. exacerbating inequalities) and may be politically difficult to introduce.

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- Without appropriate funding and commissioning arrangements patient choice is unlikely to increase efficiency or enhance quality. Furthermore, it is likely to adversely affect equity.
- Providers may respond to the incentives provided by choice in combination with Payment by Results by either merging services to benefit from the economies of scale, or expanding in a more entrepreneurial manner. This might reduce access to health care for some patients, thereby increasing inequalities.
- Choice and reliance on economic incentives may further diminish trust in the health care system.

### ***Organisation level***

- Many providers lack a commitment to offering choice. Without greater 'buy in' from providers, and greater support for providers, the choice policy is unlikely to achieve its goals.
- Incentives affect production volume and may increase hospital expenditure when providers respond to them.
- More enterprising providers may capture resources to the detriment of other providers, who may have to close services, reducing incentives, access and choice.
- Building commissioners' capacity to manage the market will be expensive and will reduce the resources available to support the development of other skills.

### ***Individual level***

- Choice should reduce unacceptably long waiting times for elective services, but certain groups of patients may need more support to benefit equally from these improvements.
- Choice among providers does not appear to be as important to patients as access to good and reliable facilities, particularly among some population groups.
- Choice of provider may be relevant to the situation of patients waiting long periods for one-off elective inpatient procedures, but other patients, such as those with chronic conditions or mental health problems, may want different choices.
- Choices are determined by multiple factors such as access to information, skills, income, health beliefs, culture and personal experiences. Patient-choice policies need to take these factors into account if they are to avoid increasing health inequalities.
- The professional ethos of staff might be undermined, together with the trust in health professionals that is a necessary precondition for effective therapeutic relationships.
- There is no empirical or theoretical evidence about patients adopting or desiring a consumerist approach to health care.

## **4.1 The implications of choice for efficiency**

Theories that have informed patient-choice policies derive from both neo-classic economics and social rights of citizenship. The current Government policy looks at choice as a market tool that can bring efficiency, reduce waiting times and improve users' satisfaction with the services. At the same time, regulation is needed to avoid unscrupulous behaviour by providers and the high transactions costs that may occur in competitive environments (Williamson, 1975; Roberts, 1989; Le Grand and Bartlett, 1993).

The evidence from health care markets such as the USA and the UK quasi-market reforms suggest that it is difficult to predict whether choice and competition will bring efficiency gains to the provision of health care. This is partly because efficiency is measured in many different ways (Goddard and Smith, 2001; Street and Jacobs 2002), but also because it is difficult to disentangle the results of specific reforms from the complex environment in which they operate. Another important confounder in terms of assessing efficiency is the increase in funding that often accompanies the implementation of new schemes, an effect seen in both the quasi-market reforms of the UK (Dixon, 1998; Le Grand *et al.*, 1998) and Sweden (Bergman, 1998). Where a new scheme has been announced in advance as cost-neutral by politicians, as in the case of Personal Medical Services Pilots in England (Campbell *et al.*, 2005), it can be extremely difficult to track what changes in funding actually took place. In addition, it is often unclear whether efficiency gains seen in relatively small pilot studies will be replicated when a scheme is rolled out more widely (Dawson *et al.*, 2004; Coulter *et al.*, 2005).

More fundamentally, choice requires there to be excess or at least reasonable capacity to be meaningful. So for example, it is hard to see how there can be meaningful choice of provider in primary care, where GP lists are closed in many parts of the country. Choice is limited at present by such system-related barriers. However, the impact of the 2003 GP Contract made it easier for patients to choose and change their practice in the near future.

The question is then whether there is additional efficiency to be gained from current resources, or whether additional resources have to be provided to make choice meaningful. This is a key debate. The risk of spending more to increase choice, e.g. by introducing new providers from the private sector, is that improvements in choice may be accompanied by increased costs, but with no improvement in efficiency. This happened in Sweden and Italy when similar reforms were introduced (Håkansson and Nordling, 1997; Anessi-Pessina *et al.*, 2004). As Propper *et al.* point out in their review of choice in the English NHS, there is difference between payer and user choice which appears to be blurred in current policy agenda (Propper *et al.*, 2005). However, there are more elementary tensions between choice and efficiency, which can already be identified at a conceptual level.

