HEALTH IMPACT ASSESSMENT
OF THE
PATIENT CHOICE AGENDA

Lyn Winters
February 2006

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HEALTH IMPACT ASSESSMENT

OF THE

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Executive Summary

This health impact assessment (HIA) has been commissioned for the Merseyside Primary Care Trusts (PCTs) Directors of Public Health and is part of the Liverpool Public Health Observatory’s core research programme. The aim of the research was to ascertain the potential health impacts on Merseyside, with particular emphasis on the implications for health inequalities, of the choice agenda as specified in the 2005-2008 targets. These targets set maximum waiting times for outpatient and inpatient appointments and a choice of provider at the point of referral.

The methods used for this HIA involved:

- Policy analysis of the choice agenda and associated policies;
- Profiling of the affected areas using national statistics and other available statistical analysis;
- Profiling of health service provision using internet sources;
- Identification of key informants by members of the steering group and snowball sampling;
- Identification of health impacts proceeded from those identified by key informants using the check-list of key influences on health as a prompt. The health impacts and any recommendations were supported and extended by a literature review of policy documents, policy analysis, relevant research, reports and academic papers.
- Identification of priority impacts was based on severity, probability, frequency, preventability and the potential and nature of future impacts on health.

The NHS Plan set forth a vision for greater patient choice, which was initially confined to patients with coronary heart disease then extended to patients waiting for a range of elective surgical procedures. Targets have been proposed to reduce waiting times, improve choice and provide electronic booking of treatment at a time and place to suit patient needs. System reforms designed to underpin patient choice, culminating in a competitive healthcare market where money follows the patient, presents a revolutionary, challenging agenda to implement and manage the associated risks.

Market forces and patient choice is regarded by the government as: a stimulation of innovation, a means of modernising the NHS to make it more personalised and responsive to consumers’ demands, driving up standards and productivity, and in the longer term, driving down costs and reducing waiting times for elective care. Furthermore, providing choice and information is seen by the government as making the NHS more equitable and should reduce patient anxiety by having an immediate confirmation of an appointment.

These reforms have been the cause of much ideological and political debate not least because they are associated with the privatisation or dismantling of the NHS. They are accused of compromising its founding principles of a comprehensive and collectivist system of healthcare. Furthermore, huge
profits that could have been directed at health care would go into private business. Specialists may move to more prosperous areas to protect their private practice or where they will get paid more. Concern was raised that if patients are being referred from outside the area or region into local reputable specialist hospitals, they will be overwhelmed resulting in limited access for local patients. Patients will not have the option of their preferred choice if the providers are full.

The associated risks from the reforms can present possible trade-offs between the fundamental aims of the NHS, thus attempting to increase efficiency and responsiveness but at the probable expense of equity. Of particular controversy is the role of new providers, to increase capacity from the independent sector and the formation of Foundation Trusts. The instigation of a competitive market in healthcare can have the perverse incentive of sucking more patients into hospital care, some of which could have been better provided for in the community. There are concerns about the efficiency and effectiveness of the financial and computing systems underpinning choice. Through limited progress on e-booking choice will have to be provided in other, less efficient ways, until approximately December 2006. Concerns have also been raised about the confidentiality of patient records.

To ensure that choice of provider leads to better health outcomes for all patients it must reduce not increase inequity of access to health care. Whether the choice agenda will increase or decrease equity in the NHS remains open to debate. The policy rests on the ability to empower disadvantaged groups, but research suggests that the poor or low income patients, the old, those with lower educational levels or family commitments will be amongst those discriminated against. The people most in need of hospital care will be also be the most disadvantaged. Choice could be easier for those who are comparatively well at the expense of the comparatively less well, as new providers do not have facilities for intensive care or high dependence beds. Patients could be prioritised on the basis of financial reasons not on the basis of their needs, which is referred to as cream-skimming.

Health inequalities could also be part of choice because some patients will be “information disadvantaged” and thus unable to make an informed choice. Information disadvantage refers to language difficulties, lack of basic skills or total unfamiliarity with the internet. Particular concern was expressed about ethnic minorities and patients with disabilities getting a fair choice and protecting confidentiality. The type of information patients will need to make an informed choice is discussed and the associated problems in providing meaningful statistical data. Other potential barriers to equitable access for disadvantaged groups include: lack of suitable transport, incurring greater travel time and costs and lower car ownership; time constraints and differences in health beliefs.

Travel could restrict choice for the frail, disabled or those vulnerable patients who want to stay near the support of relatives, putting a strain on family and
friends to keep making long-distance trips to visit. Indeed, social support is an important part of the recovery process. Experience and research evidence suggests that many patients may be parochial in their choice, unless they need to be seen by the best specialists for a rare condition or they are in severe pain. The choice of providers will be more in big cities than in rural areas.

Contrasting views were expressed on some major impacts. Quality of care was an issue for a number of reasons. Patients may be at risk in a private provider if there are complications as they do not have the resources. Research suggests that for-profit healthcare is not as good as non-profit and there could also be a trade-off between quality and volume and a temptation to cut costs that could threaten quality in order to meet national tariffs. There is no evidence that competition between providers improves quality. However, the Healthcare Commission tightly vets potential providers and the independent sector has to work to their performance guidelines. It was regretted that patient groups have limited power to monitor. Clinical priority will be affected if the patient chooses the time and place of their outpatient appointment. Research confirms that waiting times do not guarantee patients being treated in accordance with their clinical need. There is evidence of consultants treating patients in a different order to what their clinical priority would suggest to avoid breaching waiting time targets. There may be unanticipated increases in demand if GPs refer more patients and previous consumers of private healthcare switch back to the NHS through faster access.

Staff shortages in critical areas such as diagnostics and radiology could impede the 2008 eighteen week waiting time target. Critics argue that if independent treatment centres (ITCs) recruit from NHS staff how can they increase NHS capacity. As Foundation Trusts can negotiate or impose their own pay scales and conditions of service there is a risk that they will draw scarce staff away from non-foundation trusts. Furthermore, an additionality clause preventing ITCs from employing staff who have worked in the NHS over the previous six months has been lifted by a secondment agreement allowing staff to be employed by ITCs whilst remaining on NHS contracts. Consultants can do shifts in treatment centres once they have put in their required hours with the NHS. If hospitals lose staff they jeopardise their ability to offer the full range of services.

There has not been a relative increase in rehabilitation provision in line with the expansion in elective capacity in the private sector and out sourcing of work to other areas. If resources are not available in the community patients are at risk of being re-admitted possibly as an emergency or there will be increased pressure on emergency response hospital at home schemes. There has been evidence of increased 999 calls and care pathways being inadequate. It is feared that competition will destroy the spirit of collaboration within the NHS where resources are shared. Collaboration is vital to improve emergency care, services for people with chronic conditions and for highly specialist services. Whole system planning is required to ensure an integrated service across secondary, primary and community services.
Primary care may be negatively affected by choice. Some main concerns include: practice capacity, workload, consultation length and quality, and fears that existing health inequalities will be exacerbated. The choice system transfers all of the administration over into primary care without the transfer of funds from the secondary care sector into primary care to actually account for that. Some participants feared that the system would increase bureaucracy and administration, although new employment opportunities would be created and or changing job roles. Nevertheless, through the original referral system a patient could technically be sent anywhere in the country and a few have been granted operations abroad. Also, if a patient has previously had an operation they may prefer to see the same consultant again for a similar problem but under "choose and book" this may not be possible. The policy could also take resources away from the traditional Cinderella services such as mental health, district nursing for older people and public health because there are few targets. Furthermore, psychological support for the patient and family is not being considered in relation to access.

Conversely, patient anxiety would be reduced through knowing when and who they are going to be seen by and being seen quickly could reduce worries about a medical condition. Reduced waiting time is associated with improved quality of life and health in patients. Furthermore, patients going to a private provider can be confident that an appointment is not going to be cancelled because of an emergency admission. They can provide appointments with an NHS consultant in the evening or weekend, which is more convenient to people in employment and allows relatives or friends to attend giving social support. In the private sector, psychologically, patients will feel better if in a pleasant, quiet environment where they appear to have the undivided attention of health professionals. If more people are going to go into the private sector waiting times will be reduced in the local NHS hospital. Indeed the numbers of people waiting for hospital treatment and the length of time waiting is reducing.

The private sector considers that it can complement NHS provision and there has developed a deeper understanding of each other’s pressures and the NHS now has an appreciation of the roles and skills that are available in the private sector. Also, they could be seen as taking the pressure off the NHS Trusts, rather than creaming off the low risk patients. The NHS could be seen as devouring the private sector as the number of self-pay operations fall, as patients can be seen quicker. Choice could actually drive up standards particularly for cleanliness as providers will want to attract patients to their establishments. Private providers were considered to be particularly expert for routine operations where they have specialised in these procedures. It provides a rational system of referral stopping differential waiting lists for comparable consultants.

Professional training of medical and nursing staff may be compromised as it is envisaged that the case mix in the acute NHS Trust hospitals will not be sufficiently varied to provide good training. The loss of routine operations to
the private sector is already disturbing teaching. Furthermore, ITCs also have no responsibilities for research.

There were major concerns around hospital viability if money follows the patient through payment by results. This is already pushing some trusts into deficit and services are threatened particularly by the transfer of operations from NHS hospitals. Indeed, there is evidence of a significant amount of “stranded capacity” within parts of the NHS. That is, many hospitals could quickly increase activity in some services if the purchasing power of PCTs were greater. Objections have been raised that new providers will be paid more over the first five years to offset the extra costs they incur plus a guaranteed level of provision. Choice may provide an incentive to improve services, but hospitals that lose patients will go into financial decline. There could be a “sink” sub-section within disadvantaged areas where providers are under-performing, unable to attract good staff, with falling demand contrasted with prosperous leafy areas where there is high demand but not enough places and in effect the provider selects the consumers. An alternative view is that the NHS would not be destabilised as private providers could only take limited numbers, and some patients would still prefer their local hospital. Competition could be seen as healthy as skill levels of staff would be consistently at a higher level, if a provider was constantly busier.

Discussion also took place on whether patients actually value choice. The evidence from the pilot choice projects may not offer much light on this because the patients, procedures and financial arrangements were not representative of how choice is going to operate in practice. Evidence suggests that patients favour choice if they do not have to consider its relative value. Recent surveys confirm that choice is not seen by the public as the greatest NHS priority and the vast majority put a good local hospital ahead of choice of provider.

**Recommendations**

It is recommended that a working group be appointed to consider the recommendations of this HIA. The working group should identify: the feasibility of the recommendations, how they might be acted on and lead people or organisations that might implement them.

**To raise awareness**
- Raising awareness about “Choose and Book” amongst the general public through different media formats.
- To inform the general public in all residential areas that it will be their right to choose.

**Help in making a choice**
- If GPs were moved to larger practices then someone could be employed at health care assistant level for all of the GPs to sort out booking arrangements for the patients. Also in the NHS drop-in centres an individual could organise the “Choose and Book” for that area. These arrangements would ease the administration of the choice agenda.
• The decision to refer could be done by a GP and then have a patient advisor who would go through all the options outside the practice. However, not all were in agreement with this as it puts reliance on the patient to contact an outside agency, which from experience some would not do.

• More resources for primary care if booking to take place in general practice with the training of staff in dealing with patients and protecting confidentiality.

Information requirements
• Require more transparent, sophisticated data on the performance of hospitals that takes into account the differences in case mix, and to make this data available to patients in an easily understood format. This is particularly pertinent for people with poor literacy and numeracy skills so they can make a fair comparison.

Maintaining standards
• For all providers to be independently assessed to the same standards.
• Need assistance with the journey for ethnic minorities and families if travelling distances.
• Monitoring needs to take place of any problems that are occurring with the implementation of the “Choose and Book” taking into account the point of view of staff and patients.
• Continued monitoring of what providers patients are going to – for instance whether choice is being skewed because of loyalty to a particular provider.
• Two patient/carer representatives at all levels of the NHS for instance on the PCT Board, the Strategic Health Authority, select committees, scrutiny committees and the oversight Committee.

Reducing inequalities in health
• Require interpreters to be booked for all consultations within primary and secondary care for non-English speaking patients.
• Resources provided to primary care to employ people to go through the choice options with them in an advocacy role, taking into account any other needs they may have such as carer responsibilities for a child or elderly person or any medical issues they may have. The same person could be involved in the discharge of that patient as well as providing continuity of care, ensuring that all the necessary services have been identified on admission such as the patients’ home helps. The more deprived the ward where the surgery is the more intensive the resources to be allocated. That role would take the onus off the doctor.
• In NHS Centres – an individual available to organise “Choose and Book” for people who felt they could not organise an appointment themselves
• Need to run a course for would be patients and tell them all the questions they should be asking about “Choose and Book”.
• Support at point of choice for disadvantaged people such as those with communication difficulties. A pilot could be instigated in a general practice using specialist workers e.g. people able to communicate with ethnic minorities and understand their culture.
• To be fair to local people, a person’s first option has to be to go local. In 2008 you could go anywhere but if the patient was not local they would be further down the list. There would have to be quotas from certain areas.
• To avoid a postcode lottery, need targeted community education programmes, for disadvantaged people such as those with communication difficulties to explain that it is their right to choose between alternative providers. Could use local radio channels, television and local newspapers.
• Need good information, perhaps a leaflet campaign on how to make a choice in simple, plain English and in the main foreign languages spoken on Merseyside. This to be provided in a variety of venues: for instance schools, libraries, doctors surgeries, and chemists. Healthcare staff such as district nurses, practice nurses could talk it through with patients. Some information should be in large print format, simple pictorial language for people with a learning disability and British sign language. “Readspeaker” could be used on “Choose and Book” websites to help dyslexics or others with low literacy skills, a learning disability, with English as a second language, or the elderly with impaired vision. When the icon is clicked the text on the page or highlighted word is spoken. Coloured paper can be used to aid word perception for dyslexics.
• There needs to be a clearly defined advocate for people who have no capacity, or little capacity to deal with their own affairs. It would be helpful if there was some scrutiny that could be done on those advocates or family members to make sure that they are acting in the patients best interests.
• Feedback when the choice agenda is operational on where the monetary resources are going throughout the country.
• Ensure that choice of providers is local so it is easily accessible for people without their own transport.
• If the cost of travel is restricting access to services then free transport should be provided not just for the patient but the relatives of the elderly and the young and for other vulnerable groups.
• For the physical and mental well-being of the vulnerable and frail patient, where possible, hospital hotels should be developed to accommodate relatives, particularly of the young, old and the critically ill patients.
• Providers to take into account culturally specific needs such as availability of prayer mats, modesty gowns.

Aftercare
• Investment in primary care should go hand in hand with the expansion of elective care.
• Imperative that the information flow is good between the place where the elective service is and where the rehabilitation is being provided.
• Need to establish proper care pathways and links. Community support should be totally linked to elective care provider.

Manpower and training
• Cheshire and Merseyside Workforce Development Confederation will need to consider the impact on manpower and training of the choice
agenda. Private providers will need to be included in the rotation of junior doctors.
HEALTH IMPACT ASSESSMENT

PATIENT CHOICE AGENDA

Introduction
This health impact assessment (HIA) has been commissioned for the Merseyside Primary Care Trusts (PCTs) Directors of Public Health and is part of the Liverpool Public Health Observatory’s core research programme.

Aim:
To ascertain the potential health impacts of the choice agenda as specified in the 2005-2008 targets with particular emphasis on the implications for health inequalities.

Objectives:
1. Initial policy analysis
2. Review of key indicators for Merseyside PCTs on access and waiting times.
3. Brainstorming with key informants and stakeholders to identify potential health impacts for the introduction of the policy and for each stage of its implementation
4. Review of supporting evidence
5. Recommendations for the management of priority impacts.

Research question:
What are the potential impacts on health and health inequalities in Merseyside of the patient choice agenda?

Scope of the HIA
Initially, the Observatory was asked to look at the health impacts of the whole of the waiting, booking and choice strategy. At the first HIA steering group meeting it was agreed with the members to focus on the health impacts of the patient choice targets from December 2005-2008 setting maximum waiting times for outpatient and inpatient appointments and a choice of provider at the point of referral. The waiting, booking and choice policy was considered too broad for the available resources of the Observatory. The targets were of crucial interest to the PCTs as they would be required to implement them within the time limits. The policy interacts with other reforms and in total presented a radical departure from traditional block booking and referral methods. There were concerns within the public health community that these policies may adversely impact on health inequalities. As it was a national policy it would have wide interest.
Health Impact Assessment

Health Impact Assessment (HIA) can be explained as “the estimation of the effects of a specified action on the health of a defined population.”\textsuperscript{25}

Health should be viewed holistically as much more than the absence of disease, but a “complete state of physical, mental and social well-being.”\textsuperscript{26} The definition of health used in the HIA is derived from the work of Lalonde\textsuperscript{27} and Labonté\textsuperscript{28} based on a socio-economic model of health illustrated in the key influences on health in Appendix 1. These determinants of health can be illustrated as layers of influence, as in Figure 1. The socio-economic model emphasises the interconnectedness between the layers. At the core are generally fixed determinants such as age, sex and genetic characteristics that can have an effect on an individual’s health potential. The inner layer contains the lifestyle factors that can promote or damage health. According to this model the outer layers have the most influence on health. Individuals do not live in a vacuum, but interact with others in their immediate environment. Social interaction and support can have a protective influence on health even in unfavourable circumstances. The wider influence of their living and working environment will also determine how effective their social and community influences are. The wider socio-economic, cultural and environmental conditions influence how people behave; determine attitudes, general access to healthy choices and a cohesive social environment.
Figure 1: The main determinants of health


From these health determinants, it can be seen that the potential to improve the population’s health will come through social, economic and environmental reforms than through medical advances. There is growing “documented evidence that specific actions that grow out of public policy, can affect these determinants so they influence health either positively or negatively.”

