

Title: Liberating the NHS: <i>No Decision About Me, Without Me</i> – Further consultation on proposals to secure shared decision making IA No: 2042 Lead department or agency: Department of Health Other departments or agencies:	Impact Assessment (IA)		
	Date: 22/02/2012		
	Stage: Consultation		
	Source of intervention: Domestic		
Type of measure: Other			

Summary: Intervention and Options **RPC Opinion:** N/A

Cost of Preferred (or more likely) Option			
Total Net Present Value	Business Net Present Value	Net cost to business per year (EANCB on 2009 prices)	In scope of One-In, Measure qualifies as One-Out?
			No
			NA

What is the problem under consideration? Why is government intervention necessary?

Patients and service users do not have as great a say in their healthcare services as they would like. Their involvement in decisions about their care and treatment may be limited by the existing policy, regulatory or contractual frameworks within which services are delivered, a lack of the necessary infrastructure to support choices or because of the way NHS-funded services are organised. A lack of options for patients and limited shared decision making with professionals means NHS-funded services are not as responsive to patients needs as they could be and this ultimately can lead to poor outcomes. Government determines policy, regulation and contractual framework within which the NHS operates. By changing these, the Government can give patients more say in decisions about the services they receive.

What are the policy objectives and the intended effects?

The policy objective is to provide patients and service users with more say in decisions about NHS funded services. This should increase the responsiveness of service providers to patients' preferences – thus increasing convenience and improving the health outcomes. The intention is for *'No Decision About Me, Without Me'* to become the norm for the majority of NHS services. Choice of non-consultant led diagnostic test provider, and choice in maternity and mental health services are identified as priorities within the scope of this impact assessment.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Option 1: Do Nothing. The range of services for which patients would be able to make choices would continue as present. Patients would be able to choose the provider and named consultant-led team when being referred for a 1st outpatient appointment. Choice of Any Qualified Provider, for which guidance has been issued separately would be introduced starting from April 2012.

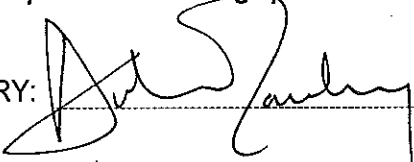
Option 2: *'No Decision About Me, Without Me'* for the majority of NHS Funded Services. A model to give patients more say in decisions about their care, treatment and the provider of, NHS funded services in primary care, before a diagnostic test, at referral to secondary care and after referral. Implementation priority is given to choice of non-consultant led diagnostic test provider, maternity and mental health services.

Option 2 is the preferred option

Will the policy be reviewed? It will/will not be reviewed. If applicable, set review date: Month/Year

Does implementation go beyond minimum EU requirements?			N/A		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	Micro No	< 20 No	Small No	Medium No	Large No
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)			Traded: N/A		Non-traded: N/A

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible SELECT SIGNATORY:  Date: 22 MAY 2012

Summary: Analysis & Evidence

Policy Option 2

Description:

FULL ECONOMIC ASSESSMENT

Price Base Year	PV Base Year	Time Period Years	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	High: Optional	Best Estimate: N/A

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate			Low

Description and scale of key monetised costs by 'main affected groups'

The purpose of this cost section is to capture the marginal cost of the policy proposals. The majority of the proposals set out under this option use mechanisms that are already in place or form part of other policy reforms including the Health and Social care Bill. The marginal cost associated with this option is therefore considered to be low. These proposals should be considered alongside related impact assessments

Other key non-monetised costs by 'main affected groups'

Maximum of 5 lines

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate			N/A

Description and scale of key monetised benefits by 'main affected groups'

Detailed evidence to model the precise changes to different parts of the NHS is not available, so the benefits of the proposals within this option have not been quantified

Other key non-monetised benefits by 'main affected groups'

Evidence suggests that patients want more say in decisions about their healthcare and that it has an intrinsic value. Patients should also derive a benefit from greater convenience in accessing services. Research suggests that where choice of provider has been introduced to routine hospital-based elective care, the results have been improved outcomes and efficiency.

Key assumptions/sensitivities/risks	Discount rate (%)
<p>The main risk to the success of the policy proposals set out in this option is the attitude and behaviour of patients and healthcare professionals. The benefits of giving patients more say in decisions about their care and treatment will be realised if patients are able to make choices over their care supported by professionals through shared decisions. If either party is unwilling to accept the principles of shared decision making, in line with patient preferences, then the full extent of the benefits may not be realised. An unwillingness to support greater choice could also lead to higher costs.</p>	

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs:	Benefits:	Net:	Yes/No	IN/OUT/Zero net cost

Evidence Base (for summary sheets)

One in One out (OiOo)

The likely future levers for giving patients more say in decisions about their care and treatment are set out in the associated 'further consultation on proposals to secure shared decision making' document. These could place requirements on commissioners through mechanisms introduced by the Health and Social Care Bill such as the Mandate to the NHS Commissioning Board. Any obligations placed upon providers of NHS-funded healthcare services (public sector, private sector or civil society organisations) would be set out in the terms and conditions of contractual agreements to provide those NHS-funded services. By virtue of applying to the public sector and/or being contractual obligations which are entered into as a precondition for delivery of these services, the proposals for 'No Decision About Me, Without Me' are considered to be out of scope of the one-in-one-out process.

Obligations fall on the public sector

The policy proposals to give patients more say in their care and greater involvement in decisions about them and their treatment would ultimately be implemented by commissioners and providers of NHS-funded services. The impacts are expected to fall on public sector bodies or on organisations contracted by public sector bodies to deliver services on their behalf.

Introduction

1. The consultation document, *Liberating the NHS: Greater Choice and Control*, sought views on the choices that people want to make, when they want to make them and what information and support they need to be able to have more say and to share decisions about their care. The first consultation period ran from the 18th October 2010 to 14th January 2011 and, for the majority of commitments¹, was to be followed by a second round of consultation on more detailed policy proposals informed by responses.
2. The Government has elected to implement the commitments to different timetables. The Government responses and policy guidance for the commitments on choice of any qualified provider² and choice of named consultant led team³ were published on the 19th July 2011 and 11th October 2011 respectively. Separate impact assessments that covered the implementation of these commitments were published alongside the respective guidance documents which take effect from April 2012.
3. The document *Liberating the NHS: No Decision About Me, Without Me – Further consultation on proposals to secure shared decision making*, which this impact assessment accompanies, sets out detailed proposals informed by the responses received, the recommendations made by the NHS Future Forum in its report following the Listening Exercise and the Government's response to it.
4. The proposals for more say in decisions about care and treatment have been set out as a model for shared decision-making all along the patient pathway. The consultation covers specific commitments to extend choice in particular areas of healthcare, e.g. mental health, maternity and diagnostic services.

Policy Proposals on Patient Choice

The current right to make choices

5. Policies are already in place to support patients to make choices about the services they receive in some parts of the NHS. Since April 2008, patients have been able to choose from any clinically appropriate provider in England when referred for their first consultant-led outpatient appointment. Since April 2009, this has been a legal right as set out in the NHS Constitution. Directions to Primary Care Trusts (PCTs) under the NHS Act 2006 currently impose legal duties on PCTs to make arrangements to ensure that patients are able to choose any clinically appropriate provider, to

¹ Set out in the White Paper Equity and Excellence: Liberating the NHS

² http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_125442

³ http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_130425

provide information to help patients choose and to prepare quarterly reports on choice related complaints.

More choice in mental health, maternity and diagnostic services

6. The proposed model of shared decision-making below is designed to deliver more say in decisions about care and treatment right across NHS-funded services and all along the patient pathway.
7. This impact assessment sets out the general model of shared decision making, and gives more details about how it can be applied to three service areas: mental health services, maternity services and choice of diagnostic test provider. As set out above, extending choice of provider to any qualified provider and choice of named consultant-led team have been considered in previous impact assessments. Delivering more say in decisions for diagnostic test provider, fits with the section of the model on Choice Before Diagnosis. Extension in maternity and mental health services fits with the section of the model on Choice at Referral. A discussion on the impacts upon these specific services can be found in the impact section below (see paragraphs 62-84)

A model of shared decision-making

8. The White Paper, *Equity and Excellence: Liberating the NHS*, set out the Government's vision of an NHS that puts patients and the public first, where "no decision about me, without me" is the norm. Patients and service users would have more choice over their care and treatment across the majority of NHS services by 2013/14 including choice of any qualified provider and choice of treatment.
9. Responses to the first round of consultation suggested that patients, service users and the general public wanted greater clarity over the choices they were entitled to make, when they could make them and the mechanisms and support available to allow them to make informed choices.
10. The 'further consultation on proposals to secure shared decision making' document proposes a model of shared decision making over care and treatment all along the patient pathway. Choices would be available in primary care, before diagnosis, when referred to secondary care and after a diagnosis is made. Shared decision-making underpins our proposals to deliver more say. We also believe information is essential to provide a firm underpinning for patients' choices. The Department of Health published *Liberating the NHS: An Information Revolution*⁴ alongside the choice consultation in Autumn 2010, recognising the importance of appropriate, timely and accessible information.

⁴ http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_120080

Figure 1: A model of shared decision making



Choices in primary care

11. In 2010, the Department of Health consulted⁵ on proposals to extend choice of registration with a GP practice. 77% of respondents supported the principle that people should be able to register with any GP practice with an open list. We intend to pilot models for implementing this principle. The consultation document had its own impact assessment⁶ and the pilots will be evaluated separately.
12. Choices in primary care also include commitments to increase choice of provider for community services and personalised care planning for people with long term conditions. The main mechanism to deliver choice of provider in community services is the any qualified provider commissioning approach. The Department of Health published detailed guidance with a separate impact assessment⁷ on 19th July 2011.
13. Progress has been made on giving patients with long-term conditions more say through personalised care planning. This includes telehealth and telecare which is being evaluated through the Whole Systems Demonstrator programme. The workstream on Quality, Innovation, Productivity and Prevention (QIPP) for long-term conditions is looking at ways of reducing the variations in care planning that people receive. The evaluation of these workstreams has not been completed. Consequently, we are unable to include the evidence in this impact assessment.

