

Are the assumptions underlying patients choice realistic?: a review of the evidence

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Introduction: This paper presents a thematic review of the assumptions underlying patient choice in the NHS to examine who is meant to be making choices in the policy, what choices they are meant to be making and how those choices are meant to be made.

Discussion: This paper suggests that policies to increase patient choice require a significant investment in terms of restructuring primary-care services to allow them to happen, as well as to present relevant information to patients, but that patients may not want to make choices about where and what type of treatment they receive for the most part, being content with having a larger say in when they are treated.

Keywords: patient choice/NHS

Introduction

Increasing patient choice is a central part of the present government's NHS reforms,¹⁻³ but has been a recurrent part of the health policy agenda for rather longer than this, becoming prominent in the 1980s under the first internal market.⁴ In the 1980s, it appeared that patients were meant to be making choices in collaboration with doctors, but in the present reforms, the emphasis has changed far more to patients making decisions about the place, time and even the nature of their treatment. This paper reviews the available evidence considering what the likely impact of patient choice is likely to be before examining its significance and suggesting the implications of giving more choice to patients.

Nature of this review

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Readers of this journal will be used to reviews being presented in a systematic manner. Examining patient choice from this perspective is problematic because of the very wide range of potential choices offered to patients, but also because a considerable part of the literature on patient choice comes from academic disciplines where work cannot be

straightforwardly combined or presented in a systematic way. What will be presented here then is a review that will be arranged thematically around the key assumptions underlying patient choice in order to attempt to present the reader with an overview of the policy and its implications.

Key thematic areas in patient choice

Increasing patient choice is a policy that is part of a raft of reforms to increase the responsiveness of health providers in the NHS.⁵ The greater responsiveness of health services is to be achieved by patients choosing the best providers for their care, to which the funds for that care will flow as a result.⁶ Policymakers are introducing a new ‘local economy of care’ into the NHS in which offering increased patient choice positions health users as consumers in a market for healthcare far more radical than the one constructed by the Conservatives in the 1990s.⁷ However, the use of the term ‘market’ conceals a great deal, and it is extremely difficult to examine the new internal market in terms of incentives, payments and regulation.⁸ This review will therefore take a different approach.

Intuitively, patient choice can be examined according to some straightforward questions that follow directly on from considering how giving patients additional choices will impact upon care in the NHS. First, a sensible place to begin is to ask ‘who’ is meant to be making the choices? Is it patients or doctors or other health professionals? Second, we might ask ‘what’ choices they are meant to be making? Are they choices about location of treatment, time of treatment, the type of treatment or something else? Third, we can ask ‘how’ choices are meant to be made? Are they being made according to receiving the best possible care or some other criteria? By reviewing what we know about each of these questions, we can attempt to explore the implications of patient choice policies.^{9,10}

Who is meant to be making choices?

A policy based around increasing or extending patient choice might seem relatively straightforward in terms of identifying who is meant to be making choices—is it not patients? A moment’s thought suggests that this is not entirely the case. Much of the health economics literature, for example, suggests that the relationship between doctors and their patients can be classified as one that represents the ‘principle–agent’ problem, in which principles (here patients) do not have the time, expertise or resources to make choices for themselves, and so rely upon others (agents) to do this for them.¹¹ In the case of healthcare, it is relatively easy to see why this is the case—it would be good to

believe that medical school working with other health professionals and gaining experience with patients leads to a situation of what economists call 'information asymmetry'—that doctors simply know more than patients do about healthcare. Asking who is making choices in healthcare, then, presents significant challenges to the way we think about doctor–patient relationships. Two particular reasons are given for why it is necessary for reforms to increase patient choice.¹²

First, and most often cited by the government, is the rise of consumerism, with the suggestion that as we are given more choices in every other aspect of our lives, we demand also choices in relation to healthcare.¹² This has led to some commentators suggesting that patients need to be empowered and doctors to hold less power in medical consultations.¹³ Critiques of medical power have focused on how medics control discussions with patients so that choices are made mostly by them.¹⁴ In primary care, it seems that the overwhelming majority of decisions remain 'doctor-led'.¹⁵ One of the most prominent commentators on the use of public markets in the public sector has suggested that the users of welfare services need to move from being passive 'pawns' to active 'queens',^{16,17} but many writers have suggested that this analysis ignores the complexity of delivery in an area as complex as health policy.^{18–20}

On the one hand, we are told in policy documents that increased choice is being introduced as a result of patient demand for it, but on the other that decisions are almost entirely medic-led.²¹ There is evidence that doctors give referrals and prescriptions less often than patients would prefer,²² and so the introduction of consumerist notions offers significant challenges for the delivery of health services²³ as it forces us to consider who gets the final say—the doctor or the choosing patient?²⁴ A recent review of the patient choice literature suggests there is evidence that patients may not actually want to make choices about the nature of their treatment in the first place.²⁵ In addition to this, we know that patients somewhat paradoxically tend to say prospectively (i.e. before they are ill) that they would like choice, but then want to delegate it to doctors when they actually become ill.²⁶ As such, patient choice might be a popular sounding policy for those who are not actually required to make choice, but rather less popular among those whom it directly affects the most. This leads straightforwardly to a discussion of what kind of choices patients might want, which we will return to in the next section.

