King's Fund Memorandum to the Public Administration Select Committee

'Choice, Voice and Public Services'

The King's Fund has been actively engaged in research and debates about choice, voice and service responsiveness in health care for many years. More recently, and with the development of policy more directly aimed at promoting choice in the NHS, the Fund has published a number of policy papers, articles and the findings of research into choice (see appendix for bibliography). In addition, the Fund has an ongoing programme of work into choice and related policy such as payment by results (see appendix for details).

This note is based on the Fund's research into and thinking on choice and is structured around the questions detailed in the Committee's paper, *Choice, Voice and Public Services: An Issues and Questions Paper.*

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1. INTRODUCTION

The case for choice scarcely needs to be argued, for choice defines the democratic capitalist state:[1] voters (through the ballot box) choose their politicians, and consumers (through their purchasing power) choose the goods and services they wish to buy. Similarly, individuals may in most cases choose whether or not to seek clinical advice – their ability to do so needs no justification.

But choice is also valued for the benefits it can bring. There are two main arguments here:

1. When people can take their business elsewhere, they put pressure on producers to be efficient and to develop new products.

If patients (or those acting for them) are able to choose between different providers, those not attracting users must respond by lowering prices or increasing quality – or go out of business. Moreover, if providers are themselves free to develop more effective services, then competition can provide a sustained impetus to improve care (provided certain conditions are met).

2. When people have a wide range of alternatives, they can choose the mixture of goods and services that best meets their preferences.

Choice is the necessary precondition for different wants to be satisfied, thus creating a better match between what is supplied and what is desired. While choice in the first sense implies

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[1] Le Grand (2002) notes that under a liberal viewpoint, choice is desirable 'as an end in itself', regardless of whether the exercise of that choice has the consequence of improving welfare. He concludes that, both from a welfarist and the liberal perspective, the patient (not the doctor) should be sovereign, but he does not consider in any detail what the limits to that sovereignty might be.

the existence of alternative providers of what might be very similar services, choice in this second sense implies diversity in the provision of care – offering either different ways of meeting the same need or the ability to respond to a diversity of needs.

These two (producer and consumer) perspectives on choice reflect a standard view of the benefits of choice in a market environment. But of course, choice can also be compatible with non-marketed services - such as the NHS. Indeed, there are numerous examples historically and currently of patients ability to exercise choice - of hospital, of treatment etc - which have been enabled through mechanisms and processes other than the strictly 'take it or leave it' incentive of a market system.

Furthermore, despite the theoretical benefits choice set within a market environment can bring to both consumers and producers[2], we know that markets can fail to deliver these benefits (providing the rationale for state intervention or regulation of markets)[3]. Moreover, no health care system (no matter what degree of market orientation) offers completely free choice to patients; all restrict, in one way or another, treatment and other options open to patients.

The key issue concerning choice in the NHS, therefore, is not whether choice is indisputably a bad thing or a good thing, but more an empirical question of where choice (and what type of choices) can bring benefits *where the cost of doing so is judged acceptable*. The 'costs' in this case are not just financial, but will include clashes with, or erosion of, other desired aims such as equity (of access).

Our responses to the Committee's questions (below) will illustrate this general stance on choice.

2. QUESTIONS

2.1 Defining what choice means in the public sector

2.1.1 How is choice in public services to be defined?
2.1.2 Will the nature of choice vary depending on the type of provision or service?

The Government's current policy on choice in the NHS is based almost wholly on just one aspect of the potential domain of choices: choice of hospital for elective treatment (to be replaced from December 2005 by choice at the point of GP referral - that is, largely, choice of outpatient department).

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[2] '*Choice mechanisms enhance equity by exerting pressure on low quality or incompetent providers. Competitive pressures and incentives drive up quality, efficiency and responsiveness in the public sector. Choice leads to higher standards.*

The over-riding principle is clear. We should give poorer patients... the same range of choices the rich have always enjoyed. In a heterogeneous society where there is enormous variation in needs and preferences, public services must be equipped to respond.'

Tony Blair speaking at South Camden Community College, 23 January 2003 (Blair, 2003)

[3] *Where the Government is committed to public services free at the point of use and available to all on the basis of need, it is important to ensure that choice is not promoted at the expense of equity or efficiency, particularly where there are market failures and capacity constraints.*

Public services: meeting the productivity challenge (HMT, 2003)

Clearly, this is a very restricted notion of choice - although one which arose from a pressing target, the reduction of maximum inpatient waiting times[4]. We have noted previously a more comprehensive domain of possible choices for patients (and indeed, choices for individuals before they need to enter the health care system) - see table 1.