The purpose of the HIA is

- To assess the potential health impacts, both positive and negative, of policies, programmes and projects; and
- To improve the quality of public policy decision making through recommendations to enhance predicted positive health impacts and minimise negative ones.
Patient Choice Steering Group

To facilitate the research process a patient choice steering group was formed, which met on a monthly basis. Its membership and terms of reference are set out below:

Dr Alex Scott-Samuel (Chair)  Director of the Liverpool Public Health Observatory
Dr Kate Ardern  Head of Public Health, Cheshire and Merseyside Strategic Health Authority
Sarah Cartwright  Expert Patient
Allison Cooke  Chief Executive, Bebington and West Wirral PCT
Ruth McDonald  Non-Executive Officer, South Liverpool PCT Board
Rose Moran  Choice Project Manager, Central Liverpool PCT
Sam Semoff  Representative from Former Toxteth Community Forum
Lyn Winters  Senior Researcher Liverpool Public Health Observatory

Terms of reference for steering group:

1. To act as a source of advice and local expertise for the researcher
2. To facilitate links with key informants for the health impact assessment process.
3. To ensure the research is completed within the timescale.
4. To approve the final report.
5. To agree appropriate circulation for the report.
**Methods for Prospective Health Impact Assessment**

The details for carrying out a HIA are contained in the “Merseyside guidelines for health impact assessment” and have been discussed in some detail in a previous observatory report. The stages in the HIA are shown in Figure 2.
Figure 2: Stages in the HIA process

Procedures

- Apply screening criteria to select project or policy
- Establish steering group
- Agree terms of reference for assessment
- Select assessor
- Conduct assessment
- Appraise the assessment
- Negotiate favoured options
- Implement and monitor
- Evaluate and document

Methods

- Policy analysis (if appropriate)
- Profiling of communities
- Interview stakeholders and key informants
- Collect evidence from previous reports
- Identify health determinants affected
- Assess evidence
- Establish priority impacts
- Recommend and justify options for action
- Evaluate and document previous reports
Policy Analysis
The purpose of the policy analysis was to identify:

- Rationale, context and strategies of the policy;
- Populations and sub-populations who are affected, positively or negatively, by the policy;
- Key informant and stakeholder sample groups;
- The relationship of the proposed policy with other policies;
- The results from evaluations of this policy and similar policies.

Profiling of affected areas/communities
Profiling of Primary Care Trusts was compiled from the Office for National Statistics Census 2001 and small area database for 2004. Also the Health Development Agency statistics for the proportion of smoking related death by Merseyside PCTs was used. A profile of health service provision in Merseyside has also been provided using internet sources including the Department of Health’s website.

Identification of key informants
Members of the steering group identified key informants. These were contacted directly by the researcher to invite them to participate. Other key informants were identified from asking interviewees for further contacts, which is known as snowball sampling. Unfortunately, not all contacts responded positively to requests to participate. Twelve interviews and eight focus groups were carried out, which included: health professionals, other experts and patients. (See Appendix 1: List of Key informants and contacts)

The informants were guided through a summary of the proposed policy, the model of health used in HIAs and the main influences on health by the researcher. They used their perceptive knowledge to highlight the main health implications of the policy, in particular the impact on health inequalities. (See Appendix 1: List and diagram of key determinants on health)

Identification of health impacts
The identification of health impacts proceeded from those identified by key informants using the check-list of key influences on health as a prompt.

Key informants were asked what health impacts they anticipated the policy would have, both overall, and on relevant population groups (ie on health inequalities). The following were presented as potential questions for discussion:

1. What are the costs and benefits of the choice agenda?

2. What will be the implications for health inequalities of implementing this policy?
3. There will be no additional rehabilitation support after elective treatment. Therefore, will the reforms perversely increase choice for well-off people who have the domestic backup and opportunities to travel?

4. What will be the implications for workforce planning in Social Services and Social Care (e.g. residential homes) and community support?
   - Will more therapies in the community need to be provided?
   - Will this impede the Choice agenda initiative?

5. What will be the impact on waiting lists and delayed discharge?

6. Will screening of patients create further inequalities, as treatment centres may prefer to take patients who will not potentially block beds?

The health impacts and any recommendations were supported and extended by a literature review of policy documents, policy analysis, relevant research, reports and academic papers. Current developments were highlighted by literature alerts from the British Medical Journal, news and reviews from the Health Service Journal and the Guardian newspaper.

**Identification of priority impacts**

The criteria to decide upon priority health impacts included:
- The severity: - having clear and important health implications, and/or the magnitude of the impact in terms of numbers of people affected.
- Probability: - the likelihood that the health impact will take place.
- Frequency: - the frequency with which key informants/stakeholders identified particular impacts as a priority.
- Preventability – predicted negative health impacts having clear and important policy implications that can lead to prevention.
- Future impacts: - the potential and nature of future impacts on health.
**Introduction to the Patient Choice Reforms**

The NHS Plan set forth a vision for greater patient choice,¹ as a central element of health policy and ten pilot schemes have been run to test the policy in practice, although seven have not been routinely monitored.³⁶ The patient choice initiative was initially confined to patients with coronary heart disease then extended to patients waiting for a range of elective surgical procedures. Patients waiting more than six months were offered a choice of having their treatment in a different hospital on a guaranteed date or continuing to wait for treatment at their ‘home’ hospital. Targets have been proposed to reduce waiting times, improve choice and provide electronic booking of treatment at a time and place to suit patient needs.¹ System reforms designed to underpin patient choice, culminating in a competitive healthcare market, presents a revolutionary, challenging agenda to implement and manage the associated risks. These risks can present possible trade-offs between the fundamental aims of the NHS, thus attempting to increase efficiency and responsiveness but at the probable expense of equity.² These reforms have been the cause of much ideological and political debate. The targets that are considered in this report are those from December 2005 – 2008.

**By December 2005**, maximum outpatient wait of 13 weeks, maximum inpatient wait of six months. All patients who need a referral to hospital (or a suitable alternative provider) for elective care can expect³⁷:

- To be offered a choice of 4-5 providers, commissioned by their PCT. This choice is essentially for an outpatient’s appointment. If patients are unhappy with the care provided by their chosen provider they will have to return to their GP for another outpatient appointment.³⁷
- To be able to book their appointment with their preferred hospital/suitable alternative provider.
- To either book their appointment electronically immediately with their GP or other practice staff, or they can call a telephone booking service or use the internet at a later stage. They can also change or cancel an appointment in this way. However, if they want to change provider they have to see their GP again.
- Information to be made available to inform their choice provided on the internet.
- To be supported in making their choice by their GP or primary care professional and, where necessary, by a range of practice, PCT and community and voluntary sector based services. PCTs will provide targeted packages of support designed to ensure that all patients, including hard to reach patients and communities, can benefit from choice.
- Aftercare and rehabilitation to be provided locally following any hospital treatment.
• **By April 2006** patients will be offered the choice of the five hospitals plus any foundation hospital and any of the new treatment centres.\(^{38}\) This will provide a choice of about 50 centres.\(^{39}\)

• **By December 2008** patients should be seen for their first hospital outpatients’ appointment within 13 weeks.\(^1\) Patient choice will be expanded to any provider that can meet the Healthcare Commission’s standards and can provide care within a maximum NHS price limit.\(^{40}\) The maximum wait between GP referral and treatment will be 18-weeks.\(^{40}\) The government will consult with the NHS on the rules governing this target.\(^{41}\)

**Range of service providers could include\(^{37}\):**

- NHS Trusts
- Foundation Trusts - independent of NHS control
- NHS and independent Sector Treatment Centres
- Independent Sector Hospitals - independent providers, such as BUPA, may apply to be on the list of choices for patients, if they are able to operate to NHS standards and at the NHS tariff.\(^{38}\)
- General Practitioners with a special interest or other extended primary care treatment services.

PCTs will discuss the options with their Patient Forums and decide which should be made available.\(^{37}\)

**Role of New Providers**

The NHS Improvement Plan\(^{40}\) states that:

• To support capacity and choice, by 2008, independent sector providers will provide up to 15% of procedures on behalf of the NHS. Procedures would include: routine elective operations, diagnostic procedures and treatments.\(^{42}\) The Healthcare Commission will inspect all providers, whether in the NHS or in the independent sector, to ensure high-quality care for patients wherever it is delivered.

• By 2008 all NHS acute trusts in England will be in a position to apply to become NHS Foundation Trusts (FTs). Non-NHS providers will also be eligible to apply to become NHS FTs. These are a new type of NHS hospital “tailored to the needs of local populations and run by local managers, staff and members of the public.” The Health and Social Care Act 2003 established NHS FTs as independent public benefit corporations modelled on co-operative and mutual traditions\(^{43}\) with freedoms to retain any operating surpluses and to access a wider range of options for capital funding to invest in delivery of new services.\(^{40}\) The first NHS FTs were authorised by Monitor (whose statutory name is the Independent Regulator for NHS FTs) from 1 April 2004. There are now thirty-two NHS FTs drawn from the top-
performing NHS trusts.\textsuperscript{43, 44} That is hospitals that have obtained three stars (recently extended to two star trusts)\textsuperscript{44} in what has been described as the “far from perfect” previous ranking system of the Health Care Commission.\textsuperscript{45}

**Limitations on choice**

Services that will not be required to offer a choice of 4-5 providers by December 2005 are\textsuperscript{37}:

- Services where speed of access to diagnosis and treatment are particularly important:
  - Emergency attendances/admissions
  - Patients attending a Rapid Access Chest Pain Clinic under the 2 week maximum waiting time
  - Patients attending cancer services under the 2 week maximum waiting time

- Services where other choices are more likely to improve the patient experience:
  - Maternity services
  - Mental health

- Paediatric services – where it may not be possible to offer choice for all referrals, particularly for referrals requiring more specialist interventions.

**Increasing capacity**

To achieve these targets the government is proposing that NHS organisations will need to increase capacity and make better use of existing capacity. In many cases this will mean service redesign and modernising job roles. The NHS Modernisation Agency has been providing support and guidance.

To increase capacity:

- Primary Care

More services are being offered in primary care that previously would have been provided in hospitals. This is being achieved through enhancing the skills of primary care professionals, such as nurses and doctors with a special interest.\textsuperscript{46}

- New Treatment Centres\textsuperscript{47}

These are dedicated units, introduced in 2003, offering pre-booked day surgery, short-stay surgery and diagnostic procedures in specialities which have traditionally had the longest waiting times such as orthopaedics and ophthalmology.
Treatment Centres, known previously as ‘Diagnosis and Treatment Centres’,\(^1\) provide pre-booked diagnosis and treatment for NHS patients. They can be run either by the NHS or commissioned from the independent sector - but always to treat NHS patients. They enable the NHS to separate out scheduled, routine treatment from emergency procedures - they should, according to the government, result in fewer cancelled operations and a smoother, more convenient service for patients.\(^47\) They are to treat 250,000 patients per year from 2005 of which 115,000 operations are transferred from the NHS and 135,000 are extra operations.\(^48\) The current health secretary has recently announced new contracts for private healthcare corporations that will be worth more than £3bn over the next five years to carry out an extra 1.7m elective operations.\(^49\) Elective surgery currently accounts for less than 20% of the NHS budget. Thus approximately 11% of non emergency elective surgery will be carried out in the private sector for the NHS.\(^49\)

A new system of financial flows - payment by results

These reforms set out in “Reforming NHS Financial Flows”\(^60\) will entail changes in the way money flows round the NHS. Funding follows patients and cost of care is based on national tariffs, a fixed price allocated to a particular procedure or group of similar procedures called ‘health resource groups’ or HRGs. Therefore, the new payments are, adjusted for “casemix” – the difficulty and complexity of the procedures involved.

The system means that providers will be paid according to what they deliver, instead of paying through block agreements and locally agreed prices, where providers were often paid a set amount regardless of the work they carried out. Payment by results (PbRs) aims to be an incentive to deliver the increased activity needed to reduce waiting times, reward efficiency, and facilitate patient choice and plurality of provision.

- The more agreed activity providers deliver, the more they will get paid.
- If they do not deliver the activity for which they have been commissioned, they will receive less funding.
- This will leave commissioners with more resources to fund activity elsewhere.

NHS FTs and the PCTs that contract with them started to operate under PbRs from April 2004 for acute inpatient (elective and non-elective) activity. On 1 April 2005, PbRs was introduced for elective activity in all other NHS trusts, with non-elective and outpatient care deferred to 2006/7 (except for FTs).\(^51\)

An extension of PbR is a fee-for-service announced in the NHS Improvement Plan.\(^40\) This is where staff would receive a bonus for treating more than a benchmark number of patients. Pilots were introduced in the Summer of 2004 to provide extra operations and outpatient consultants in a range of treatments including orthopaedics, ophthalmology and general
surgery. Other priority areas to increase patient choice have been highlighted in *Building on the Best.*

**Improvements in information technology to support choice**

This will be the world's largest civilian IT programme, costing £6bn, linking all parts of the NHS and its patients. Choice at referral will be delivered through electronic booking “Choose and Book”, commissioned by the Department of Health’s National Programme for IT (NPfIT). “Choose and Book” will involve upgrading or new computer systems in hospitals and GPs’ surgeries to deliver a complex clinic booking system.

**New commissioning arrangements**

**Merger of Primary Care Trusts**

The Audit Commission welcomes the merger of 300 PCTs into just 144, as collaboration will make them stronger commissioning bodies more able to employ demand management strategies to counter-balance hospitals within the NHS market. However, the King’s Fund warns that this programme of organisational change “risks overloading the system at a time of unprecedented change.”

**Practice-based commissioning**

This is part of the government’s attempts to devolve power from the department of health to the local NHS, and allay its anxieties over demand management. From April 2005 GP practices have been able to request indicative budgets for the services to which they refer patients. The Department of Health expects that universal coverage of practice-based commissioning to be in place by December 2006. Practice-based commissioning is thought to counterbalance the perverse incentive of PbRs for acute trusts to treat as many patients as possible and in particular patients who would better treated in the community. Family doctors will be allowed to keep all the savings they make for the NHS by referring fewer patients for expensive hospital treatment. The savings would be ploughed back into the practice to provide a greater variety of services for their patients. Indeed, a study based on admission data for four years under the operation of GP fundholding found that admission rates for elective procedures was reduced by 3.3% compared to non-fundholding practices.

However, the BMA has asked Local Medical Committees to consider how practices or groups of practices can promote in-house or locality services to patients at the same time as offering them a choice of providers. Furthermore, there is little substantive research evidence to demonstrate that any commissioning approach has made a significant or strategic impact on secondary care services.
Rationale behind the choice agenda

**Arguments for a Market in Healthcare**

The government wants to move away from central planning of the standardised “top-down”, “command and control”, “one-size-fits-all” models of public sector provision and be more responsive to patients. Therefore the choice agenda has reintroduced a market in health by giving patients the choice of free elective care from a mixed economy of NHS and private care providers, including the independent foundation hospitals. This in turn leads to competition (or ‘contestability’ which the government prefers) between providers, as money follows the patient through payment by results. Prior to 2000 the NHS was buying 60,000-80,000 procedures from the private sector in order to meet NHS waiting time targets. Working in their own time in private practice, NHS surgeons and anaesthetists were charging the highest fees in the world per procedure. Furthermore, the private sector could not plan because it did not know how much business they would receive from the NHS. Consequently the public sector often paid 40% and sometimes more, above average NHS costs for each operation it bought.

Market forces and patient choice is regarded as a: stimulation of innovation, a means of modernising the NHS to make it more personalised and responsive to consumers’ demands, driving up standards and productivity, and in the longer term, driving down costs. Thus it marks a new era of service users as consumers rather than passive patients. The government considers that if patients vote with their feet they provide the incentive for services to improve to match consumer needs. Adjusting costs to the national tariff should stimulate providers to greater efficiency.

Providing choice and information is seen by the government as making the NHS more equitable, by giving patients a choice of provider irrespective of their clinical need, ability to pay or articulate their choices. Better use of existing capacity and via market entry by the private sector should, they believe, reduce waiting times for elective care. The freedom that foundation hospitals enjoy will allow them to be innovative. The private sector should provide new ways of working which will serve as examples of efficiency and responsiveness to patient needs.

**Responsiveness**

Benefits to patients are considered to be a reduction in anxiety through receiving an immediate confirmation of their appointment at a time and place to suit thus giving greater certainty and convenience. For the NHS therefore there should be a reduction in DNAs (do not attend). Data from previous booking trails has shown that when patients participate in the booking of their appointments they are more likely to attend. Patient choice and GP commissioning will put pressure on providers to be more responsive to patient preferences.

**Interaction of reforms**

Through the interaction of reforms there is a note of caution. According to the National Audit Office, choice at referral has the potential to contribute to a
more patient-focused health service, but there are a number of dependencies and interactions with other policies that need to be managed. There are concerns about the efficiency and effectiveness of the financial and computing systems underpinning choice. Information technology requires development and “significant cultural, organisational and behavioural changes will need to be made by patients, NHS organisations and staff.” There is a tension between the need to make efficiency savings and the desire to expand choice, relying on spare capacity. With such complex reforms the results of their interactions may be unpredictable or perverse and will need to be monitored.

**Arguments against the market in healthcare**

Much of the debate on choice tends to be ideological. Critics of choice see it as a distraction of the more important task of tackling health inequalities and shifting the focus upstream from health care to prevention. They also argue that not only do patients not want choice, but the NHS will be damaged. The introduction of the Conservatives internal market has been associated with rising bureaucratic costs, lack of cooperation between NHS hospitals and hindering the spread of best practice. Arguably it is only within the last 15 years with the emergence of the Conservative internal market and contracts that patient choice of hospital mediated by the referring GP, has been undermined.

Competition has “the perverse effect of sucking more resources into inpatient care just when hospitals ought to be working with primary care teams to avoid admissions.” At the same time, through the lowering of referral or admission thresholds, the rights of patients to select their elective care provider and reduced waiting times runs the risk of increasing demand for hospital services.