Second, there is the impact of the internet.²⁷ Many doctors have now experienced patients bringing in print outs of treatments or attempting self-diagnosis as a result of either surfing the worldwide web or from being in contact with internet-based self-help groups.²⁷ As patients get access to more information, the reasoning goes, they become better informed and are better able to make more complex decisions. On the

optimistic side, some sociologists have suggested that this offers the potential for medicine to ‘e-scape’ from the confines of the medical profession and to become more generally available to everyone.²⁸ However, commentators also acknowledge the danger of basing decisions on information found on the internet and the need for some interaction with health professionals because of the obvious dangers of allowing choice to remain unchecked.²⁷

In terms of who makes decisions in a policy based around increasing patient choice, we appear to have a confused picture. The government appears to be suggesting that patients want increased choices when there is arguably more evidence suggesting that what they would prefer is good service from their local hospital.¹⁰ The internet does not address the problem of the ability of the patient to be able to tell when poor or even dangerous information is being passed around. This takes us back to our starting point that—the relationship between a doctor and patient is not the same as a customer buying a DVD player from a salesperson²⁹—there is a considerable information asymmetry for the most part, and so patient choices must be limited by this. In addition to this, patients can never have the full possible range of choices available to them because of the inevitability of resource limitations.^{30–32} GPs have been conventionally constituted as ‘gatekeepers’ for further care in the NHS, and if this role is to be suspended in the name of giving greater consumer choice, then it will have profound resource implications.^{33,34} A possible exception to the problems both of information asymmetry and resource limitations can occur where the nature of an illness is long-term, and where the patient, over a substantial period of time, effectively becomes an ‘expert-patient’.³⁵ However, to suggest this situation applies across the full range of medical conditions appears inappropriate, and the question of whether modern evidence-based medicine is actually contradictory to the notion of patient choice is an important one.³⁶

What choices should patients make?

There are three levels to this question. The first is a fairly mundane one—it is about the time of treatment and attempting to make care available in a convenient form for patients. This is not entirely uncontroversial, as organizing care around patients would almost definitely lead to weekend clinics and GP surgeries being open evenings and weekends to a far greater extent, and stresses how increasing choice agendas can both lead to conflict with medical practice and demand additional resources.^{23,37} It is fairly straightforward, however,

compared with what is involved if we consider the extent to which patients can be involved in deciding both where they are treated and for what.

A second level of analysis concerns where patients wish to be treated. How far are patients prepared to go for treatment? Patient choice policies are premised on the assumption that, in order to receive better care, patients will be prepared to go further. There is some excellent work demonstrating how choice would work if patients would travel 100 miles in order to be treated,³⁸ but whether this assumption is sustainable is open to question. Patients prefer to be treated locally,⁹ and in choosing their local GP, often claim they choose the provider closest to their home³⁹ rather than according to any other criteria. There is some evidence of patients being willing to travel beyond local services, but as yet it remains relatively unusual.⁴⁰

Third, there is the issue of whether patients want to make choices about not only the time and place of their treatment, but also about the type of treatment itself.³ We know very little about this. In particular, more research is needed as to whether patients are prepared to demand particular treatments where their doctors suggest otherwise and of the potential clash between patient choice and medical evidence that might result.³⁶ This raises serious ethical and professional questions for doctors.⁴¹

All the choices that patients either wish to make, or are able to make, represent another rather contentious area. The 'choose and book' system gives patients in GP surgeries the ability to book times and places for treatments, but the decision over the nature of the treatment must still be made by the GP, who still also has the overall say of whether the patient is referred in the first place. Whether patients actually want choices over the type of treatment, however, remains open to question, and it does appear generally that their preference would be to be treated by good local services rather than having to choose between providers.

How are choices to be made?

From the evidence we have so far considered, we appear to be drawn towards a third question, asking exactly how choices are meant to be made by patients. Again, there is a straightforward answer that is often presented that does not really capture the complexity of the problem. The simple answer is that patients, armed with good information, will make informed choices.¹³ But studies of decision-making processes appear that this is problematic in the case of healthcare. Nobel Prize Winner Simon⁴² suggested that correct and accurate decisions take

place through four stages: intelligence, design, choice and implementation. Intelligence is finding out the decision to be made; design is structuring the information in a form that allows it to make sense; choice is the choice process itself, choosing between the criteria coming from the design stage and implementation is actually going ahead with the choice and making sure it happens.

Patient choice is a policy that most affects the GP/patient consultation, and if we consider how long it might take for a patient to go through the decision-making process described by Simon, then we can see that it is almost impossible for this to occur without substantially restructuring the way that doctors and patients interact, as well as completely redesigning the consultation process. Patients might need to be referred instead to patient choice advisors in surgeries, resulting in further waiting for one to become available, and GPs will have to incur additional costs to employ more staff. Introducing choice processes requires a significant increase in resources and a rethink of the whole process involved,³⁷ and were patients to go fully through a process similar to the one described by Simon, it would surely involve more than one visit to a surgery.

