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Devolution and patient choice: policy rhetoric versus reality

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Abstract:

Background: Market reforms in England have been identified as making a clear distinction between English health policy and health policy in the devolved systems in Northern Ireland, Scotland and Wales. Patient choice is a high profile policy in the English NHS that constitutes significant changes to the demand side of health care. It is not clear what national differences this has led to regarding implementation of policy and its effect on patients.

Aim: This study examines patient choice across all four countries of the UK to understand the effect of differences in national policies on implementation and patient experience.

Methods: At the macro-level, we interviewed policy makers and examined policy and guidance documents to analyse the provenance and determinants of national policy in each UK nation. At the PCT or Health Board level we interviewed a range of public and private health service providers to identify the range of referral pathways and where and when choices might be made. Finally, we interviewed ENT and orthopaedics patients to understand how such choices were experienced.

Findings: While we found that distinct rhetorical differences were identifiable at a national policy level, these were less visible at the level of implementation and in the way choice was experienced by patients. In this paper we draw on findings from this study to show that historical similarities in both the structure and operation of health care, coupled with common operational objectives around efficient resource use and waiting times, mediate how strategic policy is implemented and experienced.

Key words: Patient choice, devolution, health policy

Introduction

While there have long been differences between the countries of the United Kingdom (UK) in the administration of public services, changes since 1999 have seen far greater political devolution to Scotland and Wales and the final fruition of political devolution in Northern Ireland (Greer and Trench 2010a), allowing explicit policy divergence to occur that is expected to lead to divergence in levels of expenditure and service delivery. The impact of these changes is, perhaps particularly interesting in the health arena as the NHS has always been seen as a 'national' service – albeit administered at more local levels – and responsibility for health system policy was a major element in the new powers granted to the devolved governments. Hughes and Vincent-Jones (2008) have suggested that "... events in the NHS represent a novel and interesting form of divergence that is distinct from the types of in-system variation or heterogeneity reported in earlier studies [of comparative health care]" (401).

This paper explores the impact of political devolution on health care policy from the perspective of patient choice. Devolution of health policy has led to what appears to be a distinct policy difference between England and the other three UK countries. This has been characterized as the difference between market style approaches to co-ordination and delivery developed in England, and more professionally led and bureaucratic approaches in the other three countries. Patient choice, introduced in England after 2001, has been a key, and prominent, English NHS policy, providing patients with a

choice of when and where they access secondary elective care (DH 2003, DH 2007). The policy was established as one of the main elements in the market reforms of the English NHS to provide a demand side mechanism complemented by the new activity-based provider reimbursement system known as 'Payment by Results' (Allen 2009, Greener and Mannion 2009). By contrast, the devolved administrations specifically rejected market style coordination and patient choice of provider. The relation between such political difference and how services were delivered and experienced by patients was examined in a UK wide study of patient choice policy undertaken between 2007 and 2010 (Peckham et al 2010). This paper reports on the findings of this study and considers their implications for our understanding of health policy within a devolved political system.

Devolution and health care policy

Since the beginning of the NHS there have always been distinctions between the organisation and delivery of health care services in England, Northern Ireland, Scotland and Wales. Essentially England and Wales operated the same structure and organisation, while Scotland had a similar, but separate structure, and Northern Ireland had a combined health and social care service. However, there was a strong family resemblance between the four sub-systems, with, for example, a shared reliance on general practitioners to act as gatekeepers to care and decide referral pathways for elective care. Similarities between health systems are also exemplified by a shared history as key building blocks in a national Welfare State, UK-wide professional bodies, staff contracts and unions which provide strong pressures towards continued institutional isomorphism. Institutional arrangements for regulation and the development of clinical practice guidance have retained a more national scope although increasing decentralization of these functions is gradually occurring (Hughes and Vincent-Jones 2008). Political

devolution is a complex phenomenon that brings into play both convergent and divergent influences. Devolution provides a context for greater diversity as it allows a different policy emphasis and greater scope for policy experimentation. But, over time, there may also be 'policy transfer' – the sharing of policy developments between one country and another (Dolowitz et al 1999). Devolution has provided a dynamic context whose long term impacts are currently unknown, but there is clear divergence in both policy processes and in resultant health policies (Greer and Trench 2010). Such differences include public health regulation, use of the private sector, payment mechanisms, professional training (especially community nursing in Scotland), organization and outcomes (Alvarez-Rosete et al 2005, Connelly et al 2010, Hughes and Vincent-Jones 2008, Blackman et al 2010).