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Individual choice is a market tool in competitive or at least contestable environments (operating under real or perceived threat of competition) but health care markets are imperfect (see Section 2.3.3).

The issue of contestability and the use of choice to create the 'grit in the oyster' to help ensure that providers offer the fast, efficient and high-quality services, as argued by its proponents (Stevens, 2003), is unproven for public services and health in particular. It is also uncertain that the small efficiency and equity gains associated with the London Patient Choice Project for both participating and non-participating trusts can be maintained.

Other economists see an inevitable tension between the expression of individual wants through choice, and allocative efficiency defined in societal terms (Appleby *et al.*, 2003a, 2003b). Trade-offs involved in the allocation of public goods presume a degree of 'collectivity' in decisions about public health care priorities (Oliver and Evans, 2005). This might for example mean that only those procedures that provide maximum benefit to the largest number of beneficiaries should be promoted (Maynard, 2003) – this is the very antithesis of individual choice. As a consequence, choice of a few predetermined options (or even one option, as is often the case in National Institute for Clinical Excellence (NICE) guidance) may be the best means to maximise efficiency.

Other potential perverse effects of choice at system level could include:

- crowding out other services, such as delivering choice of elective surgical care at the expense of other less readily identified services (e.g. preventive services);
- increased costs linked with Payment by Results and potential distortions in other parts of the service;
- increased demand for inappropriate services.

Crucially, real choice implies excess or at least reasonable capacity to make it meaningful, and this runs counter to the reality that faces taxpayers and thus policy-makers in many countries. The counter argument to this is that

*...all choice requires is differences between providers in their ability to bring new capacity on stream in response to extra demand; or a different length of queue to choose between – allowing patients to make their own trade-off between speed of access, geographical proximity, and other aspects of care.*

(Stevens, 2003)

However, there is no support from studies we reviewed to sustain this claim. By contrast, research suggests that these measures are either likely to bring one-off efficiency gains or result in high costs through expansion of facilities to increase capacity (Siciliani and Hurst, 2004). Overall, the evidence we have reviewed renders little support to

theoretical predictions of the neo-classic economics, and the introduction of competitive markets to provide patients with greater choice is unlikely to produce significant improvements in efficiency unless there is a system of payer-driven competition, as in the USA.

At an individual level there is the potential for efficiency gains to be achieved by shifting some of the costs of the service to individuals, as has occurred with other services in the UK (e.g. dentists and opticians). While this does not form part of the Government's current choice policy it is a realistic option if the potential cost of providing choice is more than purchasers can bear. Not all choices have to be available of right, and there is scope within a publicly funded system to have co-payments for certain items, even if full reimbursement is provided for basic care. This model exists in many other countries, for example in Australia where health insurance covers a basic list of drugs, and co-payment is required where a doctor prescribes outside that list. This is of course not an equitable solution, as costs fall disproportionately on those with lower incomes.

## ***4.2 The implications of choice for equity***

Many believe that there is an irreconcilable tension between choice and equity at a conceptual level. Equality of choice implies collectivity and this is in direct conflict with the notions of personal autonomy and individuality that are intrinsic to choice (Oliver and Evans, 2005). The counter argument to this is that offering patients choice will promote equity by extending choice beyond the well-off and articulate (Reid, 2003). The argument runs that only the well-off have choice at present: Government policies will extend these choices to the less well-off, thereby reducing inequity that already exists in the NHS.

The current situation is not one of equitable distribution of care in the NHS. Inequities exist in the distribution of care both in relation to geography (e.g. Hann and Gravelle, 2004) and in relation to a range of socio-demographic characteristics (Dixon *et al.*, 2003). At present the rich have the opportunity to buy themselves out of what they perceive as failing public services (Besley *et al.*, 1999). The question is whether providing more choice in the NHS will make existing inequities better or worse.

