Summary

Patient choice

How patients choose and how providers respond

Introduction

Over the past decade, the government introduced a set of market-based reforms into the NHS with the aim of increasing efficiency, reducing inequities in access to care and increasing the responsiveness and quality of services. Their policies included the introduction of fixed-price reimbursement (Payment by Results), greater devolution of central control (foundation trusts), encouragement of a more pluralistic mix of public and private provision, and an emphasis on patient choice and competition.

Since January 2006, patients requiring a referral to a specialist have been entitled to a choice of four or five providers. Since April 2008 patients in England should have been able to choose treatment from any hospital listed in a national directory of services, which includes NHS acute trusts, foundation trusts and independent sector providers, so-called 'free choice' of provider. In 2009 the NHS Constitution made this a right for patients.

This report considers how free choice of provider is operating in practice and what impact patient choice is having on hospital providers. More specifically, the report aims to answer the following questions:

- How do patients experience choice?
- What factors are important to patients when choosing between providers in practice?
- How do GPs support choice?
- How are providers responding to choice?

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The study was conducted in four local health economies in England between August 2008 and September 2009. They were all outside London and they represent a mix of urban and rural locations which differed in both their potential for competition and their progress with implementation.

We adopted a mixed method that combined interviews with patients, GPs and senior executives from hospital providers (including the private sector) with patient questionnaires (which asked patients how they exercised choice both in practice and in hypothetical situations).

Findings

Awareness, understanding and opinions on choice

The model of patient choice which underpins the policy requires that patients are aware of their ability to choose, want to choose and think choice is important. In our patient survey, 75 per cent of respondents said choice was either 'very important' or 'important' to them; older respondents, those with no qualifications, and those from a mixed and non-white background were more likely to value choice. The results show there is some intrinsic value in offering patients a choice of provider, and that GPs' perceptions that it is younger, more educated patients who want choice are misguided.

Around half (45 per cent) of the patients surveyed said that they knew before visiting their GP that they had the right to choose a hospital. Older patients and those looking after their family at home were more likely to know about choice, possibly because of their more regular contact with the health service, as were men and those holding a university degree. This went against GPs' perceptions that most patients were unaware of choice and that the young were more likely to be aware.

Although providers and GPs did not recognise choice as being important to their patients, on the whole they were either positive or ambivalent about the policy. Some had concerns that inequalities would result from richer and more educated patients choosing higher quality services and that the extra capacity required to facilitate choice would lead to inefficient use of resources. However, it was difficult to disentangle GPs' views on patient choice from their views on the often-criticised electronic appointment booking system (Choose and Book). Although a few GPs saw the benefits of Choose and Book in giving patients greater control and certainty, technical issues, inability to refer to a named consultant, increased consultation times, lack of directly bookable appointment slots, and inaccurate and inconsistent information in the directory of services were raised as issues. Despite recent improvements in the system, GPs remain reluctant to use it and some said they would stop altogether if the incentive they are paid for doing so stopped.

How is patient choice operating in practice?

Are patients offered a choice?

The policy assumes that patients are offered a range of options (including private sector providers), that that they use quality as the major factor when choosing a hospital

and that they have relevant and appropriate information on quality to inform their decision. Although GPs maintained that they always offered their patients a choice, we found that just under half (49 per cent) of patients recalled being offered a choice.

Very few patients recalled being offered a private sector option (just 8 per cent of those offered a choice) and few were aware, before visiting the GP, that they had a right to this (19 per cent were aware of the option to be treated in the private sector). This might be due in part to patients' lack of awareness that some treatment centres are independently owned and run, as they often use NHS branding.

The design of Choose and Book allows patients to make a choice themselves and book an appointment at the chosen hospital via the web or through a telephone booking adviser. Most patients were offered a choice by their GP (60 per cent of those offered choice) although a significant number of patients were offered their choice by a telephone booking adviser (20 per cent) or in written correspondence (21 per cent).

There was some resistance, even among our sample of 'enthusiastic' GPs, to offering choice to every patient regardless of circumstances. GPs appeared to be more willing to let patients choose when the referral was fairly routine but were more directive when more specialist treatment is required.

Are patients exercising choice?

In our study, most patients chose their local provider (69 per cent of those offered choice), and providers and GPs described their patients as loyal to their local trust and reluctant to consider travelling further for treatment. When considering hypothetical situations, almost one in five respondents always chose the local provider regardless of their characteristics.

Despite the strong propensity to choose a local provider, when patients were presented with hypothetical situations, in 45 per cent of cases they chose a non-local provider; this suggests that a significant minority would be willing to change to a provider whose characteristics better suit their preferences. We found that in practice patients who are offered a choice are more likely to travel to a non-local provider than those who are not offered a choice, but the difference was small (29 per cent vs 21 per cent using unweighted data).

There may be many reasons why a patient (including one who is not offered a choice) attends a non-local provider – for example, they may need specialist care not available at the local hospital. Among those who were offered a choice, one of the main reasons for choosing a non-local hospital was a bad experience with the local hospital. This suggests that the biggest threat to a hospital's market share is providing poor-quality care to individual patients because they are less likely to return, more willing to go to a non-local provider and may not recommend the hospital to friends and family.

