Choice in health care: Old wine in new bottles?

Walter Holland

Mariana Fotaki discusses and describes methods whereby individuals can exercise choice in health care provision. She states that this is a new measure and that before 1990, choice of specialist care “was needs-based and determined by the patient’s GP, with the exception of privately purchased services”. The government also believes that the introduction of choice polices in the UK is something new.2

These views ignore the past. The mantra of ‘choice’ in health services has become an icon and suggests that the practice and values of the supermarket reign. Although there is an enormous increase in the availability of information on many issues, including medical care, few commentators, or policy analysts, have attempted to analyse either the consequences of choice in health service treatment, its possibilities or its limits. No one questions that, as a general proposition, being able to exercise choice is a ‘good thing’ – but few really examine the issue in depth. In health care nowadays, one mainly considers choice in which hospital or provider should be consulted or provide care. Few really appreciate the importance of choice by the patient in the treatment undergone or selected. It is worth understanding how the present system, and problems, have arisen.

Until about the middle of the 20th century physicians had few effective agents available that would influence the natural history of most conditions; digitalis and morphia were exceptions to this. The physician could make a diagnosis, predict a possible outcome, provide a palliative medicine, for example, cough suppressant or advise surgical intervention. The surgeon was able to provide a form of treatment that would ‘cure’ – for example, appendectomy for acute appendicitis, or ‘cutting for the stone’ to relieve renal colic. The advent of chemo-therapeutic and antibiotic agents completely altered the possibilities for the physician as well as the surgeon; anaesthetic advances increased surgical capacity to alleviate pain and cure. It is not my intention to provide a history of advances in medicine – but to consider how choice can, and has been exercised in medicine.

“Choice before the NHS”

Before the NHS was introduced in 1948, the employed population received general practitioner (GP) care from their Panel Doctor, who was paid for this by National Insurance. The rest of the population, including the wives and children of the insured worker, had to pay for GP care. The insured could choose their Panel Doctor from a list, the others, of course, could choose freely. Cronin, in The Citadel, gives, probably the best account of medical care in the 1930s.3

There were two types of hospital at this time. About half were Local Authority (LA) hospitals (previously the Work Houses) and half Voluntary Hospitals and charitable foundations. In the middle of the 19th century the BMA, (or its equivalent representing general practice) had come to an agreement with the Voluntary Hospitals that they would only see patients in their out-patients department, if referred by a GP. LA hospitals rarely had out-patient departments. Thus arose the UK practice that a patient could only see a specialist if referred by a GP. There were, of course, casualty departments in the Voluntary Hospitals (which were mainly in urban areas). These were used in emergencies and to avoid payment for a GP.

The consultants (specialists) in Voluntary Hospitals, in contrast to those in LA hospitals, were not paid a salary. They received a token ‘retainer’ of, at most, £50 per annum. The consultants in voluntary hospitals were usually considered (by themselves) of a higher grade than those in LA hospitals. All Teaching Hospitals were Voluntary Hospitals. The consultants in the Voluntary Hospitals depended for their income on referrals of patients by a GP. Thus they took care to develop friendly relations with their students, most of whom would become GPs, and on whom they would depend for income. Thus a series of friendly relationships were established and this is what largely influenced the referral pattern to hospital.

Post 1948

In 1948, with the introduction of the NHS, all doctors were paid and thus the
dependence of consultants on GPs vanished. The habits of old, in the referral of patients from general practice to hospital-based care persisted, to some extent. One of the most important consequences, following the introduction of the NHS, was the spread of specialist services to the country as a whole by the creation of District General Hospitals.

GPs, in their role as primary contact, not only had to diagnose and treat minor illnesses, but also refer patients for further treatment or diagnosis to specialist care. There are many studies of the referral to hospital by GPs, for example, a study by Morrell and his colleagues.4 They had complete freedom of choice of hospital care. In general, most chose a nearby institution, but not necessarily. For example in a study of the population of North Lambeth, 62% used the local St. Thomas’ group, while 14% used four other local hospitals: Westminster, Guy’s, King’s College and the South London Hospital for Women and Children. The remaining 24% used another 93 hospitals. In a study6 in a more rural area, Farnham-Frimley, 66.5% of referrals were to the local Farnham group, 14% to other south west Metropolitan hospitals, 9% to the Oxford Group and 11% to other hospitals. The major concern, at that time, was that the Teaching Hospitals were ‘cherry picking’ the ‘interesting’ patients; this concern was subsequently shown to be unwarranted.7,8

The recent past

In recent years the relationship between a doctor and patient has changed. There is now far more communication and discussion so that a patient has become involved in the choice of treatment. This entails a great deal of effort by both sides. The relationship is, however, still unbalanced. The doctor usually has the benefit of professional knowledge, crucial in the provision of advice on treatment and referral. The doctor also often has knowledge of the competence and quality of the specialists to whom referral is made.

Patients have always been involved in the choice of referral (as well as in the choice of treatment). Observational, qualitative studies in Lambeth of the interaction between the GP and patient indicated that the patient was far more likely to be definite about which surgeon they wished to be operated by; local folklore was a potent source of knowledge. They were far more likely to abide by the GP’s advice on which physician to go to. It was not until the introduction of the health service reforms in the 1990s that freedom of choice of specialist became constrained. Now, with our government’s emphasis on choice, this will continue to be restricted – there may be a choice between provider institutions but GPs and patients will not be able to choose the individual consultant surgeon or physician. Although there may be some differences in the cleanliness of institution, or time taken to be seen, the variation in the quality of individual consultants and their team is likely to be more important in the care that the individual patient receives.