The empirical evidence on this question is fairly clear cut. Research from several countries shows, that the impact of choice on equity is consistently negative, although the effects are sometimes small. Providing more choice increases inequity. This is partly because the better off are more able to exercise choice when it is offered, for example though being better able to access information on choice or to make use of that information. An important experiment, which is often quoted to support the converse argument that choice may increase equity, is the London Patient Choice Pilot. However, conclusions from this study need to be tempered by the fact that several disadvantaged groups were excluded from participation, and

because the conditions of the pilot (very long waiting lists) have largely disappeared in many parts of the NHS.

Most of the current debate on equity and choice revolves around the ability of disadvantaged groups to exercise choice. However, one potential outcome of choice is that the advantaged (e.g. wealthy or articulate) opt back into NHS care, and this may happen if one outcome of providing choice is to improve the quality of services. There is anecdotal evidence that this may be happening, and that the demand for private surgery may be reducing in areas where NHS waiting lists have reduced. In this way, increasing choice could increase social solidarity for using the NHS, which could reduce the risk of the NHS sliding into a 'safety net' service for the poor.

Overall, the implications for policy are clear. At the very least, choice policies have the potential to increase inequity. Therefore, if choice is actually to be used to address inequity, the policy needs to include targeting of specific groups that are likely to be disadvantaged, such as older people, less educated, those on lower incomes and ethnic-minority groups (National Consumer Council, 2003; Health Link, 2004; Which?, 2005). This does not appear to be part of current Government policy. Equally, in policy documents we have reviewed, there is no explicit reference to how choice will be realised for mental care patients (Forrest, 2004), although mental care is one of the top three priorities for health care (Rankin, 2005) and most mental health services do not have waiting list targets (Layard, 2005). As Propper *et al.* argue 'it is not clear whether choice is being introduced to keep middle class individuals within the NHS, or to bring advantages of choice to all NHS users' (Propper *et al.* 2005).

### ***4.3 The implications of choice for quality of care***

Proponents of choice policies argue that policies which increase choice clearly have the potential to increase quality. Well-funded and well-supported pilot studies such as the London Patient Choice Pilots demonstrate that choice can be used as a driver to improve quality of care by improving access and reducing long waiting lists. However, the evidence we found on the whole is disappointing in terms of demonstrating system-wide improvements in quality of care resulting from choice, or from the introduction of competition in quasi-markets, which, at least in part, were intended to operate by a mechanism that includes greater choice.

The literature contains examples where competition and choice led to care getting worse, as well as to examples of improvement. In the quasi-market reforms of the 1990s that were introduced in the UK and Scandinavia it was very difficult to ascertain whether there was overall improvement or worsening in the quality of care, although in the UK there appear to have been consistent small improvements in some areas, for example in reducing hospital waiting times for some

patients. However, in all these reforms there was an increased awareness of the importance of quality of care (Forsberg *et al.*, 2001a, 2001b; Fotaki, 2001). Choice could be an important part of a longer-term process to improve quality of care, if linked to other appropriate policy initiatives.

Under Payment by Results, hospitals, in theory at least, will face incentives to compete by improving quality, since prices will be fixed. However, the experience from the USA suggests that setting a single price does not necessarily encourage high quality because of the perverse incentives involved in higher payments for complications, for example, and because the level of prices set seems to determine the level of quality provided (Burgess *et al.*, 2005).

Moreover, as Payment by Results also provides incentives to cut costs, hospitals face conflicting objectives, which may encourage them to choose cost containment over quality improvement. Given the modest use of performance data by patients and third-party payers, the financial risks of failing to contain costs within national tariffs may be seen as greater than the risk of failing to respond to data suggesting that quality needs to be improved. There is also a risk under a fixed-tariff system such as Payment by Results that hospitals may decline to treat more severely ill patients (known as adverse risk selection or cream skimming) or may under-treat such patients, behaviour which appears to have occurred in the US market (Gowrisankaran and Town, 2003). This type of response by providers is unlikely to be overt, and policy-makers and purchasers need to be aware of perverse incentives that may develop to provide worse care for selected groups.