Concerns were raised in the literature about the possible negative impact of choice on equity as higher educated groups and middle classes were thought more likely to exercise choice. In this research, while there were no apparent inequities in terms of who was offered a choice (younger and highly educated patients were no more likely to

be offered a choice than older or less educated patients), there were differences in the profile of those who attended a non-local provider. Older and more educated patients were more likely to choose a non-local provider. We were not able to assess the impact of language difficulties on exercising choice, but GPs working in areas of greater ethnic diversity felt that non-English speakers may not be getting equal opportunity to choose.

While mode of transport used for getting to hospital was not a significant factor in predicting whether patients were more likely to choose a non-local provider in practice (when data was weighted), those who normally do not travel by car were more likely to select their local trust irrespective of performance or other attributes under hypothetical conditions. This suggests that lower educated people living in cities and without access to a car may be less likely to choose a non-local provider. Some inequities might arise if these patients are not able to exercise choice in line with their preferences while others can choose to travel further to access a higher quality alternative provider.

GPs and providers believed that choice was relevant only in urban centres; in fact, patients living outside urban centres were more likely to be offered a choice and were more likely to choose to travel to a non-local provider. This may be because these small towns are unlikely to have their own hospital – leading patients (and GPs) to perceive there to be a genuine choice.

Why are patients choosing particular providers?

Our research found that patients value aspects of quality including the quality of care, cleanliness of the hospital, and standard of facilities. This was shown in responses about their recent referral in the patient survey, revealed preference analysis of the comparative characteristics of the hospitals patients chose compared to those nearby hospitals they could have chosen, and discrete choice experiment data on hypothetical choices. However, patients made little use of available information on the performance of hospitals; just 4 per cent consulted the NHS Choices website and 6 per cent looked at leaflets, both of which provide comparative information on hospital performance. Instead patients relied heavily on their own experience (41 per cent), that of friends and family (10 per cent) or the advice of their GP (36 per cent).

GPs we spoke to did not think patients were interested in information about comparative performance and distrusted it themselves. They said they used their knowledge from relationships with specific consultants, feedback from patients and their experience of systemic problems at particular hospitals to help them advise patients. Although this 'soft' intelligence may provide information to aid choices locally, it does not help patients who want to travel beyond the providers with which the GP is familiar.

Does patient choice create competition between providers?

Patient choice was intended to create competition between providers for NHS-funded patients and thereby increase efficiency and improve quality.

Interviews with providers revealed that there was some competition between providers, but the dynamics of competition differed depending on the local configuration of providers, their proximity to each other, the population they served, the type of services they provided and whether there were local agreements in place.

We were given many examples of how different providers (both NHS and private sector) were co-operating and collaborating. In some cases there were formal agreements to 'carve up' the market.

Most providers operated in a defined geographical market and their main competitors were neighbouring NHS hospitals. Generally, providers competed for patients directly only at the boundaries of their catchment areas, where another provider was equidistant. The main focus of competitive activity was securing GP referrals rather than directly competing for patients. Small and medium-sized trusts tended to compete *for* rather than *in* the market particularly where PCTs were actively tendering for community services and new outpatient services.

The independent sector was not perceived as much of a threat and rather than focusing on attracting patients via choice, they acted as a partner for the NHS, providing extra capacity to help the NHS meet waiting time targets. There were isolated examples where the NHS had actively sought to attract patients back from private providers, responding to competition by expanding their own facilities.

Providers saw GPs as a significant barrier to developing patient choice and establishing a competitive market for health care services. They perceived GPs' referral patterns to be fairly stable and giving little attention to quality. Practice-based commissioning and the development of community-based services run by GPs were also seen as a potential conflict of interest.

Providers were quite sceptical about the extent to which patients were acting as informed consumers. Any observed changes in referral patterns were largely seen to be a result of GP decisions rather than the preferences of individual patients. Consequently providers focused their promotional activities on GPs. Few providers were undertaking market research to understand what preferences influenced the choice of hospital for 'potential' patients but instead they were focusing on the experience of 'current' patients (that is, feedback and complaints) and the interests of GPs. Many providers were using this information to drive quality improvement.

The provider response to choice, competition and other factors

The model of choice as a driver for quality improvement assumes that providers receive clear signals from the choices patients make, analyse these and then use the analysis to improve the service provided. Our research suggests that choice did not act as a lever to improve quality in this way; providers were driven more by pressure from a range of other external factors such as the waiting time targets. However, providers believe this might change in the future, as choice becomes more established, more information becomes available and financial pressures limit growth in activity.

As part of their 'mission' to provide a good service to the local population, many providers we spoke to saw it as their job to be aware of what problems the hospital had (eg, high infection rates) and resolve them. They did not wait for 'signals' from patients' choices to highlight the weaknesses or problems with the services.