**Lack of strategic planning**

To allow competition to work the director of policy at the King’s Fund has called for the design of effective economic regulation and evidence that reform on this scale can be managed effectively. Which? the consumer magazine, has warned that individual choices will not necessarily lead to the services that collectively patients want and need. According to the Public Select Committee, there is scant and inconclusive evidence that patient choice, based on markets, diversity and competition, will improve performance of hospitals even though the evaluated pilot schemes give some grounds for optimism there is no reason that their results will transfer to the national choice scheme. Furthermore, competition and choice could actually increase inequalities in access and standards of care for instance, through the risk to hospital viability. Therefore the government needs to increase capacity where required and retain a strategic planning role to ensure adequate provision where it is needed. However, what is happening is that the government is withdrawing “from state ownership and from directing providers from the centre and instead [allowing] competition, regulation, and commissioning to improve performance.”
Privatisation

It was feared by some participants in this research that the private sector, with charitable status, is being given a designated percentage of NHS resources for elective care, whilst they will still be able to get funding from private sources. Indeed a private provider confirmed that their core business was now for NHS provision. And concern was raised over the suggestion that GPs may be given a monetary incentive to send patients to the private sector.

One GP felt there was conflicting policy in that the consultants’ contract was trying to limit private work. A possible risk was noted by professionals in one focus group that specialists and consultants may move to more prosperous areas to protect their private practice or where they will get paid more. Indeed, one patient group considered that patient choice would not eradicate queue jumping, by people who want to pay to see a consultant privately in the near future. Another concern, of a patient forum, was that the formation of foundation trusts funded by public and private investment was the start of the privatisation of the NHS.

In the literature, many commentators fear that using private providers is the start of privatisation – the dismantling of the NHS, with private healthcare providers, including a handful from the US, Canada and South Africa gaining millions of pounds of NHS money, that could have gone towards clinical care. Indeed, of the 48 treatment centres planned for completion by the end of 2005, 34 will be run by the private sector. Several hundred million pounds a year more is to be spent on private provision of diagnostics.

Patient choice is regarded as a pretext for a covert programme to privatise the health service, that could result in hospital closures and the slipping of standards and compromising the founding principles of the NHS with its emphasis on a comprehensive and collectivist system of health care. Indeed, the “private finance initiative” (PFI) builds and finances new hospitals from the private sector, but with a contract from the government to pay to use the hospitals for some 30 years. Since 1997 schemes worth more than £5bn have been completed or are being built. They may be inflexible to adapt to the changing needs under patient choice and future new ways of working with the advance of technology, leaving the NHS with “expensive monuments”.

Furthermore, private providers, under government contracts, also build the new independent treatment centres (ITCs). Thus, at the BMA's 2004 conference delegates voted overwhelmingly to oppose the introduction of ITCs and supported increasing capacity in the NHS instead. A recent YouGov poll found that 87% of the general public were against NHS hospitals being run by private companies for profit.

A second wave of ITCs will provide contracts worth £3bn to diagnose and treat NHS patients, including plans for private providers to take over some NHS buildings, along with equipment and staff. The government has been warned by the BMA that they may underestimate the speed at which markets can react when lucrative opportunities present themselves that they will be
unable to control. The choice agenda has already inspired one entrepreneur in partnership with hundreds of NHS consultants to build a chain of private hospitals where NHS and private patients can be offered elective care. Ultimately, the NHS may be a purchaser of services from private contractors. The rhetoric from the government is an ‘NHS of values not institutions’ keeping true to its founding principle of fairness for all. Therefore the financing and regulation of the NHS may remain with the government with the private sector increasingly providing the provision and management of the service.

There has been strong opposition to the formation of the controversial FTs with Unison and other critics raising objections. FT status in time could be opened up to organisations outside the NHS and they can also outsource some or all of their functions to the private sector. Foundation hospitals have denationalised the NHS into locally “owned” and governed bodies and it is feared that this could make them more susceptible to any privatisation in the future. As more hospitals become FTs the boundaries between private and public become more blurred.

Foundation hospitals may also undermine the NHS’s public service principles. For instance, equal access could be compromised as the government guidance states that FTs must only meet a reasonable level of demand for regulated services listed in the licence. FTs may then focus on selecting patients with the lowest costs from whom they can make a profit. It is unclear what principles or criteria the Independent Regulator will be expected to observe.
**Identification of Health Impacts**

The following health impacts were initially derived from discussions with key informants and where possible they have been supplemented or extended with evidence from the literature.

**Priority Impacts**

To identify the priority impacts the criteria for prioritising impacts, agreed with the steering group, were applied. These were based on their perceived severity; probability; frequency; preventability and the potential and nature of future impacts on health.

**Inequalities in choice**

“...my fear is that we focus very much on the system and get in the IT solutions, the system solutions in place, and we haven’t really got our head around the possibility...that this could actually increase health inequalities, and how are we going to address that?...it actually just perseverates what’s already an inequitable service.”  
[Liverpool Choice Board member]

**Choice for the relatively fit**

On nine occasions, during the qualitative research, there were concerns raised about the “inverse care law” and patient choice actually making it worse. The inverse care law stated that people who need most healthcare get least. It was considered a risk in this system that patients who need healthcare the most are not going to benefit from choice. People with poor health, complex needs and those who have multiple risk factors, particularly the elderly, will be excluded a choice of private provider because they would be at risk of needing an intensive care bed, which are not available at these providers. Therefore they may have to wait longer for treatment. It was considered that the system is ideal for a person that has one discreet problem, but is otherwise fit and well, in every other respect, and will only require a limited hospital stay, which one commentator described as “The walking wounded” Therefore, people who need the service the most, who have real problems, are not going to utilise choice.

Some comments received reflect this sentiment:

“The protocol for people who are offered choice are quite restrictive and they’re more likely to be people who are healthier and younger because, if you need back up services or anything like that, then you’re not going to be...offered choice in the first place, you’re discriminated against.”  
[PCT Board member]
“...apparently that leaves a whole lot of well people who... have to be pushed towards the private sector because the government says we’ve got to do it. Oh dear!” [GP]

“It seems here some simple procedures are going to be sorted and go home and that’s the end of it, but the majority of older people have got complications, so it’s not that simple being able to just choose, you are going to have to wait aren’t you?” [Expert patients]

“Choose and Book is only taking people without complications because they aren’t able to cope with that...and if they’re not eligible...then what’s the point of it really. It’s actually only Choose and Book for those people that are probably the ones not as much in need really.” [The Ambulance service]

The policy has been described as discriminatory, because people with lots of disabilities and/or health problems, or chronic disease and the frail elderly who are not very mobile, will not be offered choice. However, it would bankrupt the NHS to have an Intensive Care Support Unit or high dependency support in all providers.

“It assumes that health care is a short-term episode, a one-off that happens in a hospital and it’s sort of totally against the trend of the management of chronic disease and ageing population with long-term conditions.” [PCT board member]

Interestingly, a focus group study found that whilst participants were enthusiastic about choice they were aware of the costs of more choice. There was “an awareness of the need to control cost and support fair distribution of scarce NHS resources.” Whilst there was the possibility of individual benefit it would be detrimental collectively. It could divert resources away from people with the most severe problems, particularly if there was a lowering of the thresholds of severity that merit medical attention.

Problems of voice
It was mentioned on twelve occasions that some people will be able to express their health needs better than others. Therefore, people who know their way around the system and ask the right questions will get better access, whereas others might not move through the system as quickly. People who are confident, articulate and well educated, will be able to establish their right to choice, but those lacking in confidence will expect their doctor to choose or they will stick with their local hospital. However, for others it could be a big cultural change for them to make a choice.

Dialogue in a patient forum in Sefton:
FP5: “If you’ve got a sort of education...and you go to your GP and you’re a professional person, they take far more notice of you.
FP1: That’s true
MP3: Yeah, yeah,
FP5: ...I mean my husband was a solicitor and I do know, he only has to go in and they start sitting up, but if he went in like anybody else there’s a bit of a difference you know. You are treated differently...”

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Low expectations

There will be some patients who are not even getting into the health care system or they may only be accessing their GP when their condition is more serious. One commentator stated that from the referral patterns throughout Liverpool some practices refer a lot more patients than others. Yet there is a high population of sickness in Liverpool but some patients are not getting to their doctor so they will never be offered a choice, or when they go to their doctor they are not getting referred soon enough. It was considered that if people have low expectations of health care they will leave it too late to go to a doctor so in Liverpool there is relatively more emergency work carried out. Thus patients will not be given a choice in such circumstances.

“Patients in H demanded nothing at all from their GP…then I moved to W… and those patients were so demanding because they were better educated and expected more, and there’s no equity there is there?” [Liverpool Choice board]

Hence policy needs to ensure that all patients actually access their GPs in the first place and at the optimum time.

One GP confirmed that when a person needs further investigations if the procedure for making an appointment seems too difficult there are certain “psyches” that will not bother as a coping mechanism because they want to avoid having a diagnosis made. Some people dislike any officialdom:

“…if they’re talking to somebody who’s considered to be in a position of authority, they don’t know them, then it’s difficult, it’s another barrier and another inequality.” [GP]

Treatment in GP surgeries was thought to be inequitable in Liverpool. Some health professionals will have the time and inclination to go through the process with their patient particularly when the patient expects more from the consultation. It was considered that the more middle class the patients the better the service they receive and the more time doctors will spend. The more demanding the patient the better and the quicker the service they receive.

“[Choice] will affect people differentially because if I’m middle class, affluent, I’ve got lots of friends who are GPs who say to me, you should be going to B Hospital with what you’ve got, don’t let them fob you off with medical management, then I’m much more likely to challenge it…” [PCT Board Member]

When patients become ill they may not want choices as they can become very dependent, particularly the elderly so they want a health professional to make choices for them.

“GPs are going to be encouraged to give them [patients] a number to ring where they will… make the appointment and for the vast majority of people that probably isn’t going to be much of a problem, but for frail, vulnerable, elderly or perhaps people with language difficulties or for people with educational difficulties that might be, if not difficult, at least daunting.” [GP Central Liverpool]
**Recommendation:**
Need to communicate to all patients that it is their right to have a choice of provider.
A blanket approach to the choice agenda may be inappropriate and it may need to be accessed and dealt with in a different way in diverse areas.
To monitor the data on patient choice to see if the waiting times have been brought down and what socio-economic groups have benefited.

**Patients that may be information disadvantaged**
Participants considered that to make an informed choice, patients have to have a certain level of knowledge.

“Informed choice about speed of access, quality of service, outcome data and they can actually start to make some rational decisions around where they want to be treated properly.” [Service Redesign Group]

Without that knowledge patients will be automatically disadvantaged and they are the people who are perhaps not accessing as much elective surgery as they may do. [see section on ethnic minorities]

1. **People with Mental Health problems**
In a patient forum concern was raised that all people with mental health problems would not be given a choice. So these patients may be disempowered, and mental health will continue to be a second-class service.

Issue was raised that people who have a mental health problem on their medical record may not be treated and offered choice, for a physical condition, in the same way that other patients would who do not have a mental health problem, or they may find it difficult to make a choice if offered.

2. **People with Disabilities**
This would also include people who are generally socially excluded, the sort of people who social services work with, people with learning disabilities, physical or sensory disability, and older people. Social workers have consistently found that these people who need most information have the least and they lack the confidence or sometimes the ability to actually process the information or manage it. Also they can be faced with a number of obstacles, the biggest being transport.

Concern was raised about people with a severe disability, because they usually come with a carer and there are issues around confidentially in particular if the person has a learning disability. In many cases a carer may be a child. The patient should be supported to make their own decision about elective care without their relative listening or deciding for them.
“If it’s a man who has got a problem and his principal carer is his mother or his sister, they might not necessarily want to discuss something that’s very private and personal to them.” [Patient Forum Sefton]

“What we need is more time and skilled people who can actually help the person with the learning disability make their own choice, and we have had a lot of success in engaging that…they’re one of the most socially excluded groups we’ve got…their carers want to make the choice for them.” [Scrutiny Committee]

It was pointed out that in Southport and Formby PCT their chaperoning policy states that a person with a learning disability can have a chaperone with them and if the doctor finds it difficult to communicate with the patient it is perfectly OK to communicate with the chaperone.

“Enshrined within the policy of Southport and Formby PCT is the “get out” clause whereby we can say ‘does he take sugar’”
[Patient Forum Sefton]

However, it was acknowledged that to support people with learning difficulties through the choice process ensuring that they have an informed choice is very difficult. This is part of a bigger problem that requires the re-education of the entire health service. Indeed, there was concern raised that people with learning disabilities may not be able to comprehend the concept of choice.

One patient forum member was concerned that they were unable to have a say in what happens to a relative who had dementia, because of issues of patient confidentiality.

**Recommendation:**
For patients who have difficulty understanding choice there should be an impartial advocate who can make sure that they do understand what is going on without influencing them unduly.

### 3. Literacy problems

Concern was raised about how people with a literacy problem could get an informed choice as they will not be able to download information from a computer on the best hospitals. One GP was very concerned because a high proportion of their patient population had reading difficulties and would not be able therefore to make an informed choice from the options available to them.

“I’d say in this practice we’ve got 30-40% who are functionally illiterate and the same proportion are functionally innumerate and… the thing about the choice agenda is … having the information to make the choice, and I wonder if you have problems with literacy in itself if you can actually then function and make that choice, if you can actually assess that data.” [GP]

However, another GP thought that the “Choose and Book” system could be an advantage for people with poor literacy skills as they will immediately be
verbally given details of when and where their appointment is and will not have to wait for a confirmation letter.

A study performed in America used report cards which gave specific information around surgical performance to patients. What they found was that the more educated and affluent people used the information to choose the better quality surgeons. That meant there was a crowding out effect where those surgeons became fully booked and unable to take more referrals. Thus the people who did not use the information ended up by default having to go to the lower quality surgeons. [Personal communication, PCT Board member]

4. Ethnic minorities

Interviewees considered that patients who do not speak English will have communication problems that can be exacerbated by the choice agenda. For instance, ethnic minorities may be reluctant to travel long distances from areas that they know, particularly if they do not speak English. Car ownership amongst black communities is lower than for white communities. Language barriers would create difficulties if patients use public transport. However, transport can be provided by the PCT for ethnic minorities if needed and they are permitted to take a family member with them.24

The choice agenda is geared towards the average patients without communication problems:

“…with somebody who doesn’t have English as a first language, especially if they’re struggling away and you’re trying to explain complex things and make sure they understand, 10 minutes is hopeless, and with an interpreter you’ve got a third person, and then you’ve got the booking and choice on top.” [GP]

“I think things are very much geared to the average but there’s an awful lot of people within society who have communication disadvantages that aren’t recognised and you know we need to make sure that those people understand just what it is that they are being offered…it’s probably a very good scheme if it’s made accessible to all and that’s the big thing, it’s about the accessibility of it.” [The Ambulance Service]

Inevitably, dealing with patients who do not have English as a first language requires: arranging interpreters, and longer consulting times of up to 40 minutes. Already there are apparent inequalities of access to care. A Liverpool GP’s research has highlighted a high instance of CHD amongst South Asian communities, but they are under represented in terms of referrals.90 Furthermore, the rate of hip replacements in Asian women is considered to be very low and yet the need is quite great. Therefore safeguards need to be in place to ensure that they are not disadvantaged.

Unfortunately, from experience, it is not always possible to arrange interpreters at short notice. Language Line offers a quick response service over the telephone, but requires a subscription upfront. This service is fine for an emergency, but there is no personal contact. The provider has to pay for the call which could be an international call and the interpreter will
consequently not be aware of local terminology for example: income support. The interpreting service, based in Liverpool, employs interpreters on a freelance basis and cooperates with other councils in Manchester and Bury as there may be a limited supply for certain languages either because the need is high or too few or no interpreters speak a language. Demand for languages depends on current immigration policy and problems in other countries from which asylum seekers are looking for refuge. Currently, in order of priority, the highest demand is for Chinese, then Arabic, Somali, Kurdish, Russian and some East European languages. When there is repatriation in a country demand will ultimately go down for that language. In Liverpool there is a well-established Chinese community thus the need for Chinese interpreters who can speak either Mandarin or Cantonese. Within the Chinese community the demand for interpreters is for the elderly and the under 25s. For the younger age groups there are two types. The first group have low educational standards and have not learnt any English in China. On arrival in the UK they will mainly work in catering within the kitchens affording limited opportunities to learn English. They will therefore, probably require interpreters for the rest of their lives if they have limited education and opportunities to learn English. This will apply to other ethnic groups in similar circumstances such as Asian and Turkish people. The other younger immigrants are just over ten years of age and have learnt some English in school. They come mainly from Hong Kong and have relatives in this country. Through youth and educational advantage they only need interpreters for a short while before they have acquired fluent English.

It has been suggested that a member of the booking service staff visit a surgery that has a high proportion of non-English speaking patients, one or two days a week to refer patients. This is not ideal as it cannot be guaranteed that a booking service will be required on the days the extra staff are in the surgery. Patients would be inconvenienced in having to come back to book their appointment and they may not do so. There would be the extra expense of getting an appropriate interpreter into the surgery.

Unfortunately, some GPs still rely on family members to interpret. One patient forum member pointed out that they had experience, when working with doctors, of family members coming to surgeries and speaking for their wives. This is fraught with difficulties, for misinterpretation, mistakes in translation, breaches of confidentiality and so forth. Some patients will bring their family members with them because they do not want a stranger to interpret for them. This is particularly true of the Somali community who are very concerned about protecting confidentiality. Black and ethnic minority patients are more likely therefore to go to the local NHS Trust because that is the only hospital that they know the location of.

“There’s a big group of people for whom the choice itself is very probably limited by their ability to get anywhere or understand the system. I mean it’s difficult enough getting them to the [local hospital].” [GP]

Accordingly, it is thought that GPs will recommend the local hospital because they know that certain patients will not be able to get to another provider. A
GP recently had a non-English speaking patient who had been offered a choice to be seen sooner because they had been on the waiting list over six months. Unfortunately the patient had not understood that this meant going to another provider that was further away. Apparently they had received a long letter explaining they were now going to this other provider and an extensive form to complete if they had a disability. The patient came back to their GP to cancel this appointment because they did not know where the provider was. The Doctor had to write to the local hospital to explain that they wanted to go there after all.