#### ***4.4 The implications of choice in relation to responsiveness***

Responsiveness can be seen either in terms of the ability of the NHS to respond to users' expressed needs (wants) or actual needs. The term can also be used to describe the responsiveness of individual providers to new incentives in the system. The latter is addressed in other parts of this section (efficiency, quality and equity), and here we consider the response to patients' expressed needs.

Patients have traditionally had low expectations of choice within the NHS, and it is therefore not surprising that some studies have found users to be unfamiliar and wary with the concept of choice. However, when the purpose of choice is clear – for example, the reduction in long waiting times – it is clear that choice is very popular, as it is in other sectors such as education. Indeed, as the Government promotes choice in the public services as a key aspect of policy, it is certain that expectations will rise, and users will become much more sophisticated in their expectations of the service.

A key question for government is what expectations it should respond to. The previous sections indicate that introducing choice into the NHS



is not likely to reduce cost. There is little evidence that choice will be accompanied by efficiency gains, and the experience of some other countries and the experience of fundholding in the UK has been that introduction of choice is associated with a significant increase in costs.

Purchasers will therefore need to decide what they can afford, and in this they are faced with two problems. The first is that to provide choice in some areas there may need to be an increase in capacity of existing services, for example of primary care providers. Where capacity appears insufficient to meet demand (as evidenced, for example, by closed GP lists), it is very difficult to see how there can be genuine choice for users.

Secondly, there will be a demand for new treatments, some of which may be of uncertain effectiveness (e.g. some alternative therapies). Here there is a conflict between the directive approach of one set of Government policies articulated through NICE (which generally restricts the range of available treatments) and an agenda that allows patients greater freedom of choice. Some treatments, which are probably only of modest benefit (e.g. physiotherapy for back pain, counselling for minor mental disorders) are extremely popular with patients, and would be likely to figure high in any list of wants. It is important to acknowledge that patients make their decisions on the basis of less understood and less tangible motives, which might be culturally determined (Dixon *et al.*, 2003). If patients' desire for freedom and autonomy is fulfilled, this may mean that they express their preferences for aspects of care other than those anticipated by purchasers and may not make choices that are efficient from a societal point of view.

A further potential conflict between existing policies and choice exists in Payment by Results. We have earlier pointed out some of the perverse incentives that Payment by Results may bring. However, there is an additional problem of supplier-induced demand.

Encouraging hospitals to do operations that bring benefits to patients will almost certainly lower the threshold for referral and treatment, again leading to a rise in costs, at least for those operations that are sought by patients.

There are therefore a series of areas where allowing excessive patient choice could cause severe problems in other aspects of the NHS. Policy-makers need to temper patients' expectations of the choices that are likely to be available, and the timescale within which it will be possible to introduce additional choices. The issue of alternative funding arrangements such as co-payments may have to be considered if extensive choices are to be offered within the NHS.

#### ***4.5 The importance of information for choice***

In order to appreciate the potential benefits of choice, users need to be informed. This is true whether they are choosing between

hospitals, between GPs, or between individual treatment options. Patients are becoming more informed from a whole variety of sources, from the NHS's Expert Patient Programme to the widespread availability of information on treatments on the Internet. Some of this information is provided by the NHS, and some by third parties such as Dr Foster (a public-private partnership that aims to improve the quality and efficiency of health and social care through better use of information; [www.drfooster.co.uk](http://www.drfooster.co.uk)). Research shows that it is far from straightforward to give patients information that enables them to act as intelligent consumers, in terms of choosing either providers or treatments.