Choice however, did appear to provide a motivation for providers to maintain their reputation to ensure that patients returned or influenced others by speaking highly of their experience. Taken together with our finding that patients base their choices on personal experience or 'soft' knowledge, the emphasis placed on delivering a positive patient experience is not surprising.

Most providers focused on retaining patients rather than expanding into new markets or new areas and appeared unlikely to compete actively for patients in the future unless there was spare capacity or lower demand within the system. Other providers, however, suggested that the implications for income of even small shifts in elective activity could change their approach. However, none of the providers we interviewed were concerned about the financial impact of choice.

As financial pressures and reductions in waiting times decrease pressure on hospital capacity, and private sector providers are motivated to compete for NHS patients, there may be more competition for patients and the impact on providers of patient choice may increase.

Discussion

The research raises a number of key questions about the future of the patient choice policy and its potential impact on providers.

First, should the NHS continue to promote patient choice of hospital? Even if relatively few patients chose to attend a non-local provider, our evidence shows they valued having the ability to choose. We therefore conclude that given its intrinsic value, the NHS should continue to offer patients a choice of hospital.

Second, how is choice affecting providers? Choice appears to impact on quality indirectly, by creating a threat to providers that they might potentially lose patients. Our research shows that patients rely on their own or others' experience to inform their choice and that providers are aware of the need to deliver a high-quality experience to retain the loyalty of patients. Patient feedback is therefore likely to remain a significant driver of quality improvement. Because patients do not use objective measures of quality, it is hard for those with no experience to differentiate between services. More research is needed to understand what motivates individuals and organisations to improve quality.

Third, is patient choice working everywhere and for everyone? Although our research was conducted in only four areas of England, choice and competition were operating to some extent in all of the areas, despite differences between them. We found that providers were competing most actively for patients (or GP referrals) on the geographical fringes of their catchment areas and that patients outside of urban

centres were more likely to be offered choice and to attend a non-local hospital. This challenges the belief (widely held among those we interviewed) that choice is relevant only in urban areas. Choice may have therefore increased competition in some areas.

There were no significant differences between different population groups (by age, gender, ethnicity or education) in whether patients were offered a choice, suggesting that the opportunity to choose is reasonably equitable at present. However, GPs' misconceptions about the type of patients who want choice could lead them to offer choice selectively in future and there may be value in communicating to GPs which patients value choice.

There were some inequities in who chose to travel to a non-local provider; there is a potential risk that less educated patients or those without access to transport could be disadvantaged in areas where a trust is failing to maintain quality standards and large numbers of people exercise choice to be seen or treated elsewhere. It underlines the need to ensure, through regulation, that all providers meet minimum standards to protect patients.

Fourth, is choice cost effective? Our research did not try to answer this question. However, we believe that in view of the large sums invested in choice – through incentive payments, the booking system and support – policy-makers should quantify the costs and benefits of choice more clearly to convince GPs and providers of its value.

Finally, has choice been implemented effectively? Both GPs and providers had complaints about the way in which Choose and Book operates. While some of the technical problems have been solved, concerns remain that functionality does not support referral practices. If Choose and Book is to be used more widely, continued improvements will be needed in the system and training in its functionality, especially if local incentives are dropped.

Patients place a high value on the quality of care and other related dimensions of quality and safety, including the quality of care, cleanliness of the hospital and the standard of facilities, but rarely use objective measures of performance to help them choose a hospital. Systems that provide information about the quality of hospital services may need to be designed to make it easier for patients to search and compare these measures. For example, more work is needed to establish a set of standardised variables for acute hospital care with which patients can over time become more familiar. In future, patient experience data at the level of service lines and patient-reported outcomes data will be available. These offer an opportunity to present more specific data of relevance to patients when making a choice in future. Recent investments to expand NHS Choices to include feedback will allow patients to access more 'soft' knowledge. NHS Choices – and other resources – could also be promoted to GPs, as they are the main agents of choice and they currently distrust performance data.

There remains some resistance among GPs to offering choice routinely to all patients regardless of circumstances. In future if there is more direct access to diagnostics and consultant advice, GPs may be referring fewer patients to hospital and may be more likely to be referring for treatment rather than diagnosis when they do so. This could

change the nature of the referral consultation and make it more likely that GPs will be willing and able to engage patients in a decision about where to refer. A GP is currently only likely to encounter a few patients per week that need a referral, and for these patients it may be appropriate to extend the standard 10-minute GP consultation slot to allow a meaningful discussion of choice.

One way of encouraging GPs to offer choice is to present it as part of a wider agenda to engage patients in shared decisions about treatment and care. It would also be helpful to promote GPs' understanding of the value of choice to a wide range of patients. There may be limits to the extent to which the implementation of choice can be improved and, indeed, to GPs' willingness to offer choice systematically in all circumstances.

In conclusion, the policy of offering patients a choice of provider is valued by patients, and is operating to some extent within the NHS, but is not operating in exactly the way envisaged by policy. While the implementation of choice has not been perfect, it still represents a threat to providers that can keep them focused on what is important to patients.