Patient choice, as a specific theme of health care policy in England, can be seen as part of the consumerist project of New Labour, reflecting a wider emphasis on choice in all public services and the need to develop more responsive services, challenge the power of professionals, drive quality improvements and improve equity, as well as being seen as a good thing in its own right (Clarke et al 2007, Fotaki et al 2005, le Grand xxxx, Newman and Vidler 2006). While such objectives were explicit in English health policy, the emphasis on responsiveness and quality improvement, as part of the generic shift towards patient-centredness of health services, was echoed across the UK (DH 2003, DH 2007, Mullen et al 2011). In relation to choice, the explicit differences in policy rhetoric and objectives, and the consequent mechanisms introduced, reflect increasing policy divergence between England and the other nations. Such differences reflect increasingly different institutional frameworks and political ideology, as well as territorial features such as size and population distribution. For example, in England the emphasis was on consumerism and the use of choice as a driver for improving quality and

efficiency alongside other supply side developments to create contestability such as a wider diversity of providers. This approach to patient choice was also seen to provide patients with opportunities for 'exit' in addition to policies that have emphasised 'voice', where patients engage with providers and commissioners to shape services provided (Hirschmann 1972). In contrast, where choice is available in Wales, Scotland and Northern Ireland, the focus is more on the accommodation of preferences within the provision of an equitable service. In Scotland and Wales the emphasis is on patient and public 'voice' to shape services to match patient expressed preferences in the context of the diverse needs of the population (Audit Commission in Wales 2004, Fotaki et al 2005, Healthcare Commission 2005).

While there has been much written about patient choice, there is little empirical evidence on the effects of choice on healthcare provision (Dixon et al 2010) and none which examines choice within the context of political devolution and the development of devolved health care systems. In this study we set out to explore the links between choice policy and implementation. The study examined the content, practice and experience of the different policies in respect of patient choice in the four UK nations. The objectives of this project were to:

- determine the political and ideological origins of the policies on choice and their relationship with other health policies in England, Wales, Scotland and Northern Ireland,
- illuminate the range of ways in which patient choice is implemented and managed by organisations in the four countries, including delivery of choices at the point of referral,
- identify differences and similarities in how patients understand experience, exercise and value choice in the four countries

- reflect on any emerging findings on the effect of different choice policies on health systems in terms of access to care, responsiveness to patients' wishes and efficiency of resource use.

Methods

Drawing on narrative methods of policy analysis, we compared policy and implementation between the four UK home countries (Peckham and Sanderson 2011, Roe 1994, Shaw 2010). This began by exploring and analysing the provenance of the policy on choice in the four nations at the macro-level, before moving on to how selected NHS organisations and GP practices implemented choice policy at the meso-level and ultimately how patients being referred for hospital treatment for orthopaedics or ENT surgery experienced choice at the micro-level. We interviewed national policy makers, politicians and advisers (e.g. previous and current health ministers, policy advisers, senior civil service decision makers) to explore the development of policies related to patient choice. At the meso-level we selected two case study areas in each country. These were Primary Care Trusts in England, Local Health Boards in Wales and Health Boards in Scotland and Northern Ireland. Areas were selected to reflect urban/rural differences and to contain a range of service providers (including private providers and, in England, Foundation Trusts). In each area we conducted semi-structured interviews with managers and clinicians from NHS hospitals, private hospitals, primary care trusts in England, health boards in the other three countries and general practices. In each case study area we asked a sample of general practices to act as recruitment sites for patients referred for ENT and orthopaedic elective procedures. These tracer conditions were chosen on the basis of having sufficient volume of referrals to enable the recruitment of sufficient patients for interview. Details of the interview sample are given in table 1.

Table 1 here

Most interviews were conducted face-to-face at the interviewee's place of work for macro and meso-level respondents, or home for the micro-level respondents, with some being conducted by telephone where necessary. The interviews used a common, semi-structured interview schedule and were audio-taped with permission. Policy maker interviews were audio-taped and transcribed verbatim. At the meso and micro-levels interviews were selectively transcribed with data entered into a framework that was developed and agreed by three (?) members of the research team, following initial coding of a sample of interviews. Interviews were conducted between April 2007 and September 2009. In addition to interviews, we also examined policy and guidance documents relating to choice in patient referrals for elective care from each country at macro and meso-levels. In total over 150 publicly accessible documents were examined, identified by searching NHS and health department websites, references from articles and papers on choice and patient referral documents identified by interviewees and use of general web searches.