In reality, choice in health care markets is constrained by the asymmetry of information between user and provider, first recognised more than 40 years ago (Arrow, 1963). In addition, consumers and patients who possess relevant information may not use it for making health decisions, as evidence from the USA suggests (Broder *et al.*, 2004), and may not generally behave as rational utility maximisers.

Yet a recent, large cross-national study found that the need for more information about the issues surrounding treatment is the single issue that attracts greatest criticism from patients in the UK and other European countries (Coulter and Magee, 2003). Research such as that reported in [www.yourguidetogeneralpractice.org](http://www.yourguidetogeneralpractice.org) shows how patients can be involved in producing information in a way that enables them to make choices between providers, and in Appendix 7 we review some of the wide range of approaches to improving informed decision-making for individual treatments.

One major initiative by the NHS to increase patients' expertise and ability to gain information is the Expert Patient Programme, and the results of a national evaluation of this will be available in 2006. However, it is most unlikely that one size will fit all in the provision of information, and the NHS needs a wide-ranging and varied strategy for giving patients information if they are to be able to make use of the choices potentially on offer. This will be particularly important if disadvantaged groups are to exercise choice, as barriers of race, language and education limit access to information and therefore to choice.

For policy-makers, the main message is that giving information needs to be a specific priority if patients are to exercise meaningful choice. Providing information in a way that is useful to patients is not straightforward and there are particular challenges in providing information to disadvantaged groups, which is a key issue if the provision of choice is not to increase inequity.

#### ***4.6 Choices between individual treatments***

The discussion so far has centred mainly on choices between providers, for example between competing hospitals or for new types

of treatment. We have also reviewed the literature on a different type of choice, namely that made between an individual doctor and patient about that patient's treatment. Although this area is conceptually distinct, and relies on a very different literature, there are a number of common features between the two areas. The first of these, as we outline above, is the need for good information to guide patient choice. Secondly, although we did not address the issues specifically in our review, choices made between individual doctors and patients are unlikely to increase efficiency. They may increase or decrease costs, and they may lead to an improvement in quality. However, they are unlikely to improve equity unless the needs of disadvantaged patients are a specific focus.

What is needed to facilitate choice in the consulting room is different from what is needed in the management boardroom. In addition to information, patients need to be able to communicate effectively with a doctor or nurse who is able to elicit and understand their concerns. Space within the consultation (e.g. time, having a doctor who listens), are essential prerequisites for this type of choice, although choices can be aided by some of the decision-support aids, which we describe in more detail in Appendix 7.

#### ***4.7 Policy implications from other sectors***

Experience of other public sectors with longer experience of users' choice might be used to understand possible consequences and developments in health care. Therefore, the key messages from sectors examined are as follows.

- Choice of residential homes developed gradually over the last two decades in the UK without attracting the attention of voters, possibly because it affects only a certain group of users, and because it is an example of a less universal benefit that illustrates higher tolerance of some negative implications for equity and quality by users and constituencies.
- Similarly, choice in primary and secondary education, which also has a long history but is more prominent electorally, probably because it benefits the middle class disproportionately, provides ample evidence of cream skinning and negative consequences for equity.
- By contrast, direct payments common in social care attract high satisfaction by many users although they do not yield equal benefits for all groups. They are also increasingly considered for chronic and mental patients in the NHS (e.g. Rankin, 2005).

##### **4.7.1 Policy implications from direct payment schemes**

Knowledge arising from direct payments may be relevant to health care in two ways, either because direct payments might be extended

into health care or by analogy with some of the types of choice being offered in the NHS.

In drawing conclusions about the implications of direct payments for health care, the differences between the social and health care sectors need to be borne in mind, and most of these apply equally to choice of residential care and other parts of the social care market. The differences include the historically greater role for the voluntary and private sectors in social care, the unique nature of the contractual relationships with care providers under direct payments, the key importance of price to social care users, and the emphasis on user empowerment in direct payments, which is not as prominent in the choice agenda in the NHS.