Choice before diagnosis

14. We want patients to have more say in decisions before they receive a diagnosis. When being referred for a common diagnostic test by a GP, the presumption should be that a patient should be able to choose the provider of those tests as well as where and when they are carried out. This applies to tests provided in primary care in the community, and those offered by secondary care providers as well as direct access tests. The any qualified provider commissioning model (see the AQP guidance) and the choose and book appointments system will be key mechanisms to facilitate these choices.

⁵ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_120284.pdf

⁶

http://webarchive.nationalarchives.gov.uk/20100506073600/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_113490.pdf

⁷ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128460.pdf

Choice at referral to secondary care

15. As mentioned above, choice of provider for many routine services has been available since April 2008 and has been formalised subsequently as a right in the NHS Constitution⁸. In the guidance on choice of named consultant-led team, published in October 2011, this was extended to permit patients to select a named consultant-led team they want to see at any provider if they have available appointments.
16. Some services have been excluded from these arrangements, including maternity and mental health. On 25th November 2011, a 'Birthplace' study⁹ was published which will help women make informed and safe decisions about where to give birth. It will also help healthcare workers when providing advice to women and aid commissioners and providers in planning maternity services.
17. We have outlined a general principle that users of mental health services should have the same choices available to those using acute elective care unless there are good reasons not to. To give mental health service users more say in decisions about who provides their care, we have proposed permitting them to choose any named consultant-led team within their secondary care mental health service. This would mirror the arrangements in place for other acute service areas. Implementation would start in 2012/13. Further, we have proposed that for non urgent referrals to secondary mental health services, service users should also be able to choose teams led by healthcare professionals other than consultants. This recognises the differences between mental health and acute elective care services. However, we have also acknowledged that choice of provider may not be feasible for secondary mental health services because of the need to ensure integration with social care. Commissioners would be expected to consider how best to achieve more choice of provider locally taking into account local features of mental health services.
18. We also propose expanding the choices for service users who use Improving Access to Psychological Therapies (IAPT) programme¹⁰ so that choices are available whether IAPT services are provided in primary or secondary care. The extension of choice of provider of community (primary) care based IAPT services was discussed in the any qualified provider guidance.

Choice after a diagnosis

19. We are clear that patients, their carers and families should be involved in decisions about their care all the way along the patient pathway. This applies equally to decisions about their treatment, care management and support once a diagnosis has been made. The presumption should be that patients make choices from a set of options that are clinically appropriate and financially affordable. There may be times when providing a choice of treatment is not appropriate, possibly due to the specialised nature of the condition or where urgent treatment is needed. Nevertheless, the patient should still remain involved in decision about their care as much as possible.
20. Personal health budgets are an important element that will allow patients to have more say in decisions about their care. They are currently being piloted in the NHS in England and the pilots are expected to run until October 2012.

Consultation Questions

21. The further consultation document asks the following questions:

⁸ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613

⁹ <http://www.bmj.com/content/343/bmj.d7400?tab=full>

¹⁰ <http://www.iapt.nhs.uk>

No Decision about me, without me

Q1. Will the proposals provide patients with more opportunities to make shared decisions about their care and treatment in the following areas?

- a) primary care
- b) before diagnosis
- c) at referral to secondary care
- d) after diagnosis

Q2. Are the proposals realistic and achievable?

Q3. Looking at the proposals collectively, are there any specific areas which we have not recognised appropriately in the consultation document?

Q4. Have we identified the right means of making sure that patients will have an opportunity to make shared decisions, to be more involved in decisions about their care across the majority of NHS funded services?

Q5. Do you feel that these proposals go far enough and fast enough in extending choice and making “no decision about me, without me” a reality?

22. Respondents are also invited to comment on the impact assessment. Submissions of evidence on the impacts upon services including information on the costs and benefits of the policies are particularly welcome.

Problems under consideration

23. The way in which the NHS is configured and the way in which services are commissioned means that patients are not as involved in decisions about their care as they could be and that the choices they have over their care and treatment are often limited. Patients have to put up with what is offered whether or not the service is convenient or the patient is happy with the quality. Yet we know that patients want choice. A British Attitudes Survey¹¹ found 95% of people feel that they should have choice over the hospital they attend and the kind of treatment they receive. The King's Fund found¹² 75% of respondents said that choice of hospital was either 'very important' or 'important' to them. More recently, a Department of Health commissioned survey¹³, of 5,000 people in England, conducted in October 2011 found:

- 81% of respondents want more choice in where they are treated;
- 79% of respondents want more choice of how they are treated; and
- 75% of respondents wanted a choice of hospital consultant in charge of their care; and
- 75% of respondents wanted a choice of hospital consultant in charge of their children's care.

24. The problem is not limited to a lack of choice and lack of opportunity to engage in shared decision-making in the NHS. Comparisons with other countries suggest outcomes in some areas of healthcare across the NHS are not as good as they could be, for example rates of amenable mortality¹⁴, mortality rates of respiratory diseases¹⁵, acute complications of diabetes¹⁶ and incidence

¹¹ British Social Attitudes survey, Natcen, <http://www.natcen.ac.uk/study/british-social-attitudes-25th-report/findings> (2009)

¹² Dixon, A., Robertson, R., Appleby, J., Burge, P., Devlin, N., Magee, H., Patient Choice: How patients choose and how providers respond The Kings Fund (2010)

¹³ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalassets.dh_131611.pdf (see page 26)

¹⁴ Nolte, E., McKee, C. M., *Measuring the Health of Nations: analysis of mortality amenable to healthcare* BMJ 2003; 327:1129 (2003)

¹⁵ Eurocare-4, www.eurocare.it

¹⁶ OECD, Health at a Glance 2009 (2009)

of MRSA infection rates¹⁷. A recent report by the Care Quality Commission on Dignity and Nutrition for Older People¹⁸ suggests that non-clinical aspects of care could also be delivered better. Other reports have shown that the NHS score relatively poorly on being responsive to the patients it serves and lacks a genuine patient-centred approach where patients are often expected to fit in around services^{19, 20}.

25. One reason why outcomes are not as good as they could be is because services are not as responsive as they could be to patient preferences. For example: patients not being fully informed about their condition and treatment options; there are limited options for patients and their GP to choose the best provider for their care and treatment; and there are institutional and individual attitudes and behaviours that do not put patients at the centre of care. Where services are not responsive to patient preferences, there is potential for a misallocation of scarce healthcare resources leading to poorer outcomes.
26. The proposals will give patients more say in decisions about the NHS-funded services they receive. In conjunction with other reforms set out in the Health and Social Care Bill 2010, this will help make services more responsive to the preferences of patients. Over time resource allocation should become more aligned with these preferences rather than those of third parties like commissioners or providers. Ultimately, this should mean providers deliver better services with better outcomes for patients.

Rationale for government intervention

27. Government is best placed to introduce more say in decisions about care and treatment because the NHS is a public service funded through general taxation. As such it determines the policy, regulatory and contractual framework within which healthcare services are delivered to patients. The Government is committed to giving patients more say throughout the NHS all along patient pathways and across services.

What are the policy objectives?

28. The policy objective is to give patients more say in decisions about the care and treatment they receive; increasing convenience and ensuring they get the services they want. Allowing patients to choose from whom, when and where they receive services should also help to drive quality improvements: first by increasing the responsiveness of service providers to patient preferences; and second by a knock on effect of better outcomes as a result of the improved responsiveness.
29. At present patients only have a choice at the point of referral over which provider they can go to for their first consultant-led outpatient appointment. Guidance published on 19 July 2011 and on 11th October 2011 extends choice to patients in some community based services and the consultant-led team in charge of their care. The policy objective is to go further still, with the presumption of 'No Decision About Me, Without Me' to become the norm for more areas of care and to cover the treatments received; not just the hospital that provides the service. Diagnostic tests, maternity and mental health services are a priority.

Evidence that supports choice

30. Paragraph 23 above has already discussed the evidence that patients want more say and involvement. This section sets out the evidence base that demonstrates that it can lead to better outcomes. It also discusses the academic studies that investigated the effects of the reforms that introduced choice of provider for elective acute services from April 2006.
31. There is a rich body of academic literature that has investigated the relationship between market structure and outcomes, productivity and innovation. In general, a market that is plural and provides more choice to service users tends to be more productive and innovative than those that are

¹⁷ European Antimicrobial Resistance Surveillance System (EARSS) incidence of MRSA per 100,000 patient days (2008)

¹⁸ Care Quality Commission, Dignity and Nutrition: Inspection Programme (2011)

¹⁹ The Tallinn Charter, Health Systems for Health and Wealth Draft Charter World Health Organisation (2008)

²⁰ Is the NHS becoming more patient centred? Trends from the national surveys of patients in England 2002-2007 Picker Institute 2007

monopolies. Some of this material was covered by the impact assessment published in January 2011 by the Department of Health to accompany the Health and Social Care Bill 2011. As annex B of the Health Bill impact assessment acknowledges, some of the most frequently cited studies are:

- Nickell (1996)²¹ finds that firms which face more competition have significantly greater productivity growth than those facing muted competition. He estimates that up to 40% of productivity differences between Organisation for Economic Cooperation and Development (OECD) countries is accounted for by the level of entry and exit by firms;
 - Djankov and Murrell (2002)²² find that, in transition economies, the degree of competition has a significant impact on economic performance;
 - Ahm (2002)²³ reviews a large number of studies on the link between competition and innovation and concludes that competition encourages innovation activities and has a significant impact on long term productivity; and
 - The Office of Fair Trading (OFT) commissioned a study²⁴ by Frontier Economics on choice and competition in public services. They concluded that “supply side flexibility around entry, exit and expansion is critical”.
 - The Office of Health Economics (OHE) (2012)²⁵ has undertaken an intensive review of the use of competition in health services. It concluded that “... evidence both from the UK and internationally suggests that quality based competition with prices fixed by a regulator can be beneficial, producing higher quality care at the same cost on average and, importantly, not leading to increased inequity in access to care.”
32. These studies suggest that the right approach to competition on the supply side of any sector of the economy can help deliver efficient services. This includes productive efficiency in the short run – ensuring providers are getting the most out of the resources invested in the services they deliver; allocative efficiency – ensuring services get the right balance to match service user needs and preferences; and dynamic efficiency – ensuring the providers deliver innovation and productivity gains over time.
33. The number of studies that directly draw on experience in healthcare markets is relatively limited. This is because the degree to which choice has been available in healthcare has been limited. During 2010, a number of studies were published that looked at the impact of earlier reforms to introduce patient choice in elective care in England. These studies build upon academic literature from a number of countries, notably the US, which discusses competition in healthcare services.
- Cooper et al (2010a²⁶, 2010b²⁷) found that following the introduction of choice in 2006 “... that in markets with fixed-prices, hospital competition can improve patient outcomes.”;
 - Bloom et al (2010)²⁸ also used the introduction of choice in 2006 to investigate the impact of competition on management and outcomes. They conclude that ‘... our measure of management quality was robustly associated with better hospital outcomes...[and]... more hospital competition appears to cause improved hospital outcomes.’
 - Gaynor et al (2010)²⁹ is a third paper that uses the introduction of choice in 2006 to investigate the impact of fixed price competition. Their findings corroborated those of Cooper, and they state in their concluding remarks ‘...that competition is an important mechanism to enhancing the quality of care patients receive. Monopoly power is directly harmful to patients, in the worst way possible – it substantially increases the risk of death.’

²¹ Nickell, S. Competition and Corporate Performance. *Journal of Political Economy*, 1996. Volume 104

²² Djankov S and Murrell P, (2002). Enterprise Restructuring in transition: a quantitative survey. *Journal of Economic Literature*, 40(3), 739-92

²³ Ahn, S. (2002). Competition, innovation and productivity growth: a review of theory and evidence, *Economics Department Working Papers No 37, OECD*

²⁴ Choice and Competition in Public Services: A Guide for Policy Makers. March 2010

²⁵ <http://www.ohe.org/publications/article/report-of-the-ohe-commission-on-competition-in-the-nhs-108.cfm> (see page 6 para4)

²⁶ Cooper, Z., Gibbons, S., Jones, S. and McQuire, A. (2010a) Does Hospital Competition Save Lives? Evidence from The English NHS Patient Choice Reforms, LSE WP 16/2010

²⁷ Copper, Z., Gibbons, S., Jones, S. and McQuire, A. (2010b) Does Hospital Competition Improve Efficiency? An Analysis of the Recent Market-Based Reforms to the English NHS CEP discussion paper no.988

²⁸ Bloom, N., Propper, C., Seiler, S. and Van Reenan, J. (2010) The Impact of Competition on Management Quality: Evidence from Public Hospitals CMPO WP 10/237

²⁹ Gaynor, M., Moreno-Serra, R. and Propper, C. (2010) Death by Market Power: Reform, Competition and Patient Outcomes in the NHS CMPO WP 10/242

- Both Bloom and Gaynor found that the volume of patients that moved from one hospital to another was not large and that the viability of the hospitals was not called into question. Nevertheless a significant improvement in quality was observed.
34. In summary, there is some evidence that plurality of supply in service provision can lead to more efficient delivery of goods and services in the wider economy. Further, there is an emerging evidence base to support the assertion that fixed price competition as introduced to some areas of the NHS (elective care) has had positive effects in terms of both efficiency and outcomes for patients.

What are the underlying causes of the problem?

35. There are considered to be a number of underlying problems that can hinder patients from having more say in decisions about their care leading to services not reflecting patient preferences. These are discussed below, in turn.

Functionality of support systems

36. A prerequisite for patients to be able to exercise choice is that patients need to know what options they are making a choice over. Choice of provider at the point of referral is supported by and exercised through the Choose and Book (CAB) system. This is an electronic referral and booking system that lists the appointment slots available to patients for any given services and allows patients (or their healthcare professional) to choose between them. They can then choose to book the appointment via a computer at the GP practice and leave the GP surgery with a confirmed appointment; book it by telephone at a later date to fit in with other diary commitments or book directly online outside the practice through the use of a Unique Booking Reference Number (“UBRN”). Evidence suggests³⁰ that initially, in some cases, the system proved difficult to use. Since then, the user interface has been improved. Some concerns about the CAB system may stem from the way in which it has been implemented locally or the way in which it is used.
37. As more say in decisions about care and treatment is expanded to other services beyond elective care, systems to support patients will continue to be important if the take up of the choice offer is to be successful. If patients and healthcare professionals are unable to use the systems as intended or as efficiently as possible, then the aspirations of the proposals will not be met.

Attitudes and behaviours

38. Patients need a conducive atmosphere in order to make choices; one where both patients and professionals have bought into the idea of the patient being involved in decisions about their care and where ‘No Decision About Me, Without Me’ is the norm. Since the NHS was established, relationships between healthcare professionals and patients have developed which promote the professional as the decision maker and the patient as the passive recipient of care. This is not universal; many clinicians and others would seek to involve the patient in decisions and many patients would seek to influence the direction of their care.
39. With patient choice being concentrated on choice at the point of referral to first hospital outpatient consultant-led appointments, the attitudes of GPs, among professionals, has been most important so far. If GPs are hostile to the idea of choice, then this could be a reason why the proportion of patients reporting being offered choice in the Patient Choice survey plateaued at 49%³¹. In its 2010 report, the King’s Fund³² interviewed GPs and hospital providers about what they thought about choice. They summarised their findings thus:

‘In general, the majority of those we spoke to among GPs and providers were positive or ambivalent about choice. Many felt that patient choice had existed within the NHS prior to the recent policy focus, and therefore, choice was really nothing new. A small number of interviewees felt that the policy had focussed the minds of GPs and providers on what really mattered to patients.’

³⁰ Kings Fund Patient Choice (2010)

³¹ Dixon, S., Report on the national Patient Choice Survey- February 2010 Department of Health (2010)

³² King’s Fund, *Patient Choice* p38 (2010)

40. This suggests that healthcare professionals are not against choice in principle. The take up figure of around 50% suggests, however, that some GPs may be reluctant to turn their acceptance into action within the consultation room – at least in such a way that patients recall a “choice conversation”. This might be the result of a perceived time pressure associated with offering patient choice, i.e. a belief that to offer choice effectively costs time that they do not have. For example, one GP told the King’s Fund ³³:

‘If you have to refer that patient and have to create a choose and book letter... ..you have to explain their choice... ..then you have to explain the process... ..and it takes time... ..at least 15 minutes.’

41. The King’s Fund suggests that it is past problems with the Choose And Book system³⁴ that has influenced GP views on choice more generally.
42. In summary, the evidence about attitudes appears to be broadly positive, or ambivalent at worst. The proposed changes to make more ‘No Decision About Me, Without Me’ the norm through the healthcare system and to embed it into the decision making process could face initial problems as behaviours will have to change. However, the evidence suggests there is little cause for long term concern.
43. Patients will have to regain their voice and be more demanding about the quality of care they receive and look to hold providers to account. Healthcare professionals will need to facilitate patients’ involvement in decisions about their healthcare and support patients seeking reassurance about those decisions. As a result, better decisions will be made and the quality of care and outcomes would be improved.

Offer of choice

44. A lack of available options may have restricted the ability of patients to make meaningful choices to date. But the survey evidence, (see para 23 above) suggests that any problems of matching healthcare to patient needs is not caused by patients’ unwillingness to embrace choice. Therefore, one should be able to take some comfort that as and when choice is expanded to other areas of care (beyond choice of first outpatient appointment) patients will be willing to make choices as they become familiar with what is on offer.
45. The Patient Choice Survey³⁵ commissioned by DH suggests that the awareness level of choice by patients rose steadily but slowly (reaching 54% in Feb 2010) during the period over which the surveys were conducted. The plateauing at just below 50% of patients recalling being offered choice, from Spring 2008 onwards, could be a supply side blockage as much as a lack of demand side push from patients.

Information

46. Choice is at its most powerful to shape services if those choices are fully informed because the matching of patient preferences and needs to healthcare services will be more closely aligned. At present, the NHS generates large amounts of information in some areas and smaller amounts in others. For example, the NHS has historically collected data on the use of input resources like staffing numbers and available beds, but not on the outcomes from treatment. The Government recognises the need to do more. In the consultation *Equity and Excellence: An information Revolution*³⁶ (October 2010 – January 2011), the Government sought views on the requirements of information to support patient choice. The Government is also committed to publishing more information about outcomes through the NHS Outcomes Framework³⁷, and will use them to hold the NHS to account.
47. Information must be accessible, if it is to have a positive effect on decisions. The Government currently funds NHS Choices; a website for disseminating information to patients. The Government has also consulted on whether other organisations alongside NHS Choices may also be well placed

³³ Ibid p42

³⁴ Ibid p45

³⁵ Dixon, S., *Report on the national Patient Choice Survey- February 2010* Department of Health (2010)

³⁶ http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_120080

³⁷ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131700

to deliver information to patients, for example patient representative organisations or private sector firms.