At the macro policy level, we analysed the documentary and interview data by focusing on a narrative of the historical process of the development of policy within each country, attempting to identify which particular factors helped to shape the policy that finally emerged. These 'narratives' were then shared and discussed by the research team to identify what was common and what was distinct between the four countries. The analysis was inductive in approach, deriving a number of criteria relating to political, ideological and technical factors that best explained both the emergent policy and why these differed between the nations. At the meso-level, we transcribed initial interviews and the

transcripts were read by at least two team members within each country. Researchers agreed an analytical framework and selectively transcribed from the rest of the interview data. The research team identified similarities and key differences across case study sites by type of organisation, case study area and country, with comparison between country selected as the most appropriate analytical structure. Detailed referral pathways were produced for ENT and orthopaedics in each nation to identify the processes and points in time at which choices were made. These were shared between researchers and compared in order to develop common methods of presentation. At the micro level, recordings of interviews with patients were not fully transcribed, but, following initial discussion of a number of complete transcripts, the research team developed a data extraction framework (in an Access database) that could record both 'fixed responses' and summaries or partial quotations of more discursive responses, following the structure of the interview guide. The database entries were analysed on both a 'within person' and 'by topic' basis. The researchers also prepared initial country-level summaries.

We present findings confirming the relation between national policy on choice in the four UK countries and its subsequent implementation. The findings are presented by the level of analysis, with a discussion of national policies first, followed by data from the meso and micro-levels.

Findings

National policies on patient choice

English policy has explicitly placed patient choice as a measure for improving quality and performance as part of market style incentives to attract or retain patients. Conversely in the other countries the emphasis has been on attempts to engage patients and the public to help improve services and performance through voice mechanisms. These distinctions were very apparent in the process of the research reported here - both at a policy level but also when examining NHS processes. Thus health care policy on patient choice differed between England, Northern Ireland, Scotland and Wales relating to differences in ideology. The significance of choice policy was most clearly articulated by policy makers in England:

“We were moving from an NHS that was being run like an old nationalised industry, into this new world that we were calling the patient –centred, patient-focused NHS, a patient-led NHS, where essentially all the incentives within the system would lead the NHS constantly to improve the quality and the speed of care that they gave the patients” (Former Secretary of State for Health, England)

“I think we should empower people, and choice mechanisms in other contexts like education have tended to demonstrate that if you empower the public, the consumers of public services, quite often it’s people who have literally not known how to challenge the services that you provide to them who suddenly find that they get a voice, an influence and they begin to shape the service far more effectively in the future.” (Conservative Party Health Spokesperson, England)

Governments in Northern Ireland, Wales and Scotland showed far less determination to widen choices of service providers and were opposed to the introduction of a market style approach to health care. Policy makers in Wales, Scotland and Northern Ireland were keen to make clear how they differed from English health policy. In Scotland the focus was on developing a more collaborative health system:

'Our model is different from the English model... We are trying to create a more integrated way of working in Scotland – single-system working, with the different parts of the health system working together collaboratively.' (Malcolm Chisholm, Minister for Health, Scottish Parliament Health Committee 23 March 2004)

In Wales the English policies were rejected in equally clear terms by the First Minister and Minister for Health and Social Services respectively:

"[We are] more interested in community values than consumerist values. Our attitude to the future of the health service is not about how much competition, how much out-sourcing, how much consumer choice" (Morgan, 2003)

"Though the market model may give patients a louder voice, this will be the shrill cry of consumer choice, not the sceptical thought and responsible voice of the citizen." (Jane Hutt quoting Julian Tudor Hart) (Hutt, 2004)

These doubts translated into a strategy – *Designed for Life* – whose stated aim was to “... empower the community to have its voice heard and heeded, rather than simply being given a choice of treatment location.” (WAG 2005).