Table 1: Potential choices in health care

CHOICE	COMMENT
Health-seeking behaviour	Choice of lifestyle, diet etc will have a fundamental impact on an individual's health – and hence need for health care.
Payer/purchaser Package of insured care	Choice of payer/purchaser or package of insured care within the NHS would require reorganisation of the system.
Whether to seek care	A basic choice when ill is whether to seek professional care or to self-treat. Self-treating raises other issues concerning choice: eg access to drugs.
Type of care Treatment Health care professional Accepting advice	As regards type of care, it is usually possible to choose between conventional and alternative medicine. Within both regimes there will be a variety of treatment options provided by various practitioners, whose advice may or may not be accepted
Provider Time of treatment	Choice of provider - public or private, local or not etc - and time of treatment are likely to be linked, although other factors - travel distance, quality of care offered etc - will also inform choice.

Source: Appleby, Harrison and Devlin (2003)

2.1.3 Is "choice" simply a euphemism for competition and market mechanisms?

While the term 'choice' has been used as a euphemism for competition and market mechanisms it is clear from the variety of these choices (and the possible different limitations society may deem it necessary to impose on different types of choice) that such a 'one size fits all' notion of choice would not necessarily be the best (that is, efficient, effective or equitable) option in order to promote choice in all circumstances. For example, choice of treatment or surgical options, choice over when to see a doctor or, indeed, choice over whether to seek treatment in the first place are not competition issues.

Some forms of service - such as emergency care - may also fit uncomfortably into a competitive model due to the nature of the service provided. In principle, a market for emergency care could be created through franchising arrangements (whereby providers bid

[4] Actively facilitating patients' choice of hospital based on waiting times can act to even out variations in waiting times across hospitals and hence bring down maximum waits.

for a contract to become a monopoly provider for some fixed period). However, how patients needing emergency care would then exercise choice under this arrangement is hard to envisage.

2.2 The concept of customers of public services.

2.2.1 Is it possible to have customers of public services as well as active citizens and democratic accountability or are they mutually exclusive?

Is it possible to identify a customer for the entire range of government functions or is it limited to public facing activities as envisaged, for example, in the Next Steps approach of the late 1980s?

In our view it is not only possible to have 'customers' as well as active citizens and democratic accountability, but absolutely necessary and desirable. First, while patients may have choices within the NHS, it remains a tax-funded public service and as such requires a democratic input to decisions concerning, for example, its overall funding. Secondly, decisions concerning the distribution of total funds across the NHS require social value judgements in relation to equity which also require democratic input. Thirdly, there are decisions required to be taken in the NHS which are not best made (or in fact, made at all) as a result of all the separate decisions patients may make as a result of their individual choices. For example, decisions concerning major service redesign and drug availability are best made collectively.

2.2.2 Is it necessary to devise a more precise and generally acceptable definition of who the user or customer for each service is?

As for defining or pinpointing who is the 'customer' - or the person really exercising choice - in the NHS, it is not (or will not be) always the patient receiving care. Patients may not always be in the best position to exercise choice for a variety of reasons - due to their health status or their lack of medical knowledge, for example. Asked what one of the most common questions patients pose, clinicians are likely to say, 'What would you do, doctor?'. This question is a recognition by patients of information asymmetry and also trust that the clinician has the requisite knowledge and will use it to make the best decision for the patient in front of them.

But it also blurs the distinction between consumer and producer, which can give rise to problems in an economic environment where the producer faces incentives which, at the margin, may interfere with the clinical decision. In other words, the doctor may not act in the best interests, clinical, of the patient. Such an economic environment not only includes a market, but could also include circumstances where, for example, internal budgetary arrangements mean that a producer may benefit financially (directly or indirectly) from the clinical decisions they make.

2.3 Mechanisms for expressing choice

2.3.1 Are targets and league tables, customer surveys and complaints systems sufficient for ensuring adequate responsiveness to consumer preferences?

Evidence as to the best mechanism for ensuring the goals of choice - more responsive, efficient, effective and equitable services, for example - are met is patchy, sometimes contradictory and often absent.