Patient choice, in England, has only been considered as a new concept since the introduction of the ‘market reforms’. It is not clear that the political emphasis on choice has been examined critically. There is some variation in referral patterns between individual GPs and in different parts of the country. Furthermore, there is some variation in requests for referral between individuals coming from different social/ethnic groups. Although choice, in abstract, is to be welcomed, exercising choice of place of advice, investigation or intervention is often constrained by cultural, social, geographic, or quality factors.

Choice restricted to an institution may mean that individuals go to modern looking buildings with poor services, or may be constrained by distance, for example, in a Norfolk village the choice may be between Norwich (15 kilometres), King’s Lynn (65 kilometres) or Bury St. Edmunds (95 kilometres). It is unfortunate that politicians have seized on this issue without adequate consideration of what it actually can contribute to the improvement of the quality and quantity of health services. Providing computer programmes for GPs is relatively easy – and it is obviously a relatively cheap trick. But whether it provides a cost-effective solution to health service improvements is doubtful. It is only a minor correction to the problems of a health service market, to regain what existed in the past.

References


Marianna Fotaki

Walter Holland mistakenly argues that in my paper ‘Patient Choice and Empowerment – what does it take to make it real?’ I present patient choice as a new policy objective. In fact, I discuss the evidence on what, in my view, was an unsuccessful attempt at introducing greater patient choice as part of the quasi-market reforms in the UK in the early 1990s, to demonstrate the exact opposite. One of my key arguments, which Walter echoes in his argument, is that these quasi-market reforms, instead of improving actually reduced patient choice. One of a number of reasons for this was the reduction in the number of specialist providers that GPs would refer patients on to because of the limiting effect of cross-boundary flows via Extra-Contractual Referrals.7

I also argued, that by looking at similar experience from quasi-markets in the UK and various public competition models that were phased into several counties in Sweden in the early 1990s, we realise that the lessons of these reforms have been only superficially, if at all, taken account of in the current policy approach in England. Like Walter, I also make the case that the present patient choice debate
is more about rhetorical pronouncements and presumptions about the needs of service user rather than about substance. This is because the concept of choice is expected to fulfill several mutually conflicting policy goals of equity or universality. As one recent scoping review indicated, it is uncertain whether choice and competition can improve either efficiency or quality of service provision for the majority of those using the NHS.

The real question then is what are the reasons for this policy recycling and ‘re-invention’, despite its rather limited success in the recent past in the UK and elsewhere? Some analysts have concluded that more market-type reforms are needed for choice to produce its expected benefits while others have proposed that the shift to ‘choice’ reflects the changing values of increasingly business minded and individualistic constituencies. Regardless of his interesting historical review of the use of patient choice, Walter in his article here does not, however, offer any plausible answer to this question by arguing that current reforms “are only a minor correction to the problems of the health service market, to regain what existed in the past”.

Neither nostalgic nor euphoric analyses will enhance our understanding of how policy works and what are the drivers behind policy makers’ decisions. Multi-disciplinary theoretical frameworks and non-conventional insights from disciplines other than political science and economics might perhaps be needed to illuminate these dynamics. This is a pressing issue, as irrespective of whether patient choice policy succeeds or fails, it will have a lasting impact on how health care will be provided and who will mostly benefit from the changes still to come.

REFERENCES


Walter Holland

There is a difference in comprehension between Marianna Fotaki and me. In her original article she states “individual patient choice is currently being launched as a new and ground breaking idea in the English NHS” – certainly she describes a number of caveats in the market-oriented system of the 1990s but fails to put these policies into perspective as to what went on before.

It is difficult for a practitioner to argue with theoreticians, we can only quote anecdotal evidence or evidence from empirical surveys designed for other purposes. It is crucial for academic workers in health policy to have some knowledge of what happens in practice – reality is often far from theory, and most of us who have actually delivered a service are aware how centrally imposed policies can be subverted.

As Marianna states far too little research has been done on how health policies are devised, implemented or evaluated. As one who, in the past, was involved in the development of some health policies, I am well aware of the possible contributions of theory, research, practice and personal beliefs in policy formulation. Thus I do not consider that analysis of “frameworks or insights” will be of great value – nor do I consider offering solutions – I believe it is far more important to state clear objectives for health policy development in terms of desired outcomes and then evaluate what achievements have been made – and modify them as necessary.

Marianna Fotaki

It is always a daunting task for an academic who is also a former practitioner (medical and senior policy adviser) to demonstrate the fence on which s/he sits. A social psychologist and an influential teacher of management change Kurt Lewin, said that there is nothing so challenging as a practical problem. He also said that there is nothing so practical as a good theory. The divide in the social sciences between theory and practice is in my view artificial. The applicability and capacity of both to make the world more comprehensible and meaningful is their raison d’etre. I have argued for this integration of theory and evidence from a wide range of social disciplines, not only economics and political science, but also for example, from the perspective of clinical psychology and management theory. Often prevailing policy analyses take insufficient account of these other factors that shape policy, nor do they consider how they impact on health care organisations and users of services alike.

My aim was not either, to make a case for, or against, the introduction of individual choice into publicly financed and provided health care systems. It was rather to offer a critique of the ways that complex and diffuse concepts such as choice are translated into rhetorical policy pronouncements, despite the existing evidence of their limited success as demonstrated in the market oriented reforms of the 1990s, and without taking into account complexities involved in policy implementation. Despite Walter’s arguments to the contrary, I think I have made it clear that current patient choice policy is being ‘re-discovered’ and ‘invented’ afresh as if it operates in an a-historical vacuum.

What I think unites practitioners turned academics like myself, is their desire to bring together disparate bodies of literature to make sense of their experience, and to improve the understanding of how policies operate in reality, rather than how they should work according to normative assumptions or any preconceptions.