

**Systematic review of the impact of patient choice of provider in the
English NHS**

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Abstract

Objectives

To review the evidence on the implementation and impact of patient choice of provider policy, introduced gradually in the English NHS since 2002, in relation to the benefits proposed by government, and the concerns of commentators and critics.

Method

Systematic review based on searches of electronic databases and of bibliographies of studies and previous reviews, plus consultation with subject area experts.

Results

By 2008, approximately 46% of patients referred for non-urgent hospital care in the English NHS recalled being offered a choice of provider at the point of referral. The factors most likely to be taken into account by patients exercising choice in 2008 were perceptions of cleanliness/low levels of hospital-acquired infection and of the quality of care.

Almost all the evidence of the impact of patient choice of provider policy came from two sets of pilots in the early 2000s involving surgical patients who were facing considerable waits for treatment. When offered a choice of quicker treatment at an alternative hospital, the majority of these patients (57-67%) took the opportunity. The offer of choice did not appear to be skewed by socio-economic status or ethnicity. In the London Patient Choice Pilot, patients opting for treatment at an alternative hospital tended to be more positive about their care than those who did not, particularly if they had been treated at an NHS treatment centre or a private hospital. Speed of treatment was not the only consideration of patients who also took into account travel time, travel costs, the reputation of the hospital and where follow up care would be provided. Waits at a distant hospital would need to be considerably shorter than at the local hospital to persuade patients to travel. The London Patient Choice Pilot contributed to lowering waiting times overall by diverting some patients from hospitals with higher waits to those with lower waits and encouraging use of new capacity in NHS elective treatment centres.

Conclusion

The evidence on patient choice of provider in the English NHS is dominated by studies of pilots which differ significantly from current choice policy making it difficult to predict what effect routinely offering free choice of provider to all non-urgent patients will produce. Evidence from the pilots undertaken in the early 2000s, hints that choice of provider should increase the amount of choice and contribute to further reductions in waiting times. It may contribute to higher quality of care in that patients exercising choice have tended to report a higher perceived quality of care. There is some evidence that specialist providers are responding to patient choice with a concern for organisational reputation and efforts to improve the patient experience.

Whether this will translate into improved services for patients needs to be the subject of future evaluation.

There is no evidence available on the impact of patient choice of provider on the cost-effectiveness of services. There was little sign in the pilots that choice of provider was offered differentially to different population groups or was increasing inequities of access to services though older patients, those on low incomes and women were more likely to choose not to go to an alternative provider when offered a choice. However, it seems important to ensure that interpretable information on the quality of care and personal support in making choices is made available to all patients, particularly those unfamiliar with the NHS and less well educated.

Introduction

The English health reforms are a set of inter-related changes that have been put in place incrementally since 2002/03 aimed at bringing about improvements in system performance through the development of market-style incentives within the National Health Service (NHS). The core of the reforms comprises the introduction of: patient choice of provider; so called provider 'payment by results'; greater provider diversity and greater autonomy; practice-based commissioning; and regulatory reform. This package of policies is intended to create a system that is patient-centred and 'self improving' (Department of Health 2005) (see Figure 1). Taken together, these changes represent the most radical alteration of the NHS since its inception in 1948, despite the fact that the underlying principle of care free at the point of use available to all on the basis of need remains firmly in place.

The reforms are the third of three successive distinctive periods in NHS policy since New Labour came to power in 1997 (Stevens 2004). Rather than the policies of each period replacing their predecessors, reforms have tended to accumulate or 'layer', producing a complex mix. The first period was based broadly on cooperation (accompanied by increasing the supply of health professionals and service 'modernisation'). In the second 'command and control' period, major investment in the Service took place in return for improvements in performance (further 'modernisation'). Pressure for service 'modernisation' was based primarily on the setting of quantitative, time-limited national targets backed by a rigorous system of performance management and inspection through the NHS hierarchy and 'naming and shaming' of poorly performing organisations using widely published 'league tables'. The third phase re-introduced competition to the English NHS after the 1997 abolition of the Conservatives' internal market of the 1990s, while the increase in NHS funding continued at an unprecedented rate. By 2002, a consensus appears to have formed among Ministers and their advisors that the existing 'command and control' policies, such as the setting and enforcement of targets, had reached their limit and that an element of competition was required to make the most efficient use of resources and meet patient and public expectations. Thus the market reforms can be seen as an attempt to 'sharpen' the incentives for quality and efficiency improvements in the system so that the large increases in funding would be well used while building on the policies and achievements of the two previous periods.

Stevens (2004) has argued that what has emerged from the accumulation of the three periods of policy development is a three-pronged approach which incorporates elements of cooperation, command and control, and competition, and which attempts to transcend the limits of any single approach, reflecting New Labour's pragmatism and ideological attachment to the 'Third Way'. This three-pronged approach is said to be a specific response to the nature of the relationship between the state, the medical profession and the public that largely shapes the English health care system. The challenge, according to Stevens, is 'to ensure that this mixed model is internally coherent and the individual policy instruments appropriately balanced'.

The English NHS market reforms since 2002/03

The NHS Plan (Secretary of State for Health 2000) had encouraged NHS commissioners of services (PCTs) to make greater use of private sector providers in order to speed up their ability to meet NHS targets. In 2002, the government published *Delivering the NHS Plan* (Secretary of State for Health 2002) which went much further in encouraging a more diverse range of providers of services to NHS patients and in putting much greater emphasis on patient choice of provider to drive service improvement. At the same time, government Ministers and the Department of Health began to decentralise responsibility for service improvement to the local level and to downplay the significance of national targets and upward accountability to the 'centre' (Ministers and the Department of Health).

These market-related mechanisms set out schematically in Figure 1 are a mix of supply, demand, transactional and management/regulatory changes. On the supply side of the system, the reforms comprise the development of a more diverse and independent pattern of providers of clinical services to the NHS, including more autonomous NHS Foundation Trusts (FTs) and independent sector treatment centres (ISTCs) providing elective surgical services. The first FTs were created in 2003. These are high performing NHS Trusts that have successfully applied to become free-standing, non-profit making, 'public benefit corporations'. FTs remain part of the NHS but have greater financial and managerial freedoms (e.g. they can borrow from the private sector up to limits set by the regulator and develop joint ventures with the private sector). Unlike ordinary NHS Trusts, FTs cannot be directed by the Secretary of State for Health. Instead, their behaviour is regulated by an independent economic regulator known as Monitor established in 2004. FTs are however subject to quality inspections by the Healthcare Commission which is responsible for assuring the quality of services provided to NHS patients. The intention is that all NHS Trusts should eventually achieve foundation status. By the end of 2006/07, there were 62 FTs. At the time of writing (July 2008), there were 100.