However, patient care advisors have not encountered any problems for ethnic minorities. Non English speakers tend to let their relatives arrange the appointment with the private provider or Language Line can be used and the PCAs liaise with the provider to book the interpreter to meet the patient at the provider and sit in on the consultation and the pre-op. The private provider interviewed had experience of successfully dealing with non-English speaking patients through Language Line who are able to come in on the day of the procedure. They can provide patient information in different written languages if necessary.

There are problems with having material printed in foreign languages, for instance Somali, as it is only a recently written language so Somalis would not be able to read it. The main languages spoken in a Central Liverpool practice by ethnic minorities, in order of frequency, are: Somali, Arabic, Bengali and a number of Farsi Kurds. Some people speak French and Portuguese from African countries and a few Turkish languages are also spoken by patients.

When the patient arrives at the provider there are cultural issues that need to be taken into consideration such as: the availability of prayer mats; modesty gowns, special foods and so forth. Many thought choice also represents a big cultural change in re-empowering patients who may have an inherent trust in health professionals and want them to make a decision for them.

The Social Inclusion Unit has patient profiling data on thousands of non-English speakers in Liverpool but it is incompatible with hospital data, so cannot be linked up. If the system worked it would forewarn hospitals of patients’ needs. At present, there’s an actual form that the GP has so that when that GP is making a referral, if that person is going to need an interpreter in the provider they fill out a form and a copy goes along with the referral and another copy goes to the interpreting service so they can make sure that there is a person there.

[See section on Losing Resources for other services]

**Recommendation:**
To monitor where patients are resident and to which providers they are being seen. Also if possible monitor their ethnic origin and whether they are English speakers.
Choice being limited by excess travel

It was felt that age and the nature of the condition was an important factor in choice. Most elderly patients or those who are severely ill do not want to travel, but stay local to access the support of their family and friends. However, if patients have got a rare and or specialist condition or for heart surgery it was thought they will be prepared to travel to be seen by the best specialists.

“What we do know is…where there’s a centre of excellence or where patients’ perceive it’s worth going to, patients will travel and they’ll travel any distance.” [Liverpool Choice Board]

Frail and disabled people would be restricted in their choice and would not necessarily be able to access the best care because of lack of transport.

“We’re finding the biggest [obstacle] is transport…for a lot of our particularly disabled people or frail people, they’ll go where is nearest they won’t actually choose on the basis of the quality of the service because they won’t feel able to. So I think in a way it sounds very good for…sort of middle class or reasonably comfortably well off people who are used to travelling around, used to picking and choosing, and I do worry that actually the group it should be reaching the most is going to be the group that it reaches the least.” [Scrutiny Committee]

People may be prepared to travel if they are in severe pain and can be seen quickly. Otherwise the majority of people will be parochial in their choice because they have experience of a local provider and it is easily accessed, or they may not be used to travelling far. In a study by a Liverpool GP cardiac patients were not taking up an invitation to go to Broadgreen for treatment. However, more affluent groups may be prepared and able to travel to other providers in 2008.

“…it’s a cultural thing. And some people can actually be, certainly from where I work, extremely parochial. I worked in the Dingle, and people from the Dingle didn’t go over into Granby…it wasn’t done…”

They’re not going to a different hospital elsewhere they have to have their passport stamped...to leave their own road.” [District nurses’ discussion]

A private provider with a large catchment area covering Merseyside and Cheshire felt that patients eligible for free transport should be made aware that it is available when they are making a choice. A patient forum thought that if the cost of travel is restricting access to services then free transport should be provided not just for the patient but for the relatives of the elderly, the very young and for other vulnerable groups. Also, the feasibility of providing hospital hotels for visitors of the vulnerable and frail should be investigated.

Choice limited by the Digital Divide

There was much discussion in one focus group about the digital divide where some thought it would have an impact on health. It was considered that the
impact of technology should be included in the HIA. One commentator talked about the differential use of modern technology such as the internet. Other participants confirmed that some patients would not know how to or want to use the internet to find out about which service is most appropriate for them and of the best quality. It was suspected that the internet would be used more in affluent areas. If not all patients can have access to the internet then an inequality is created. Having the use of the internet to obtain information can make the patient feel in control. For instance before they come to the outpatients they can ask pertinent questions about their treatment and they would have some idea, based on an informed choice, where they would want an appointment.

It was also considered that the access to the internet had broadened so there are internet cafes and libraries giving free access time on the internet. Thus many more people will have the opportunity to use the technology. Not all agreed that because the technology was more widely available all people will feel at ease using it. Some considered there is a risk that a large percentage of patients will not feel comfortable using the internet in particular those with learning difficulties. Furthermore, the gatekeepers of choice, the health professionals, will have differential skills in the use of IT. Those who are conversant with IT could be giving a better service to their patients. There was evidence from the referrals at six months, to private providers, that some practices were using IT whereas others will prefer to fax a letter.

**Recommendation:**
Introduce more centres for the use of IT by the general public, for instance at housing action trusts and similar places.

**Equity issues from the literature**

**Definition of equity and empowerment**
To ensure that choice of provider leads to better health outcomes for all patients it must reduce not increase inequity of access to health care. Whether the choice agenda will increase or decrease equity in the NHS remains open to debate. The argument for choice is that giving all social groups the right to choice of providers, regardless of their ability to pay, should reduce health inequalities in access. The policy rests on the ability to empower disadvantaged groups to make informed choices. To this end the Department of Health is issuing a leaflet to patients via all GP practices with ‘power questions’ that patients can ask their GP when making a choice. The BMA warned that this would put more pressure on doctors’ availability. The leaflet will also give information about which services have been commissioned in relevant areas and where patients can get additional health advice.

**Problems with empowerment and consumerism**
Empowerment brings personal responsibilities and one commentator asks that if inappropriate choices are made about health needs does this represent
The emphasis on individual consumerism may be good for the articulate and mobile, but there are fears that some patients will not make good shoppers such as the inarticulate, the very sick, the old or the very poor. There will be inevitable tensions between individualism and collectivism. As there are finite resources that can be directed at healthcare, it may be necessary to curtail expanding choice if the benefit received by one patient is at the detriment of another. That is, if the sum of individual choices is not for the benefit of the collective good.

Groups not exercising right to choice

Research suggests that certain groups in society may not exercise their right to choice or because of the choices of others they may not be able to. They will therefore lose out on the accompanying benefits of a speedier return to health enabling them to enjoy better health for longer. They may have to settle for slower and possibly declining services. In one sense this is clearly inequitable and particularly pertinent if intimately linked to the unequal distribution of other resources across society such as income, power and education. Forty percent of older people view choice as irrelevant and they are much less likely to be prepared to travel out of their local area to a provider. As older patients tend to be frequent users of health care, this is significant. Poorer patients may also fail to take advantage of choice.

The London Patient Choice Project [LPCP] identified some equity issues through the modelling of patients’ choice behaviour from actual and stated preferences. Patients are less likely to opt for quicker treatment at an alternative provider if they are: aged 60 and over; female or they have low education levels; if they have family commitments; or their income is low. Waiting times at distant hospitals would have to be considerably lower to persuade patients to travel.

Two-thirds (67%) offered a choice in the LPCP chose to go to an alternative provider. No inequalities in actual access to, or uptake of alternative hospitals by social class, educational attainment, income or ethnic group, were found although people in paid employment were more likely to opt for an alternative hospital. However, all participants were offered the provision of free transport, which was a popular aspect of the scheme attracting high satisfaction ratings. Furthermore, all had the help of a patient care advisor to guide them through the process. Without these provisions inequalities in access may have been shown. Interestingly, what was unclear to researchers was why less than a third (32%) of patients eligible for the LPCP was actually offered an alternative choice of hospital.

Barriers to exercising choice

The London School of Economics found that poorer patients tend to either not go to their doctor at all or present at a later stage of their illness. The research concludes that the potential barriers to access include: lack of suitable transport, incurring greater travel time and costs and lower car ownership; time constraints such as an inability to get time off work and
differences in beliefs about the need to seek medical attention. Travel difficulties can also interfere with the ability of relatives and friends to visit. Furthermore in relation to need lower SEGs receive fewer referrals to secondary care. The middle class has the advantages of connections and communications. This shows in their confidence and ability to articulate and their networks which will enable them to communicate effectively and promote referral when necessary.

A Health Link study has revealed that people most in need of hospital care may be the most disadvantaged. Health Link included over 50 organisations in their study who work with hard to reach groups. Thirteen organisations facilitated involvement of vulnerable populations and carers in this study.

People over the age of 65, who make up two-thirds of patients admitted to hospital; certain ethnic minorities, people with a disability and those living in poverty are more likely to suffer conditions requiring hospital care. These groups might also be subject to “information disadvantage” that could hamper their access to choice. Information disadvantage refers to language difficulties, lack of basic skills or total unfamiliarity with the internet. The National Consumer Council states that 20% of adults (or 1 in 5) in England amounting to around seven million people had problems with basic skills, making them unable to understand and interpret information that could lead to better health.

**Selection of patients by providers**

Pressure to generate surplus income could encourage private providers and FTs to try to select patients, treatments and services on the basis of financial gain and risk - thus reducing the availability of choice. Therefore, patients will be prioritised on the basis of financial reasons not on the basis of their needs. Indeed, a poll of chief executives found that 97% thought not all hospitals would be able to provide all services in the future. It is argued that ITCs are directing care at the “comparatively well at the expense of the comparatively less well.” Thus they are discriminating against certain patients. Whilst there have been reductions in waiting times for cataract surgery, there are dramatic increases for chronic eye conditions. This is an example of where individual choices are constrained by choices that are made elsewhere in the system.

[See section on New Providers – cream-skimming]

**Inequitable provision**

Choice of provider may provide an incentive for hospital services to improve but this is not the same as closing inequitable gaps in service provision and quality. The choice on offer is greater in big cities where there are a number of providers accessible via public transport, rather than scant provision in rural areas. Hospitals that lose patients will go into financial decline resulting in poorer services for those patients using their home hospital and a consequent widening of inequality. Indeed, evidence from school choice shows that polarisation can occur where the market splits into two. There is a “sink” subsection within disadvantaged areas where providers are under performing,
and they are unable to attract good staff, with falling demand contrasted with prosperous leafy areas where there is high demand but not enough places and in effect the provider selects the consumers.  

Discharge rule at odds with patient choice
The insistence that patient choice must drive the NHS is at odds with the discharge rule, designed to end bed-blocking, putting elderly and chronically sick patients at risk. Under this ruling social services departments are fined £100 if they do not arrange to move a patient out of hospital within two days of notification from the hospital trust. Hospitals lose money under PbR if the patient remains on the ward beyond the average length of stay. This could result in these patients being put in inappropriate interim accommodation away from a relative. Conversely, if patients are discharged before the average length of stay the hospital will make a profit. Thus they reduce their exposure to financial risk by transferring costs into the community.

Implications for policy
The findings of the LPCP have implications for policy. Arranged and free transport to the alternative provider would greatly increase the uptake of choice, particularly for parents or guardians. Indeed, it was announced recently, that under the travel cost scheme patients on a low income of up to £15,050 will be eligible for the equivalent of the cheapest form of public transport if they are treated at a distant hospital. Patients preferred follow-up at their home hospital therefore this should be provided at the patients’ home hospital rather than at an alternative provider or at the patients’ own home. Richer patients are more likely to take into account the reputation of a provider when making a choice and migrate in greater numbers to those with the better reputations than poorer patients. Muslims perceive that hospitals in predominately white areas will have little or no provision of Halal food. This suggests careful consideration to be given on the information on quality of providers in order to facilitate well informed choices.

The researchers monitoring the LPCP concluded that for all patients to have an equal opportunity to make choices they must be aware of their right to choice, have access to adequate information and support whilst monitoring systems are in place to ascertain the impact of choice on different socio-economic groups.

Health Links has made a number of recommendations to enable vulnerable groups to make an informed choice. Detailed recommendations covered: information needs when making a choice such as facts on access; quality; and hospital policies. Furthermore, suggestions were made on how patients would like to access information and make their hospital appointment. For those patients who are already frail and/or dependent then key workers need to be geared up to enable them to make a choice. A sympathetic adviser should be available for disadvantaged patients to enable them to interpret information. Indeed MORI has concluded that all age groups, especially the elderly, prefer face-to-face advice as the main mode of receiving
information. Thus supportive and informative contact from NHS staff will be influential in the development of positive perceptions of the initiative. From the CHD patient pilot, it was recommended that all patients offered choice should be supported by a Patient Care Advisor. They played a key role in ensuring that patients had a positive experience of choice. Unfortunately no extra financial support has been promised from the government for patient support, which is particularly important for vulnerable groups that may find it difficult to negotiate the system. Other Health Links recommendations covered: freephone helplines, free internet access at online centres and libraries and a learning package to simplify choice for those with basic skills. The National Consumer Council has recommended that information from the NHS should be available in plain language to help patients with basic skills. Also bilingual staff and trained interpreters should be on hand for people with limited English. The staff at libraries and centres should be fully briefed about choice. There should be nationwide consistency of information in content and formats.

For equity reasons the government is seeking to support patients and is developing guidelines to support disadvantaged groups. It has been suggested that foundation boards would benefit from the presence of a public health director or senior public health advocate. Furthermore, that regulation of hospitals in the future must be mindful of and protect the needs of the whole community. There has been a call for specific help for the most disadvantaged and chronically ill to enable them to make meaningful choices. If attention is not paid to supporting vulnerable groups it is feared that greater choice will increase inequalities.

The National Consumer Council outlined the major challenges ahead when expanding choice in public services: to be clear about the relative value of choices to the public and service users; to ensure greater choice is matched by greater fairness; to understand the practical barriers to expanding choice and how to overcome them and to manage the limitations of choice in producing more responsive services. The Public Select Committee concluded that choice can be compatible with equity, but only if services are designed and motivated to enhance fairness.

**Impact on social support networks**

If patients have to travel to a distant provider it will cause added concern and put a strain on their family to have to keep making long-distance trips to visit. It was considered that having the support network of family and friends is one of the things that can influence outcomes in a positive way. They are a very important part of the recovery process.

“It was highlighted with some of the people...that went to the wonderful hospital in Glasgow because the cardiac waiting list at Broadgreen was so long...although the patient could go...they said what about the visitors and their relatives...being away from your support network and of course...if something goes wrong, you're an awful long way from home.” [Patient forum, Sefton]
Impact on Public Services

Selected access in private sector

A private provider stated there had been occasions where private patients had stated that their GP was refusing to refer them so there was a risk that because of political opinions that some GPs may not inform patients that they can go to a private provider under the NHS and this will create an inequality in health care options. However, it would be difficult to monitor GPs to see if patients were being given a choice.

However, in four focus groups (including 2 patient groups) and three interviews, it was considered that the private sector will cherry pick as they can only take limited numbers of low risk patients, so they have a strict protocol on what patients they can accept and even within that it is difficult to assess if they are sticking to their protocol. They will not take patients that have multiple health problems and might be at risk of intensive care afterwards or the need for a high dependency bed. Thus they will be taking the less complicated cases leaving the NHS hospitals struggling with very sick dependent patients.

According to the literature, private providers will be forced to cherry pick or cream-skim the easiest, healthiest and cheapest cases, as they do not have the facilities for intensive care or out-of-hours cover.\textsuperscript{113} They have little responsibility for follow-up and many cannot cope with complications. Indeed, it would be unsafe for them to do the more difficult cases, but in practice it means discriminating against certain patients. Thus NHS Trusts must continue to deal with any complications that might arise and provide the full range of expensive emergency and high-dependency care, with higher risk patients liable to increased morbidity and mortality and face apparently poorer performance.\textsuperscript{75} Yet both are paid the same national tariff under “payment by results”, despite the “diminishing continuity of care and responsibility of private treatment centres”.\textsuperscript{81} The BMA has warned that the tariffs used in the PbRs scheme are too insensitive to the mix of cases presented. So unless it is made more sophisticated, case selection will be a key factor of the profitability of the organisation concerned.\textsuperscript{59}

[See Section on equity issues – Selection of patients]

Inaccessibility of some new providers

Three interviewees thought some patients, such as the elderly, would not travel if the private provider is not easily accessible and for this reason a new provider near Liverpool has been established for orthopaedic electives from Central Liverpool PCT, because the previous provider in Chorley was considered too far away even if transport was provided. [Direct communication, Choice manager]. Having an accessible provider has greatly increased uptake of patients being offered choice. On four occasions it was pointed out that if the patient qualifies for free transport their relatives will still be faced with difficulties of getting to the provider and visiting regularly.
particularly if they are on a low income. If relatives are some distance away patients, particularly in low income families, will feel isolated. People want their family near them to give support. Patients may also have to have their post-op and physiotherapy at the private provider so accessibility of the provider is important. It was considered that choice is meaningless if you have to travel. For instance a single mother without support for looking after children would be forced to attend a local hospital and may have to wait longer.

In 2008 when potentially patients can have treatment anywhere in the country, patients without transport will be limited in their choice. Indeed, the elderly and people in rural populations would be disadvantaged. With this increased choice in 2008 there will possibly be a greater need to transport people for longer distances for admission for elective procedures and discharge using the ambulance service transport. This is not a cheap option as it requires two members of staff and an expensive vehicle.

It was pointed out by one participant that it would not be advantageous for a patient who is very sick, confused or elderly to travel a distance.

[See Inequalities: Barriers to exercising choice]

**Negative impact on quality of care**

One service provider considered that the shorter waiting lists may be in those providers where the quality of care is relatively not as good. Therefore, choice is being given on availability not quality.

Many years ago...you could choose your own consultant then there were huge waiting lists for those that we considered the best...Bringing back that choice element which could lead to it being very, very difficult to access what is considered perhaps the best care and that perhaps not considered quite as good quality being the one where the shorter waiting lists are. [Ambulance service]

There was some concern expressed in a patient group, that if the private provider does not have a waiting list are they performing enough operations to be competent?