48. Other streams of information, beyond official statistics, may also be of value to patients. These include user feedback, word of mouth on past experience and reputation. Some NHS and Foundation Trusts already encourage feedback from patients to help shape services. The Care Quality Commission conducts surveys on patient experience and satisfaction.
49. Therefore, while some information exists on a wide range of activity and experience, it is not comprehensive. Evidence from the King's Fund³⁸ suggests that patients make limited use of it at present to make decisions about their care. The majority of information they do use is provided by GPs. However, as choice becomes more embedded in the NHS, there is the potential for information to become more widely used to support decisions.

What policy options have been considered

Option 1: Do nothing

50. The present choice offer is primarily at the point of referral to consultant-led first hospital outpatient appointments. Patients can choose the provider of Acute Care Services in England as delivered under the Standard NHS Acute contract at referral to a consultant led first outpatient appointment and any subsequent care. Services such as mental health, maternity, end of life care and diagnostic services are presently excluded from the formal choice offer.
51. Under the do nothing option, patients will continue to be offered this formal entitlement to make choices. Additional choice options may be available locally. Patients will also receive an increasing choice offer of locally provided community services under the Any Qualified Provider policy. A second extension to the choice offer is will take place at the point of referral to allow not just choice of provider, but also choice of the named consultant-led team within providers. This increases the accountability of the service provider to patients. Both of these extensions to choice come into effect from April 2012.
52. Under the do nothing option a degree of involvement about care and treatment will be available to patients. However, it will be limited primarily to the point of referral to hospital before extending to some community and mental health services and to choice of named consultant-led team. The coverage of community and mental health services for which the any qualified provider commissioning model will apply is expected to continue to increase over time under the do nothing option.

Derivation of policy options

53. The policy options for implementing the additional proposals were influenced by the pre-existing policy on choice and shared decision making and the way in which any qualified provider and named consultant-led team proposals are being implemented. Further influences were the existing infrastructure to support patients to make choices (for example, NHS Choices and the Choose and Book system) which are considered out of scope for this impact assessment and subject to other policy developments. Option 2 below was designed to build upon the current choice offer and systems to extend the choices available incrementally.
54. The proposals set out in *Liberating the NHS: No Decision About Me, Without Me – Further consultation on proposals to secure shared decision making* reflects the principles that patients should have more say in decisions about their care and treatment. It does not prescribe the operational details of the precise means through which the policy proposals will be implemented. Some elements of implementation will be for local commissioners, individual patients and service users to determine. In other cases, the precise means of implementation will be contingent on Parliamentary approval of the Health and Social Care Bill³⁹.

³⁸ King's Fund, *Patient Choice* p86 (2010)

³⁹ <http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/HealthandSocialCareBill2011/index.htm>

Option 2:

55. The proposals are designed to meet the commitments to extend patient choice as set out in the *White Paper Equity and Excellence: Liberating the NHS*. The presumption of 'No Decision About Me, Without Me' will become the norm for the majority of NHS-funded services by 2013/14. Thus choice will be a reality in primary care, before diagnosis, at referral to other service providers and after diagnosis. A summary of what this means is given in paragraphs 7-21 above. Full details are given in the consultation document *Liberating the NHS: No Decision About Me, Without Me - Further consultation on proposals to secure shared decision making*, which this impact assessment accompanies.
56. The further consultation document asks respondents specifically whether they agree with the proposals. These proposals formalise and extend beyond existing choices that are available to some patients some of the time. Phased implementation of the changes would mean patients and service users would have more say in decisions about the provider of diagnostic tests and who provides their maternity or mental health services.
57. There are a number of levers that are proposed to help deliver more say in shared decision making subject to Parliamentary approval of the Health and Social Care Bill. The proposed levers include requirements placed on commissioners for example, by the NHS Commissioning Board, and requirements on providers through contracts. At this juncture, we cannot be specific as to the precise mechanisms used to implement the proposals until the Bill has been passed by Parliament and the new organisations such as the NHS Commissioning Board and Monitor have been established
58. The model of shared decision-making includes specifically:
- Choice of GP practice (covered by a separate IA⁴⁰)
 - Use of the any qualified provider commissioning model for community based services, (covered by a separate IA⁴¹)
 - Choice of diagnostic test provider,
 - Choice of named consultant led team for referrals to a consultant led first outpatient appointment for acute elective services (covered by a separate IA⁴²),
 - Extension of choice of named consultant-led team to secondary care mental health services,
 - Extension of choice to other professional-led team in secondary care mental health services,
 - Choice of place of birth within a maternity network,
 - Shared decision making and choice of treatment and care planning.
59. Many of the practical mechanisms that are required to facilitate 'No Decision About Me, Without Me' are already in place. Beyond the contractual arrangements that define the commissioning process and relationships between purchasers and providers in the NHS; these include the electronic appointment booking system known as Choose and Book; and support for patients, e.g. information on different providers and treatments and Local Healthwatch – organisations to signpost patients to the options available to them.
60. In order to expand patient choice to include choice of diagnostic test provider and choice in maternity and mental health services, some of the terms in the NHS Standard Contract will need to be amended. Additionally appointment slots for relevant services may need to be added to the Choose and Book system by providers of those services.

Impacts

61. The impact section has separate parts for choice of diagnostic test provider, choice in maternity services and choice in mental health services. It then has a final part that covers generic issues relevant to the presented model of shared decision-making.

⁴⁰ http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Consultations/Liveconsultations/DH_113437

⁴¹ http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_125442

⁴² http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_130425

Diagnostic Services

62. The expected impact from expanding choice of provider of diagnostics services is that the patient will have more say in decisions about who provides the diagnostic service they receive and when and where they receive their diagnostic tests. Choice of diagnostic test provider in primary care was covered by the Any Qualified Provider impact assessment. Choice of consultant led secondary care diagnostic test provider is within scope of existing choice policy.
63. More patient and service user involvement in decisions about the provider of non-consultant led diagnostic tests means that there is the potential for referral patterns to change, both to and within organisations, as patients exercise choice. Patient experience should improve as providers respond to the choices patients make. Principally, this is likely to mean improved convenience over appointment times and innovation in how these services are provided.
64. In the short term, referral patterns are not expected to change dramatically. This is because the choices available to patients will be constrained by the options available. However, the choices that patients make will send signals to providers about the popularity of their services leading to changes in service provision in the longer term.
65. In the medium term, providers will have the opportunity to respond to patient preferences. For less popular providers this may be deciding how to improve their service to make them more attractive to patients. Or if this is not possible, making a decision about disinvestment. For more popular providers, they may need to consider whether they wish to make more slots available.

Benefits

66. The main benefit to patients from more say in decisions about diagnostic test provider is that of greater convenience. Related to this is the intrinsic value to patient from more choice.
67. An evidence base that allows for quantification of these two areas of benefits does not exist. Nevertheless, we know that patients value choice (see King's Fund report on Patient Choice). Further evidence, if it becomes available, would be included in the final impact assessment that will accompany policy documents to be published later in the year.

Costs

68. Potential costs for increasing choice of diagnostic test provider through its extension to non-consultant led secondary care diagnostic tests centre on the cost of adding appointments to the Choose And Book appointment system. The cost that interests us in this impact assessment is the marginal cost of putting additional diagnostic services onto the system. This is because the main infrastructure of the system is already in place so the set up costs have already been accounted for.
69. These marginal costs are believed to be low or negligible. This is because the functionality to host appointments slots for diagnostic services already exists.
70. Service providers face potential costs when making appointment slots available on Choose And Book. These are principally management costs. For providers that already provide NHS-funded services and are connected to the patient administration system (PAS) the marginal cost should be minimal. This is because the PAS and Choose And Book system are compatible – in effect automating much of the process. The main exception are the Picture Archive and Communication System (PACS) and the Radiology Information System (RIS) which are not currently compatible with Choose and Book. Scoping work is planned to look at the issues and costs associated with making it compatible in the future.
71. New providers of NHS-funded services may face an IT hardware cost to connect to the Choose and Book system. For example, they may need an N3 connection (the name of the secure IT connection that links them to the NHS system) and other hardware that allows them to use NHS PAS. Additional marginal costs from linking to choose and book are minimal as explained above for existing providers. It should be noted that connectivity with NHS systems is a condition of doing business with the NHS and should not therefore be counted as costs of the extension of choice per se.

On maternity services

72. The area of maternity that one would expect to see an impact upon is the decisions women are able to make about the place where they give birth to their baby. On 25th November 2011, a study Birthplace⁴³, was published which provides evidence for those women with 'low risk' pregnancies about the risks and outcomes associated with different planned places of births – at home, in a midwife led unit and in an obstetric unit. The findings will help women make informed choices when planning a birth and can be used by commissioners to plan maternity services at a local level.
73. The table below gives details of the places where births currently take place. The vast majority occur in obstetric units.

Births In England, 2007

Type of unit	Number of units	Number of maternities	Percentage of maternities
Obstetric	180	590,859	92%
Alongside-midwifery	26	19,192	3%
Freestanding-midwifery	56	11,261	2%
Home Births		18,323	3%
Total	262	639,635	100%

Source: Birthplace Study, ONS, NHS IC

74. The impact, from giving women more say in decisions about the place of birth of their baby, on the configuration of services will depend on the choices women make. Local commissioners and providers will need to be responsive to these choices and ensure they have resources in the right places. However, the expectation is not that the result will be a large net change in places of birth, but that women will have more involvement in their care.

Benefits

75. The main benefit to women will be more say over the service being delivered to them. We do not have evidence that allows us to quantify this benefit but the evidence listed above shows that it is a choice that women want and that this has an intrinsic value.