For example, over the last few years, the English NHS has been very successful in dealing with what patients and the public have consistently reported as top of their list for lack of responsiveness: waiting times. During this time it has also been subject to almost unremitting ministerial and managerial pressure through a target regime to reduce waiting times. One might conclude the two are linked. However, there is no research which conclusively pinpoints the impact targets per se have had on waiting times, or has been able to disentangle the combined impacts of extra funding, better sharing across the NHS of ways to deal with waiting lists etc. Broadly, we might conclude that all these factors have had a bearing on the reduction in waiting times. Whether these non-market, non-choice, hierarchical interventions ensured, as the Committee's questions and issues paper poses, 'adequate responsiveness to consumer preferences' is, in the circumstances, arguable. However, the fact remains that waiting times are now at an historic low, and falling.

A further example of where improvement in services has been achieved through non-market processes has been in cancer and heart care. Here, much of the improvement - better access to effective drugs, quicker access to diagnostic services - have been driven by health care professionals and the Department of Health.

2.3.2 Is contestability a further requirement to make choice fully responsive? If so to what degree?

Would a more competitive, choice-based system have achieved these (or better) results? For obvious reasons, this remains unknowable. However, publishing league tables or conducting customer surveys are only weak incentives to changing the performance of providers of health care. For example, since 2000, the NHS has published detailed information on the costs of operations by hospital which have on average shown around a three-fold variation across England. This variation has remained virtually unchanged despite dissemination of this information throughout the NHS.

The strength of the incentives to spur providers to change lies at the heart of this matter. Intuitively, a choice-based system together with a provider payment system that directly linked activity to payment embodies a much stronger incentive for providers to respond to the choices patients make (the threat being loss of income and possible exit) than 'naming and shaming' through published league tables. While strong incentives can effect positive and desirable change, in practice there will be risks and consequences for costs. For example, a hospital that loses a relatively small proportion of its patients to others (for what ever reason) may be unable to respond (at all or quickly enough) to retain patients and be financially destabilised to the point where its existence is threatened. This would interfere with the freedom of choice of those patients who would want to choose that hospital. How the benefits of the exercising of choice by one group of patients is to be balanced against the costs incurred by another as a result of those choices is extremely tricky.

2.4 Choice and equity

2.4.1 Is there a generally understood definition of what equity means in respect of public services? Does equity currently exist in public service provision? If not who have been the main beneficiaries and why?

The very creation of the NHS was a major contribution to expanding choice in health care. Collective funding and universal access free at the time of use overcame a key barrier to using health care: lack of income. Nevertheless, while the population's health (across all groups) has improved tremendously over the lifetime of the NHS - to which the NHS has contributed - removing the income barrier has not resulted in completely equal access for equal need (or, necessarily, equality of utilisation, let alone equalised health outcomes).

In their useful review of decades of research into the extent of inequalities in the utilisation of NHS services, Dixon et al (2004) conclude that while the evidence is mixed, an overall conclusion would be that inequalities in utilisation do exist (to varying degrees) for some, but not all, services.

However, the continued existence of access/utilisation inequalities does not in itself justify a policy of choice. As Dixon et al state, if there are inequalities in utilisation, there is a need to properly understand why these occur before formulating policies to deal with the problem. For example, differences exist between lower and higher socio-economic groups in their experience of travel times to health care facilities, travel cost, time trade offs, confidence, articulacy and 'voice' in dealing with health care professionals and health beliefs, and all play a part in explaining differences in the use of health services. Given these multiple explanations for the existence of inequities in use, offering patients a choice of hospital for their inpatient treatment is unlikely to address the central inequalities problem; indeed, it might exacerbate it if, for example, the root cause of the inequality is a tendency on the part of poorer people not to consult their GP in the first place.

There are two further equity questions concerning choice: to what extent should we be concerned that some patients will make choices which may seem irrational? And, secondly, does patient choice introduce a new equity goal for the NHS: *equal opportunity of choice?*

On these, evidence from the London Patients Choice Project (LPCP) (Burge et al, 2004); Coulter et al, 2004) and the national Heart Surgery choice scheme (Le Maistre et al, 2004)) revealed that when offered the opportunity of quicker treatment, around 50% chose this option. This finding raises the difficult equity question of whether we should be concerned that 50% did *not* take up the offer. If we could be sure that the choices made by those who did not take up the chance of quicker treatment were in some sense genuine (ie there was 'equal opportunity to choose') then perhaps the resultant inequality in access (and possibly outcome) should not be of any concern. But take up of choice in the Heart Surgery scheme was found to be higher amongst, for example, younger rather than older patients (le Maistre et al, 2004) which might suggest that older people may have faced particular barriers in their decision to take up the choice offer (eg travel arrangements).