The government was determined that the additional funds flowing into the NHS should increase capacity, particularly for services such as waiting list surgery and routine diagnostics where waiting had been a problem. From 1999, it had gradually developed NHS 'treatment centres' in response. These are stand-alone centres on NHS hospital sites specialising in high volumes of low risk, straightforward operations that do not require a hospital admission. By the end of 2005, there were 32 NHS treatment centres. However, acquiring additional services from new ISTCs as well as existing private hospitals became government policy in 2004/05. Bids were invited from private providers to set up ISTCs to provide extra surgery to NHS patients. As a result, around 10% of NHS procedures were carried out in the independent sector in 2008.

As the range of providers of services to the NHS became more diverse (the 'supply side' of the emerging market), the government acted to alter the way in which services were commissioned (the 'demand side' of the emerging market) and the capacity of the system was thereby increased. PCTs remained responsible for commissioning NHS services from a budget allocated in relation to the relative needs of their populations (though their numbers were reduced from 300 to 152 in 2006). However, they were required to further devolve their budgets and decisions to general

practices (called practice-based commissioning), thereby allowing GPs once again to shape the pattern of local services in a manner similar to the former GP fundholding scheme of the 1990s NHS internal market. PCTs negotiate contracts on behalf of practices in line with their wishes to avoid the increase in transaction costs observed under the Conservatives' quasi-market of the 1990s. More specialised services are commissioned by PCTs or even groups of PCTs. Highly specialised services are commissioned at national level. Some PCTs also have responsibility for social care, previously the responsibility of local authorities, and are known as Care Trusts.

An additional element in the demand side changes to the English NHS is the right of individual patients rather than PCTs or even practice-based commissioners to choose where they go for their treatment. The aim is that patients' choices will drive the system in large part. Thus from January 2006, where care could be planned, NHS patients were to be offered a choice of five providers at the point of referral of which at least one had to be from the independent sector. In January 2008, this was superseded by free choice of any accredited provider. This element in the market reforms is the focus of the current review.

The crucial transactional element in the reforms linking demand and supply side changes, is the so called 'payment by results' (PbR) provider payment system which is a fixed national tariff for hospital services based on 600 Health Resource Groups (HRGs) - the British adaptation of the US system of Diagnosis-Related Groups. In fact, PbR is a system of paying for each service or treatment delivered according to a national set of prices based on the NHS average and is not payment for patient outcomes ('payment for activity' would be a more accurate title). The aim is that providers of all types (public and private) compete on level terms to attract patients on the basis of the accessibility and quality of their services since there is no price competition (unlike in the 1990s internal market where prices were locally negotiated). There is pressure on providers with costs above the national tariff to become more efficient (though they may equally stop providing certain services rather than work to improve their efficiency). PbR is supported by the gradual development of integrated clinical information systems through the 'Connecting for Health' (CfH) programme.

Finally, there have been changes in system management and regulation such that ordinary NHS Trusts are no longer subject to the direct oversight of the Strategic Health Authorities (SHA), though these retain oversight of the PCTs as service commissioners. Foundation NHS trusts have still greater autonomy since they are no longer subject to ministerial direction. Consistent with this effort to devolve responsibility to the local level and to give providers more freedom from central control, the number of national targets has been reduced, but providers are obliged to operate to a set of 'core' national standards. At the same time, there is independent regulation of providers in terms of their clinical safety and quality of care through the work of the Healthcare Commission. Currently, the Healthcare Commission assesses NHS and independent sector health care organisations (since these now provide increasing amounts of care to NHS patients) against a set of standards and national targets, with an emphasis on ensuring that progress is being sustained. This results in an annual 'health check' of each organisation. From September 2008, the Healthcare Commission will be amalgamated with the inspectorates responsible for mental health

services and social care to become the Care Quality Commission, responsible for the inspection and quality regulation of all health and social care providers in England.

Progress with the NHS market reforms

Arguably, the supply side changes such as greater diversity and independence of providers have been implemented more completely and are more developed than the remainder of the reforms described above. Commissioning is generally held to be the least developed and weakest part of the system as it was in the 1990s NHS internal market (Le Grand et al. 1998). Supply side changes and the incentives generated by PbR as well as individual patient choice of provider have all been developing in recent years ahead of developments in commissioning, and are likely to put commissioning organisations under pressure in a cash-limited system, since they have the potential to encourage increases in output which may run ahead of the resources available.

Systematic reviews of the impact of the health reforms

As part of a programme of research evaluating the market reforms, a set of systematic reviews has been commissioned by the DH. The aim of the reviews is to identify and synthesise research and analysis on the implementation and impact of the current reforms in the English NHS with a view to contributing to future policy development. The reviews consider the following questions in relation to each element of the reforms as well as the reforms as a whole:

1. What were the intended aims of the reforms?
2. How were the reforms implemented?
3. To what extent have the intended aims of the reforms been realised?
4. What predictions were made about the reforms by commentators? Were these realised?
5. Were there any unexpected consequences of the reforms?
6. What are the implications for the reforms of the findings and conclusions of the review (e.g. are there modifications that would improve the effectiveness of the policies)?
7. What can be learned about health system reform (both content and process of policy change) relevant to improving the performance of the NHS from this evidence?

The aim of the current review is to consider the available evidence on the implementation and impact of the policies on patient choice of provider in the English NHS that have been introduced in stages since 2002/03.

The development of patient choice policy

Since publication of the English NHS Plan (Secretary of State for Health 2000) 'choice' has been a recurring theme across a range of health policies from emphasis on individual behavioural choices in the public health Green Paper (Department of

Health 2004a), to more recent announcements that choice of provider would be extended to all aspects of health care including long-term conditions (Department of Health 2006). The main focus, to date, however, has been on providing patients with a choice of hospital for elective care, and this is the focus of the current review.

The implementation of this policy was undertaken in stages, beginning with pilots involving patients who had been waiting six months or longer for heart surgery (Table 1). Initial implementation was accompanied by evaluation commissioned by the DH for the first pilots which were in heart surgery (the Coronary Heart Disease choice scheme) and for selected procedures in London (the London Patient Choice Project).

An important development in the implementation of patient choice of provider came in 2002 with the introduction of PbR. PbR is designed to work with patient choice by enabling 'money to follow the patient' thereby, in theory, rewarding preferred providers who were assumed to offer higher quality services. Choice has also been accompanied by the introduction of NHS and independent sector treatment sectors to increase surgical capacity thereby facilitating greater choice.