The lessons from direct payments for the NHS are mainly indirect, as current policy does not plan extension of direct payments into health care. Nevertheless, policy-makers will note the popularity of direct payments with some groups of service users, and there is at least the potential to introduce direct payments into parts of the NHS. Direct payments are perhaps most relevant to the NHS in terms of being an extreme example of choice, where the users can purchase services to meet their own needs; that is, a system fully oriented towards user responsiveness. Cautions which need to be borne in mind in considering such an option, or any alternative which moves more strongly in the direction of user responsiveness, include:

- the need for users to have high-quality information when making choices;
- the need for people to have time when making complex or sophisticated decisions;
- the need to monitor quality of care (which may conflict with users being able to have freedom to choose their own provider);
- the risk of increased bureaucracy;
- the risk of excluding people unable to make the sophisticated choices involved in direct payments.

#### **4.7.2 Policy implications from residential home care**

The marketisation of social care in the UK stems from a policy introduced by the Conservative Government in 1980. People who entered residential or nursing homes provided by either the private or the voluntary sector became entitled to greater social security benefits. An unintended consequence of this was a massive increase in the number of care-home residents, leading to rising costs to the state (Hudson and Henwood, 2002).

The 1990 NHS and Community Care Act aimed to both control costs by formally introducing a quasi-market and remove incentives favouring residential care over care at home (Weiner *et al.*, 2002). A ring-fenced grant for community care was set up, with local authorities purchasing services on behalf of older people from both the state and

the voluntary sector, based on assessments of individual need (Ware *et al.*, 2003). Local authority expenditure was capped by successive Conservative and Labour governments, resulting in a squeeze on funding for social care (Johnson, 2002).

The principal lessons for the NHS from this experience are those that have also been seen in some health systems which introduced choice alongside a quasi-market (especially in Sweden). This is the risk that providing choice may increase costs in a way that is difficult to control, and that controlling such costs inevitably restricts choice. These are important political decisions to anticipate. Also introduction of market mechanisms into residential care has resulted in their limited availability in certain areas of the country and increase in bureaucracy with uncertain improvements in quality.

### **4.7.3 Policy implications from primary and secondary education**

There are several important points of comparison between education and health and therefore useful lessons to be learned. Similarities extend to the common pedigree of the reforms, their content and their almost simultaneous introduction with the quasi-market health care reforms in the late 1980s in the UK. In both cases, choice and competition among schools and hospitals were expected to improve performance. However, cream skimming in the form of selection made on the basis of academic ability is institutionalised in the education system in the UK, but forms no part of the plans for the NHS. In education there is more scope for selection by mortgage and choosing to live in a more desirable residential area for the mobile middle class than in health care. Selection is therefore much more prominent in education than in health, where risk-averse selection would be the corollary.

However, the experience of education is an important lesson for health, and with an appropriate – or, rather, inappropriate – incentive structure it is easy to see how adverse selection procedures could operate in the NHS. This is perhaps most likely if the market comes to contain multiple private, for-profit providers, when the population's attachment and resulting responsibility associated with the current NHS might be lost.

The second main point of comparison is whether competition between schools has increased standards in education. As with health, the issue is complex because choice and competition are only two of a range of factors at play. However, it is probably fair to say that choice in education has produced both winners and losers among schools and parents, a somewhat similar conclusion to that on the impact of choice on quality of health care. Introducing choice, either for individual patients or as part of a competitive market, cannot be relied upon to improve quality on its own.

Research evidence from choice in education presented in this report indicates various negative and some positive implications for both equity and quality outcomes. It also suggests that it is difficult to examine and measure parents' willingness to exercise choice under various constraints imposed by the way choice is implemented, and by other constraints to access (i.e. purely geographical constraints in rural areas). More importantly, it provides clear evidence that if choice is to work for the benefit of users there needs to be some flexibility in supply and a degree of excess capacity, otherwise providers – in this case schools – will choose the pupils, as happens in many areas in the UK at present.