Costs

76. The Birthplace Prospective Cohort Study conducted a cost-effectiveness analysis of planned births by birth setting for women and babies at 'low risk' of complications prior to onset of labour. The analysis showed that the adjusted mean costs for intrapartum care per woman, at 2010 prices were:
- For all 'low risk' first time mothers - £2,075 (OU), £1,983 (AMU), £1,913 (FMU)
 - For all 'low risk' first time mothers without complicating conditions at start of labour care - £1,940 (OU), £1933 (AMU), £1881 (FMU)
 - For all 'low risk' multiparous women - £1,142 (OU), £991 (AMU), £969 (FMU)
 - For all 'low risk' multiparous women without complicating conditions at start of labour care – £1,077 (OU), £978 (AMU), £954 (FMU)
77. Using the above estimated mean costs, an overall average for 'low risk' pregnancies is determined as £1558.50 (OU) and £1471.25 (AMU). Therefore, the potential saving to the NHS per woman delivering in an AMU instead of an OU is £87.25.
78. As stated above, the expectation is that the pattern of births will not change much as a result of the proposals. Nevertheless, the cost data shows that the average cost of births in different settings is very similar and that, if women choose to give birth in settings other than obstetric units then the cost could be slightly lower in the long run.

On Mental Health Services

79. The expected impact upon mental health services is that secondary care service users will be able to choose the consultant (or other healthcare professional) led team to whom they are referred

⁴³ <http://www.bmj.com/content/343/bmj.d7400?tab=full>

within an organisation. The number of adults who access secondary care mental health services in England in 2010/11 are shown in the table below – with the majority using non admitted outpatient services. These services may be led by consultants or other healthcare professionals. Overall, we do not expect the number of patients accessing such services to increase as a result of the greater choice proposed as the routes for referrals will not change.

Adult Service Users for Secondary Mental Services, England 2010/11

	Total	Admitted	Non-Admitted	No care
Adult Service Users	1,287,730	106,719	1,094,138	86,873

Source: NHS IC, Mental Health Minimum Dataset 2010/11⁴⁴

Benefits

80. The benefit to patients should be twofold. First, they should be able to choose a team that they prefer, either because they have received services from them before and wish to see the same person or because the team was recommended to them. Second, they will have greater convenience from being able to select appointments that suit them at the point of referral.
81. To date, choice in secondary mental health services has been relatively limited. Therefore, we do not have evidence of the direct impact choice in mental health services will have that would allow us to quantify the benefits. Nevertheless, one would expect it to deliver similar benefits to those found in the papers by Cooper and Gayner from Free Choice in elective care.

Costs

82. As for diagnostic services, an area of potential costs for increasing choice of mental health services is the cost of adding appointments to the Choose and Book system. This is because the main infrastructure is already in place so the set up costs of the system have already been accounted for.
83. Again, the marginal cost is expected to be low as the system is already capable of supporting mental health services. The same discussion as given above for diagnostic services also apply to mental health services.
84. A second area of costs could be that patients choose an appointment with a healthcare professional that offers a different range of treatments for the condition being referred. If these treatments are more expensive than the treatments the service user would otherwise have received, the cost of delivering the service to that patient would rise. At present, we do not have any evidence that this would happen and conversely, there is an upside risk that patients may choose appointments with professionals delivering treatments that are less expensive. Further evidence will be presented in the final impact assessment, if available. Whatever the choices made, in the short run, changes to referral patterns will be constrained by the capacity of the popular team to treat patients. This point is expanded upon in the 'spare capacity' discussion in the risk section below.

On applying the model of shared decision making across the NHS

85. This part discusses issues generic to the model of shared decision making. In general the expected impacts are that:
- Patients will have more say in decisions about who provides their services and when and where they receive them.
 - Patients will be more involved in decision making about the treatment they receive.
86. The consequences of these impacts are that:
- referral patterns of patients, both to and within organisation, has the potential to change as they exercise choice about from whom they receive care;

⁴⁴ <http://www.ic.nhs.uk/pubs/mhbmhmds11>

- treatments received by patients will better match their preferences as they are involved in the shared decision making about their care;
 - in the medium term, quality of services and patient experience will improve as providers respond to the choices patients make – leading to improved outcomes and convenience and experience for patients which has value in and of itself,
 - in the medium to longer term, commissioning decisions by commissioning groups and investment decisions by providers will improve as they respond to signals from patient choice and changes in usage patterns
87. As discussed above, the introduction of the model of shared decision making will be implemented in a phased way. This will be true in terms of the engagement with patients as they become more familiar with exercising more choice. It could also be true from the perspective of service providers. Some local commissioners and service providers may embrace more choice sooner than others depending on local decisions.
88. One would not expect greater choice of provider to lead to all patients moving to the ‘best’ provider in one go. One would expect referral patterns to shift over time and this will provide a signal to providers and commissioners about where investment and disinvestment decisions should be made. Different patients will have different ideas about what is best is for them. Consequently, there may be no single ‘best’ provider for a given service in a given area. There may be many high quality providers meeting different patient needs. This is discussed further under the heading “spare capacity” in the risk section in paragraphs 130-133.
89. A second factor that will determine how the landscape of service providers will develop is the economies of scale for a service in a given geography. Some services require large up front investment in equipment, and therefore may only be efficiently delivered by a relatively small number of providers. Other more straightforward services, e.g. hearing tests or podiatry services, may be efficiently delivered on a smaller scale and thus will support a more plural provider base.
90. Extending choice applies to choice of treatment and care planning as well as the range of services. This will involve more shared decision making, including the use of patient decision aids.
91. Owing to the lack of evidence, it is difficult to model the choices patients and service users will make and consequently the specific impacts upon particular services. Here, we discuss the important elements of benefits and costs from the proposed general principles of patient choice. As it is difficult to model which choices patients will make, one cannot be sure of the specific outcomes for each service. However, the general principle is that, if we can demonstrate that the benefits are likely to outweigh costs as a result of giving people more say and involvement over their care, then this should hold for any individual service unless there are specific differences or features of that service that should be taken into account.

Benefits

92. As the coordinating document for the impact assessments that accompanied the Health and Social Care Bill 2011⁴⁵ made clear, the benefits from choice are linked to the reforms proposed in the Bill and it is difficult to attribute quantified amounts of benefits to individual policies. This is because it would be artificial to separate out individual policies from the suite of reforms. The evidence is not robust enough to support a disaggregating of the benefits in this way.
93. The main means by which more say in decisions about care and treatment contributes to benefits include:
- Greater convenience and intrinsic value of more say and involvement for patients and service users
 - Improved quality of care and health outcomes for patients and service users; and
 - Potential cost savings or productivity gains from more efficient provision by providers and a more efficient allocation of resources to services in line with patient preferences.

⁴⁵ see para 37, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123635.pdf

Intrinsic value of more say and involvement in shared decision-making

94. We know that patients want and therefore value choice (see paragraph 18 above). The executive summary of the King's Fund Report (2010) notes that:

“even if relatively few patients chose to attend a non local provider, our evidence shows that they valued having the ability to choose. We therefore conclude that given its intrinsic value, the NHS should continue to offer patients a choice of hospital.”

However, no research appears to have been carried out on quantifying this intrinsic value. Therefore, we cannot quantify the value, though additional evidence shows that those patients who were involved in shared decision making and had greater participation in their care felt more in control⁴⁶.

95. Evidence⁴⁷ suggests that having “activated” patients, who participate more in their care through shared decision making, increases treatment adherence and improves outcomes.
96. Some academic papers have been published that quantify some of the benefits in terms of improved outcomes to health and greater efficiency of provision. These are summarised below.

Improved health outcomes

97. A paper by Gaynor et al (2010)⁴⁸ looks at the effects on health outcomes as a result of the expansion of patient choice in 2006. They used mortality rates (both AMI mortality and all-cause in-hospital mortality) as the measure of quality. They found that the policy change did have a statistically significant impact on mortality rates. They estimate that the policy change led to a change in mortality rates that equates to 3,353 life years saved at a value of £227 million.
98. The authors point out that this covers only one area of quality. Hospitals undertake many interventions for admissions where risk of death is low. For these, other measures of quality would be more appropriate, e.g. quality of life, but for which no suitable measured variable was available. If one could measure quality of life for other areas of health interventions, it is likely that the value of the health gain would be higher than the £227 million that the authors estimate.
99. As well as the expansion of choice, the paper considers the impact on lives saved from the change in market concentration of hospital provision between 2003 and 2007. A fall in market concentration (measured as a HHI⁴⁹ calculation) means that a hospital acts less like a local monopoly provider. They find that “a hospital in a lower HHI market would have 3.1% fewer deaths per year... this translates into 54,771 more lives saved, with a monetary value of... £3.7 billion.”
100. They also note that they could find no change in either operating expenditure or operating expenditure per admission following policy implementation, so the life year gains were achieved at no additional cost to the taxpayer.
101. A paper by Loh et al (see reference 38) investigated shared decision making in primary care treatment of depression. They found that 60% of the variation in outcome was attributable to patient adherence to treatment and that shared decision making could improve adherence. They therefore concluded that shared decision making can lead to improved outcomes through better treatment adherence.
102. In summary, the evidence shows that allowing patients to choose the provider in one area of health care (elective surgery), or having more say over their treatment, has improved the health outcomes for those patients on average. While it is not possible to quantify the benefits, one would expect similar improvements in other areas of the NHS once patients are able to have more say and involvement in those areas. In addition, those patients who are able to participate in their care are more likely to adhere to their treatment and receive better health outcomes as a result.