But despite such political rhetoric, choice remained a strand that ran through several important policy documents. The 2001 Welsh NHS Plan had identified the need to develop health services that complied with patient preferences, and in 2005 the National Leadership and Innovation Agency for Health Care published a revised *Guide to Good Practice: Elective Services*, later adopted as policy by the Assembly Government, in which the first of six core principles was ‘Patient Choice’ ‘The patient should always be offered reasonable choice in their appointment. Choice means that the patient can choose the location, the date and time, and the consultant. The reasonable nature of the choice means that choice may be limited to those locations where clinics and/or theatre sessions are held, dates and times that clinics and lists are scheduled, and consultants or other staff that are qualified to perform the procedure or see the patient. Reasonable patient choice means that where an option is available, the patient has the right to choose that option’ (1).

Regarding choice of treatment location, the Assembly Government introduced a Second Offer Scheme in 2004 whereby patients could be offered an alternative choice of treatment and/or location if they had exceeded the national waiting time limits (generally 18 months, but eight months for cardiac and four months for cataracts). The Scheme was centrally driven and specifically aimed at reducing waiting times to address criticism about poor performance compared with England (Audit Commission in Wales 2004, Talbot et al. 2004, Healthcare Commission, 2005). Crucially, patient choices under this

scheme were not linked to resource flows via a 'payment-by-results' type resource allocation mechanism, and informants told us that the intention has always been to discontinue the scheme once commissioning had improved sufficiently to achieve the Access 2009 waiting times target. But the scheme did expand options for a group of long waiters, who now could not only select between any alternative sites offered within their local NHS trust, but also consider a non-local option.

The Welsh view of choice was a nuanced one that did not translate easily into a simple policy slogan. A special advisor explained that Ministers were not against choice in itself, but rather the sort of choices that privileged the articulate consumer over the less able.

"But the truth of the matter is, I think, that the assembly government has never been against choice. ... but if I am allowed a certain type of choice in health which means that I am able to navigate my way to the front of the queue um because I am well-informed and articulate and have money behind me to travel and stuff like that in a situation where there are not enough operations for the people who wanted them then exercising my choice has impacted on your choice and your room for manoeuvre has now been diminished by my expanding room for manoeuvre. That's the sort of choice that we have been against. So there are many other sorts of choices that we can make in health that don't have that impact. We are certainly not against those." (special advisor to First Minister)

Although it is tempting to characterise the Welsh position as ‘voice not choice’ (Hughes et al 2009), we shall see below that that, potentially at least, the patient referral process in Wales did provide patients with choices at certain critical junctures.

In Scotland the NHS Plan stressed the need to be responsive to patients’ views. The emphasis here was on providing information for clinical choices to be made in consultation with patients (Scottish Executive 2000), but patient choice of secondary provider was subsequently facilitated by the National Waiting Times Database which provided service users and their GPs with information to support GP referral decisions. In addition, the introduction of GP specialists and the establishment of the Referral Information Service in 2003 subsequently increased the availability of alternative routes to treatment and information aimed at increasing patient choice (NHS Scotland 2005). The White Paper *Partnership for Care* stated that under the National Guarantee, patients had the right to be treated elsewhere (e.g. elsewhere in the NHS, in the private sector or exceptionally elsewhere in Europe) if they had not been treated by their local NHS organisation within the National Guarantee period (Scottish Executive 2005).² But the concept of choice was not treated as a separate policy objective:

“It’s actually quite difficult to find Scottish policy on choice and that’s because it’s embedded in a whole host of other documents. We don’t have that, it is not something that’s separately about choice or about patient experience, it’s more about public engagement, but rather we try and pull all of those things together all of the time.” (Senior Scottish Government Official)

Finally, in Northern Ireland, the opportunity for choice was more limited intrinsically given the much smaller size of the health system. However, the concept of 'choice' resonated with Northern Ireland politicians and other policy makers, but was a term that only truly appeared in the context of education (school selection policy). It barely figured in political or policy discussion with regard to the Health Service during the period of this research. However, in 2005 the Northern Ireland government introduced a Second Offer Scheme (similar to Wales) and a review of health and social care services in 2005 by the King's Fund economist recommended further expansion of choice for specific treatments and specialties (Appleby 2005).