In addition, research linked to the LPCP has shown that different income groups place different weights on factors which influence their take up of choice (Burge et al, 2004). For example, higher income groups are more influenced by the 'reputation' of a hospital in making their choice. As with the differences in take up rates between young and old, whether

this matters from an equity point of view depends on the 'genuineness' of the choice that might be made: those on lower incomes may genuinely prefer the choices they make even if there is likely to be a tendency for this group to gravitate to hospitals with poorer reputations.

However, if 'equal opportunity to choose' is the new equity goal for the NHS arising from patient choice, then the NHS will need to act *unequally* (as it does in its resource allocation to primary care trusts) towards some individuals/groups in order to ensure such equality of opportunity. This could mean, for example, that some groups - the elderly, the poor - should be compensated for the extra travel associated with exercising choice.

2.4.2 Must there necessarily be losers in a system involving choice and contestability?

We have already noted (2.3.2) a hypothetical example of a situation in which the choices made by one group of patients could lead to another group losing out. However, how a choice system is designed, the limits that are set and so on, crucially determine whether or not there are losers (or the extent of the losses suffered and possible options for compensation)

2.4.3 How can a choice-based provision of public services avoid providers "cream-skimming" the less difficult or resource intensive users of the service?

The problem of cream skimming can be largely but not wholly addressed through the careful design of the payment system for providers. The Department of Health are currently rolling out a fixed price activity-based scheme - Payment by Results (PbR) - which is similar to other payment systems used in many other countries. In essence, PbR sets a fixed price (currently the English average) for different types of activity performed by hospitals. The number of categories (health care resource groups - HRGs) runs to many hundreds and patients classified to a particular HRG will, on average and within certain limits, consume similar amounts of health care resources. Evidence from a number of countries suggests that, at the margin, there is a risk, however, of gaming on the part of hospitals to assign patients to higher price HRGs. There will be a need for inspection - involving the individual review of samples of patients' case notes - to monitor this. However, in general, cream skimming is unlikely to present a major financial problem.

However, there is a related issue which is the incentive PbR (and similar systems) provide to cut costs through shaving back on the quality of care. There is some evidence from other countries that one impact of activity-based fixed price reimbursement systems is to reduce the length of stay for patients in hospitals. This may be desirable up to a point if lengths of stay are 'too' long, but could become problematic if pushed too far - shifting costs previously born by hospitals onto other parts of the NHS, social services, or patients and their carers. Again, experience from abroad suggests that PbR-type payment systems require continual monitoring and appropriate adjustments to deal with undesirable outcomes such as this.

2.5 Information for users

2.5.1 To what degree is the ability to evaluate different providers necessary for consumer choice?

While choices can be made without reference to any information (in effect, randomly), patients and the public have expressed their opinions concerning what information they

would like in order to exercise an *informed* choice and, moreover, how they would weigh different factors to do with the 'characteristics' of a hospital/provider (reputation, proximity etc). The availability of information on those aspects of a provider's performance, or a treatment's outcomes (or whatever the choice at hand is) is very important. Without this information choices will be random or based on misinformation: In other words, the power that choice has to exert pressure on providers to improve their performance and for the needs and preferences of patients to be better matched with supply will fail.

2.5.2 How should those users less able to make informed choices because of their income or situation be empowered to do so? What form should the provision of information take?

On the basis that 'equal opportunity to choose' is the new equity goal for the NHS, then the NHS will need to act *unequally* towards some individuals/groups in order to ensure such equality of opportunity. This could mean, for example, that some groups will require additional help in making their choice - for example, extra time with GPs other health care professionals.

2.5.3 How is satisfaction with and the performance of services to be measured, by whom and how is that information to be made available?

There are numerous measures of performance of providers currently available, but a crucial piece of information which is not routinely collected in the NHS on a comparable basis is the impact the NHS has on individual patients health status. While knowledge of variations in length of stay, or readmission rates will no doubt play a part in many patients choices, we would suggest that knowledge of the variations in health outcomes - of individual clinical teams, clinicians, treatments etc - is vitally important. In fact, such information is important regardless of any policy on choice. We and others have argued elsewhere that methods exist to collect comparable health outcome information and that the NHS should not delay in investigating the practicalities of doing so (cf Appleby and Devlin, 2004; Kind and Williams, 2004).