In 2003, patient choice was extended to all NHS patients who had been waiting more than six months for surgery. In 2005, choice at the point of referral was introduced for cataract surgery and then for all patients requiring surgery. Patients were required to be offered a choice of 'four or five providers' of which one had to be in the independent sector (Department of Health 2003). Choice at the point of referral was accompanied by 'Choose and Book' an electronic system for booking elective appointments.

'NHS choices' website was launched in June 2007. The site provides information to support patient choice. This includes both advice on lifestyle (such as healthy eating) and assessments of hospitals made by the healthcare commission. This information is available only for hospitals and not for individual treatments or wards.

In January 2008, free choice at the point of referral was introduced for any planned hospital treatment. In principle, patients are now able to choose from any provider which can meet the standards of the Healthcare Commission (and its successor) and can provide the care within the national tariff price (Department of Health 2004b).

In the initial pilots for patient choice, all patients were contacted by a patient care advisor (PCA) and those patients opting for an alternative hospital were offered free transport. In the current policy roll-out, patients are expected to be provided with information on alternative providers and supported in making their choice by their general practitioner (GP). Primary Care Trusts (PCTs) are expected to provide PCAs for patients requiring additional support and only certain patients are eligible to have their travel costs met (Department of Health 2004c). Thus, compared with the pilots, the current policy implemented throughout the English NHS offers less intensive support to patients and applies to all patients, not just to those who have already waited more than six months for surgery.

Table 1: Implementation of patient choice of provider in England

| | |
|---|---|
| April 2002 | Introduction of Payment by Results (prospective case-based payment for NHS hospital services). |
| July 2002 | Patients waiting six months or more for a heart operation offered the choice of faster treatment at an alternative hospital. |
| October 2003 | Introduction of NHS and Independent Sector Treatment Centres |
| August 2004 | Patients waiting more than six months for elective surgery offered the choice of moving to another hospital for faster treatment |
| January 2005 | Choice at the point of referral for cataract patients |
| December 2005 | Choice at the point of referral for all patients requiring surgery. An electronic booking system ('Choose and Book') introduced to enable all patients requiring elective care to be offered a choice of at least four providers. |
| June 2007 | 'NHS choices' website launched to provide information to support patient choice. |
| January 2008 (introduced April 2008) | For non-urgent treatment, patients given the right to choose any provider that meets NHS standards and can provide the service within the maximum price the NHS will pay ('Free Choice'). |

Proposed benefits

The government has argued that a number of distinct benefits should flow from offering patients increased choice of provider:

1. Greater choice: a key aim of the NHS Plan was to increase choice for patients (Secretary of State for Health 2000). This is choice conceived as a worthwhile in itself, rather than a means to an end, and reflects the view that choice is intrinsically desirable and valued (and increasingly expected) by patients. Government policy in this area is driven by the judgement that there is too little choice in public services.
2. Greater patient empowerment: The government sees patient choice of provider as leading to patient empowerment, by putting patients 'in the driving seat' of reform (Department of Health 2001).
3. Shorter waiting times: in addition to giving patients more choice, the initial pilots also aimed to reduce what were then long waiting lists for elective surgery.
4. Quality (effectiveness and responsiveness): the introduction of PbR was designed to add an incentive to improve the quality of the service by encouraging hospitals to compete to attract patients and thence revenue.
5. Equity: the government has argued that choice of provider would lead to improvements in equity, by extending to all NHS patients a choice that was previously only available to people with enough money to opt for (faster) care in the private sector (Blair 2003, Milburn 2003).

Concerns

Commentators and critics raised a range of concerns about the patient choice policy.

1. Do patients want choice?

Proponents of consumer choice in public services, including in the NHS, cite evidence such as that from the British Social Attitudes survey of 2004/05 to show that not only is choice wanted by the majority of people, it is wanted even more by the sorts of people who are unlikely to be able to afford to pay for private health insurance or out of pocket care and can, therefore, be equity-promoting (Le Grand 2006).

Respondents from manual backgrounds were more likely to say that they wanted a choice of hospital, appointment time and treatment in the NHS than those from professional or managerial backgrounds (Appleby and Alvarez-Rosete 2005). However, interpreting these findings is not straightforward. In fact, the question wording in the British Social Attitudes Survey was not directly about user choice, but couched as, 'How much say should NHS patients have ...' which would presumably cover 'voice' mechanisms such as surveys and consultations as much as individual choice (Taylor-Gooby 2008). Furthermore, as Greener (2008) points out, there is a big difference between 'prospective choice' (being asked if you would like a choice) and 'current choice' (having to make a choice when needing a service). Greener cites Schwartz (2004) who shows that the vast majority of people say that they would like to choose different providers if diagnosed with a serious illness, but that once diagnosed with a serious illness the percentage falls to a small minority. In addition, Appleby and Alvarez-Roseté (2005) show that choice is less important in determining satisfaction with care than the perceived quality of the service.

Other evidence supports the view that people like the idea of having choice, in principle, but that their desire for choice is not overriding. Clarke et al. (2006) cite research by the National Consumer Council (2003) to argue that support for choice is often driven more by the idea of choice as a compensatory mechanism in the event of receiving a poor quality service. Users of public services appear to have a preference for good quality, local services in the first instance, followed by a choice of other providers if local quality is inadequate.

Critics observe that choice policy does not consider the potential negative effects of (more) choice on individuals (e.g. patients may experience anxiety when faced with having to choose from a range of options, particularly if they do not feel qualified to make such choices or do not wish to choose for themselves). Bauman's critique of global consumerism identifies an ever increasing dissatisfaction with goods and services among consumers even as the amount of choice available increases. In part, this is because these goods and services are marketed as capable of meeting needs that they cannot feasibly meet (Baumann 2007).

2. Impact on equity

Perhaps the primary concern with patient choice of provider is its impact on equity. Competition places a premium on information and mobility, thus privileging higher socio-economic groups (Besley and Ghatak 2003). Dixon and Le Grand (2006) suggest that the risk of increasing inequities can be ameliorated by providing a 'package of supported choice whereby individuals from lower socio-economic groups would receive assistance in making choices, including an identified key worker to act

as patient care advisor and to help with transport costs.’ Current choice policy, though less supportive to patients than the pilots, contains elements of ‘supported choice’. For example, patients with low incomes are eligible to have their travel expenses met. Nonetheless, there are some patients, such as those with communication difficulties or low literacy skills, who will continue to face barriers in exercising choice.