Despite differences in ideology one consistent theme emerged from our data - the central importance of tackling waiting lists. Choice in all countries was very closely linked to initiatives for reducing waiting times for patients. In Scotland the focus on equity of access was a key policy driver and in Northern Ireland and Wales the 2nd Offer scheme was a centrally managed approach to avoiding long waiting lists. However, waiting times were referred to in all countries. In England a key policy objective was to provide equity in terms of providing choice of provider so that those who could not afford the option of private sector treatment could have similar choices in the NHS. One senior policy official in the Department of Health described choice as *"... an essential driver for addressing capacity problems in the NHS – first priority and then tackling waiting lists."*

Interestingly, in Wales explicit reference was made to the comparison of English and Welsh health system performance – highlighted in the 2004 Audit Commission report. In 2004 Peter Hain, the then Welsh Secretary, made a speech stating that he hoped that the new Welsh Assembly Government

would consider solutions that had worked in England such as independent sector treatment centres. In response, Health Minister Brian Gibbon replied that solutions that worked in England might not work in Wales, but signalled a more focused approach to reducing waiting times. But there was severe pressure on WAG resulting in the *Access 2009* initiative (). This initially set a target of a maximum wait between referral and treatment of 26 weeks (the '2009 access target'), as well as a series of interim waiting times targets, achieved through increased capacity but also by offering patients a 2nd offer at another hospital if they breached maximum waiting times.

“So the inequalities then became inequalities compared with England rather than inequalities within communities in Wales, the focus had to shift. So we had to sort that out before you could go any further. So that over the last three years has been sorted with the government putting extra money into what they call their 2009 project which is 26 weeks by now and indeed that’s all being delivered, that’s fine, it’s all going through.” (Senior Welsh NHS Official)

Waiting times were also important policy drivers linked to patient choice in Scotland and Northern Ireland. As suggested above, although patient choice was not a key instrument of policy in Scotland in the way that it was in England, a choice of provider policy was adopted as one of the mechanisms for tackling uneven waiting times across providers, and ensuring that patients were not disadvantaged by long waits with their local providers. *Partnership for Care* (SEHD 2005) described patient choice, in the form of choice of provider, as a means to tackle uneven waiting times across providers, and ‘patient focused booking’ (choice of outpatient appointment) was described by a number of interviewees as one of the factors that had helped to reduce waiting times. A similar concern about variations in

waiting times between hospitals was also expressed in Northern Ireland where policy explicitly set out to address inequalities in access and waiting times (DHSSPS 2008).

Choice Policy in practice: implementing, managing and experiencing choice

At the meso and micro-levels, we examined how choices were offered to, and experienced by, patients. We examined referral processes in general practice and hospitals as well as the role of local Primary Care Trusts (England), Local Health Boards (Wales) and Health Boards in NI and Scotland. While staff in the English NHS articulated a different understanding of patient choice to their counterparts in Scotland, Wales and Northern Ireland, the referral systems which delivered choices to patients shared a number of similarities. At the organisational level, interviewees in Scotland, Northern Ireland and Wales generally reflected the opposition to choice of provider policy that was expressed by national policy-makers. However, it was apparent that all systems aspired to offer as many choices as possible to patients, including offering a choice of provider where possible although explicit patient choice policy normally led to more options of provider being made available to English patients. This also led to a more proactive approach to patient choice in England, whereas in the other countries choice was generally offered in response to patient requests.

The key mechanism for offering choices was a booking system and all countries had systems which offered a choice of date and time of appointment. The 'Choose and Book' system was the high profile 'face' of choice policy in England, which offered the opportunity for patients or their referrers to directly book the hospital appointment of their choice. In Scotland, there was the SCI Gateway system which allowed electronic booking of appointments and in Wales and Northern Ireland patients were able to request alternative dates and times for their appointments to those offered by providers.

Whilst these booking systems offered a degree of consistency in the way referrals were made and the way choices were offered to patients, it was also the case that there was often a lack of a consistent approach to offering choices to patients within the booking systems.

Booking systems functioned to offer choices to patients, but were also important in structuring the choices offered to patients. All those involved in allocating appointments to patients shared the priority of achieving waiting time targets.

... in 2003 ... we launched our product called the National [Waiting Times Database] which gave the average waiting time to see a consultant for routine conditions if you like, well in the main specialties, so that person can go to their GP, the GP says yes you need a cataract, you could go to your normal hospital but you could also go on the internet and check this database and if you find somewhere with a shorter waiting time then perhaps you can be referred there. (Senior NHS Scotland official)

The booking procedures which delivered referral choices to patients were also used by service providers to control allocation of resources. Booking systems functioned as mechanisms to define and thereby limit choices in order to allow queues to be effectively managed, whether this was by limiting the options open to patients on the Choose and Book menu in England, or by restarting patients' outpatient waiting times when patients had rejected a 'reasonable' offer in Wales.