What this means is working out how patient choice is meant to work is extremely problematic. If patients are meant to be making choices about where to be treated, for example, and we have seen that there is little evidence that this is the case, then they will require a great deal of information about the possible alternatives, to be able to work out what is important for them and to come to a final judgement. At present, the patient choice leaflets are incredibly limited and give only information regarding local transport links, car parking spaces and the Trust's overall star-rating—none of which may be relevant in making a decision for any particular patient.⁴³ The logistics of keeping information concerning every possible referral in a GP surgery, even if based electronically, are almost overwhelming. The alternative is that, instead of providing detailed clinical information, patients make choices on generic information about facilities such as public transport links or car parking spaces, both of which are important, but surely not as important as the quality of care offered.

In all then, the process by which patients are meant to make choices is an extremely under-researched area⁴⁴—but is surely central to any reform that expects to extend patient choice. We do not know what kinds of information patients require in order to make choices, we do not understand the simple mechanics of introducing a decision making process into GP consultation and we do not know whether introducing patient choice is more likely to lead to non-clinical criteria such as the availability of car parking spaces becoming more important.

Discussion

From the above, we have a great deal of muddle, but some potential for working out what the implications of patient choice might be.

First, in terms of who makes decisions, any policy of patient choice depends upon doctors and patients working far closer together. The NHS has come some distance already on this, but for us to be able to move toward a 'co-production' of care model in which patient choice is a central part, a change is required in which patients will lead the process of making care decisions.⁴⁵ However, we must fundamentally question whether this is actually what patients want.⁴⁶ There is a great deal of difference between choosing when treatment is given and having to choose where or what kind of treatment is given. Although it makes sense to assume that patients will want the first, it is not clear whether or not they want the other choices.^{25,47}

Patient choice policies also have to be extremely careful in assuming that all patients are the same. Chronically ill patients with long-term conditions may want to become experts and involved in self-managing their care, but this is not necessarily representative of other patient groups. Government assumptions that extending choice in education can be shown to work, and so can be transplanted unproblematically into healthcare, are deeply flawed, as the two services are almost completely different in terms of their nature, the extent to which we are able to provide information about them and the ability to extensively review that information before making a choice.³⁹ It may well be that factors that are grouped under the heading 'social capital'⁴⁸—educational attainment level, social background, location of residence and professional status—may also affect whether a particular patient will feel comfortable making choices or not. Extending choice processes into healthcare requires considerable professional support that will allow those in lower socio-economic groups area not disadvantaged as a result.⁴⁹ The further a patient has to travel as a result of the choice process, the more likely the social class becomes a factor as those with personal transport are far more likely to be able to travel further or afford for relatives to visit.⁴⁰

In terms of how patients should make choices, we have a significant problem in that we cannot assume that health can be treated as a product much as any other and that patients have the expertise to make choices around it. Instead of assuming that simply providing more information for patients will allow them to make choices, we must instead think about choice in a more coherent way—we must understand how patients might make care decisions and consider how we can better prevent evidence for them that includes significant

clinical and non-clinical factors. We must also allow patients not to make choices where they wish—it makes little sense to force a patient into choosing on a fairly arbitrary basis when an experienced and knowledgeable doctor can assist them.

Finally, we must recognize that choice processes for health do not operate in the same way as they do in other services—they occur in a social setting where the support of family and friends is crucial, and so, as a result, narrowing them to an individualistic process which does not take account these factors ignores the importance of individual support networks that are so crucial in welfare.⁵⁰

Conclusion

The review presented here makes for rather uncomfortable reading. Many aspects of patient choice are still under-researched, but we can attempt to draw together the present studies to suggest the following.

First, the scope of choices required by patients may be over-estimated by the present policy. Patients do want choices about when they are treated, but are reticent to take responsibility for choosing where they are treated or for choosing the treatment they will receive. As such, as presently implemented, ‘choose and book’ is more likely to be concerned with times rather than places for treatment.

Second, patient choice policies have to accept that the doctor–patient relationship is an asymmetrical one in which patients are, for the most part, not as informed as doctors about the condition for which they are being referred. Even where patients believe they have found out about a particular condition, the source they are relying upon may be unreliable in the case of the internet, or out of date, or they may be diagnosing the wrong condition. Medical knowledge is not infallible, but recognizing dependence upon medical knowledge is not necessarily disempowering for patients.⁵¹

Third, any patient choice policy will require a significant re-orientation of primary care services, especially in order to allow patients the time, space, information and understanding to make sensible choices. It is not clear, at present, how this is to occur. This is an area, unless choice is going to be made on non-clinical factors alone, where those in charge of policy need to do some hard thinking very quickly.

Finally, in the absence of detailed comparative clinical information, it would seem that patients are meant to make choices on the basis of other factors. One possibility is that they will decide on the basis of non-clinical information instead, but there must be doubts as to whether this can lead to an improvement in patient care.

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