Theoretically choice policy could improve the quality of all services, not just the services used by the better off (Besley and Ghatak 2003). Le Grand, for example, has suggested that the movement of as little as 5-10% of users should be enough to provide an incentive for all providers to improve the quality of their services (Le Grand 2007). Le Grand argues that equity concerns come largely from those ideologically opposed to the *process* of reform, i.e. the use of market-based incentives. He argues that the previous system of provision contained inequities that favoured the better off, who could opt for private health care or use their ‘pointy elbows’ to obtain more or better health services from providers. Le Grand calls for evaluation of the impact of choice policy on equity to focus on the *outcomes* of reform and to compare these with those of the previous system.

As well as inequalities in the *quality* of services received by different groups, there are also concerns that choice policy will create inequalities in *access*. In theory, the reforms could mean that the geographical configuration of services would be driven over time by the individual decisions of patients rather than an assessment of the relative needs of different populations served. As Klein (2006) observes:

The logic of the new NHS model is, in short, that it is the market which will determine the menu of options available to patients: so, for example, it may reduce the options available in any geographical area if it leads to the closure of local hospitals or a cut in the range of services they provide. This raises the question of whether there are any balancing mechanisms which allow collective - as distinct from individual - preferences to be articulated (2006:234)

3. Capacity and inefficiency

Some commentators have suggested that in the NHS, patient choice was likely to be limited by capacity constraints, and that increasing capacity to enable choice (e.g. by encouraging new providers from the private sector) could increase costs without improving efficiency (Fotaki et al. 2005).

The creation of spare capacity could also reduce efficiency through stimulating supplier induced demand as providers attempted to make productive use of their (new) assets. Changes to admission thresholds could lead to new capacity being used for new activity. According to Edwards (2005):

In a system with a fixed budget this may not be affordable without reductions in spending elsewhere. Supplier induced demand can mean that resources are not used optimally and potentially that patients receive treatment that could have been delivered more cost effectively or may even be inappropriate (2005:1465).

4. Information

Another anticipated problem was the lack of available and appropriate public information on the quality of care offered by different providers (Appleby et al. 2003). Information on the quality of care provided by different providers is essential for informed choice, but in health care providing information for patients is a complex task. While information on waiting times is relatively straight forward, other performance indicators are more difficult to interpret. For example, does a high number of medical errors indicate poor quality care or a good safety culture?

The provision of public information may also have unintended consequences. For example, providers may improve performance only in those areas that are measured. Providers may also respond by avoiding patients who are likely to harm their performance or by manipulating performance figures (Propper et al. 2006, Smith 1995).

5. Impact on other parts of the service

As elective care, especially surgery, is only a small part of the work of the NHS, it has been suggested that a focus on providing patient choice of provider could distort the system by diverting resources inappropriately from other parts of the Service (Fotaki et al. 2005). Although in future choice will be extended to all areas of NHS health care, some have argued that while choice may work in the case of a small number of discrete procedures, other areas, such as the management of long-term conditions, require collaboration, rather than competition to provide continuity of multi-disciplinary care (Ham 2007, Roland 2008). Roland, for example, argues that:

The greatest demand on the future NHS will be to provide high quality coordinated care for patients with multiple chronic disease. Recent NHS initiatives have increased the range of providers in both primary care (e.g. walk in centres) and secondary care (e.g. independent sector treatment centres). This has the potential to worsen coordination of care - an area in which UK performance is already poor compared with other countries (2008:626).

One response to this concern is to develop new forms of 'integrated' care, for example, linking together primary and specialist provision in new ways. In some cases, these sorts of developments may reduce the amount of choice available to patients, unless they are able to choose between different integrated care organisations.

Methods

The search strategy was designed to identify empirical and theoretical research from a range of disciplines including political science, health and social policy, sociology, anthropology and health economics on patient choice of provider. The review included research published in peer-reviewed journals, reports from academic institutions and other forms of 'grey literature'. These were identified by searching electronic databases, including *Medline*, the *Kings Fund Library* database, *Social Sciences Index*, *Econlit* and *SIGLE*, and through collaboration with researchers and analysts in the Department of Health and other relevant organisations.

The review uses a framework developed by Figueras et al. (1997) for use in the evaluation of health sector reforms (Table 2) to organise the findings. This framework identifies the overall goals of health systems as health gain and the provision of high quality of care. These principles are then translated into more measurable criteria of: equity, effectiveness, efficiency and responsiveness. The framework also includes objectives that relate to the viability of reforms: political and consumer acceptability, sustainability and accountability.

Table 2: .Framework of objectives to evaluate health sector reforms (Figueras 1997).

| 1. Guiding goals | 2. Operational objectives | 3. Viability |
|--|--|---|
| <ul style="list-style-type: none"> • Health Gain • Quality of Care | <ul style="list-style-type: none"> • Equity of finance and delivery • Effectiveness • Efficiency (technical and allocative) • Consumer choice and responsiveness | <ul style="list-style-type: none"> • Acceptability • Sustainability • Accountability |

Results

Evidence on implementation

Two sources of information on the extent of implementation of choice of provider were identified. The first of these is the National Patient Choice Survey, undertaken bimonthly by the DH to assess the implementation of choice at Primary Care Trust (PCT) level. The results from the September 2008 survey published in February 2009 are reported here. Questionnaires were distributed to 142 major acute NHS trusts and 16 Independent Sector Treatment Centres. Providers were asked to distribute the survey to patients who had been referred by a GP for a first outpatient appointment during the two-week period 15 to 28 September 2008. Patients aged under 16 or referred for specialties exempted from patient choice of provider policy were omitted from the survey (including urgent referrals, ‘two week’ cancer patients, antenatal patients and those referred to rapid access chest pain clinics or mental health specialties).

There were 93,029/248,000 valid responses (response rate 38%). Although the survey results were weighted for age and sex bias among respondents, they may have been subject to other response bias for which no adjustment can be made. The survey found that 46% of patients recalled being offered a choice of hospital for their first outpatient referral.

Of the patients who were offered choice, 49% said they had used the GP as a source of information to choose their hospital and 34% said they had used their own experience or that of friends and family. A booklet about choice was used by 8% and 5% used the NHS Choices website.

Table 3, below, shows the factors influencing choice of hospital. In the September 2008 survey, patients were asked to select, from a list of ten factors, those they

considered most important when choosing a hospital (the average number of factors chosen was 5.4). ‘Hospital cleanliness and low infection rates’ (note that these were grouped together in the questionnaire) were selected most often.