I think Choose and Book was probably to try to even out referrals to different hospitals, and to named consultants within hospitals...we know locally there were consultants that were popular and some that were very unpopular...Choose and Book was another way of evening workload out, and I can see the logic behind that in a way.' (GP, England)

'You can refer to a named consultant but I am not sure what effect that has. You can write the letter but it's a bit unclear to be honest. I have sat in meetings and still come out unclear as to whether that actually means anything or whether they just pool it anyway. I don't really know I am not sure anybody really knows.' (GP, Wales)

All systems put the onus on patients to contact the provider to make the appointment rather than automatically allocating appointments. Indeed, many interviewees saw the key benefit of booking systems which offered choice of date and time, and the driver for their adoption to be their effectiveness in reducing the number of patients who did not attend their outpatient appointments, rather than the opportunity to offer choice to patients. Interestingly, the use of defined choice menus within the Choose and Book system in England had given providers the opportunity, which many of them appeared to take, to restrict patient choice to the option of referral to a specialist team rather than to a specific consultant.

'The patients might get a choice of this month or next month, or this week or next week, but they don't really get a choice because the consultants' timetables are very set. They don't really get a choice., If ... if they couldn't come in on a morning and needed to have an afternoon list they

would probably have to go to a different consultant to do that because the timetables are very restricted.' (Manager, in-patient and day case surgery, England)

In other cases, a similar management of choice availability was achieved by only reactively offering choices to those patients who asked for a specific option, or often, in the case of referrals to a named consultant, not honouring the choice that had been made when allocating referrals between the consultant teams. In addition, the 2nd Offer schemes in Wales and Northern Ireland only offered 'another choice' rather than other choices:

'Patient Access Policy has been good in helping to reduce waiting times but it acts against patient choice because the patient will see the next available consultant. The patient cannot really make a lot of choice regarding the referral, at least in terms of who they see. Waiting time targets must be met and this will affect choices regarding referral.' (Director of Head and Skeletal Services, Northern Ireland Hospital)

The administration of each system had an impact on the choices that were offered to patients. For instance, booking systems which invited patients to phone for an appointment upon receipt of a letter, led to the allocation of appointments on a first come first served basis, with those phoning early having the best choice of appointments. A mixture of booking systems was in operation leading to potential differences in the choices offered to patients. In the case of England, the existence of various booking systems meant that there were a number of different advice sources for patients. For instance,

patients booking over the internet would have a free choice of appointments from the menu available, and those booking over the phone with a provider would be offered one appointment at a time.

In all countries, the choices available to patients often depended on the referrers' understandings of choice availability. In Scotland, Wales and England, GPs said they were uncertain about the referral options available, most commonly whether referral pathways were mandatory or optional. That this confusion existed in England, where the referral options had been formalised into an electronic menu was perhaps surprising. However, the confusion could partly be explained by GPs not knowing their way round the system effectively, and not being aware of the options for appointments which were available. Moreover, whilst referral choices, particularly in terms of English choice of provider policy, were often imagined to be located with the GP, there were a variety of other points in the patient referral pathway at which choices were potentially available to patients, most notably through interface services between primary and secondary care such as intermediate triage arrangements in orthopaedic services, referral management centres and in some cases assessment by GPSIs.

Despite this, the GP remained the key gatekeeper of the referral pathway and guide to the 'appropriate pathway' for patients. Some patients in all four countries reported difficulties 'getting past' GPs to forms of specialist care that they wanted. This experience may have been a result of GPs' attempts to follow standardised care pathways and referral management protocols that had been introduced with the intention of improving the effectiveness and efficiency of health care. Patients' 'success' in overcoming such restrictions to access the forms of care they wanted seemed to depend in part on their persistence and skills in negotiating with (or shopping around between) GPs.