On five occasions it was pointed out that patients could be at risk in a private provider if there are complications. In the event of a serious complication the patient will have to be returned to the NHS hospitals, as they do not have the resources. Furthermore, after an operation patients may not be monitored regularly if in a private room.

At a choice board focus group the NHS consultants’ concern about the quality of care in the independent sector was raised. This has created some tensions, as some consultants would not let their patients come off their waiting list.

One patient group considered that for some procedures the private sector had been shown to be not as good as the NHS, but at present these procedures, (in obstetrics and cosmetic surgery) were not being offered under the choice
agenda. Some nurses stated that although the environment was better in the private sector, specialist nurses were employed in the NHS. Therefore there were some suspicions raised around standards of care in the private sector not being as good as the NHS such as post-op care.

There is substantial evidence in the literature that for-profit healthcare is not as good as non-profit healthcare. Non-profit consistently provide better access, quality and cost-effectiveness. For example, higher mortality rates have been found in private for-profit providers when compared to non-for-profit in the US, even after adjusting for disease severity and staffing levels. Non-profit health systems have higher rates of screening and other preventive healthcare than for profit competitors. The difference in outcomes is thought to be a reflection of for-profit having to hold down costs while delivering a profit and consequently, any limitation in care could adversely affect patient outcomes. Yet one of the reasons for using the private sector is for an improvement in standards, but the competitive tendering for hospital cleaning has led to a deterioration in standards. To ensure quality and standards all potential providers will be tightly vetted by the Healthcare Commission. However, there are still fears about patient safety, particularly if the majority of elective patients are old and in poor health. It is claimed by the BMA leader that the private treatment centres have inadequate safety controls and medical authorities were investigating mistakes in cataract operations that may have led to patients going blind.

Indeed, there could be a trade-off between quality and volume, where hospitals drive down quality in order to compete. A study examining the levels of competition and quality of care in all acute hospitals in England during the 1990s found that death rates following emergency admissions for heart attacks (a measure of quality of care) were highest in those areas that had to compete for business. The most prestigious teaching hospitals were situated in the areas that had the most competition yet the hospitals outperforming them, with least competition were the district generals with lesser status and fewer specialists. Commentators argue that the Department of Health does not require the same standards in the independent sector as in the NHS. “Six surgeons working for the private sector on NHS cases have already been suspended for what are termed serious surgical errors.” However, this is claimed as scare mongering that the standards and training of all surgeons working in treatment centres are registered with the General Medical Council. Also ITCs are registered with the National Care Standards Commission and are covered by the Healthcare Commission. The independent sector has to work to strict performance guidelines and is regularly monitored for clinical effectiveness by local NHS clinicians.

However, the BMA has warned that given the lack of evidence that competition between providers increases quality they do not consider the market in healthcare to be the best route for the NHS to raise responsiveness.
Monitoring of care important - not just waiting times

Two patient group members felt that the private providers and the NHS should be monitored to the same standards by independent inspectors who had no invested interest in the care establishments they were monitoring. This comment was brought up in connection with care homes for the elderly, but could apply to providers of elective care.

As a practice nurse pointed out there can be no real choice until there are guaranteed standards. Otherwise patients could be sent to providers with reduced waiting time, but not necessarily with the best standard of care.

Expert patients were concerned that without independent monitoring to maintain quality, in order to increase capacity standards might slip. For instance nurses’ roles will increase without the necessary experience for that to happen. They felt they have personally witnessed a drop in standards in community care. They were also concerned that hospital nurses would be working extra hours at night in the private sector thus limiting their effectiveness during their NHS work. Furthermore they considered there was no effective way of complaining without causing ill feeling.

“...standards are going to slip and nobody’s going to monitor the services in the community, so people are going to land up for simple reasons having to go back into hospital anyway.” [Expert patient]

“Also they’re trying to with European standards...limit the amount of hours...but a lot of these nurses...within that capacity are actually doing other private work...a night shift the night before they come in, so with the best will in the world they’re not switched on, so although there’s staffing, there’s no monitoring on it.” [Expert patient]

One service provider commented that nutrition and cleanliness that were fundamental years ago for the health service have not been maintained, but they are now becoming important again.

Experts say that with targets and performance indicators waiting times have come down. However clinical quality is important not just outputs. Therefore performance indicators need to measure things that matter to patients such as clinical outcomes, speed of access and the quality of the patient experience and present them in an understandable way.120

[See Section on patient information]

Standards of care

It was felt that standards of care should be equal – that is within a range that is classed as acceptable and patients should not have to use their judgement to find the best treatment.

“If surgeons have standards that aren’t within an acceptable range ... if somebody is clearly outside what people determine is some kind of acceptable range, you shouldn’t be leaving that to individuals to try and figure that out for themselves.” [PCT Board member]
We would all hope that …at consultant surgeon level …that people are at a standard that is safe and really it shouldn’t matter when they get to that level, you know, where we send them.” [Practice Nurses]

However, according to the Service Redesign Group there are some significant differences in redo rates for some surgical procedures such as orthopaedic and cardiac surgery.

**Reductions in patient power and voice**

It was considered that patient groups such as user groups, and forums have limited power to monitor:

Patient 1: “…the degree of involvement is very superficial really, it’s a political thing, I’m delighted to be involved…but it doesn’t really make any difference it leads to this situation where you’ve got service user groups, you’ve got patients forums, you’ve got PALs, you’ve got all sorts of bloody things, all striving to do apparently the same thing. It’s a load of cobblers.

Patient 2: And at the end of the day we’ve got no power.” [CTC service users group]

Patient 1: “The point is if there is no power you are wasting your time. Look at the PPIs…you can have people who don’t turn up for meetings and you’d throw off in any normal group you can’t do anything about it…

Patient 2: The PPI, I think it has an awful lot of shortcomings to be totally inclusive…

Patient 1: I think it was a brilliant idea to give the public a voice, give them powers, because they have got some powers but they are very conscribed…” [Patient forum Liverpool]

It would be helpful if there were two patient representatives on the PCT board and Scrutiny Committees. Two were needed if a proposal was put forward so it could be seconded.

The Labour party promised to increase the involvement and power of the public and patients in the NHS. After the demise of the community health councils (CHCs) in 2003, there has been a bewildering tangle of organisations that some observers have claimed have done little to increase patient power, but have confused the public about their responsibilities and rights. It is suggested that the patient forums are not as powerful, political and effective as the CHCs. Indeed, the Chair of the London Ambulance Service PPI forum claims that many are “virtually inactive”.

In the case of choice agenda, providers’ marketing and empowered consumers’ choices are taking over from formal consultation as a means of reflecting patients’ views where patients are expected to vote with their feet. A very different model of public engagement (new localism) is represented in the FTs to be “owned” by their members that will be drawn from local residents, patients and staff. However, to meet the vigorous supervision of Monitor, the independent regulator of FTs, many have appointed to their boards non-executive directors with particular commercial skills rather than
strong links to the local community. Furthermore, each FT is at liberty “to determine the detail of the arrangements for the membership and election to the Board of Governors”. The government continues to alter the structure of public involvement with no one clear model of engagement. Which? calls for explicit mechanisms to give patients and the public opportunities to influence the decisions that frame the choices open to individuals.

**Impact on clinical priority**

Expert patients were concerned that if the patient decides their choice of provider and the time and date of their outpatient appointment, then how can patients’ priority be assessed? In the previous system the consultants could screen all referrals and see patients on a priority basis. However, the PCAs pointed out that GPs could still mark referrals with urgent and they are seen within ten weeks if they choose to go to a private provider and within 17 weeks if they stay with the Trust. For endoscopies they can be seen within the urgent two week rule.

The literature makes clear that waiting-time targets do not guarantee that patients are treated in accordance with their clinical need they only ensure equal treatment for equal waits. The National Audit Office survey found that 300 (54%) of their sample of 558 consultants had to treat patients in a different order than their clinical priority indicated so not to breach the waiting time target. Eighty percent (240) of the 300 consultants stated that deferring treatment of urgent patients had had a negative impact on patients’ health. Which? Feels that the government should carefully monitor its policies to ensure that patients receive treatment according to their clinical need and that the patients with the poorest health are not left untreated.

** Provision of Aftercare**

Several participants including patients, service providers and other health related professionals showed concern over aftercare services. There has not been a relative increase in rehabilitation provision in line with the increase in elective capacity in the private sector and out sourcing of work to other areas. The risk is that in the pressure to meet targets for elective waiting times support and welfare services are not considered in the package of care. This has implications for continuity of care on discharge particular for vulnerable patients and those with chronic conditions as they will not be seen within their local areas and it is not linked in a seamless way to a care pathway. If resources are not available in the community patients are at risk of being re-admitted possibly as an emergency or there will be increased pressure on emergency response hospital at home schemes. One commentator asked: Will the NHS Trusts get compensated for increased emergency care? The older, sicker, and poorer patients and other vulnerable groups would be most at risk if community services breakdown as they will have less support at home.

However, the private providers have a responsibility for the patient for a certain period of time, which includes some aftercare such as occupational therapy and physiotherapy. Private providers have been given contact details...
for social services from the patient care advisors. Community services such as district nurses will still be required to see patients where appropriate. The feared increases in numbers of patients coming to district nurses has not yet materialised due to the nature of the relatively uncomplicated procedures that have been carried out to date. The present emphasis on day cases is unrepresentative of surgery in general and the need to commission whole packages of care.

Evidence from past experience illustrates how care pathways can be inadequate. For instance, a scrutiny panel recently found insufficient packages of care for elderly patients after discharge from hospital. When patients have been sent out of Merseyside to reduce waiting times, communication networks between elective care providers and primary care have failed. Heart patients have had problems getting support from social services after receiving treatment outside Liverpool:

“CABGs [Coronary Artery bypass Grafting surgery] for instance, as soon as they get out to Manchester instead of Liverpool …the discharge arrangements quite often fall down because social services can’t seem to work across… now we are forced to give choice to the patient but we’re not sure if its going to be of benefit, it might be of benefit by accessing quicker but it’s not necessarily going to be of benefit on the whole pathway of care.” [Member of Service Redesign Group]

The Ambulance service were concerned that potentially there could be an increase in emergency calls putting extra pressure on their service. With the expanding throughput into hospitals if community services breakdown people may be left without any alternative but to ring 999. There has been evidence of this happening already. It is not good quality of care for the patient to be taken into an A & E department rather than using primary care services. Furthermore, if there are too many people going in for emergency care then elective procedures will have to be cancelled.

Therefore there is an increased risk, when choice is offered, particularly nationally in 2008 for elective care, that the further away the location of the provider from the patients’ normal residence that the system will break down. The focus is on the initial referral not the long term care beyond in the form of an integrated service. Distant or new providers will not understand local discharge processes or what support mechanisms are available. Also the less the local community / primary care staff will understand how distant systems operate. Practice nurses felt that they and other community nurses needed to be familiar with services from new providers and in other areas so they could forewarn patients of what to expect during their elective care and post-op to reduce the patients anxiety. District nurses required detailed information about procedures to follow after discharge. For the new system to work, it will require a lot of communication networks, co-ordinating and organisation, as well as investment in nursing and other community teams. Service integration, collaboration not competition is required.
**Recommendation:**

- Resources ring-fenced for community services, to support shorter length of stay in hospitals.
- Improved liaison and communication between new care providers and after care services (including social and medical) to facilitate continuity of individual patient care.

There is agreement in the literature that there are no clear arrangements or costs for longer term follow up or complications from the independent sector, only the expectation that the NHS will do this without the guaranteed resources. The time a patient spends in hospital is only part of the “care pathway” but whilst capacity in the secondary care sector has expanded there has been no parallel investment of local community support services for follow-up care.

FTs may make it more difficult for the NHS to provide an integrated service through a planned and co-ordinated approach. Indeed a poll of NHS chief executives found 65% feared foundation status would make cooperation among different parts of the NHS more difficult. FTs are free to duplicate existing services or to ignore local health needs. There is no guarantee that Foundation Trusts will lead to greater local accountability or social ownership. They can be run with only a small number of members unrepresentative of the user population. Their driving force will not be to serve the local population, but to gain as much business as possible, thus “as autonomous institutions, it will be impossible to make them fit local health plans.”

There is a need for whole system planning to ensure an integrated service across secondary, primary and community services.

Public information on quality of care

**Clarity of information**

GPs and others felt that choice would depend on the clarity and the quality of the information that comes with the system, about the preferred providers. Indeed, without this, how will patients be able to make an informed choice based on sensible comparisons on quality of care and outcome not just on waiting times? The expert patients commented that if you do not know the individual’s success rate that limits your choice. Without adequate information patient choice was described as a “pseudo choice” or “tokenism”; but not a real choice.

“...we’re not at this stage giving patients choice, it’s basic choice about whether we go to a faster hit...you should really introduce it on the basis where they’ve got informed choice about speed of access, quality of service, outcome data and they can actually start to make some rational decisions around where they want to be treated properly.” [Service redesign group]

Under the freedom of information act there is an official procedure whereby the general public can request information on mortality rates from providers.
The Cardiothoracic Centre Liverpool has decided to make this information public and risk adjusted mortality figures are available on their intranet site with an explanation of what they mean. The mortality rates are adjusted for: general health of the patient using the New York Heart Association Classification [NYHA], sickness level, age, gender, procedure, pre-existing diseases and other risk factors such as cholesterol level and BMI. However, not all patients will be competent in using the internet.

[See section on: Choice limited by the Digital Divide, under Inequalities in choice]

**Type of information**

Some discussion took place on the type of information that should be available to patients such as mortality rate by operation, clinical outcomes, numbers of patients dying from MRSA, and infection rates. However, some participants were sceptical if such figures would be in the public domain for fear of people not wanting to book into certain providers. Furthermore, details on complication rates and procedures might be beneficial to doctors making a choice but may be incomprehensible to patients. From a GPs’ perspective, if they were making a choice, it would be beneficial to know specialists’ competencies.

“Some [consultants] will go for different techniques, and you have to know which hip they’re using, especially if it’s your mum having a hip replacement, you want to know, as well as things like their infection rates and maybe clot rates, DVT rates, all those sorts of things, rather than just maybe an overall complication rate. An overall complication rate might just be lots of minor complications or it might be lots of major complications.” [GP]

“If you say post-op infections…oh let’s say 3% in their hospital or 5% - what does that mean? And if professionals will be struggling to define that, what’s the patient who knows even less. He’s gonna struggle to find what is a serious complication, what’s not, what does it mean serious…?” [GP]

Frequency of carrying out procedures was important as an indication on how competent a surgeon was to be accompanied by guidelines on what was an acceptable number of operations to be performed per week. A private provider agreed that comprehensive details should be available to patients including: physical environment, infection rate, clinical outcomes, how long surgeon has been working for provider and staffing levels on wards. One GP commented that whilst it was positive if information is given on providers not everyone can have the best.

It was felt that there was a general ignorance on the part of patients on where was the best place to receive treatment for a newly diagnosed condition.

“The point is when you’re first [diagnosed] as a patient, you’re over-whelmed…your immediate reaction as a human being is panic and then how are you supposed to know which is the best one to go to…if the information isn’t provided…how is this new free market going to aid the patient?” [patient forum Sefton]
It was considered helpful if a booklet is produced that gives the strengths, the weaknesses and distance from public transport for every hospital.

**Validity of clinical outcomes**

Some discussion centred around the fact that the NHS would be taking more complex cases which brings into question the validity of outcome measures. If the NHS is taking sicker and more vulnerable patients then mortality, morbidity and complication rates are going to be higher than in the independent sector. If patients are aware of these they will affect their choices.

**Information required for an informed patient choice**

**Need for support in making informed choice**

The Consumers’ Association argues that patients need to be able to make informed choices. This requires information that is reliable and of good quality otherwise choice is meaningless. Patients also need the time and support from professionals to facilitate informed choices and to interpret information. In particular informed advice should come from someone the patient could trust and they had a good relationship with such as a GP, but patients were aware of the limitations on a GP’s time.

**Evidence from pilot scheme**

Waiting times were the only information on which to make selections in the choice pilots, but as waiting times reduce other criteria will be necessary such as quality of care. Patients in pilots in the London patient choice project and the CHD choice scheme wanted specific information about the quality of care offered in hospitals. In particular, details about follow-up care, experience and qualifications of surgeon, operation success rates, standards of hygiene and safety record. For those in less advantaged groups practical details about travel arrangements for themselves and their families, accommodation and contact details of patient care advisors and other key workers was important.

**Evidence from focus groups**

More sophisticated tools than star ratings, to measure trusts’ performance are being examined by the Department of Health and the Healthcare Commission. Focus groups with the public and patients have found that they are ambivalent about the value of these performance indicators although there was wide agreement that performance should be monitored in some way. The participants wanted specific details about local services such as: waiting times, consultants’ special interests, their clinical experience and their success rates. For this reason, they preferred the more locally relevant hospital guides produced by Dr Foster, an independent organisation providing patients and the public with healthcare performance information on the internet. Recent focus groups conducted with the public have found people required: waiting times; quality and outcome measures; operation success
rates (by hospital and consultant) and quality of aftercare; transport services; parking; distance from home; facilities for visitors and MRSA rates.\textsuperscript{89} Indeed, if there are high infection rates in NHS hospitals, a recent Mori poll in the Midlands has showed that 73\% of those surveyed were much more likely to opt for private treatment if it is MRSA-free.\textsuperscript{130} Providers may have to work out how good they are and how to convey this to the public.\textsuperscript{92}

**Problems in providing meaningful statistical data**

Healthcare is not an ideal consumer good and the information to support informed patients' choice is not yet available.\textsuperscript{5} Indeed, choice in practice has been limited to the reduction of waiting times for inpatients, with the exclusion of mental health and children's services.\textsuperscript{131} It may be difficult for patients to judge quality of services therefore choice may not be informed and individual choices may not amount to what the collective actual need.\textsuperscript{11}

McKee\textsuperscript{132} has pointed out that there are at least three possible problems in trying to provide meaningful statistical data to assist patient choice. In the first place, to provide data that is comparable to facilitate an accurate judgement between good and bad performance, that reliably captures the differences in case mix.