These results differ from earlier surveys that employed a ‘spontaneous’ rather than ‘prompted’ method. Instead of asking patients to choose from a list of ten factors, patients were asked to give up to three important factors they would take into account when choosing a hospital. When this method was used in May 2007, location and accessibility were overwhelming the most frequently mentioned factors. The change in method makes comparison over time difficult. It may be that patients have become increasingly concerned about cleanliness. Or it may simply be that the two methods give different results.

Table 3: Patients’ views of factors regarded as important when choosing a hospital for non-urgent care

| | September 2008 (select most important factors from a list of ten) | September 2007 (give up to three important factors) |
|-------------------------------------|--|--|
| Cleanliness/low levels of infection | 74% | 22% |
| Quality of care | 64% | 20% |
| Length of wait to appointment | 63% | 20% |
| Friendliness of staff | 57% | |
| Reputation of hospital | 55% | 20% |
| Location/transport/easy to get to | 54% | 65% |
| Car parking | 46% | |
| Reputation of consultant | 45% | |
| Good personal experience | 41% | |
| Convenience of appointment time | 38% | |
| Other | 1% | |

Source: Department of Health. *National patient choice surveys*

The second source of data on how the policy has been implemented is from a qualitative study of GPs’ views and experiences of patient choice (Rosen et al. 2007). The study used six telephone interviews and six focus groups (n= 30). Focus groups were held at the end of 2005 in Ashford, Croydon, Westminster, Yeovil, Crewe and Dudley. Sampling was undertaken until the point of thematic saturation. The study found that GPs varied in the extent to which they actively supported patient choice. Some GPs in inner cities had always offered their patients a choice of hospital. However, in towns with a single local hospital, there was a strong feeling that the difficulties of travelling to distant providers would limit the extent to which patients would choose any hospital other than the local one, and that maintaining a good local hospital was seen as essential for patients who could not or did not want to travel.

There was frustration from GPs using the ‘Choose and Book’ system that they were unable to refer to a named consultant or that the local provider was not included in the ‘menu’ of choices (for example, if the PCT had removed the local hospital from the menu because it did not meet the prevailing waiting time target). Other PCT policies, such as the use of referral management centres that required all patients to be referred to a single independent treatment centre, were said to restrict patient choice.

All GPs were concerned about the implications for equity, specifically the risks of differential access, and the constraints of geography and transport that might affect different population groups differently. This applied not just to GPs in rural areas but was also expressed by GPs in inner cities whose populations were deprived or elderly. Concerns were raised that allowing access to good departments within a local hospital by non-local people with their own transport would further disrupt access for local people who could not easily choose to go elsewhere. Also, language barriers, ability to understand complex information and personality type were all seen as potential barriers for some people to benefit from choice.

Evidence of impact

The vast bulk of the evidence on the impact of patient choice of provider relates to the choice pilots undertaken before the policy was implemented more widely. Six studies of patient choice of provider in England were identified, five of which are of the pilots undertaken up to 2005. The first of these (Le Maistre et al. 2003) was an evaluation of the coronary heart disease (CHD) scheme that was introduced in 28 NHS trusts in England in 2002. The aim of the scheme was to increase patient choice and reduce waiting times for elective surgery for heart disease. In this scheme, patients who had been on the waiting list for heart surgery for six months or more were given the option of going to an alternative hospital. The study used a postal survey to collect information on patients' experience of being offered choice for heart surgery. Questionnaires were sent to 4330 patients who had recently undergone heart surgery. Responses were received from 3431 (79%). Of these, 2525 (75%) had been offered a choice of alternative hospital for treatment and 57% had opted to go to an alternative hospital.

The majority of patients who chose an alternative hospital were satisfied with their treatment. For example, 89% said that they would 'definitely' recommend the patient choice initiative for CHD (8% responded 'yes, probably', 1% responded 'no' and 2.5% responded that they 'couldn't say'), although there were some negative experiences with transport arrangements and the arrangements made for accompanying persons.

Four studies were commissioned by the DH to evaluate the London patient choice project (LPCP). The LPCP began in June 2002 and ran until March 2004. The project involved 35 procedures in five specialties – ophthalmology, orthopaedics, ENT, urology and general surgery. Patients who had been waiting for treatment for more than six months were offered a choice of being treated more quickly at an alternative hospital. Patients with comorbidities or in a planned programme of multiple operations were excluded. Integral components of the project were the patient care advisor (PCA) who contacted patients to provide information on the project, and free transport for patients who opted for treatment at an alternative hospital.

The LPCP acted as a single purchaser for London. Trusts with spare capacity were given new monies to treat patients who chose an alternative provider. Unused capacity that had been purchased by the LPCP to treat 'choice patients' could be used to treat the trust's own patients. Where there was a shortfall of 'choice patients' and

the trust did not fill the slots with other patients, the LPCP paid 50% of the contracted price. Trusts with long waiting times also had an incentive to participate in the project. The LPCP meant that some of their patients would be given a choice of an alternative provider, thereby freeing capacity and helping them to meet their government waiting time targets.

Out of a total of 32 NHS trusts in London, 24 agreed to participate. Trusts that declined to participate comprised those with relatively short waiting lists as well as those with little inpatient activity in the relevant specialties. Trusts with long inpatient waiting lists ('originating trusts') were 'buddied' with two 'receiving' trusts. Patients waiting for more than six months for treatment were offered the choice of remaining with the originating trust (OT) or obtaining more rapid treatment at one of the two receiving trusts (RTs).

The Picker Institute evaluated the LPCP in terms of patient experience (Coulter et al. 2005). A 'Before Surgery' questionnaire was received from 2144/3988 (54%) patients. An 'After Surgery' questionnaire was received from 977/1839 (53%) patients. The Institute also undertook 27 qualitative interviews with patients awaiting surgery and 24 interviews with patients who had completed surgery.

A notable finding from this study was that only 32% of patients who were eligible for choice were offered a choice of hospital. According to the authors:

the reasons for this are not entirely clear. It is possible that waiting times in the relevant specialties decreased rapidly after the scheme was launched, but it is also possible that staff in (originating trusts) developed ways and means to ensure that their patients were not offered the opportunity to go elsewhere.

A significant minority of patients (18%) waiting for surgery said they would not consider an alternative hospital under any circumstances. Due to low response rates from the surveys, a record review was used to estimate uptake of choice. The authors estimated that 67% of those offered the opportunity of going to an alternative hospital chose to do so. There was no difference in uptake on the basis of socio-economic or ethnic group, but people in paid employment were more likely to opt for an alternative hospital than those not in paid employment. The vast majority (82%) of patients who opted for an alternative hospital were treated in NHS treatment centres (i.e. new NHS centres specialising in elective surgery for uncomplicated conditions), 13% went to other NHS hospitals in London and 5% went to private hospitals.