#### ***4.8 Conclusion***

Introducing choice to health care is a complex process with unpredictable results. Choice may or may not increase efficiency, has the potential to increase quality, is likely to increase costs, and is probably more likely to increase than decrease inequalities. There are clear benefits to choice both in terms of using choice to improve provider performance, and in seeing choice for patients as a good in its own right. However, the potential limitations drawn out in this report should be regarded as important caveats. These have individual policy implications if choice is to be introduced to the NHS in a way that makes it as efficient and effective as possible.

We conclude with a quotation from a recent Which? report (Which?, 2005) that encapsulates larger issues that are at stake and considerations that have to be taken into account when concerning patient choice as both a means to an end and as a good of its own value:

*Giving consumers many more choices about healthcare involves many complex issues that are peculiar to health and healthcare. People's needs are diverse, complex, unpredictable, and vary significantly from one person to another. Decisions are often based on technical and scientific information, which is difficult for most consumers to find and understand. The effects of these decisions can be profound and far-reaching and the burden of making decisions is greatest at times of considerable stress and vulnerability.*

(Which?, 2005)

## Section 5 Recommendations for future research

We start this section by outlining priority areas to address any gaps in research on choice that we have identified, to guide future commissioning activities of the SDO. A similar structure is followed in subsequent parts of this section, as in earlier sections of the report. Gaps are therefore identified in terms of the impact of choice on efficiency, equity, quality and responsiveness. Then research gaps are identified for areas that enable or constrain choice, including information and factors that influence choice of individual treatments. Finally, gaps in research are drawn from other sectors that link with patient choice or where patient choice might be expected to have an impact.

Priority areas in order of importance are as follows.

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

## **5.1 Future research on choice and efficiency**

There are no commonly accepted definitions of efficiency apart from broad concepts dividing it into technical efficiency (maximisation of outputs for given inputs) or allocative efficiency (maximisation of outputs in relation to opportunity costs which are often defined in societal terms). One consequence of this is that both measurement and interpretation of results relating to efficiency are heavily dependent on the indicators used.

This is a complex area and there are, for example, many different models and degrees of competition operating in health care systems. The effect of these is in turn dependent on what kind of market and rules apply in each individual context. Since the methods used to make comparisons are far from uniform, it makes it difficult to draw generalisable conclusions across studies.

Future research on the impact of choice on efficiency should therefore:

- develop conceptual frameworks that more accurately reflect the reality of efficiency when public goods are concerned, taking into account the particular imperfections of health care markets. This is important because traditionally only the public health aspects of health care are regarded as public goods in the economic sense, while health and social care are nearly always regarded as private goods (even when provided by public bodies);
- identify how choice can be used to promote contestability in the NHS;
- undertake comparative analyses with other public sectors and other health systems that go beyond description to identify common patterns and opportunities for transfer of knowledge;
- identify situations where additional resources are required for the extension of choice, and relate these to the anticipated benefits;
- identify cost implications resulting from patients choosing individual treatments.

## **5.2 Future research on choice and equity**

The literature on the impact of choice on equity is central to the considerations of government policy, which attempt to reconcile choice with voice to avoid undesirable outcomes that choice may bring when used as a market tool. The thinking behind current Government policy is that choice may be used as an instrument to increase equity in the NHS, whereas previous experience in health and other sectors clearly indicates that it has the potential to do the reverse.

We know that choice may have different impacts on different groups of users or even the same users under different circumstances. Therefore future research on the impact of choice on equity should:



- consider the equity implications of choice on the whole patient population and not, as in some recent research, merely those who meet certain eligibility criteria for exercising choice;
- investigate how greater choice could support equity, using multiple research methods from a variety of disciplines at least including economics, sociology, psychology and management;
- identify the way in which health beliefs, family history, culture and socio-economic circumstances affect the choices that patients make, and the extent to which these limit the ability of population groups to exercise choice;
- identify interventions that target choice within the NHS to disadvantaged groups to ensure that they benefit from those new opportunities, rather than allowing the wealthy and articulate to benefit further from the choices on offer.