Secondly, to use this data to genuinely improve performance in quality, rather than opportunistic behaviour in either recording or work undertaken, designed to improve what is reported. For example the recorded practices undertaken to meet the four hours waiting time target in A&E, by not admitting patients from waiting ambulances until they are ready to be seen, leaving them in a kind of “target-free limbo” deposited in inflatable tents. In this vein, Appleby, from the King’s Fund, reports on a study that has been looking at the consequences of the use of risk-adjusted mortality report cards on CABG surgery in the USA.\textsuperscript{133} The results suggest that the report cards can lead to competitive pressure on poor-performing providers to show an improvement, with providers tending to select healthier patients. He concludes that “decisions on many patients’ treatments...could change in ways which improve (statistical) performance but leave patients little better off.”\textsuperscript{134}

Thirdly, McKee explains that by only concentrating on procedures data misses that vast amount of care that does not require one. Also, given the rapid pace of healthcare change the information could be largely out of date.\textsuperscript{132} Thus the recent experience of other patients may be insightful.
**Impact on Primary and Community Care**

**Negative impacts**

**Increased workload**
Concerns were raised on thirteen occasions that insufficient attention had been given to operational processes within general practice to make the choice agenda deliverable.

Many participants were concerned it would greatly increase the workload within primary care for administration. The choice system transfers all of the administration over into primary care without the transfer of funds from the secondary care sector into primary care to actually account for that. In the past the decision to refer a patient will have been the end point.

Questions were raised about whether it was the best use of a GP’s time to be making the actually referral, particularly as there were competing demands in General Practice such as GPs having the pressure to meet 48 hour access targets.

“The GP who’s trained for diagnosis and treatment and problem solving to be spending their time making phone calls or tapping things into a computer system, it doesn’t exactly seem to me to be the most ideal use of their time.” [GP]

“You can see the potential for there being loads more work in Primary Care…the people at the PCT…they’re getting hit over the head with all the targets and stuff so they’ve got to do the immediate. They know that this is like this awful hurricane that’s on its way but they haven’t got time to baton down the hatches and sort of prepare for it because they’re still having to keep the show on the road...” [PCT Board Member]

**Longer GP consultations**
The choice agenda has human resource implications, as it has the potential to greatly increase GP consultation time for patients requiring elective care. In the first place, a condition, which is complex enough to warrant a referral, will require a consultation that is longer than the 10 minute standard. Secondly, in order to explain the choices to patients more time would be required within general practice either with their GP or another member of staff. The whole process could impact on the quality of the GP consultation. It was felt that with time pressures GPs may not have the inclination to go through choices with patients. It will probably take some time for the patient to make a choice, and frequently it’s a family decision therefore, out of one consultation, there are suddenly an array of consultations.

Furthermore, if patients want to change their mind of place of provider they will have to make another GP appointment or not bother to book. Within a large practice GPs may be able to delegate the booking activity to another member of staff or let the patients book their appointment themselves where appropriate. However within a small busy practice there may be insufficient
staff to delegate to. Furthermore, cover would be required if the delegated member of staff was off sick or on holiday. If GPs do not have the time to go through the choice agenda, their patients are at a disadvantage.

“...will GPs sit down for 20 minutes while I go through my diary ‘can’t go that day, go to bingo, no, can’t go that day, get my hair done’ ...when they have got a waiting room full of patients...they’ve got that much prescriptions to sign and house calls...they might do it that way, but how can you audit that…” [Liverpool Choice Board]

Exacerbating inequalities in GP provision
Some practice nurses felt that choice should come after sorting out some basics in the system such as the wide variation in general practice provision throughout the country.

“It will be another stress on the system and we haven’t got the basics of the system. I just feel like choice is like the cherry on the cake, we haven’t actually done the cake yet…” [Practice Nurse]

In St Helens in some deprived areas there are shortages of GPs so the GPs in these areas are already under pressure to cope with patient demands, and patients can wait two weeks for a non-urgent appointment. Having to implement the choice agenda will put more strain on their service.

“…in St Helens there’s a shortage of GPs we’ve got the scenario that there are GPs that are quite desperate to retire and they’re persuaded to stay on because they can’t be replaced at that particular moment.” [Scrutiny Committee member]

Members of staff using the “Choose and Book” IT system will require training in how to operate it and deal with patients’ queries. Expert patients commented that it would deter people getting elective care if the member of the general practice staff booking referrals was not approachable.

Patient confidentiality at risk
The issue of confidentiality was raised, on three occasions, if referral is designated to another member of staff. A separate room would be required to ensure the patient’s confidentiality, but the patient may not want a third person to know details of their medical condition, particularly if they are going to get an intimate operation. The whole process is further complicated if the patient is either: non-English speaking, has a learning disability, or has poor literacy or numerical skills.

[See section on health inequalities]

The BMA is also concerned about the confidentiality of the IT patient data.

Risk that choice will not be offered
Two GPs pointed out that, from December 2008, GPs would be unable to know about all the different providers, when patients have unlimited choice of providers that meet the healthcare commission standards. There is a risk that, the more cumbersome the system of offering the patient choice, the
more likely that a choice would not be presented and the patient will be referred to a provider without any discussion.

“...so officially we’re saying people have the choice but in reality just because it takes too much time people just won’t do it, the choice is not given.” [GP]

To ensure that all patients requiring elective care are guided equitably, and confidentially to make an informed choice, greater consideration needs to be addressed to facilities, staffing and training implications within general practice.

**Practice based commissioning**

If practice based commissioning starts it may act as a perverse incentive for the GP not to refer if their budget has dwindled. This conflicts with the GP acting as an unbiased “perfect agent” for their patients ensuring that they have a fully informed choice of elective care. Also the government’s goal of tackling areas of under treatment is inconsistent with practice commissioning being based on what practices spent in the previous year.

**Negative impacts on primary care from the literature**

Approximately 4% of GP consultations results in an elective referral, that is 9.4 million per annum. GPs are concerned that “this focus on faster access to care for all patients may prevent doctors from achieving the best clinical outcomes for some individuals.” GPs are sceptical that the required investment of their time and resources will be matched by the benefit to patients. Indeed the Audit Office has warned that the main risk to the delivery of choice is the engagement of GPs. From their GP survey they found that 61% of GPs felt negative about choice. The GPs’ main concerns included: practice capacity, workload, consultation length and fears that existing health inequalities will be exacerbated. A Mori poll found that 88% of GPs and 46% of the general public were worried that extending patient choice would put more pressure on GP workloads and 84% of GPs and 74% of general public believed that patients would still find it difficult to express healthcare choices.

**Losing resources for other services**

According to a professional participant, the PCT is being forced to pay for private sector activity, so if the GPs do not offer the choice of the private provider then the PCT may have to pay again for a patient to go to a local NHS provider. If the PCT has to pay twice for patients to get treatment then that could take resources away from the traditional Cinderella services such as mental health, district nursing for older people and public health because there are few targets. The targets around public health are long term reductions in mortality and inequality, but they do not have the immediacy and priority of reducing waiting times. PCTs have been concentrating on the 2005 target because that is the first target, whilst different solutions are needed for 2008 when choice is unlimited.
A GP felt that the Choice agenda takes resources out of primary care that could be used to reduce health inequalities.

“I think there is an inequality in that [choice] takes resources out of the practices that are already struggling, because we’ve got a deprived population and a large black and ethnic minority population and communication is our main aim, [Choice] then detracts from other things that we might be able to do, like spending a lot of time trying to get women to come for their smears, because it will be done by the same personnel...the people who are getting the best choice will be...very articulate...”  
[GP]

It was considered a potential inequality that a lot of effort from the PCT personnel and practice staff is diverted onto the choice agenda to ensure it is performed well. Thus, it detracts resources in the form of funding, personnel and time that could go, for instance, into more successful prevention or management of heart disease. Resources are geared towards choice because of the targets; other things that do not have targets are not given a priority.

Another commentator thought that the choice agenda would reduce waiting times but at the expense of vulnerable people such as those from ethnic minorities. If there was a genuine aim to reduce inequalities then it could have been spent looking at what the PCT inhabitants need and want rather than imposing choice.

Payment by results focuses resources and attention on in-patient care rather than building up primary health care, community services and primary prevention. If PCTs go into deficit they may have to pull money out of other services, which are without targets and take resources out of training, research and development.

“...in twenty years we may not have the equivalent of the innovative stuff that’s come out about fertility...the innovative stuff around the Walton Centre...because it was pump-primed for people to do it slowly and the operations used to take eight, nine hours...”

“...well I think consumerism tends to focus on getting the most out of the most and can disadvantage those minority diseases which we do not know in twenty years time might be a significant drain on our health...We focus on treatment with the most easy to do, most standard...Your minority diseases which affect a small number of people have less choice ...but they might be the most debilitating...and that takes it back to it being a drug company you know, pharmaceutical led health care system.”  
[Practice Nurses]

Providers might be attracted by what procedures are the most profitable and concerns rose that some providers would not have the skills and experience to specialise.

“What makes the money! ...the likes of cancer surgery, I thought they were encouraging that each consultant has to be a specialist before they can do these
operations. So now are we saying that it actually doesn’t have to be a specialist it can be a general hospital with someone with a free bed?” [Scrutiny Committee]

According to the issues raised in the literature the NHS organisations have been warned that they will lose their licence to treat NHS patients and will be removed from patient choice menus if they cannot deliver minimum cost and quality standards – including the 18-week maximum waiting time after the introduction of free choice in December 2008.  

Whilst the 18-week target for operations is welcomed, it may detract from other urgent NHS work such as improvements in mental health services and public health. The BMA (British Medical Association) is concerned that some other “Cinderella” services such as those for the elderly and maternity may suffer as funding is directed to meet the target. Also PbR rewards increased hospital admissions rather than promoting improved care for people with long-term conditions. Public health is a long-term agenda that can be lost in rapidly changing organisations and restructuring. There are tensions, between more interventionist policies to create the conditions for a healthier population and current health policy which is directed at the interests of the individual consumer. Furthermore many fear the real tensions and conflicts between the market for healthcare being introduced into the NHS to increase capacity for choice and public health issues. For example what perception will FTs have of their public health responsibilities?

**Impact on Professional Training**

It was reported on three occasions that when the choice agenda becomes operational it is envisaged that the case mix in the acute NHS Trust hospitals will not be sufficiently varied to give a good training to junior medical staff,

“...how are you going to provide facilities for training...if you're taking huge bits of work off the hospital? And ultimately that then affects the quality of that hospital...accreditation and everything else and if you go into a downward spiral.” [PCT member]

It was claimed that the loss of routine operations to the private sector is already disturbing teaching:

Member 1: ...one of your consultants wanted his house officers to watch a hernia operation, and he couldn’t find a hernia on his list to do a teaching afternoon.
Member 2: What has been offered as choice is all that sort of area.
[Liverpool Choice Board members]

It was felt by one GP that the private sector already takes advantage of the public sector in terms of training. The independent sector said they would welcome the opportunity to be more integrated in the wider healthcare community and assist in the training of nurses and medical professionals. They feel they could offer a broad brush of experience and as the choice agenda progresses more procedures may start to move out of the acute NHS Trusts. Furthermore, having junior doctors input was considered a good thing

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Health Impact Assessment of the Patient Choice Agenda
because they are on the cutting edge of education they can bring new ideas with them.

However, it was envisaged at one professional focus group, that choice could have huge manpower implications for the NHS if junior doctors did some of their training within the independent sector, because they are a vital part of the workforce.

**Recommendation:**
It was suggested by the Liverpool Choice Board, that the Cheshire and Merseyside Workforce Development Confederation will have to take the impact on human resources on board as part of the impact of choice.

The literature review confirms that ITCs have no responsibilities for research or teaching and the associated costs. Taking into account the NHS’s research, teaching and commitments to treat complicated cases the BMA has stated that it is misleading to suggest that ITCs are a more efficient way of providing care, or to overlook the fact that they need established NHS infrastructure to operate. Furthermore, the transfer of most of the easiest procedures out of the NHS is now damaging the training of future surgeons and biasing the case-mix for NHS research. The loss of routine cases will undermine the core function of the NHS, which is risk pooling. The Select Committee has urged the government to do more to prevent the private sector gaining an unfair advantage.

**Impact on hospital services and viability**

**Impact from “Payment by Results”**
There were divided views in the interviews on the implications of the financial system underpinning the choice agenda, where the money follows the patient.

**Negative scenario:**
Many interviewees feared the destabilisation of NHS services could result leading to the possible closure or the reduction of services within some hospitals alongside the expansion of popular providers. Lack of revenue might force some hospitals into closure as schools have done in the past through not attracting enough pupils, particularly those with academic ability. This could lead to huge gaps in service provision. PbRs would establish a competitive market for health care and perverse incentives: such as discharging patients early and cherry picking.

Some patients were concerned about a drop in standards, and the erosion of local services and thus choice adversely affecting vulnerable groups who were less mobile. Patient groups and some professionals feared a two-tier system, where some areas would have better resourced services than others such as poorer hospitals in the inner city. There may be more incentive to provide a better service in the more affluent areas.
“I’m slightly concerned that you might get a difference in the quality of service emerging, almost like in America where they have those community hospitals and then they have the very swish private ones.” [Scrutiny Committee member]

The North West may be penalised because there is more deprivation, and consequentially higher SMRs than the national average. Indeed, from one professional’s experiential evidence from working in an NHS Trust, in comparison to wealthier districts in Southern England patients present much later and in some cases in an emergency situation in more deprived areas, but the assumption under the national tariff is that the standard of health and recovery is the same. The fear is that NHS providers in deprived areas are going to lose out, thus reducing the choice of providers for vulnerable groups. At present there is little evidence of any planning for this scenario.

“No one in the system as far as I know at PCT level is saying, oh right we’re planning for this many more cases of this length of stay, nobody has even done an analysis of what the current length of stay is that we’re likely to be aiming for...” [PCT Board member]

Private sector needs guarantees and a certain amount investing in it, which conflicts with the policy of offering the patient free choice. If more patients go to the local NHS Trust then will the PCT have to pay twice? However, if there is patient choice then there has to be a financial system that follows the patient.

**Positive scenario:**
Patient care advisers, on the other hand, considered the NHS would not be destabilised as private providers could only take limited numbers, and some patients would still prefer their local hospital or would not be offered an alternative, particularly if they had multiple health problems. Competition could be seen as healthy if it meant that a provider was constantly busier, then the skill levels of staff would be consistently at a higher level. If NHS hospitals are not automatically going to receive local residents, it could act as an incentive to improve their services, including improved cleanliness to reduce inflection rates. The nature of being a patient can make a person vulnerable and not want to complain. Therefore patients’ choice will show where they prefer to go and if a hospital has poor standards then, one view is that, it should lose money and ultimately close. Some commented that hospitals might specialise in order to attract revenue nationally in 2008.

**Impact on Hospital Services from the literature**

**Payment by results**
Payment by results could destabilise the universal healthcare system as patients exercise choice and potentially take the finance for their treatment elsewhere. According to delegates at a BMA annual seniors conference in June 2005, PbRs is pushing some trusts into deficit. Paradoxically, despite increased funding into the NHS in May 2005 it was
reported that almost a third of health trusts were in serious deficits and it was anticipated that some hospitals would have to close services due to increased use of the private sector, patient choice and PbRs. If national tariffs are too challenging hospitals will go out of business and conversely, providers that can attract patients and treat them for less than the national tariff will flourish. PbRs is a more businesslike approach that has exposed financial weaknesses. But it means that income and expenditure are much more difficult to predict. Through the threat of financial instability, there is the further risk of gaming in the system to get extra finances by hospitals assigning patients to a high price treatment. This presents the need for monitoring through individual review of samples of patients’ case notes.

[See section on loss of hospitals and services]

Unfair distribution of resources

Objections have been raised, in the literature, that there will be an unfair playing field between new and old providers. New private providers will be paid more ‘a market forces factor’ over the first five years to offset the extra costs they incur, through speedy set-up and rapid staff acquisition, resulting in a dual tariff system. Under this system, local NHS Trusts commissioning operations from private centres will pay the standard NHS rate, topped up by a “market forces” supplement paid by the government. Indeed, ITCs are paid on average 40% more than NHS providers and are often guaranteed five or ten year contracts.

The guaranteed level of private sector provision in the patient choice scheme is effectively a transfer of commercial risk to the NHS. This is likely to hamper the efficient use of NHS resources where the NHS hospitals have the capacity to manage its commitments using its own facilities. Indeed, there is evidence of a significant amount of “stranded capacity” within parts of the NHS. That is, many hospitals could quickly increase activity in some services if the purchasing power of PCTs were greater. The rule could mean the transfer of surgery to the private sector when the surgery could be carried out just as well, if not better, within the NHS hospitals. It is claimed by the BMA that already the transfer of operations from an NHS hospital in Southampton to an ITC has caused the closure of a ward and brought staff redundancies. Even FTs were struggling to find patients because of the government’s policy of guaranteed contracts to ITCs. The BMA states that PbRs could only work if public and private organisations were treated equally.

It has also been argued that FTs could lead to greater inequalities between hospitals. They can borrow from both public and private sectors and are able to keep all operating surpluses and asset sale proceeds themselves. However FTs may be poor value for money as they will incur higher rates of interest if they borrow through the private sector. There is a danger that FTs will receive higher levels of capital finance at the expense of the rest of the NHS, as private borrowing will not be accounted for within the Department of Health’s overall spending limit. Indeed their ability to borrow money and their proposed right to have legally-binding contracts with PCTs for at least five years, will give them considerable advantage over NHS hospitals and could lead to a two-tier health service.
Some NHS Trusts in financial difficulties

Indeed many trusts are already saddled with long-term debt, although the Department of Health has stated that they would be prepared to look ‘sympathetically’ at the financial plight of some indebted trusts, particularly where a number of factors had converged to take the situation out of the trusts’ control. The Chair of the Audit Commission has conceded that there will be real dangers for the NHS in the short term, particularly in view of the increased number of NHS organisations that have experienced financial problems.