When patients were given a choice of provider, practical issues, such as location of hospital, travel arrangements and convenience for families, were very important. Interviews revealed that convenience and familiarity were of even greater importance to some interviewees than having their operation more quickly. Many of the interviewees who had declined the offer of choice said that they had been given insufficient information to enable them to make an informed decision. Personal knowledge of a particular surgeon or word-of-mouth reports from other patients were the main sources of information for most people. Of those who had opted for their home hospital, 75% had received previous treatment at that hospital. Most patients (67%) preferred to obtain information from their GP.

Patients who opted for treatment at alternative hospitals tended to be more positive when asked to give an overall rating of the care they had received. They were more likely to report that they had been treated with respect and dignity at all times (90% compared with 83% of home hospital patients, $p < 0.05$) and more likely to rate the care they had received as 'very good' or 'excellent' (88% compared to 76%, $p < 0.001$). They were also more likely to say that they would definitely recommend the hospital to others (83% compared to 64%, $p < 0.001$). Patients who had treatment at an alternative hospital that was an NHS treatment centre or a private hospital were more positive about their experience than those whose surgery had taken place at an ordinary NHS Trust. Patients treated at alternative hospitals were significantly more likely to have had a post-operation check up (83% compared to 73% of patients treated at home hospitals, $p < 0.01$). Both groups were equally satisfied with their follow-up care.

The vast majority of survey respondents (85%) were happy with their choice of hospital and there was no significant difference in this respect between groups. As with the CHD study, there were some negative experiences with transport (e.g. late arrival of transport or an uncomfortable trip home).

The second study (Burge et al. 2005) combined results from a study of hypothetical choices ($n=2114$) with a study of the actual choices made by patients involved in the LPCP ($n=19,976$) to model the influences on patients' choice of hospital. The study of hypothetical choices used a discrete choice survey. This method, which asks respondents to choose between scenarios, is designed to provide information on the relative importance of different factors affecting choice decisions. The survey had a response of 54% (2114/3998). Overall, the study showed that, in theory, patients were willing to choose to get better quality, but that ease of access was very important in theory and in practice. The study found patients were *less* likely to opt for quicker treatment at an alternative provider if:

- the reputation of the alternative hospital was worse (or unknown) relative to the 'home' hospital;
- the travel time to the alternative provider was greater than the 'home' hospital;
- patients had to organise and pay for their transport to the alternative provider; and
- follow-up care was delivered by the alternative rather than the home hospital

Considering individual characteristics, the survey found patients were *less* likely to opt for quicker treatment if they were older; female; had low education levels; had children under the age of 18; or had an annual income of less than £10,000. These factors interacted, so that, for example, the influence of reputation was much stronger for those with income over £10,000.

Analysis of the actual choices made by patients involved in the LPCP found that, in general, patients tended to act to minimise their waiting and travel time, whilst trying to obtain treatment at a hospital that was seen as offering a high quality of care. Other findings were that older patients tended to stay at their original hospital; men were more likely to move than women; there were variations between specialties so that, for example, ophthalmology patients were more likely to change provider than gynaecology patients.

The study concluded that:

- waiting times at a distant hospital would have to be considerably shorter than at the local hospital to persuade patients to travel;
- unless waiting times are at least three months less than the local hospital, patients would be unlikely to take up choice if they had to arrange and pay for their own transport; and
- reputation is a very important factor in a patient's decision to move hospital.

The combination of the two methods to analyse patient choices went some way to balance the weaknesses of the individual studies: The study of hypothetical choices did not look at what patients actually did and had a low response rate. The study of actual patient choices did not collect data on socio-economic status, the transport indicator did not take account of those reliant on public transport; and the reputation indicator was restricted to NHS Trust 'Star Rating' and Trust-based patient surveys whilst in real-life, as found in the Picker Institute study (Coulter et al. 2005), patients are more interested in the reputation of the individual consultant, and more likely to base their judgement on the experience of friends and family, and advice from their GP.

The third study on the LPCP analysed the system-wide impact of LPCP (Dawson et al. 2004). Areas of consideration included its impact on activity, waiting (numbers and time), equity, demand (including referral rates from primary care) and prices. Analysis used three tracer specialties: orthopaedics; ophthalmology; and general surgery.

The study compared mean waiting times of OTs, RTs and non-participating NHS trusts. Before the introduction of the LPCP, waiting times in London were falling and waiting times continued to fall in the rest of England where choice was not offered. The LPCP was introduced at the same time as national changes to waiting time targets, funding and capacity. To 'control' for these factors, waiting times in London were compared to other metropolitan areas.

The study found that non-participating NHS trusts had made the most progress in reducing waiting times before the introduction of patient choice and by the end of the study they were still offering lower waiting times than participating NHS trusts. Waiting times in RTs and non-participating trusts continued to fall in line with the rest of England. For ophthalmology and orthopaedics, there was a statistically significant reduction in waiting times in OTs (compared to the rest of England). There was no significant difference between London and comparator groups for general surgery. This might be explained in part by the fact that choice procedures accounted for only a small proportion of general surgical activity. Overall, there was a convergence in waiting times in London achieved by reducing times in OTs towards those of RTs.

No evidence was found to support the hypothesis that choice has been associated with either reduced referral or treatment thresholds.

The study found that the financial incentive to take on additional choice activity was weak if the trust had not received new investment to boost its capacity in the shape of

a treatment centre. The final report concluded that 'it would appear that the financial incentive of extra income for treating extra choice patients is on its own weak. It is the prior investment in new capacity and the consequent need to fund that capacity that is the key incentive' (2004: 21).

The number of patients eligible, offered and opting for choice fell significantly below expectations in that only 43% of contracted capacity was used for choice patients. 34% was used by trusts to treat their own patients. The study found that OTs were reluctant to give up patients, even when there was no financial penalty for doing so. The authors suggested that the threat of losing patients stimulated more activity within these trusts. Trusts may have sought to avoid exporting patients so as to ensure long term financial viability by maintaining credibility with, and future demand from, local purchasers.

The fourth study on the LPCP (Ferlie et al. 2005) focused on the organisational response. The study involved seven case studies of health care providers involved in the LPCP (six NHS, one private). It found that the RTs were a high-performing, self-selecting sub-group characterised by strong leadership, a 'can-do' organisational culture and good relations with clinicians.