⁴⁶ Department of Health analysis of “Self care survey”, Department of Health/Ipsos-MORI, 2009

⁴⁷ Loh et al. “The impact of patient participation on adherence and clinical outcome in primary care of depression”. Patient education and counselling 65(2007) 69-78

⁴⁸ Gaynor, M., Moreno-Serra, R., Propper, C., Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service The Centre for Market and Public Organisation working paper series no 10/242 (2010)

⁴⁹ Herfindahl Hirschman Index = $\sum_i^N s_i^2$; where s_i is the market share of the firm_{*i*} in the market

Improved efficiency of provision

103. Gaynor et al (2010) also discuss the benefits in terms of reduced length of stay of hospital admissions. They estimate the value of the reduced lengths of stay to be £24 million as a direct result of introducing the choice of provider policy and, similar to the life years gained, the value of shorter stays for a hospital in a lower HHI market at £0.4 billion. Again, these data do not cover all hospital activity and only give a partial picture.
104. The efficiencies listed above are short-term efficiencies, i.e. efficiencies a provider can make from better use of existing resources or greater focus on the efficient use of these resources that arise from competitive pressures. However, a provider can also achieve long term 'dynamic' gains over time by making the right investment decisions that allocate resources in the most productive areas or those areas which align most closely with patient preferences. Patients' choices inform these decisions by providing signals to providers (and commissioners) about precisely which services patients want to opt to use. This type of efficiency gain is applicable to all areas of the NHS where patients are granted opportunities to make choices.
105. In summary, there are a number of ways that allowing patients more say in decisions about NHS services can lead to benefits. However, the evidence does not allow us to extrapolate reliable quantitative values for them. This section has, therefore, provided a discussion of the types of benefits that are expected to arise and summarised the available evidence as to their expected magnitude. This is based on the limited NHS based evidence and analyses that are available, of introduction of more patient choice from 2006.

Costs

106. As mentioned in paragraph 59, the delivery of more say and involvement in decisions about care and treatment relies on a number of mechanisms. These have a cost to the NHS and are discussed below. Many of them are already in place so the marginal cost of using them to implement the proposals is low.

Information to support choice

107. The costs associated with information provision to assist patients and service users make decisions about their care will be considered in a separate impact assessment that will accompany the publication of the Information Strategy.

Choose and Book

108. The costs associated with the Choose and Book system are discussed in paragraphs 68-71. The costs discussed there in relation to diagnostic services apply more generally to appointments for any service being added to the system.
109. To reiterate the points: the main infrastructure is already in place and funded. The service areas to which choice is initially being extended, e.g. diagnostic test provider, maternity and mental health services are already able to be incorporated into the booking system but this functionality is not currently being used for all appointments. Therefore, the marginal costs of expanding the use of Choose and Book to host the appointment slots for these services are negligible or low as the functionality is already in place and maintained under existing budgets.
110. Service areas that are not currently listed on Choose and Book would incur a development cost if they were to be added in order to, for example, produce new categorisations of services. Further consideration of these costs will be necessary if additional development work is subsequently required for e.g. ensuring compatibility with the RIS.
111. Again as already raised, for providers of healthcare, there would be a small unquantified cost associated with the process of listing new services on Choose and Book.
112. For providers that already provide NHS-funded services and are connected to the patient administration system (PAS), the marginal IT system cost to providers would be expected to be close to zero. This is because the PAS system is expected to be already fully compliant with Choose and Book.

113. There may also be a management cost to each provider in ensuring appointment slots are available and entered on to the system. The management cost arises in providers ensuring that their slots on the system are up to date. Further consideration of these costs will be undertaken during the consultation period.

Decision aids

114. Patient Decision Aids (PDAs) are designed to help patients make difficult decisions about their treatments and medical tests. They are used when there is no clinical evidence to suggest that one treatment is better than another and patients need help in deciding which option will be best for them.

115. Between July 2010 and August 2011, NHS Direct were commissioned by East of England Strategic Health Authority to develop 8 online patient decision aids (OPDAs). They covered:

- Localised prostate cancer, Benign Prostatic Hyperplasia, and Knee Osteoarthritis adapted from US versions under license from Bupa Health Dialogue in phase 1;
- PSA Testing, Amniocentesis / CVA Screening and Breast cancer adapted from hard copy versions produced by Cardiff University in phase 2; and
- Osteoarthritis of the Hip and Cataracts developed in-house in phase 3

116. The costs of the project were as follows:

	Cost
Development of 8 OPDAs	£913,000
Website set up costs	£103,000
Annual cost to host and maintain 9 OPDAs on website and telephony back up*	£175,000
Total	£1,191,000

* Recurring annual cost

Source: NHS Direct

117. The programme to develop further decision aids has been extended at a cost of £1 million under the Shared Decision Making Programme hosted by NHS Midlands and East. The programme has already been costed and the funds allocated.

Local Healthwatch

118. The costs of Local Healthwatch are set out in the Impact Assessment that accompanies the Health and Social Care Bill. Funding will be the responsibility of Local Authorities. This will include the transfer of existing budgets for NHS Complaints Advocacy, Local Involvement Networks and Patient Advice and Liaison (PALs) Networks. An evaluation⁵⁰ of existing services suggest that they cost £19.3 million per year in England. Of that, 75% of the budget supports patients to make choices by providing information and through signposting. Additional funding will be provided to compensate for the increased demand for choice. The table below shows a summary of financial costs of Healthwatch associated with choice.

Table 2: Summary of financial costs to Healthwatch to support patient choice

£m	2011/12	2012/13	2013/14	2014/15
Existing PCT expenditure on PALs	19.3	19.3	19.3	19.3
Cost of providing support for choice (@ 75% existing spend)	14.5	14.5	14.5	14.5
Additional funding to support choice from Spending Review settlement	0	0.5	1	1.5

⁵⁰ Evans et al, National Evaluation of Patient Advice and Liaison Services Final Report, (2008)

Total to support choice	14.5	15	15.5	16
Total to support choice in 2010/11 prices (discounted at 3.5%)	14	14	14	13.9

Source: Impact Assessment on Health and Social Care Bill, Annex D Healthwatch p102

119. Although this table has been included here for clarity and completeness, the costs should not be included in the costs of the current proposals as it has been included in the cost of implementing the Health and Social Care Bill. The marginal cost to Healthwatch as a result of the measures covered by this impact assessment are zero. But, as the table shows by 2014/15, Healthwatch will have a budget of £16 million to support patient choice.

Risks

120. There are a number of potential other costs that could arise from choice and greater patient involvement in decisions about their care. These include an increase in the time of healthcare professionals and patients to make a choice about their care; the need for spare capacity to facilitate choice; increased costs if patients choose to receive services from providers located in geographically more expensive location, e.g. London, increased transport costs from patients travelling further to receive care.

121. These areas have been covered in previous impact assessments relating to the *Greater Choice and Control* consultation process^{51, 52}.

Healthcare Professionals' time

122. Previous impact assessments relating to the *Greater Choice and Control* consultation have discussed the possibility that extending patients' choices to new areas could lengthen GP appointment times. The evidence in the report by the King's Fund⁵³ provides a range of views from GPs themselves. Some believe that delivering choice via the Choose and Book System takes a considerable amount of time while others do not. Of course, providing more say over care and treatment is about more than the use of an appointment booking system. It is a model of care with open patient engagement in shared decision making with their healthcare professional; one where the options of treatment and provider is an integral part of the discussion between the two. This is acknowledged in guidance by the General Medical Council⁵⁴. Therefore, the requirement is not for increased time for an appointment but a change in behaviour on the part of both patient and clinician.

123. Delivering shared decision making will require healthcare professionals across many services to have good communication skills. The level of competence may vary between individuals and there remains a risk that poor communicators may require longer average appointment times if greater patient involvement in shared decision making is to be delivered. Another risk is that, if some healthcare professionals with poorer communication skills cannot adjust to new ways of working, the level of engagement with the patient falls short of the ambition of the policy. Finally, there is a risk that where healthcare professionals do not engage with patients, there is less shared decision making and the full range of benefits identified above do not flow.

Patient time

124. For patients to make an informed decision about their healthcare, they will need to get the information necessary to support their choice from one source or another. Otherwise, they risk making choices that do not align with their preferences. The level of information required will vary depending on their condition and their preferences. Typically, patients may receive the information they need from their GP or another healthcare professional. Alternatively, they may have carried out some research on disease or condition specific websites or on broader healthcare internet sites such as NHS Choices. If patients undertake any research or information gathering to reach their

⁵¹ http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_125442

⁵² http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_130425

⁵³ http://www.kingsfund.org.uk/publications/patient_choice.html

⁵⁴ http://www.gmc-uk.org/guidance/good_medical_practice/contents.asp

decision, it will have taken them time, which may carry an opportunity cost. We have no evidence on either the average time a patient might take or the distribution of different approaches to researching choices amongst patients. Patients have a choice whether they seek out information about the different options available to them and we assume that patients will only research their choices where they perceive there to be an intrinsic benefit from doing so. One of the important aspects of the policy is that patients who do not want to make a choice or who prefer to delegate it to their healthcare professional can do just that. Because of these uncertainties, we have not attempted to monetise this potential cost to patients.