We would further argue that while the Healthcare Commission (an arms-length NHS inspection body) and private organisations (such as Dr Foster) currently provide performance information, the NHS/Department of Health need to review the desirability of greater independence of its statistical information service and other information gathering systems. This may not lead to actual independence of these functions, but the public and patients probably need to be assured that information promulgated by the NHS and providers (including the private/independent sector) is reliable and trustworthy.

2.6 Voice and public services

2.6.1 What mechanisms (complaints, feedback) exist or should be created for exerting influence on providers? Are they available to all?
2.6.2 Does the complaints system operate effectively and equitably in the public sector? If not what should be done to improve this?

The current NHS complaints procedure was introduced in 1996 and was subject to independent evaluation in 2001 (Posnett et al, 2001)). This found a high level of dissatisfaction with the complaints process. As the evaluation noted:

'Among individuals whose complaint was dealt with locally, only one-third believed that their complaint had been handled well. No more than 20%-30% were satisfied with the time taken to deal with the complaint and a majority were dissatisfied with the outcome. A majority thought that the current procedure was either unfair or biased and a high proportion found the process to be stressful or distressing.'

And, *'among individuals who had requested independent review, around a quarter believed that their complaint had been handled well. No more than one in ten were satisfied with the time taken to resolve their complaint and only 13% were satisfied with the outcome. Almost three-quarters believe that the complaints procedure is either unfair or biased. A significant majority found the process to be stressful or distressing.'*

The complaints procedure in the NHS is now undergoing reform to try and address patients' dissatisfaction. Whether these changes will improve the situation remains to be seen.

Having a process by which patients/consumers can complain about the services they have received is desirable - not just for a public service such as the NHS, but for private businesses operating in markets.

However, the problems the NHS has had with its complaints system suggests that this form of 'voice' may be inherently weak, not just in addressing and remedying individual complaints, but exerting any significant pressure on providers to change their systems/behaviour as appropriate. The fact that the independent evaluation found that most NHS staff were pretty satisfied with a system with which most patient complainants were not, suggests a problematic bias in the process.

NHS patients also have recourse to the courts in order to pursue complaints/compensation - and evidence suggests that they are doing so in increasing numbers, with the NHS paying out increasing amounts overall in compensation. In principle, this should lead to the NHS adopting procedures which reduce the risk of liability. One perverse effect, however, could be to increase 'defensive' medicine and avoidance of high-risk/'difficult' cases.

2.7 Devolution and diversity

2.7.1 Is diversity a prerequisite for choice? If so, does diversity refer to good and bad performers or to the requirement for some unique selling point from the provider such as faith or specialist schools?
2.7.2 Does choice risk reinforcing the so-called "postcode lottery"?

Real choice would require diversity in the characteristics of the services on offer. For example, in the case of back pain, patients are, in some parts of the NHS, offered the choice of alternative providers such as chiropractors. Moreover, as patients differ physiologically (in their reaction to drugs, for example), good medical practice (not choice in a competitive framework) dictates that patients are offered choices which not only best meet their clinical needs, but best deal with their physiological differences.

We would not include 'good and bad' performance as elements of the characteristics of a service; it is hard to imagine why a patient would want to choose a poorly performing

hospital. However, individuals may well want to trade off different characteristics - a longish wait in order to see the consultant of their choice, for example.

Such diversity raises a potential problem in terms of standards and equity, however. In a system which offers diverse services, at any point in time, some patients' needs/desires may be better met than others. Over time, however, providers may respond to the signals generated by the choices patients make, and change the characteristics of their services in order to be more responsive. In other words, while inequalities (which may be felt to be inequitable) may exist at any one time for certain patient groups, over time these may be addressed. On the other hand, of course, they may not, depending on the judgements providers make in response to the array of priorities, incentives and costs they face.

2.8 Choice and the public good

2.8.1 Can the consumer be "sovereign" in the public services? If not, why not?

Given the diversity of services within the NHS and the range of possible choices open to patients, it is impossible to provide a general answer to this question. For many choices potentially available, patients will, for example, lack information (or due to their state of health, be unable to process information) on which to base a useful decision (that is, one that maximises the utility they derive from the service). This information will often include knowledge of what intervention they need to deal with their health problem. In this sense, 'consumers of health care are not sovereign.

