



When it comes to health care, are you a patient or a consumer? Is the right to choose your hospital or doctor important to you? Is more choice always a good thing? **Anna Dixon** and **Sarah Thomson** make an initial diagnosis.

Your doctor tells you that you need a routine surgical procedure. Your local hospital won't be able to treat you for six months. You can't afford to go to a private hospital where they could operate next week. But a public hospital in the neighbouring region could treat you in three months' time. What do you do?

This is the choice offered to patients in England who have to wait for more than six months for elective cardiac surgery, cataract surgery and hip and knee replacements under the National Health Service (NHS). Since a pilot scheme was set up in London in 2002, just over half of

cardiac surgery patients and about three-quarters of patients waiting for eye surgery offered a choice have chosen to be treated at an alternative hospital, with most patients reporting high levels of satisfaction (see www.pickereurope.org and www.londonchoice.nhs.uk).

Choice of hospital is something patients in countries such as France, Belgium and Germany have always taken for granted. But in countries in which patients have traditionally had little choice, such as England, Denmark, Sweden, Norway and the Netherlands, it has been introduced to tackle the problem of long waiting lists by maximising use of hospital capacity.

Since the mid 1990s the Scandinavian countries and the Netherlands have given patients the right to be treated at hospitals in other regions and even abroad. By publishing information about waiting times for different hospitals on the internet and via cable TV, patients themselves were able to check if they could get faster treatment elsewhere.

But in contrast to the pilot scheme in England, the proportion of patients choosing to be treated in alternative hospitals as a result of long waiting times was very small – only 2.1 per cent of patients in Denmark and 10 per cent of patients in Sweden. Among patients in the Netherlands, only a handful travelled to other regions in order to obtain faster treatment, despite surveys indicating a high level of willingness to travel up to 20 kilometres from home.

Why are there national variations in the uptake of choice of hospital? Are patients

in England more predisposed to exercise choice or are there other reasons for differences between countries? We suggest that key features of the NHS pilot scheme were responsible for higher uptake in England. First, the NHS arranged or paid for transport in the pilot scheme, whereas patients in Denmark had to cover their own travel costs. Secondly, the English Department of Health provided additional resources for the pilot project, but Danish regions did not receive any extra funds to implement their scheme. Thirdly, hospitals in Denmark could refuse patients from other regions if patients in their own region were waiting for more than three months, so only hospitals with spare capacity accepted non-local patients. Finally, each patient in the English scheme was assigned to a patient care adviser who handled all the arrangements, while patients in Denmark had to find out about alternatives themselves and may have lacked reliable information regarding quality, waiting times and patient satisfaction.

Evidence about policies introducing choice of hospital show that when patients are left to choose on their own, few opt for treatment beyond their local hospital. Rather, they prefer conveniently located facilities and settings with which they are familiar. Such behaviour differs markedly from willingness to travel as stated in response to surveys and polls. It suggests that the information needed to decide to be treated at an alternative hospital may be too difficult to access.

When choice of hospital is extended to the whole of England in 2008, patients will not benefit from active support from patient care advisers or additional resources to cover travel costs. So as waiting times fall and patients' costs rise – for example, the costs of obtaining information and paying for transport for themselves and accompanying relatives – it will be interesting to see if the number exercising choice declines.

Giving patients a greater degree of choice in health care is generally assumed to be beneficial, but the growth in health care choices can have limits and drawbacks.

If you fall seriously ill you may not be in a fit state to choose where to be treated. Your priority will probably be to get to the nearest hospital as quickly as you can. So choice of hospital is most likely to be exercised by patients undergoing minor surgical procedures, such as cataract, hernia and tonsil operations, on an outpatient or day care basis. In Denmark, choice of hospital meant that regions faced greater economic uncertainty, reduced planning and rationing capacity and skewed financial incentives. It also increased transaction costs, lowered access to some specialist departments and resulted in poor coordination among providers.

Many countries restrict choice of first contact care – for example, patients may need to visit a general practitioner or family doctor before they can access more specialist care in the community or in hospital. There are several good reasons for this. Most patients can be adequately treated by generalists in a community setting; only six per cent of patients are referred to specialist care. Moreover, so-called 'gate-keeping' systems encourage the cost-effective use of more expensive specialist treatment as well as ensuring continuity of care, providing access to preventive care and avoiding duplication. Consequently, both France and Germany are introducing reforms to limit patients' choice of first contact care, even though these policies are unpopular with patients and resisted by doctors.

The low take-up of choice of hospital where choice has traditionally been limited, and strong opposition to restricted choice of first contact provider where patients are used to easy access to specialist care, suggest that we are conservative as patients. We base our behaviour on cultural and embedded norms – so in some countries we are patient patients, in others we are more active consumers willing to shop around for the best that money can buy. What kind are you? ■



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LSE Health and Social Care

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