Conversely, GPs reported that patients demonstrated little interest in choosing between different providers:

'Of course the vast majority of patients have no desire to go out of the area. It is rare indeed for someone to request a referral outside and those that do so come equipped with a piece of knowledge they have heard of....I am able to listen to it but not act.' (GP, Wales)

'We tell them all [about choice]. I usually say 'would you like to go to so and so', and by the time we've got outside of [county] they're looking at you as though I'm mad, and I have to actually say 'I'm sorry, I just have to say to you that this is your choice'. 'I want to go to [the local hospital] please'. I would literally say 95%...' (GP, England)

Although in some cases GPs did not offer a choice but suggested where the patient should go:

"... my GP just referred me to the rheumatology at the[local hospital]. it's the nearest hospital and they know me there. (Patient, NI)

"It wasn't a very long discussion. He just said 'what about Z hospital?' As I live in Z, quite nearby."
(Patient, England)

Differences in choice policies did not appear to have resulted in any obvious systematic differences in the experiences of, and views about, choice, recounted by patients interviewed for this study. There was as much diversity of patient experience within as between nations, and patients raised similar issues in each of the four countries. In fact, patients in our study typically said that they did not want to be offered choice for its own sake, but did want to be offered appropriate choices, irrespective of which country they lived in.:

“I prefer to see a lady doctor and I think you should have the choice of whether you see a female or male consultant that makes you feel comfortable...if I could have a choice, that would be the only thing I would choose.” (Patient, NI)

On the whole, patients valued being able to access good and individually appropriate health care, and being treated at places and times that were reasonably convenient for them personally. Patients wanted this to happen as part of their discussions with the GP as a dialogue rather than just being faced with a menu of choices. Patients reported that their wishes were not always considered:

“I never felt that the GP offered me what I wanted, I had to ask for what I wanted” (Patient, England)

Of central importance was being involved in referral decisions - at least in the sense that as patients they are listened to, given information about the rationale for their referral, and kept informed about how their referral should be made and was progressing. Irrespective of the health system the choices

offered to patients were on the whole limited (see table 2). Providers were, on the whole, able to offer patients a choice of time and date of appointment but exerted more control over other types of choices including location and who provided care.

Table 2 here

Choices for patients were also increasingly being restricted by the introduction of interface services set up to manage referrals before they entered secondary care. These services consisted of both clinical and administrative triage and/or assessment. The driver for the establishment of interface services was the need for the demand management of referrals. However, in England these services were in some cases associated with the delivery of choice to patients. For example, in orthopaedics, services had been established to ensure that choices were offered in the same way to all patients in the area. In other situations, these services were seen as limiting choice:

“I still haven’t got my head around how this stacks up with choice. Because surely if you’ve got an interface service, in order to make it value for money you need to put all your referrals through that service that would normally have gone through secondary care and therefore you’re not offering the patient a choice I don’t believe” (Head of Performance and Commissioning, English NHS Trust)

“The ICATS system does not give patients a choice of consultant, or hospital or treatment option. That is a policy, a regional ministerial policy decision designed to deliver on the problem of the waiting lists.” (Health Board, Chief Executive, NI)

Discussion and conclusion

Choice was a limited concept in all four countries with patients only routinely offered choice of date and time (when), with fewer choices about location (where) and consultant (who), and very little choice about treatment (what). Thus, while at the national policy level there appeared to be a substantial difference between countries policies on choice, at an operational level and in the way choices were experienced by patients, there was much less difference, with substantial similarities in the way patient choices were managed. Policy differences were generally explained in terms of maintaining distinctiveness – especially in Scotland and Wales where explicit reference was made to being different to England. At an operational level there were three broad themes that emerged from our data that explain why there were more similarities in the provision of choice. It was clear that common processes for patient care and making referrals were a significant factor. All patients access elective care via their GP with GPs playing a central role in referral decisions. For providers there were two distinctive factors. The first was that hospitals in all countries are faced with the problem of matching the supply and demand of healthcare in such a way as to maximise the use of their existing resources. Secondly, waiting time targets were a common feature in all four countries and politically these were seen as most important in terms of policy goals.

Policy differences were thus more rhetorical than actual. There was a clear distinction at national level between England, where most emphasis was placed on individual choices at the point of referral, and the other countries where individual choice was less emphasised. Notwithstanding this difference, elements of both individual choice (of provider, time and date of appointment) and voice (collective

public involvement in health service planning/commissioning) existed in all four health care systems. Choice was generally embedded in managed booking systems aimed at achieving efficiency in the use of resources and, particularly in Scotland and Wales, to introduce equity in waiting times. In fact, patient choice, however developed, became a mechanism used by the NHS to contribute to shorter waiting times. While national policies had envisaged that the provision of choices would contribute to reducing waiting times there was a clear distinction between patient choice in England which aimed to provide choice to patients to select their healthcare provider and schemes in the other countries which were explicitly designed to address inequalities in access and waiting times between patients (and providers).