But such 'information asymmetry' is not unique to health care, and exists in many other services in which consumers are usually thought of as being sovereign. One traditional provider response in these circumstances is to 'professionalize' their role, and act more as advocates/agents (usually coupled with internal or external professional scrutiny and regulation to ensure compliance with the professional role). Such actions do not guarantee consumer sovereignty, but provide some checks and balances and to an extent deal with the information asymmetry.

So, where consumers may not be sovereign, there are potential, if partial, solutions. But there are of course many choices and decisions within health care where only the patient knows what they want and needs no professional intermediary to advise, for example, on whether to see a male or female doctor. For other types of choice the information requirements may be minimal and easily supplied and understood.

Whether consumers *can* be sovereign is one matter, whether they *should* (always) be sovereign is another. It may be generally felt, for example, that consumer sovereignty should be limited or usurped in certain circumstances for the general good (or, indeed, for the good of the individual). For example, society has taken the view that the patient's choice to refuse treatment should be, in certain circumstances, denied. It also takes the view (articulated through the work of NICE) that, at the margin, the benefits of certain therapies do not justify their costs; in the name of consumer sovereignty, should patients be allowed to choose treatments rejected by NICE, with the consequent increase in costs and reduction in NHS efficiency (and effectiveness for individual patients)?

2.8.2 Is there a risk that a consumerist approach to public services will undermine the public service ethos?

Possibly. It is possible to imagine, for example, that a more consumerist approach in health care may incline health care professionals to cede some professional responsibility to patients and that as a result this may reduce health care professionals' feelings of public service duty and obligation (which often manifests itself in terms of working longer hours than contracted and performing functions which may not strictly be part of their job descriptions).

We would note, however, that it is accepted by health care professions through formal consent procedures and the notion of concordance with medicine regimes that more weight has to be given to the user/consumer when decisions are to be made. None of this is in contradiction to the public service ethos but rather a redefinition of what it should mean in practice.

2.9 Capacity in the public services

2.9.1 Will the extension of choice create unmanageable demands on the capacity of public services to provide? If so, is some degree of excess capacity necessary for choice to operate effectively?

Hypothetically, completely free choice in all the domains we noted earlier would create unmanageable (and unaffordable) demands. But in no economic system is there completely free choice; markets always limit choice in one way (prices) or another (contractually defined). The issue for public services whose global funding is limited and finite is, therefore, what degree and type of choice can be offered within the total financial limits and what sacrifices would need to be made in order to do this.

One sacrifice that may need to be made for certain categories of choice is a reduction in efficiency as a result of ensuring extra capacity is available to ensure real choice. The sacrifice may be worth it, but this is an empirical question which requires measuring and valuing the costs and benefits of offering a particular type of choice (eg choice of hospital) to patients. It is not therefore correct to dismiss choice on the basis that excess capacity may be required and that this would be wasteful without assessing the benefits choice may bring.

2.9.2 What are the cost implications of this? Should it lead to an extension of Private Finance Initiatives?

Given the previous answer, the issue of capacity and cost should be approached the other way round; that is, having set a global budget, work out what is possible to offer within that budget (and what opportunity costs will be incurred) rather than set out a 'vision' for choice and work out what the global budget should be.

There is no particular link here between extra capacity (if needed, for certain categories of patient choice) and PFI. The only possible link might be that PFI may offer a more cost effective route to expanding capacity in the short term - but there are doubts of its cost effectiveness in the long term.

2.9.3 Are user charges an inevitable outcome of greater choice? Might user charges help widen choice?

User charges are not an inevitable outcome of greater choice. Charges may, however, increase the willingness of the NHS to supply certain services that are currently felt to be peripheral to patient care or of low priority - such as bedside televisions - by covering the extra costs. Of course, while in one sense increasing choice, the cost of doing so is a new inequality based on (in)ability to pay.

2.9.4 Would enforcing equity in a co-funded, choice-driven system imply a proliferation of regulators on the model of the Office of Fair Access for the universities?

This question presumes that it is only in a co-funded, choice-driven system that regulation, monitoring and inspection is desirable. Such things have been a feature of the NHS (and of course many other parts of the economy) for many years. Organisations such as the Healthcare Commission, Monitor (the foundation trust regulator) the National Patients Safety Agency etc have a number of roles, some of which include ensuring that minimum clinical and other standards are met, that variations in performance are reduced and that performance in general is raised. Striving for an equitable NHS has and continues to be approached in a variety of ways - through the weighted capitation formulae, a reliance on staff attitudes and signing up to the general mission and objectives of the NHS (which includes equity of access), the explicit setting out of minimum clinical and other standards, requirements to carry out 'equity audits' and so on. Whether additional measures would need to be put in place to ensure equity of access as a result of greater patient choice is arguable. Moreover, as we noted earlier, more choice and greater diversity may necessarily mean greater inequity at any point in time, but that this may be worth bearing if choice raised standards across the board.