Financial difficulties are considered to be attributable to cost pressures arising from pay modernisation; the reduction in waiting times, which has been expensive; “greater transparency in reporting of annual accounts, and the more exacting requirements of payment by results.” According to the NHS Confederation, representing managers and trusts, government targets have led to some Trusts over-committing themselves on spending in order to deliver improvements in service. The Audit Commission has concluded that PbR will work in the longer term, but only if Trusts and PCTs mitigate the financial risks, by significantly improving their arrangements locally, particularly in financial management, data quality, contracting and clinical understanding.

Extent of financial deficits

The Department of Health has confirmed that the NHS in England had a deficit of £140m in 2004-5, and there is an estimated deficit of £700m for the end of 2005. The health secretary has ordered NHS cuts to eliminate the deficit, which amounts to 1% of NHS spending in England. The National Audit Office and the Audit Commission have concluded after a joint investigation that many hospitals were ill-equipped to survive in the competitive healthcare market. They report 12 trusts with deficits of more than £5m in 2003-04 the biggest being Mid Yorkshire Hospitals with £18.6m. Some hospitals had to cut costs by reducing nursing and closing beds. Hundreds of bed losses were announced in June 2005. Whereas much of the extra resources going to the NHS is being spent on bringing in the private sector with major additional transaction costs. The choice agenda may involve significant costs for the NHS requiring more supply-side flexibility which is likely to require more resources.

Individual choice is not compatible with the collective good

Ultimately there is a real risk through lack of planning that service provision will be “determined by the ability of hospitals to compete in markets rather than one determined by social needs.” Furthermore, relatively small...
changes in patient demand could destabilise small General Hospitals. It is the articulate middle classes that will be most likely to exercise choice; therefore the service provision of hospitals will be determined largely by the choices of the eloquent few, rather than a planned process considering the needs of the many.  

Given the present lack of robust information about quality in many services and consequent difficulty in making comparisons, early access could lead to inferior services. Indeed, will hospitals resort to “wasting” resources on advertising campaigns to attract patients?

**Loss of hospitals and services**

There is a risk that FTs could destabilise smaller general hospitals. Patients may choose to go to FTs through their perceived superior status. They will be in a better position to compete as they can exercise their financial freedoms such as borrowing from the private sector.

The current health secretary has dismissed claims of widespread hospital closures, but conceded that some hospital departments that are not working efficiently and effectively will have to improve or risk closure. However, when asked if politicians would be prepared to see hospitals close as a result of patient choices the former health secretary John Reid remarked: “This politician is. I back the patients. If the public who own public services say they prefer the quality here rather than there, they are better placed to decide than providers.” But choices cannot be made on outcome of care, if this information is not available.

It is feared that “patients may lose the one choice that is important – a good comprehensive local hospital.” “When the dictates of the market replace the public service ethos patients will suffer…they will come second to profits.” Indeed the Healthcare Commission’s chief executive has said that “quality of care is inextricably linked to good financial management.”

**Consequences through lack of services**

If a hospital withdraws an unprofitable service that will mean less choice for patients, particularly if hospitals close and the quality of the treatment on offer could depend on where a patient lives.

Appleby quotes from a study conducted in Los Angeles County on the impact of a hospital closure where lower income residents reported increased difficulty in accessing care, working age people were less likely to receive HIV tests, and seniors less likely to receive flu jabs. The research reported some evidence that the increased distance from the nearest hospital raised infant mortality rates and stronger evidence for increased deaths from unintentional injuries and heart attacks. Appleby asks that although the closure resulted in savings from hospital costs do we value these efficiency benefits more than equity losses. Another consequence of hospitals losing patients, according
to the health secretary, is that if services are lost then medical staff could be laid off if they were not getting enough referrals.164

**Recommendation to manage financial difficulties**

Guidance on a code of practice was promised by the Department of Health from Autumn 2005 on how health communities should manage failure in the system.157 The Guidance has not yet been produced, but turnaround teams and management specialists will work with NHS organisations forecasting financial challenges to help them provide more cost-effective services for patients and achieve their financial balance.165 Monitor, the regulator of foundation hospital trusts, claims that there is no regime in place to deal with the financial failure of a hospital. Therefore measures should be arranged to put a hospital into special administration so it can continue treating patients whilst its financial affairs are put in order.166 Monitor is issuing a consultation paper calling for the regulation of the NHS by two independent bodies: one for health and safety and the other for economic regulation. Conflict of interest is avoided by having two independent regulators otherwise quality of care could be compromised for the sake of economy.166 At present a system of inspection and regulation is carried out by a number of bodies, but none can intervene financially.167

**Recommendation for funding emergency care**

The Audit Commission suggested that hospitals should be paid a basic sum for running an emergency service so that it could be guaranteed, after which they should be paid ‘marginal costs’ for the volumes of work they carry out.168 Even then, there could be problems for A&E departments if specialists such as orthopaedic surgeons were no longer available because their department had been closed as a consequence of PbRs.169 Which? warns that, to avoid destabilisation of the whole system, it is vital that the Government finds more effective ways of funding emergency treatments.170
Other impacts on quality of care

Impact on personal and family circumstances

Negative impacts:
One focus group of patients and a group of health professionals, considered it may be unsettling for some patients to be told they have to choose. It puts the stress on the patient to make the “right choice”. Expert patients considered that it was a big cultural change for some patients to make a choice and many might prefer the health professional to do that for them, particularly more vulnerable, frail, elderly, and less educated or the very ill.

“I think older people tend to be more accepting perhaps, it’s a terrible generalisation but I think probably they are more accepting of ‘doctor knows best’.” [GP]

One service provider commented that psychological support for the patient and family is not being considered in relation to access. This is particularly important when the patient is very vulnerable and if they have a serious or life threatening condition. It was pointed out by expert patients that GPs will refer anyway to the provider with the shortest wait without the elaborate “Choose and Book” system. Whilst it will be an advantage for patients to have treatment quicker, putting the emphasis on the speed of access, can mean that the actual quality of the experience can be neglected as psychological outcomes are as important as clinical and there is no target for psychological outcomes.

Positive impacts
On four occasions it was mentioned that patient anxiety would be reduced for two reasons. Firstly, because they know when and who they are going to be seen by and if patients know immediately when their appointment is they can potentially organise their lives better. Secondly being seen quickly could reduce anxiety and worries about a medical condition.

Two GPs and patient care advisors felt there would be a reduction in DNAs for elective care. As patients will have less time to wait and will be able to choose the date and time that is convenient to them. The number of patients not attending is thought to be related to them getting a date that is unsuitable and having difficulty in changing their appointment under the present system or through them forgetting to go because they have experienced a long waiting time for their appointment. Furthermore, at private providers appointments can be made in the evening or weekend with NHS Consultants which will be more convenient for people in employment and it enables a friend or relative to come with them thus giving them social support.

At two focus groups it was discussed how patients can feel confident that their appointment at a private provider is not going to get cancelled because of an emergency admission. A cancellation can also be traumatic if a patient has built themselves up emotionally for an operation.
“Once you’ve got a mix of elective and emergency then your elective is always threatened by the emergency that takes precedence over it. So yeah that’s the beauty of the private sector.” [Ambulance Service]

Where the private sector has a good track record it will provide assistance in keeping waiting lists down\(^ {115} \) as routine procedures will not be cancelled to cater for life-threatening emergency work.\(^ {171} \)

**Improved quality of life**

Health professionals and patients considered there may be some occasions where people do not want to wait a long time, because their quality of life is deteriorating. Being able to be seen quicker would help a patient who was in severe pain which can interfere with sleep and socialising or, if through waiting, a patients’ health was getting steadily worse.

The numbers of people waiting for hospital treatment and the length of time waiting is indeed reducing.\(^ {20} \) Furthermore, reduced waiting time is associated with improved quality of life and health in patients. For example when patients who waited longer than three months for coronary artery bypass grafting (CABG) where compared to patients being treated sooner, they had significantly decreased physical and social functioning although there was no difference in the quality of life between the two groups of patients before their operations.\(^ {19} \)

**Impact of physical environment**

In the private sector psychologically patients will feel better if in a pleasant, quiet environment where there are higher staffing levels than NHS. Such factors will aid recovery.

*Respondent A: Private wing at the Cardiothoracic Centre and that is fully subscribed most of the time. And its because of the package, what they are getting.*

*Respondent B: If you compared that with an orthopaedic trauma ward where half of the ward is elderly ladies etc, the other half of the ward is very violent trauma related to drugs and they bring a certain clientele in with them and it’s not a nice environment, you certainly wouldn’t want to be in it, or do you want to go to a nice room in the private sector? [Choice Board Focus Group]*

**Other Impacts on public services**

**Improved access to healthcare**

Reducing waiting times for elective care, was mentioned on four occasions in the focus groups, by giving free access to private providers. If more people are going into the private sector for treatment, the waiting times will be reduced in the local NHS hospital. One of the real benefits from choice was
thought to be stopping differential waiting lists between equivalent consultants. However, one patient group considered that patient choice would not eradicate queue jumping, by people who want to pay to see a consultant privately in the near future.

**Free access to private sector**

Four interviewees considered that the need to pay for private work will reduce because it thrived on higher levels of NHS waiting lists. One commentator thought it was good that choice was giving patients on a low income access to private care. The private sector has confirmed that they are taking patients that they would not have accepted before, as the NHS is now their core business. For instance, they are taking smokers and obese patients and to enable staff to adapt to their patients’ changing needs they are going through a programme of developing an acceptance of diversity both socially and clinically. They deny that they are still cherry picking patients as they are now in a more competitive environment, but they can complement NHS provision.

“...its not about the private sector versus NHS sector, its about economies of scale and what makes sense and there’s no point in keeping in a small area like this two intensive care units going.” [Private Provider]

**Positive impact on quality of care**

It was felt by some participants that choice may actually drive up standards of cleanliness as providers will want to attract patients to their establishments. One patient group thought “Choose and Book” might have a positive outcome in making doctors who are not very patient friendly or have antiquated practices, to change. A professional group felt that the introduction of choice so far had reduced waiting lists and was an incentive for consultants to work “harder and smarter” saving the Trust money.

The use of private providers was perceived during the interviews/focus groups on five occasions to either increase or maintain the quality of care provided for inpatients. For example private providers being used by Central Liverpool PCT all have NHS Consultants working for them. In particular Consultants from Wrightington Hospital, which specialises in Orthopaedics, have the reputation of being the best specialists in orthopaedics in the North West.

“Wrightington Hospital is a north west centre of excellence for orthopaedics. I would go there rather than go to Joe Bloggs.” [Choice Board member]

Private providers were considered to be particularly expert for routine operations where they have specialised in these procedures. At three focus groups members had received personal recommendations from patients who had access to the private sector. The patients perceived it as cleaner than the NHS, and they have been impressed by the whole package of care, particularly the hotel facilities. One GP affirmed that patients at private facilities will appear to get the undivided attention of a consultant and their junior staff.
“We send out the forms to the patients that go to [private providers] And they’re nearly always five, which is the top score and nine times out of ten they’re at five for everything.” [Patient Care Advisors]

A private provider confirmed that they provide a high quality service with good clinical outcomes and low infection rates. They considered that they do not just provide good hotel facilities and a lovely environment. They are also heavily regulated by the Healthcare Commission to conform to national minimum standards and their reports are freely available on the internet. Therefore, this evidence should provide confidence to patients that they are coming into a quality organisation.

**Factors obstructing 2008 target for 18 weeks**

The King’s Fund has highlighted factors that could obstruct the achievement of the target. For instance there may be unanticipated increases in demand if GPs refer more patients and previous consumers of private healthcare switch back to the NHS through faster access. Furthermore, staff shortages in critical areas such as diagnostics and radiology could impede this target.

The Healthcare Commission has called for healthcare organisations to report any unintended consequences of NHS targets.

**Increased bureaucracy**

Two patient groups and four professionals felt the system underpinning choice was either an over complication or increased bureaucracy. For instance one participant considered that we were moving from a relatively straightforward administrative process involving commissioning from local NHS Trusts to a complex, inflexible bureaucratic system that is being foisted upon health providers to serve the process without enhancing the quality of the service.

Furthermore, it is not giving NHS managers the time to plan effectively. Indeed expert patients commented that they thought the whole procedure and structure of the “Choose and Book” was an over-complication and they would prefer to be referred by their GP who knows them and what kind of a patient they are and deal with consultants they have been to in the past because you have a “context” as they understand their case. Another patient group felt that it was such a complicated system requiring so many “bits of information” for it to work, that mistakes could be made.

**Positive Health Impacts on primary care**

**Rational system of referral**

If choice is given to the patient it will stop the GP referring to a consultant because they knew them at medical school: “the old boy network” [Patient forum Sefton]. It was also pointed out that one of the real benefits from choice was that it would stop differential waiting lists for consultants where there is generally no significant difference between clinicians and outcome.
Patient Care Advisers have been instructed to go into GP surgeries and train receptionists in offering choice to patients, so that the GPs are freed up. Thus if a patient changes their mind about where they are referred they can transfer through the receptionist. The GP will have filled in a pro-forma identifying any contra-indications such as heart condition that would stop them being referred to certain providers.

**Employment enhancement / opportunities**
Choice agenda will mean changing job roles and it could make the receptionist’s job more interesting and will cut down on referrals going missing in secondary care. It could also mean increase in employment opportunities in primary care if more staff are required for administration of patient choice.

However, it was pointed out that on average the GP referral rate is only one patient per session so this would not necessarily create a huge workload.

**Limiting choice of secondary care**
Through the original referral system a patient could technically be sent anywhere in the country and a few have been granted operations abroad. So if an elderly person wanted to go outside Merseyside to be near relatives whilst they were in hospital it would be possible for their GP to arrange this. From January 2006 the choice is limited to a specified four or five providers. Also at two patient forums it was confirmed that under the present system patients had been offered a choice of where they wanted to go for elective care and GPs have an idea about waiting lists at different providers. Furthermore, if a patient has previously had an operation they may like to go back to the same consultant for a similar problem but under “Choose and Book” this may not be possible if the consultant is not available and only the provider is booked. It was considered that this is another reason why GPs are not enthused about the policy as they cannot book with a superior specialist who may have a low complication rate. Therefore a surgeon who has a high complication rate instead may have to see their patient.

Concern was raised on three occasions, that if patients are being referred from outside the area or region into local specialist hospitals that have a very good reputation then they might become full. And a service could not expand because there are only so many consultants in each specialism so local patients will be forced to travel further a field.

“The impact ...as a result of Choose and Book that hasn’t been thought through is around large numbers of patients coming into an area to take up choice because their service in their area is not adequate...then to the detriment of local people.” [Service Redesign Group]

As a result the Specialist Trust might alter their admissions criteria so they are becoming more specialised or selecting cases that can be discharged relatively quickly without any complications. A similar situation occurred a few years ago when the local social services were accused of bed blocking when three-quarters of the patients blocking beds came from outside the borough.
and it was the responsibility of the social service departments in the areas of the patients’ residence. This impacted on the local social services performance indicators and local patients could not be given a bed. Therefore, people will not have the option of their preferred choice if the providers are full. A similar situation arose when parents were offered choice of school, so the popular schools with the best examination results became full and parents’ choice was limited with much aggravation after having their expectations raised. Also some schools were closed in deprived areas because only children with transport problems could go to them whilst other parents were exercising their choice to go to other more successful schools.

Indeed, in an extreme scenario, choice may lead to the development of more specific hospitals for instance a hospital that specialises in hernia operations, but professionals may lose job satisfaction if all they are concentrating on is doing hernias and they are de-skilled from doing general surgery.

Delegates at the 2004 BMA conference condemned the governments’ plan to give patients a choice of four or five hospitals as offering no real choice, of surgeon or what investigations or treatment they have. Thus a wholehearted commitment to extending choice would offer a wide range of different services, not just a choice of provider supplying the same service. One delegate emphasized that patients want the NHS on their doorstep and more time with their GP.

Interaction of reforms

Many commentators, in the literature, feared that the NHS is entering a period of instability, coupled with uncertainty on how major reforms servicing the patient choice initiative, outlined above, will interact. Unfortunately there is no guidance on what the future of the NHS will be after 2010. Whilst the BMJ Editor likens the reforms to “a giant and rapidly moving healthcare experiment” that is based on ideology not evidence. According to MORI polls, GPs and consultants feel that the choice agenda will have a negative effect on the NHS primarily through concern over the effectiveness of mechanisms to make it work and more bureaucracy. Throughout Europe insurance-based systems cost more to administer than the NHS with 20% of healthcare spending going on administration and in the U.S. it represents nearly a third of healthcare spending. Some GPs are concerned that local specialist centres will be overwhelmed when patients from outside the area exercise their right to choose, thus limiting access for local people.

Increased employment and training opportunities

As the private sector is increasing its business, there are employment opportunities for all grades of staff, from support services to health professionals. However, a private provider confirmed that some of the health professionals will be from overseas, rather than using NHS resources, and where appropriate bringing new people into nursing and getting them trained on site.
Greater collaboration and understanding between NHS and private Sector

According to a private provider of health care, the NHS and private sector have developed a deeper understanding of each other’s pressures. The NHS now has an appreciation of the roles and skills that are available in the private sector. This has increased confidence in how the private sector manages patients.

One commentator felt the private provider could be seen as taking the pressure off the NHS Trusts, rather than rather than “creaming off” the low risk patients.

“The private providers didn’t ask for those cases, they were given them by the Dept of Health, and the way that came about was that the Trusts were asked what are your pressure areas, so all the Trusts said, varicose veins, hernias, haemorrhoidectomies, breast augmentation operations, tonsillitis, etc, etc, they are all our pressure areas. The Dept of Health then went to the private sector and said, can you do these operations, they said yes.” [Choice Board member]

Competition destroying the spirit of collaboration within the NHS

However, from the literature it appears that senior NHS consultants fear that competition will destroy the spirit of collaboration within the NHS where resources are shared. Collaboration is vital to improve emergency care, services for people with chronic conditions and for highly specialist services such as cancer. These patients require integrated services – co-ordination between hospital specialists and primary care teams.