The interplay of choice policy with waiting time policy is crucial in understanding both the development of choice policies and the way they were implemented. This dynamic was a result of shared characteristics between the health systems in terms of the overall shape of health care provision and the need to ensure that resources - in terms of outpatient clinics, consultant time etc - were used efficiently to meet the waiting time limits present in each system. While some additional capacity was introduced into the NHS during the period of the research, all systems faced resource restraints which in turn placed constraints on choice. That similar systems – booking systems, referral management and intermediate assessment services - developed in all systems is not, therefore, surprising.

But it was clear from our study that a distinction could be drawn between choices pro-actively offered to patients in England while in the other countries choices were responsive in that patients could

request alternative providers or date and time of appointment. Despite this, the actual process appeared to vary little between the four countries. This uniformity of experience at the provider and patient levels tended to be reinforced by common approaches to booking processes. Despite the high profile of 'Choose and Book' in England, use has remained low and the responses in our study mirror those in surveys of patient choice which have found that only about half of all patients eligible are offered a choice and very few patients use the Choices website (DH 2010, Robertson and Dixon 2009). Low levels of usage have partly been due to the reluctance of some GPs to use the system, meaning a paper-based referral system is running in parallel, and partly as a result of technical problems (BMA 2009). Levels of booking system use in the other countries have not been similarly assessed but, given the findings in our study that referral systems tended to function fairly similarly, there may be little difference across the UK. In addition, the widespread use of intermediary referral management schemes and assessment services has tended to lead to more limited and predefined patient referral pathways. Ultimately, though, key determinants were the common tasks of efficient resource use and waiting list targets faced by provider organisations in each system in terms of the process of referral, and allocation of appointments.

While at a macro policy level clear distinctions were made between policies about choice, our research found that at an operational level there were more commonalities than differences. The reason for these similarities could be sought in the institutional arrangements for health care in the UK. While some ideological and institutional features pull the countries in different directions, certain core organisational and political imperatives – linked to the need to deal with, and focus resources on long waits – mean that referrals are managed in a similar way, despite headline policy divergence. In any

event, the seemingly sharp national level policy differences appear to have limited importance as determinants of how each system provides access to elective services and how these services are experienced by patients.

One relevant question that arises from our research is the issue of who decides what choices are offered to patients. Choice policies seemed to develop without wider discussion with patients or their representatives. The sets of choices of where (whether any provider in England or a second offer in Wales and Northern Ireland), when and who are predominantly determined by the NHS. The findings from our study suggest that ultimately both the degree of choice and the choices made available to patients are determined not by patients nor the public at large, but by national and local policy makers, service commissioners and health care providers attempting to meet other strategic goals.

Footnotes:

1. This project was funded by the National Institute for Health Research Service Delivery and Organisation (NIHR SDO) programme (project number 08/1718/147). Visit the SDO programme website for more information.
2. The wording of the later patient information document, *The NHS and You (2005)* suggests that in practice, patients will be offered a choice of provider elsewhere in Scotland.

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Table 1: Interview respondents

Study level	England	Northern Ireland	Scotland	Wales	TOTAL
Macro: National policy makers	15	6	11	11	43
Meso: service providers	41	16	22	46	125
Micro: patients	33	19	23	24	99
Totals	89	41	56	81	267

Table 2: A comparison of choices and referral systems across the UK

	England	Scotland	Wales	Northern Ireland
Choices				
Provider	Yes	No (Exception basis only)	No (Exception basis only)	No (Exception basis only)
Consultant	At providers discretion	At providers discretion	At providers discretion	No
Time/date	Yes	Yes	Yes	Yes
Site	At providers discretion	At providers discretion	At providers discretion	At providers discretion
Referral systems				
Waiting times	18 week referral to treatment target in operation	18 week referral to treatment target to be reached by 2010	26 week referral to treatment target to be reached by 2010	9 week outpatient waiting time target. 13 week target for operations.
Clinical triage services orthopaedics	Yes	No	Yes	Yes
Clinical triage services ENT	No	No	No	No
Administrative triage	Yes (1 case study)	Yes (1 case study)	Yes	No
Electronic booking systems	Yes	Partial	No	No