Spare capacity

125. Some commentators have suggested that the policy of more patient choice in the NHS is inefficient and costly as it will require the system to maintain spare capacity to allow for choice (Fotalki et al 2005). This is a misunderstanding of the way in which choice policy operates and the way in which appointments for elective care are booked. In practice, providers do not have to carry spare capacity in order for any patient to be treated. Patients select an appointment from a range of available slots at a specified point in the future; typically a first outpatient appointment will be a number of weeks after the decision to refer is made. This delay between the point at which the choice was made and when the appointment takes place reduces the need for providers to maintain spare capacity to facilitate choice. Patients can only choose from appointments that are available. If a provider, or individual healthcare professional, is popular, patients will have to wait for the next available slot. This mitigates the risk that all patients choose appointments with the same consultant-led team which could potentially destabilise the system. Consequently, providers will be able to decide how much capacity they need depending on how many appointments they wish to offer. Some providers could carry excess capacity but this would be a consequent of poor planning and such risks exist now.
126. This willingness to wait by patients reduces the need for provider to maintain spare capacity. By being willing to wait the cost of allowing choice is shifted onto the patients themselves in terms of the time they must wait.
127. In the short term, the result could be that popular providers will have longer waiting lists and longer waiting times than those less popular. The difference in waiting times between providers will be an indication of the difference in value patients assign to the relevant providers relative to the supply of appointments. Waiting times and lists may fluctuate but are unlikely to rise indefinitely. As the waiting time for a popular provider goes up so does the cost to the patient of waiting (for example anxiety), until it becomes preferable to switch their choice and go to a provider with a shorter waiting time. Therefore, in the short term, the choices patients make act as a mechanism to match the demand for a service with the available supply and send signals about the demand for particular services. Prior to patient choice no mechanism existed to allow this matching outside of central planning and large regional variation in waiting times persisted. It is possible that an extreme scenario could materialise where a healthcare professional is so popular that she has long waiting times for her appointments while others have free appointment slots. In this scenario the system would be inefficient. However, there is no evidence to suggest this situation is realistic; the probability of it happening is likely to be low. Even if it were to happen, it is unlikely to be a problem in anything other than the short run.
128. In the medium to long term, rising and falling waiting times and list sizes will act as a signal to providers about where more capacity is required and from where some capacity can be disinvested. Again, this provides an efficient means to allocate resources and ensure that unused spare capacity does not persist.

Higher cost areas (MFF)

129. Concerns have been raised that if patients choose to receive services from out of area providers, then this could lead to higher costs for some commissioners if those providers have a higher market forces factor (MFF). In the impact assessment for expanding choice of provider to include choice of named consultant-led team, an example was given where some patients living in areas within easy travel of London may choose named consultant-led teams at institutions with celebrated reputations in central London.

130. As choice of named consultant-led team was dealt with in a separate impact assessment, that analysis will not be repeated here, other than to note that the projected impact on the budgets of affected commissioners was small. Aspects of the proposals for 'No Decision About Me, Without Me' that this impact assessment accompanies are about generating options for patient to choose closer to home; as services become responsive to patient needs. Therefore, the impact on commissioners budgets is expected to be small.

Transport

131. Policies that give patients more say in decisions about their care and treatment have the potential to increase transport costs. For example, patients may choose to travel to a provider of the service that is located further away from them than the provider from whom they would receive the service, had patient choice not been extended. These arguments were considered in the impact assessment that accompanied the extension of choice from choice of provider (for first outpatient hospital appointments) to choice of named consultant-led team for those appointments. Using assumptions about the increased number of journeys, the estimate suggested that the cost to NHS transport schemes (i.e Patient Transport Services and Healthcare Travel Costs Scheme) could be up to approximately £885,000 per year as an upper bound. The costs to patients, paying for their own travel, was estimated to be in the range of £2million - £2.9million under some specific assumptions although there is no clear evidence on costs to patients of patient choice. Both these estimates assume that the extra cost comes from patients attending appointments at locations that involve more travel than if choice had not been available. It assumes patients cannot choose a hospital closer to home because this is the default position for the no choice scenario.

132. This assumption does not apply to the proposals considered in this impact assessment. Most of the proposals are designed to encourage providers to move services out of the hospital and deliver them in the community closer to home. Therefore, when a patient makes a choice they will have options of a range of locations. There is no evidence to model potential referral patterns as services from these locations are not yet available, but the suggested locations are the High Street or retail units in shopping centres. Therefore, the assumption used here is that patients will choose options that suit them best, for some this will mean shorter journey times and for others it may be longer. The net effect is assumed to be no increase in journey distance or cost. In reality, the expectation is that the journey distances should be shorter overall as the emphasis of the policies under consideration are to encourage provision closer to home.

Summary

133. Option 2 sets out the areas of expected impacts, costs and benefits that would arise from introducing the proposals to give patients more say and involvement in decisions about their care and treatment as set out in the document *Liberating the NHS: No Decision About Me, Without Me – Further consultation on proposals to secure shared decision making*. Many of the proposals extend choice into areas where little patient choice existed previously. Insufficient evidence exists to allow detailed modelling of the effects. Therefore, to present quantified costs and benefits is likely to give a false impression of the expected impacts. It is worth noting further that while we requested that respondents to the first round of consultation provided thoughts on costs and benefits of the proposed options in the first round of consultation, none were forthcoming with any details that suggested the costs would be unaffordable. Respondents will have another opportunity to comment on the affordability during the final round of consultation.

134. Many of the mechanisms for delivering the proposals exist at present or are being introduced as part of the wider reforms of the healthcare system, and are being covered in other impact assessments as set out above. The marginal cost of many of using the mechanisms to support these proposals is expected to be low as giving patients more choice over their care does not place an additional burden on them. This is particularly true for priority areas of diagnostic test provision, maternity and mental health services.

135. Research by Cooper et al and Bloom et al show that where choice of provider has been introduced to routine elective services in secondary care, outcomes and efficiency have improved. While this evidence is insufficient to support detailed modelling of the impacts of choice policy, it nevertheless suggests that introducing patient choice to other areas of the NHS could deliver similar types of benefits.

136. Therefore, overall we consider that the evidence on patient choice suggests that the proposals are likely to be cost-beneficial. Further analysis on the costs will be conducted for the revised impact assessment which will accompany the final proposals later in the year.

Annex A – Specific Impact Tests

Competition

The Office of Fair Trading has published screening questions to help determine whether a policy is likely to have an impact on competition. These are:

Would the proposals directly limit the number or range of suppliers?

The proposals allow patients increased opportunity have more say in decisions about their care and treatment, including the provider of the care or treatment. It does nothing to directly limit the number of providers of care.

Would the proposal indirectly limit the number or range of suppliers?

Yes. Patients and service users can only choose from providers who meet the terms of the NHS Standard Contract. These terms mean providers must deliver to NHS prices and meet pre-determined levels of quality in service provision. Suppliers not meeting those requirements will be excluded.

Would the proposals limit the ability of providers to compete?

No. The proposals are intended to allow any organisations that meet requirements and service specification to be able to compete. The proposals open up the range of services about which patients can make choices. Notwithstanding this, all holders of NHS contracts will have to register with the Care Quality Commission and with Monitor. The proposals here do not change those requirements.

Small Firms

The proposals aim to give patients more say in decisions about their care; and to increase the range of service to which the principle of ‘No Decision About Me, Without Me’ applies. Some services may well be suitable for small firms. Therefore, one would expect the policy to have a positive impact on small firms.

Environmental Impacts

There is no reason to expect any significant environmental impacts

Human Rights

There is no reason to expect any significant impact on human rights

Justice System

There is no reason to expect any significant impact on the justice system

Rural Proofing

Providing more say in decisions about care and treatment could potentially have an impact on those living in rural areas. People living in these areas may have different priorities and therefore different considerations when making choices than those living in urban or sub-urban areas, and may face greater difficulties in exercising choice.

While around 20% of the population in England live in rural areas, only around 10% of hospitals are located in these areas. This can be explained by a lack of critical mass of population, which limits the potential to exploit economies of scale and therefore makes healthcare services relatively more expensive. Services are therefore more likely to be located in areas with greater population density, where average costs can be minimised. The proposals for more choice are designed to make it easier for new providers to offer services and to be more responsive to patients. However, with rural areas having higher costs, the change in rural provision of health services may be small.

Despite the barriers to choice that exist in rural areas, research from the Kings Fund (2010) found that respondents living in small towns and villages or in rural settings were significantly more likely to be aware of choice, to be offered a choice and to choose a non-local hospital than those in cities, large towns or suburbs.

This impact assessment covers the proposals for more say, for all across the NHS. Access to information about choice can be an issue for people living in rural areas, whether that is from a library, directly from healthcare providers or by computer via the internet connections. It is not expected that providing more say will disadvantage rural patients, but they might not benefit as much as patients in urban areas.

Annex B: Evidence to support Patient Choice

- B1. The original design of the NHS joined the purchaser and the provider arms of healthcare systems. Secondary care services were given a block grant to deliver healthcare to local populations. Doctors responsible for delivering services had a large say in what should be provided. Giving incumbent providers a say over service design meant that the NHS proved to be slow to change as health services evolved, the range of services grew, treatments became more complex and expectations rose. Two shortcomings of the system have been its lack of responsiveness to patient preferences, resulting in poor patient experience, and poor ability to allocate resources to where they are most needed, resulting in outcomes being not as good as they could be.
- B2. Successive governments have looked to introduce reforms by splitting the purchaser and provider arms and to introduce elements of the market into healthcare. The aim was to allocate resources better and improve patient experience. The reforms have included competition between providers and the ability of patients to choose between them coupled with a payments regime that allows resources to follow the patient.
- B3. An important part of these reforms is to give patients more say in decisions about the care and treatment they receive. This can drive up the average quality of services and deliver better outcomes through a number of mechanisms:
- a) Competition through choice of provider leads to changes in patient flows, which improve the average quality of care;
 - b) Competition through choice of provider that creates a genuine threat of patient moves and therefore lost business, and revenue, (contestability) provides sharp incentives to providers to improve the quality of the services they provide;
 - c) Greater patient empowerment, including shared decision making and choice of treatment, affords a better match of patient preferences with treatment characteristics which may lead to better outcomes and is considered a benefit in its own right; and
 - d) Individualised patient centred services can reduce health inequalities and promote equality of access.
- B4. The following paragraphs discuss the merits of each of these in turn and gives a summary of the supporting evidence.