### ***5.3 Future research on choice on quality***

Most of the research in this area is US-related and uses observational designs. Marshall and Romano (2005) suggest that the challenge now facing the research community is to use more experimental studies to investigate how choice could be used to improve quality of care.

Future research on the impact of choice on quality should:

- provide experimental or quasi-experimental evidence on the impact of choice on quality of care;
- include comparative research measuring effectiveness, safety and quality of services provided by plurality of providers, particularly when they operate under the pressure of potentially conflicting objectives (e.g. cost reduction);
- extend the current limited spectrum of research investigating limited outcome of measures;
- use better clinical data to overcome the problems associated with having to use administrative data for risk adjustment;
- provide experimental evidence of the impact of the public release of performance information on quality of care;
- understand how choice policies can accommodate the potential conflict between evidence-based medicine (e.g. NICE guidance) and freedom for patients to choose their own treatments;
- investigate the relationship and trade-offs between economic incentives and choice in relation to individual and organisational trust in public services, which might be a key factor in ensuring service quality (Davies and Rundall, 2000).

### ***5.4 Future research on choice and responsiveness***

The debate on benefits brought by choice in terms of higher responsiveness to user needs for more timely delivery of service needs

to pay particular attention to the perceptions of the user groups with a traditionally lesser voice (ethnic minorities, disadvantaged groups).

Future research on choice and responsiveness should:

- identify the choices different user groups wish to make, identify the factors influencing different kinds of choice and identify differences in the value and meaning attached to choice by different user groups;
- describe professionals' attitudes and responses to choice, both at individual and organisational levels, and seek to understand potential conflicts that arise from the different perspectives;
- identify how professionals can be engaged in promoting patient choice, over and above externally imposed targets or market incentives;
- identify the barriers that limit full patient engagement in decision-making and the exercise of choice at the micro-level of health care, and identify how shared decision-making can be promoted in consultations;
- evaluate the effectiveness of new approaches to patient choice such as the Choose and Book scheme.

### ***5.5 Future research in choice of individual treatment***

Patient choice about and around treatment is a complex, uneven, multi-sided and even a conflicting issue that varies according to personal characteristics and personal circumstances. More importantly it is dependent on the condition in question (with chronic and non-life-threatening diseases commanding more willingness to exercise choice on the whole). The interaction of factors that affect choice are quite poorly understood and are likely to change rapidly. It is therefore important to understand:

- what are the modifiable and non-modifiable factors according to patients' characteristics that are likely to affect choices in health care including age, ethnicity, gender, income and interrelations among these;
- contextual factors influencing patients' treatment decisions leading to better understanding of patients' cultural and ethnic concerns about health;
- factors affecting patients' engagement or disengagement and participation in health services;
- how choices are made for a variety of different conditions inferred from empirical studies which would use process-tracing techniques for different patient groups;
- the effect of emotion on decision-making in the patient choice arena;

- the relationship between individual choice and personal responsibility for health as experienced by different groups of users.

### ***5.6 Future research from other sectors with relevance to health care***

This report is not concerned with identifying research gaps in other public sectors reviewed but looks at what knowledge can be transposed and replicated in health care. Therefore, research should be focused on comparisons between different public services and health in the first instance. It could also look at specific issues to health care identified while reviewing direct payments, residential care, and primary and secondary education. Possible topics for future research might include:

- identifying how patients can best participate in assessing and monitoring service quality using comparative perspective of other public services;
- what opportunities there are to extend direct payments into health care;
- identifying which sections of society benefit disproportionately from direct payments, and how inequalities might be reduced;
- identifying reasons for higher acceptance of inequalities that are present in education and residential care as compared with health care;
- comparing different models of direct payments and how they could be applied to UK health care;
- identifying how patients and carers could better use information, such as inspection reports, to influence choice of residential home;
- examining the role of choice in relation to individual and institutional trust in market-orientated and non-market arrangements for public services, and what are the trade-offs involved under both governance systems.

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