As in the study of the system wide impacts described above, the study of organisational response found that the majority of capacity came from treatment centres. Choice 'provided a financial lever and guarantor of patient flows to enable (treatment centres) to develop rapidly.' The single private hospital case study 'was effective in rapid capacity creation and managed relations with clinicians well.' OTs were more like to export patients if they had experienced a crisis of poor performance; otherwise clinical resistance to exporting appeared to be strong. Initial estimates of the number of patient flows were excessive. Poor information flows and weak IT systems were perceived to be major barriers to change.

Finally, a study by Thorlby (2006) investigated if patient choice of place of HIV care affected the way units delivered services. HIV/AIDS services share some of the features of the current policy on choice, namely the free choice of centre and a funding system where funding follows the decisions of patients. The sample was 5/25 HIV units in England that agreed to take part in the study. In-depth interviews were undertaken with five staff and five patients from each unit. The study found that HIV services provided responsive care to patients. This was defined by patients as 'being treated as an individual' and 'kindness' from staff. HIV units were also characterised by offering a range of services, reflecting the principle of providing holistic care, and comfortable and attractive surroundings. Patients tended to assume that the quality of the clinical care would be the same across units.

Staff attributed the provision of high quality responsive services to generous funding enabling staff to provide the model of care they believed was best. Nonetheless, it was evident that senior staff took steps to attract and retain patients, primarily through their 'bedside manner', the range of services available to patients and the timing of clinics.

Discussion

The currently available evidence concerning patient choice of provider in the English NHS is dominated by the findings of the initial choice pilots. Their relevance to current choice policy is tempered by significant changes that have occurred in the interim in the objectives and content of the policy, and the associated incentives generated by other parts of the health reforms. The initial pilots were also confined to elective, mostly surgical, treatments whereas choice of provider policy is now extending to other services such as maternity, general practice/primary care and the management of long term conditions (Secretary of State for Health 2008).

PbR has also changed the incentives on provider organisations since the choice pilots took place. In the LPCP, patients waiting more than six months for surgery were offered a choice of alternative provider. For originating trusts, loss of patients did not incur a financial penalty at that time and could be beneficial, in terms of helping them to meet strictly enforced targets for waiting times. Currently all elective patients have choice at the point of referral, and each referral brings income under PbR, whilst non-referral carries a financial penalty in that a hospital is only paid for the elective cases it treats. In the LPCP, the number of patients taking up the offer of treatment at another hospital was vastly overestimated and originating trusts experienced clinician resistance to exporting patients, even though these trusts were not penalised financially and exporting patients could help with meeting waiting time targets.

Have the intended benefits of patient choice of provider been realised?

Initially, patient choice of provider policy appears to have been introduced primarily to increase the amount of choice available to patients (i.e. choice viewed as intrinsically desirable and good) and to reduce elective waiting times, especially for patients who would otherwise have experienced long waits for treatment. The empirical studies showed that it met both these objectives, using spare capacity to offer patients quicker treatment at an alternative hospital. Now that waiting times have been significantly reduced (largely due to toughly enforced targets and increased capacity in the system), there is a question as to how willing patients will be to move if they no longer face long waits. The empirical research reviewed here has shown that patients are unlikely to move to a more distant hospital unless the wait is considerably shorter than at their original (local) hospital. Even when faced with a wait of six months, a significant minority of patients would not consider treatment anywhere other than their local hospital. This is perhaps unsurprising given the importance of local health services to people (Glasby et al. 2006), the practical concerns of transport, for themselves and visitors, and the fact that, as the research above shows, patients' assessment of the quality of services is drawn from personal experience or personal recommendation rather than an assessment of databases of performance indicators.

Choice of provider was also introduced as a means of improving the quality of services as providers competed for patients. This is currently the *main* focus of choice of provider policy, despite the fact that ease of access seems to be still the overriding consideration in patients' choices (see Table 3). So far, the only evidence available on whether choice of elective provider has contributed to better or poorer quality of care comes from patients' ratings of their care in the LPCP (Coulter et al.

2005). Patients who had chosen an alternative hospital tended to have a more positive view of their care than those who stayed put, particularly if their care had been in an NHS treatment centre (a centre specialising in elective surgery) or in the private sector. It is possible that these findings are less an effect of choice on quality than an attempt by patients to rationalise their decisions to go to another provider. Since such choices were novel at the time, it is also possible that the offer of choice was perceived as either a reflection of the poor quality of care at the original hospital and/or an indication of the superior care available at the alternative hospital.

In terms of improving equity of access, the LPCP evaluation found no difference in the uptake of choice by socio-economic status or ethnicity, though those in work were more likely to take up the offer of choice to be treated more quickly in another hospital (Coulter et al. 2005). The lack of differential take up by socioeconomic status may be a reflection of the relatively high level of support offered to patients in the LPCP and the fact that all the patients involved had already waited a considerable time. Older patients and women were also more likely to stay at their original hospital than take the offer of treatment elsewhere (Burge et al. 2005). A possible explanation for the effect of age is the finding that 75% of those who opted to stay at their original hospital had previously been treated there (Coulter et al. 2005). Therefore, the hospital and possibly the staff were already familiar to some extent, and the patients had some knowledge of the quality of care on offer.

Have the concerns of commentators been realised?

The main concern of critics of patient choice of provider was that it would increase existing levels of inequity of access to, and outcome of, care. Much of this concern was shared by GPs at the same period (Rosen et al. 2007). There is little indication of systematic inequities in the various pilots. In relation to elective services, all socio-economic groups appeared to want to be able to choose, at least in theory, and take up was unaffected by socio-economic status and ethnicity. However, this may have been due to the fact that these patients had already waited a long time and were 'supported' in their choices. Current choice policy provides less support.

Another driver of potential inequity in an environment of choice is differential access to the information necessary for choice between more and less educated and affluent sub-groups in the population. Many of the patients in the LPCPs who declined the offer of choice of provider said that they had been given insufficient information to make an informed decision. There is currently no evidence on the relevance and quality of information available for patient choice of provider and whether it is distributed equitably and/or used equitably across the patient population. Improving the information on quality of care within the NHS, its accessibility and interpretability are currently government priorities following the final report of the Next Stage Review (Secretary of State for Health 2008). As choice is extended to a wider range of services and situations, it becomes increasingly important to make information on quality accessible and comprehensible to all groups in the population, especially less well educated people and those who are unfamiliar with the NHS. However, the evidence to date suggests that the bulk of the information used for elective choices appears to come not from the NHS Choices website, but from personal knowledge or word-of-mouth, suggesting that formal sources are less central than informal sources.