Patient choice of provider (Competition)

- B5. The most simple aspect of patient choice is that patients are not constrained to go only to a local hospital for treatment, but can elect to go to an alternative. The monopoly of provision is removed from hospitals which can lead to improvements in the average level of quality in a number of ways:
- 1) patients move from poor performing providers to better ones, changing the distribution of patients receiving better care and consequently the average quality of care received by the median patient. This does not necessarily change the performance levels of individual hospitals in the short term;
 - 2) poor performing hospitals lose patients. This acts as a signal of relatively poorer performance, the hospital may close, or reduce capacity, in the medium term again changing the distribution of care received across patients; alternatively
 - 3) poor performing hospitals lose patients and management respond by improving performance in the medium term and consequently the hospital attracts patients back.
- B6. The bulk of evidence on competitive health service markets comes from the US and investigates the relationship between competition, prices and capacity (see Dranove and Satterwaite 1992; Hughes and Luft 1991, Joskow 1980). More recent literature looks at the impact of hospital competition on clinical performance (Gaynor 2004; Gowrisankaran and Town 2003; Propper et al 2004) and is moving towards the consensus that higher levels of fixed-priced competition lead to improved clinical performance so long as the reimbursement price is high enough to cover the marginal cost of

treatment. Publications using UK NHS data (Cooper et al 2010a, 2010b; Gaynor et al 2010; Bloom et al 2010) support these findings.

- B7. Cooper et al test whether financial incentives led to improvements in quality. They use the January 2006 introduction of choice for patients in England to create a quasi-natural experiment to estimate the impact of fixed-price competition on 30 day in hospital mortality from acute myocardial infarction (AMI). They exploit the fact that the introduction of choice reforms will create sharper financial incentives in markets where choice is feasible and that prior to 2006, in the absence of choice, hospitals had no direct financial incentives to improve performance in order to attract more patients. Their results suggest ‘...that in markets with fixed-prices, hospital competition can improve patient outcomes.’
- B8. Observable quality is the key to improving levels of quality. The competitive incentives, introduced through offering patients a choice of provider, have the potential to lead to a negative effect if patients and commissioners cannot adequately observe the quality of services and if prices are variable. Commissioners will be drawn to cheaper services to stay within fixed a annual budget, which creates an incentive to providers to offer cheaper services potentially at the expense of quality. If patients are unable to distinguish quality levels between alternative providers, they will be unable to choose to avoid poor quality providers. Therefore good quality providers will not be rewarded for higher quality so poor quality could crowd out the good.
- B9. Papers by Popper (2008, 2004) suggest that price competition can lead to lower quality. Both papers use data covering the internal market between 1991 and 1999. It found that competition led to improvement in measurable areas of service (i.e. lower waiting times) but a deterioration in non-measured areas of quality (higher mortality rates).
- B10. This is summarised by Frontier Economics as follows: On balance, the evidence suggests that the outcome for price and quality competition will depend on the preferences of consumers of healthcare services, and the quality of information available to them. The implication is that this form of competition is likely to lead to quality improvement that benefits patients if there are quality-focused and well-informed commissioners. This, in turn requires that there is sufficient robust quality information available. On the other hand if quality is difficult to observe this form of competition carries the risk of creating perverse incentives to lower quality in order to lower costs.

Contestable and transparent markets

- B11. In 1776, Adam Smith warned of the dangers of monopolies, ‘...monopolies... ..is a great enemy of good management.’ While competition wards off complacency in management, a market does not have to have a plural provider base for patient choice of provider to have the desired effect. Incentives and competitive pressure still exist so long as markets are transparent and contestable. Here transparent means that it is possible to observe the level of quality of the provider, and the cost of the service, and contestable means that new providers are free to enter the market. This means that there is a credible threat that should the standards of the existing services fall below what is acceptable then a new provider could enter the market and take business from the incumbent. This credible threat is sufficient to ensure management maintain acceptable levels of quality and efficiency.
- B12. Bloom et al conclude that ‘...our measure of management quality was robustly associated with better hospital outcomes...[and]...more hospital competition appears to cause improved hospital management.’ Their paper seeks to test the hypothesis that competition between hospitals can lead to better hospital performance through improved management practices by using an instrumental variable model. The degree of competition is measured as the number of other hospitals within a given catchment area, the hospital performance clinical outcomes measure is mortality rates following emergency admissions for acute myocardial infarction (AMI) and surgery. Data on management performance is collected from an 18 question survey. The first stage of their model shows that management practices and hospital performance are positively correlated; the second stage that competition is positively correlated with management quality.
- B13. Like Bloom et al, Gaynor et al also uses the introduction of the 2006 reforms on hospital outcomes. It uses a panel of data for 162 hospitals between 2003 and 2007 and find that the effect of introducing choice of hospital was to save lives without raising costs. Indeed they go on to state in their concluding remarks ‘...that competition is an important mechanism to enhancing the quality of

care patients receive. Monopoly power is directly harmful to patients, in the worst way possible – it substantially increases their risk of death.’

- B14. In both of these studies, the volume of patients that moved from one hospital to another was not large. The viability of the hospitals was not called into question through loss of business. Nevertheless, a significant improvement in quality was observed.

Patient Empowerment (Shared Decision Making and Control)

- B15. The following paragraphs discuss how involvement in decisions and choice of treatment can lead to better outcomes and are valued by patients as a benefit in its own right. Patient decision aids are an evidence-based tool to support shared decision making between patient and clinician. They involve patients more in the decisions about their care, increasing their sense of control.
- B16. Patient decision aids are most commonly employed where there is not a single best treatment ('preference sensitive' decisions) and where patients need support to help them work out how treatment options fit with their preferences, values, lifestyle and what they are looking for from treatment. Often these are elective surgery options (eg knee replacements or hernia repair) but patient decision aids are also useful in certain decision points for long-term conditions such as starting insulin treatment or a disease modifying drug for rheumatoid arthritis. At least 500 decision aids exist worldwide.
- B17. A review of 10 systematic reviews of patient decision aids (O'Connor et al, Cochrane Library 2009) found that they improved patients' participation, increased their knowledge of treatment options, realigned their expectations, and improved the match between their values and subsequent treatment decisions. It also led to people making decisions about their care and subsequently people being treated quicker. However, most studies suggested little difference in satisfaction with decision making and with health outcomes.
- B18. International evidence shows that involving patients in their care and treatment can improve their health outcomes. Bechel et al (2000) found that patient centred care led to improved outcomes when measured by rates of unexpected mortality and rates of complications. Fremont et al looked at whether patient experience of non clinical aspects of care affected health status. They found that patients who received patient-centred care following a myocardial infarction reported higher satisfaction scores for their care and higher health status scores 12 months later than patients in a control group. Kaplan et al (1989) investigated the effects of the patient-physician relationship and communication on health outcomes of patients with chronic diseases. They found a positive correlation between improved communication and better outcomes whether objective measures (e.g. blood pressure or blood sugar levels) or subjective ones (survey responses on health status). This evidence shows that shared decision making is applicable in a wide range of health contexts and that clear improvements can be obtained.

Health Inequalities

- B19. A full equality analysis is published separately alongside this document and the Government's response to the consultation. A summary of the evidence is outlined below.
- B20. Concern has been raised that choice can widen inequalities because less articulate and vulnerable groups are less likely to exercise choice and that some population sub-groups may find it more difficult to digest performance data (RAND 2006). Also in 2006 the King's Fund found that PCTs felt that equity of choice may be difficult to deliver, particularly for non-English speaking groups.
- B21. However, Dixon and Le Grand (2006) hypothesise that choice may narrow inequalities as a greater number of access points will provide patients with a wider range of services more adapted to individual need. Instead of better services only being accessed by those who go to great lengths to navigate the system, choice will help reduce the barriers of access making them accessible to a larger section of the population.
- B22. A study by Cookson and Laudicella considered the impacts on inequalities of choice and competition reforms introduced in 2006. They examined socio-economic equity and utilization of hospital services. They found that the reforms had not undermined socio-economic equity in hospital care and, if anything, may have slightly increased utilisation of elective inpatient care in low

income areas. They went on to say that, disparities in health care utilisation are relatively impervious to changes in the supply side, brought about by health care reforms, suggesting that inequity is caused by under-lying socio-economic need and care-seeking behaviour, which do not change rapidly over time.

Conclusion

- B23. Fixed price competition between providers, facilitated by choice from 2006, has been shown to be particularly effective. Gaynor et al calculated a rough estimate that net benefits from improved mortality and reduced length of stay was £227 million. This evidence appears to suggest that large number of patients do not have to move from one provider to another to achieve the results. Improvements appear to result from the threat of patients choosing to go elsewhere coupled with the transparency provided by the availability of information on the quality of performance.
- B24. Other evidence gives cause for caution, pointing out that where aspects of quality cannot be measured, there is potential for competition with variable prices to lead to lower quality of those aspects. This emphasises the need to measure the multi dimensional aspects of quality to ensure against unintended consequences and that one aspect of quality is not sacrificed for another.
- B25. Shared decision making and giving patients more say over their care are important elements of choice. A truly patient centred approach to care can improve outcomes and patient experience and individualised services can improve inequalities through improved access to care.
- B26. Choice and transparency can combine to have a positive impact as patients choose the services that best fits their requirements. The commitments to give patients more say in decisions about their care and treatment are not proposed in a vacuum, the regulatory framework, subject to parliamentary approval, in the Health and Social Care Bill 2011 sets out proposals designed to boost transparency and accountability. The information revolution, on which the Government consulted in Autumn 2010 will play an important part in improving services through transparency.

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