2.10 Raising standards

2.10.1 What is the nature of choice within a framework of uniform standards?

If 'uniform standards' means setting a minimum baseline for the standards of care and treatment, then there would be no conflict with patient choice. As we already note, professional standards may also embody the notion of patient empowerment through, for example, offering choices.

2.10.2 How can an individual's choice enhance national standards and accountability?

In theory, patients choices may reveal what standards (and what level) patients value (which may well be different to those set by health care professionals and policymakers. If so, then this information could be used to recast national minimum standards perhaps.

2.11 Evidence base

2.11.1 Is there already sufficient evidence, research and experience to judge the effect of greater choice on equity in public services?
2.11.2 Does the functioning so far of parental and patient choice support the argument that it promotes equity?

Not really. We have noted some evidence earlier in this submission to suggest there may be equity issues to deal with, but choice (in terms of current choice policy) in health care is only just rolling out. For example, no data has yet been published on activity for the first year (2003/4) of the Payment by Results system. Even when it is published later this year, PbR only covered a very small fraction of hospitals' activity in that year so it may be hard to detect impacts on hospitals' behaviour. And, of course, patient choice at point of referral has yet to be implemented across the NHS in England.

2.11.3 Are there lessons which can be learned from other countries and if so are they readily applicable here?

We have already alluded to some of the experience of other countries in some of our responses above. However, there is a general point that it can be difficult to make true comparisons between different countries as, while systems may seem superficially similar (for example, activity-based payment systems) in practice differences in detail and context can mean that comparisons are misleading.

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Appendix

Recent King's Fund work on patient choice: 2003/2004

1. *What's the real cost of more patient choice?* (2003) Appleby J, Harrison A, Devlin N

A King's Fund Policy paper setting out definitions of the scale and scope of choice and possible costs and benefits of choice in the NHS

2. *London Patient Choice Project Evaluation: a model of patients' choices of hospital from stated preference choice data* (2004) Burge P, Devlin N, Appleby J, Rohr C, Grant J

The first of two reports from the LPCP evaluation. Two further publications planned (*Applied Health Economics and Health Policy* and *BMJ*). The interim results were presented at the 5th European Conference on Health Economics at the LSE in September.

3. Patient choice (2004) Appleby J, Dixon J *BMJ* 329:61-62

Short editorial on choice and difference between Labour and Conservative policies on choice

4. Patients choosing their hospital (2003) Appleby J, Harrison A, Dewar S *BMJ*, Feb 2003; 326: 407 - 408.

Editorial on choice (choice can lead to inequality and inequities)

5. Patient choice: The case of HIV/AIDS Units in London

Current research being carried out by Ruth Thorlby looking at how choice has operated in HIV/AIDS units in London. Data collection and some analysis likely to be complete by December; write up in January 2005.

6. Mapping travel/time for hospitals in England

Work by Mike Damiani, Jennifer Dixon and Carol Propper showing numbers of hospitals accessible within certain times across England. Some areas of the country shown to have poor access in terms of numbers of accessible hospitals within 1/2/3 hours. Mimeo published by Bristol University/submitted paper to *BMJ*.

7. Measuring success in the NHS: Using patient assessed health outcomes to manage the performance of health care providers. Appleby J and Devlin N (2004)

Report for Dr Foster Ethics Committee looking at costs and benefits of routine generation of patient assessed health-related quality of life information. Among benefits, this sort of information vital for informing choice by patients.

8. Assessing the impact of the first year of Payment by Results on trusts' activity and waiting times. Appleby, J, Smith A, Devlin N, Parkin D, Jobanputra R. (2004-2005)

Payment by Results (PbR) is the fixed price activity-based reimbursement system which provides the financial incentive associated with patient choice. This research will test the hypothesis that hospitals will differ in their response to the implicit incentives in PbR on the basis of their HRG costs relative to the national tariff.

9. Paying hospitals to get results. *New Economy,* Journal of the IPPR. Appleby J, Jobanputra R (forthcoming, December 2004)

Review paper of Payment by Results, looking at international evidence of outcomes from similar systems