Again, though, this suggests that better off, more educated people are likely to be better connected to health professionals and have greater access to information informally from friends and acquaintances involved in health care.

The final set of concerns related to costs and inefficiency. There have been concerns that because choice requires spare capacity, it will increase costs and that the increased costs will not be offset by any quality gains resulting from patient choice, thereby reducing NHS efficiency. There is no direct evidence as yet on whether choice of provider has increased costs, though research on social care and education suggests that it can (Fotaki et al. 2008). On the other hand, Dawson et al. (2004) found no evidence in the LPCP that choice of provider was associated with reduced treatment thresholds (i.e. no evidence of supplier-induced demand).

Are there limitations on the extent of patient choice of provider and do they matter?

The provision of health care in the NHS is characterised by long-standing collegial relationships, for example between GPs and specialists (Tuohy 1999, Ferlie 1994). Oliver (2005) has argued that incentive mechanisms that are based purely on economic notions of choice and competition are unlikely to succeed in this environment. The National Patient Choice survey suggests that only a minority (45%) of eligible patients are currently offered a choice of provider. GPs may resist offering the choice of an alternative provider if they believe that such a referral could threaten the viability of local services depended on by other patients (e.g. for emergencies). The evidence from the study by Rosen et al. (2007) suggests that problems with the 'Choose and Book' system, such as being unable to refer to a named consultant, have also contributed to a lack of enthusiasm among GPs for routinely offering patients a choice of provider.

On the other hand, specialist providers may take a different view of choice under PbR since their organisations stand to gain if they can attract and retain patients. The study of competitive HIV services by Thorlby (2006) found that patients received personalised care and that specialists were acting to recruit and retain patients (although the staff themselves attributed quality to generous funding that enabled them to provide high quality care). This suggests that choice of secondary care provider in the presence of PbR has the potential to deliver more responsive services. This is in line with the current priority for the NHS which is to provide 'personalised' care (Secretary of State for Health 2008). It also underlines the importance of aligning incentives with the motivation of professionals to improve patient care.

Although not yet rigorously evaluated, it appears that provider organisations are responding to patient choice (despite modest take-up by GPs and patients) with a new focus on improving their organisational reputation through efforts to improve the quality of services (Dixon et al. 2008, Health Care Commission and Audit Commission 2008).

While concerns about the extent to which patients are offered and take up the offer of choice are relevant to assessing the impact and success of the policy in the English NHS, they are, as Fotaki et al. (2008) argue, only relevant to the objective of maximising choice. If the goal of choice policy is also to increase efficiency, quality

or responsiveness on the part of providers, there may be no need for many or most patients to exercise choice for it to have its effect. Patient defections, even on a small scale, will affect providers' incomes and will signal that there may be problems in the way in which services are being provided. For this to happen, there must be some excess capacity in the system to allow choice to occur, but choice does not have to be exercised by everybody.

Even if the exercise of choice in this way improves the performance of the system, there is still the empirical question as to whether the benefits of choice exceed the cost of the additional capacity, information and patient support required to enable choice. So far, there have been no studies in the English NHS attempting to compare the marginal costs with the marginal benefits of free choice of provider. For example, there is no evidence so far as to whether an increase in patient choice of provider is associated with any increase in the cost-effectiveness of the relevant services in an environment where prices are fixed according to the PbR tariff. There is also no evidence as to whether patients together with their GPs choose more cost-effective providers over less cost-effective when given free choice of provider.

The future of choice policy

So far, policy in the English NHS on patient choice of provider has been focused on relatively discrete and, arguably, relatively straightforward choices. The government plans to extend patient choice of provider to a wider range of services beyond elective surgery and also to give greater weight than hitherto to patient choice of treatment (e.g. pilots of patients managing their own budgets for the management of their long term conditions) (Secretary of State for Health 2008). These developments involve more complex choices than where to receive an elective procedure and are likely to take place when patients are more anxious and more unwell. In such situations, using health services is plainly 'not like shopping' (Clarke 2007). In distress and illness, people rarely see themselves as choosing services; rather research by Clarke et al. (2008) suggests that services are viewed as relational rather than transactional, and with a public as well as a personal character.

This insight suggests that while it is likely to be increasingly important to provide patients with relevant, timely and comprehensible information on the options available and their likely consequences (which will be costly), patients are likely to need support in the form of well informed staff that they can relate to and with whom they can discuss the decisions they face.

Choice policy may well raise more profound long-term issues as it broadens and deepens in future. Taylor-Gooby (2008) argues that incentive-driven user choice is typically regarded as simply a value-neutral means to direct behaviour towards beneficial ends. He raises the question of whether reforms that focus on individual choices rather than meeting social needs, could progressively weaken support for the redistribution of resources on which institutions such as the NHS are based. Reviewing research on motivation and rational actor models, mostly drawn from economics and psychology, he concludes that the context in which people make individual choices influences their behaviour and the values that underlie their behaviour. Individualised choice does not inevitably drive people towards purely

self-interested action that damages collective welfare, as long as institutions are properly designed (e.g. there are enforceable rules to prevent self-interested behaviour that have been developed through wide participation). He draws on a second body of research from economic sociology and social psychology on how values relate to institutions to show that the values that guide people's behaviour are not simply individual characteristics, but are embedded in the contexts in which people live. For example, the more predominant market arrangements are in a society, the more likely people are to attribute poverty, ill-health and so on to individual lack of effort and laziness on the part of the individuals affected, and, therefore, the less support there is for government redistribution to deal with these phenomena. Taylor-Gooby (2008) raises the possibility that shifts towards individual user choice in public services such as the NHS designed to strengthen and improve such services could erode the very values supportive of collective provision and the redistribution necessary for such provision, thereby frustrating the goals of reform. Viewed from this perspective, the proposals in the Next Stage Review final report for pilots of individual budgets to be controlled by people with long term conditions (Secretary of State for Health 2008) are especially interesting since, as has already been pointed out by Timmins (2008), having a budget for care effectively elides the distinction between what the NHS pays for and what the individual can pay for herself. In such circumstances, it may become increasingly difficult, firstly to prevent the patient 'topping up' her NHS care from private means since the NHS has effectively made a cash contribution to her care; and, secondly, in the longer term, it may raise the question of why money is being taken from individuals in the form of taxes only to be returned to them in the form a budget to purchase services. In this example, an attempt to extend individual choice and control may shift the boundary between the individual and the collective realms.

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Figure 1: Overview of system reform mechanisms

