Types of Choice

• Choice of provider (where?)
  – Hospital, GP surgery
• Choice of service (what?)
  – Treatment, procedures
• Choice of time (when?)
  – Appointment time, opening hours
• Choice of access channel (how?)
  – Face to face, phone, web
Justifications For Extending Choice

Extending user choice in public services can be justified on the grounds of:

• ‘What people want’
• Incentives for quality, efficiency and responsiveness
• Equity

Can also be criticised on all these grounds
Criticisms of Choice

Extending user choice in public services can be criticised on the grounds of:

• People don’t want choice, they want a good local service.
• Inefficiency due to excess capacity, fragmentation of services
• Inequity: poor disadvantaged in making choices
• Inequity: cream-skimming.
What people want

### Give us a say

*How important is it to you to have more choice over which hospital treats you and your family, and which state school children in your family attend? %*

<table>
<thead>
<tr>
<th>Importance</th>
<th>Hospitals</th>
<th>Schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very/fairly important</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not very/not at all important</td>
<td></td>
<td></td>
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</tbody>
</table>

*Which of these statements comes closest to your view about the National Health Service? %*

- The NHS badly needs to be reformed to allow patients more control
- The main thing the NHS needs is more money
- There is nothing seriously wrong with the NHS
- Don't know

Source: YouGov
Choice and incentives

Consider ‘monopoly’ system: one with fixed catchment area and one hospital per area. Success dependent upon combination of:

- Goodwill and professionalism of hospital staff. Knights, not knaves.
Of Knaves and Knights

’In contriving any system of government, and fixing the several checks and controls of the constitution, every man ought to be supposed a knave and to have no other end, in all his actions, than private interest. By this interest, we must govern him and, by means of it, notwithstanding his insatiable avarice and ambition, co-operate to the public good’

David Hume
Of Knights and Knaves

'If it is accepted that man has a sociological and biological need to help then to deny him opportunities to express this need is to deny him the freedom to enter into gift relationships'

Richard Titmuss.
Choice and incentives

Consider ‘monopoly’ system: one with fixed catchment area and one hospital per area. Success dependent upon combination of:

• Trust to the goodwill and professionalism of hospital staff. Knights, not knaves.
• ‘Voice’ mechanisms, such as verbal persuasion or appeals procedures.
• Centrally driven performance management: targets plus penalties/reward
• Choice of residence.
Problems with trust, voice and performance management

Trust
- Complexity of motivation.
- Even perfect knights have their own agendas

Voice
- Clunky
- Favours the middle class

Performance Management
- Long-term demoralisation of work force, stifles innovation.
Choice in theory

Extend patient choice with money following the choice. Possible result:

• Higher standards, greater productivity, more responsiveness by incentivising staff

• More equity through:
  – reducing role of voice mechanisms favouring middle class
  – extending choice to those who can’t move to ‘good’ areas

But cream-skimming?
NHS without choice: existing inequities

- Unemployed, and individuals with low income and poor educational qualifications use health services less relative to need than the employed, the rich and the better educated.
- Intervention rates of CABG or angiography following heart attack were 30% lower in lowest SEG than the highest.
- Hip replacements 20% lower among lower SEGs despite 30% higher need.
- A one point move down a seven point deprivation scale resulted in GPs spending 3.4% less time per consultation.
Choice in theory (cont)

So choice may be the way to obtain a good local service. But certain conditions must be fulfilled:

• Alternatives must exist.
• Good information for all (including disadvantaged) with assistance where necessary
• Low transactions costs
• Motivation. Sensitive to finance.
• No opportunities or incentives for cream-skimming. Users, not providers, choose.
Availability of Alternatives

- 92% of population had two or more acute NHS trusts within 60 minutes travel time.
- 98% of population have access of up to 100 available and unoccupied NHS beds. 76% to 500.
Choice in Practice: UK choice

- 67% of patients offered a choice in London have taken up the offer to be treated at an alternative hospital more quickly, 75% in Manchester and 50% in the cardiac scheme.
- In England exc. London, in six months ending March 2003 fall of 2% in ophthalmology referrals, and decline in the mean waiting time of 6%. In London where the choice project was in operation there was an increase in referrals of 5-6%, and a decrease in waiting time of 17%.
Choice in Practice: International

- Positive (though not always massive) effects on quality, productivity and responsiveness.
- Impact on equity unclear, although perhaps better than alternatives. Need to assist the poor in making choices remains.
- Little effect on anything when internal structures and/or external systems were poorly designed.
Policy responses: Cream-skimming

• Stop-loss insurance.
• No provider discretion over admission
• Risk-adjusted tariffs
• SEG-adjusted tariffs.
Policy Responses: Equity and Supported Choice

Build on PCA experience in choice pilots. PCAs in targeted GP practices/PCTs. Responsibility for drawing up treatment plan in conjunction with GP, offering choices, negotiating with providers, helping patients navigate the system, helping ensure compliance with treatment regimes, managing transport support.