Loss of self-pay operations and corporate business

A contrary view to privatisation is that the NHS could be seen as devouring the private sector. As waiting times come down the number of self-pay operations is falling fast as patients do not want to waste their money on queue-jumping. The private sector has to offer lower prices and sell off capacity as they adapt to the NHS market as their main source of funding. Whilst consultants and anaesthetists fees are cut under competition from lower fees paid in the new treatment centres. Indeed, BUPA announced in June 2004 that is was cutting its fees to consultants because its markets were under threat from the NHS. The private sector could lose corporate business through falling waiting lists and will want to replace this business through the big NHS market. However, the point remains that the NHS is being taken over by big business and private healthcare teams, so money that could go towards clinical care is being diverted to corporations and their shareholders. Much of the big business comes from America where health care is claimed to be worse than in the UK.

Impact on NHS staffing

According to one focus group, there will be a reduced need and/or a change in role for secretarial staff in primary and secondary care if the bookings are electronic and there is no need for correspondence. Furthermore, the
The structure of nursing in hospitals is changing because there are less trained nurses. At another focus group it was stated that hospitals have been consultant led, so this is taking away some of their power to pick and choose when they operate. However, as noted above, there are expanding job opportunities in the private sector because of the increasing business from the choice agenda.

**Capacity issue for 2008**

There was some concern expressed about where the increased capacity was going to come from to reduce waiting times to the 18 week target. Places like South Africa could provide some additional hospital staff. However, there are ethical issues in employing professionals from countries with greater healthcare needs. Furthermore, the European Working Time directive, reducing junior doctors’ hours, puts extra pressure on the NHS consultants because they now have less support from junior staff. Thus although the elective care service is growing the PCTs are uncertain of whether there is a skilled and experienced workforce available to meet this expansion. Even with the additional independent sector contracts not every HRG [health service resource group] is covered because there is a national shortage of clinical capacity, for example in orthopaedics. According to a choice manager, there are many people who have been waiting over six months who have fallen outside choice, with the exception of cataract surgery where there is ample capacity and the waiting list has been reduced to three months.

The Department of Health has announced that in the second wave of contracts, work that is transferred from existing NHS trusts will have an additionality clause dropped that prevented the ITCs from employing staff who have worked in the NHS over the previous six months. This has been lifted by a secondment agreement allowing staff to be employed by ITCs whilst remaining on NHS contracts. The six-month rule was introduced to protect staffing levels in the NHS, but now up to 70% of staff in ITCs can be seconded from the NHS. Doctors in specialities without shortages can work full time for ITCs on leaving the NHS without having to wait six months. The current health secretary has also lifted a ban preventing consultants from doing shifts in treatment centres once they have put in their required hours with the NHS. The BMA chairman has welcomed this development as it creates another earning stream for doctors and with NHS doctors working in ITCs it should improve standards of care. The chairman also stated that this was better than the government increasing capacity by relying on countries such as South Africa and the Phillipines that have greater needs for the skills of medical and nursing professionals. Furthermore, the Department of Health is granting local flexibility in implementing staff policy for ITCs to respond to local shortages and workforce issues.

Critics argue that if ITCs recruit from NHS staff how can they increase NHS capacity. Private hospitals do not have additional resources as most of their operations are performed by NHS Consultants. Choice could be severely limited as the NHS will never have the spare capacity to mimic other areas where choice can be offered to consumers. The European working time
directive from August 2005 cutting the number of hours that junior doctors can work increases the pressure on staffing.\textsuperscript{109}

There is a risk the FTs will draw scarce staff away from non-foundation trusts. The FTs can negotiate or impose their own pay scales and conditions of service. With the prospect of increased pay and working in a hospital with a higher status staff may be recruited from non-foundation trusts.\textsuperscript{15} This will undermine their performance and put them on reliance on temporary staff. If hospitals lose staff they lose their ability to offer the full range of services.\textsuperscript{177} A lack of NHS capacity would limit the ability of patients to exercise real choice.

\textit{Does having a choice really matter to patients?}

\textbf{Pilot projects unrepresentative}

Evidence from the pilot choice projects may not offer much light on this because the patients, the procedures undertaken and the financial arrangements are not representative of how choice is going to operate in practice. For instance, the early work on cardiac patients is not representative of all patients because they tend to be very knowledgeable. No analysis was carried out on the patients that were not offered choice, who could have been sicker and poorer. In the London pilot the private sector were not involved and treatment was not based on the standard tariff so there was no element of competition. Patients were also offered free transport.

"With the London Choice, you didn’t have payment by results, you did that extra payment to reward Trusts…it was, you know, they lined their pockets with gold basically to take people out of the margins." [PCT Board Member]

"…they were transporting them around in Ford Galaxy’s all over London and at the time some of the research was done the waiting lists were horrendous, the waiting lists are coming down now." [Service Redesign Group member]

\textbf{What is important when patients make a choice?}

It was considered very difficult to actually assume what patients will use as criteria to choose. One choice manager confirmed that people have tended to make choices for what one person described as ‘irrational’ reasons. It was also assumed that people are more likely to make rational choices when they are not ill. Several participants thought patients might be persuaded by the reputation of an institution or consultant. One or two bad cases in the press could change people’s views about a provider. If a patient does not have faith in the provider they will probably end up with a worse outcome. The majority of patients do not ask about clinical skills, but are concerned about the hotel facilities at the private provider.

"…hardly any patient has asked about the clinical capabilities of the consultant, not asked about morbidity, mortality rate, re-admittance rate, anything at all, they’ve asked about how soon is it, the food, Sky television, transport, locality, can I park…"
“I suspect people pick hospital of their choice for the wrong reasons: they have been there before and they liked it, they are nice, I like the flowers they have there, they make lovely tea. It can be for all sorts of reasons why people have an affinity. And some people have an affinity with the places because of my mother was in there and they treated her wonderfully, 40 years ago.” [Scrutiny Committee]

“A large study looked at why private patients go private and clinical was not the main reason, it was because they wanted the operation sooner and they liked the facilities: such as good food, a private room and TV.” [Liverpool Choice Board].

Others commented that they would be prompted to make a choice if they could be seen quicker or on the basis of cleanliness and the absence of MRSA. District nurses and one councillor reported that many people had mentioned standards of cleanliness as being of great importance because of the publicity that had been given to this issue.

It was pointed out that the elderly or any person with a chronic condition will probably want to stay with the consultant and staff that they perceive as knowing them well. One GP acknowledged that: there is the “perception of a relationship” if they have seen an understanding health professional before and that “gives them faith.” Indeed, expert patients would prefer continuity of care, with the same competent consultant; to be treated with respect, at a provider that is patient orientated and easily accessible. However, it was acknowledged that although a health professional may have good interpersonal skills it was no guarantee of their competence.

Do people want a choice?
Two interviewees commented that there was no overwhelming evidence that patients actually want choice, although it was estimated that 70% of patients being given a choice had taken it up within Liverpool on the GSupp [General supplementary – extra money given by the government to bring down waiting times on certain specialities: ENT, urology and general surgery]. That is, they had moved from their planned appointment at an NHS hospital to an independent provider where they could be seen quicker. However, some participants felt that people do not have real choice at the moment. According to one interviewee people moving to another provider does not prove that they have been actively engaged in a choice of provider.

“…choice is defined by people who move. I don’t accept that….I don’t think we’ve got people actively engaged at the moment. I don’t think they’ve got real choice. We’ve got people being directed to the independent sector capacity, because we’re desperate to fill the slots, not because we want to give them choice. The government have made a financial commitment to the independent sector, they don’t want to under use it, so they want to coerce people to go else where.” [Choice manager]

“…choice is a highly charged political issue, and we can’t get away from it I mean there are those people you know, who argue that what patients are most concerned
about is that everyone should have access to...the best possible services locally...choice is just a smoke screen to avoid that issue...it makes good headlines come election.” [CTC patient users group]

“ If you just ask people if they want more choice they will say yes, unless you can put the question into context with the possible implications of more choice.” [PCT Board Member]

Choice may be irrelevant to the majority of people:

“I think the example of it: ‘yeah I go the day before Uncle Joe's wedding’, I mean how many people are going to plan this into their life. You know if you need an operation, you gonna have the operation done and your GP can tell you where it’s gonna be. I mean maybe one in a thousand people who’s got a real bee in their bonnet or they’re an expert patient and they know what they want and who they want it from, but I doubt that’s true for the majority of people.” [Social inclusion unit]

“I would expect 90% of patients would say to the doctor, doctor if you had choice what would you recommend.” [Scrutiny Committee member]

Some people may be less interested in choice once the waiting list has been lowered. It was acknowledged that too much choice could be scary and cause anxiety in some patients. Another interviewee, whilst acknowledging some concerns about choice, felt it was a positive thing as being able to choose provider and having confidence in them could enhance recovery, by a kind of placebo effect. The PCAs felt that most patients valued the offer of choice, but there were some exceptions: they are concerned about MRSA or NHS money going into private providers or they prefer to stay under a specific consultant because they have built up a rapport. Indeed some people may trade off speed of access against personalised choice in terms of who they want to see. On the other hand some participants felt patients would not have an opportunity to sample private healthcare otherwise. However, some health professionals would not choose a private provider because they do not have emergency cover or a doctor on site overnight.

Second opinion

If people perceive that they can actually be booked into hospital much easier and there is that extra capacity, they are more likely to say they would like a second opinion. On the other hand some patients may be afraid to ask in case they upset the consultant, but they should be encouraged to ask for one. However in one patient forum the question was raised if the money follows the patient would a patient be entitled to a second opinion?

Patients favour choice if they do not have to consider its relative value

Surveys of patients opinions on the value of choice have shown contradictory outcomes which reflect the questions asked. The public is often asked if it would like choice, but without reference to its relative value. Seventy-one percent of the public thought it was important for them to be able to choose
which hospital to go to. In another poll, 66% thought it was either fairly or
very important to have a choice over which hospital to be treated and 61% thought that choice over public services such as health would give them more
control over their life. Eighty-nine percent of those surveyed by the College of
Health would accept an earlier date for treatment at an alternative hospital.

Evidence from patient CHD pilot
The first study to look at patients actually offered choice was a pilot of
patients’ experience of CHD choice within 28 acute NHS hospitals in England.
They were offered an alternative hospital, by a patient care advisor, if they
had been waiting six months or more for an operation, they were fit enough to
travel and had no date for an operation in the near future. In this pilot just
over half (57%) offered choice opted to go with an alternative provider.
Patients under 60 were more likely than older patients to travel for a faster
treatment, (61% and 56% respectively).

Patient choice not seen by public as NHS priority
Recent Mori polls confirm that choice is not seen by the public as the greatest
NHS priority, where involvement in decisions about treatment was the top
priority for 76% of respondents. Also, in a 2005 BMA survey of 2,000
people asked to rank 10 NHS spending priorities choice of hospital came last.
In order of importance: cleaner hospitals, improved A&E, shorter out-patient
waits, new treatments research and funds for prevention were the top five
priorities. The bottom of the list was where to go for an operation. Given
the choice between the Government giving extra money to all hospitals or
making more money available to help patients have more choice over where
they are treated 72% said the former and only 24% said the latter. Similarly,
the consumer watchdog Which? found that 89% of their survey put a good
local hospital ahead of a choice of provider. Indeed, having a good local
service would eliminate the need for choice. Choosing a hospital can be an
“unwanted and overwhelming burden” with the elderly being the most choice
adverse. It is also considered unlikely that patients will wade down a list
of 40-50 providers. Frequent service users such as the elderly would prefer
to have practical choices that can offer them dignity and enhance the quality
of their life, rather than a choice of provider. For instance, the timing of meal
times and what they would like to eat.

Problems with information Technology

Technology not secure
The British Medical Association (BMA) has raised concerns that the “Choose
and Book” system may not hold personal information securely.

The idea is that health professionals will have limited access to patient
records, so one concern raised by a health professional was that it could
introduce an element of risk if professionals were unaware of something
pertinent in the patient’s medical records. However, some practice nurses
thought e-booking was in theory a better system than having a big paper trail.
Delays in IT

Two patient forums, expressed little faith in a national IT system, especially if the Child Support Agency was anything to go by. The communication about “Choose and Book” had been kept low key, probably because there were concerns that it would not be up and running in time.

On four occasions it was mentioned that there have been significant delays in implementing the IT system behind “Choose and Book” and without the system it will be impossible to meet targets. In autumn 2005 an “Indirect Bookable Services” or IBS was being used to book patients. The Patient Care Advisors [PCAs] have been using Excel spreadsheets that are not linked to the providers PAS [Patient Administration Systems]. Therefore the PCAs have been using protected time slots for appointments and manually via faxing mail-merged letters confirming appointments, to providers, GPs, patients and the PCTs. Many man-hours have been spent by facilitators in GP practices putting all their patient records onto computers.

From the literature it is considered that through limited progress, e-booking will not be fully available by January 2006. Therefore, choice will have to be provided in other, less efficient, ways until approximately December 2006. Furthermore, it is considered unworkable by the British Medical Association (BMA) because it has not had the input from clinicians and they fear it will compromise patient confidentiality. In early 2006 people will be given the option of barring information in personal electronic health records from being shared across the new NHS-wide computer system or restrict access to it perhaps only allowing their medical history to become available to NHS staff in life-threatening emergencies. However, integrating a nation’s records on one system makes them potentially accessible by hundreds of thousands of people. To safeguard confidentiality and appropriate use “The Care Records Guarantee” is a commitment that records will only be used in ways that respect the patient’s rights and promote their health and wellbeing.

Discussion

In the discussions, there were contrary views on a number of issues. However, the criteria for prioritising impacts (see p24) were applied. In the literature as well, these reforms have been the cause of much ideological and political debate not least because they are associated with the privatisation or dismantling of the NHS. They are accused of compromising its founding principles of a comprehensive and collectivist system of healthcare. Furthermore, huge profits that could have been directed at health care would go into private business. Specialists may move to more prosperous areas to protect their private practice or where they will get paid more. Concern was raised that if patients are being referred from outside the area or region into
local reputable specialist hospitals, they will be overwhelmed resulting in limited access for local patients. Patients will not have the option of their preferred choice if the providers are full.

The associated risks, from the reforms, can present possible trade-offs between the fundamental aims of the NHS. Thus attempting to increase efficiency and responsiveness but at the probable expense of equity. Of particular controversy is the role of new providers, to increase capacity from the independent sector and the formation of Foundation Trusts. The instigation of a competitive market in healthcare can have the perverse incentive of sucking more patients into hospital care,\(^3\) some of which could have been better provided for in the community. There are concerns about the efficiency and effectiveness of the financial and computing systems underpinning choice. Through limited progress on e-booking choice will have to be provided in other, less efficient, ways until approximately December 2006.\(^4\) Concerns have also been raised about the confidentiality of patient records.

To ensure that choice of provider leads to better health outcomes for all patients it must reduce not increase inequity of access to health care. Whether the choice agenda will increase or decrease equity in the NHS remains open to debate.\(^5\) The policy rests on the ability to empower disadvantaged groups, but research suggests that the poor or low income patients, the old, those with lower educational levels or family commitments will be amongst those discriminated against. The people most in need of hospital care will also be the most disadvantaged.\(^6\) Choice could be easier for those who are comparatively well at the expense of the comparatively less well, as new providers do not have facilities for intensive care or high dependence beds. Patients could be prioritised on the basis of financial reasons not on the basis of their needs,\(^7\) which is referred to as cream-skimming.

Health inequalities could also be part of choice because some patients will be “information disadvantaged” and thus unable to make an informed choice. Information disadvantage refers to language difficulties, lack of basic skills or total unfamiliarity with the internet.\(^8\) Particular concern was expressed about ethnic minorities and patients with disabilities getting a fair choice and protecting confidentiality. The type of information patients will need to make an informed choice is discussed and the associated problems in providing meaningful statistical data. Other potential barriers to equitable access for disadvantaged groups include: lack of suitable transport, incurring greater travel time and costs and lower car ownership; time constraints and differences in health beliefs.\(^8\)

Travel could restrict choice for the frail, disabled or those vulnerable patients who want to stay near the support of relatives, putting a strain on family and friends to keep making long-distance trips to visit. Indeed, social support is an important part of the recovery process. Experience and research evidence suggests that many patients may be parochial in their choice, unless they need to be seen by the best specialists for a rare condition or they are in...
severe pain. The choice of providers will be more in big cities than in rural areas.

Contrasting views were expressed on some major impacts. Quality of care was an issue for a number of reasons. Patients may be at risk in a private provider if there are complications as they do not have the resources. Research suggests that for-profit healthcare is not as good as non-profit\textsuperscript{9,10} and there could also be a trade-off between quality and volume and a temptation to cut costs that could threaten quality in order to meet national tariffs. There is no evidence that competition between providers improves quality. However, potential providers are tightly vetted by the Healthcare Commission and the independent sector has to work to their performance guidelines. It was regretted that patient groups have limited power to monitor. Clinical priority will be affected if the patient chooses the time and place of their outpatient appointment. Research confirms that waiting times do not guarantee patients being treated in accordance with their clinical need.\textsuperscript{11} There is evidence of consultants treating patients in a different order to what their clinical priority would suggest to avoid breaching waiting time targets.\textsuperscript{12} There may be unanticipated increases in demand if GPs refer more patients and previous consumers of private healthcare switch back to the NHS through faster access.\textsuperscript{13}

Staff shortages in critical areas such as diagnostics and radiology could impede the 2008 eighteen week waiting time target.\textsuperscript{13} Critics argue that if independent treatment centres (ITCs) recruit from NHS staff how can they increase NHS capacity.\textsuperscript{14} As Foundation Trusts can negotiate or impose their own pay scales and conditions of service there is a risk that they will draw scarce staff away from non-foundation trusts.\textsuperscript{15} Furthermore, an additionality clause preventing ITCs from employing staff who have worked in the NHS over the previous six months has been lifted by a secondment agreement allowing staff to be employed by ITCs whilst remaining on NHS contracts.\textsuperscript{16} Consultants can do shifts in treatment centres once they have put in their required hours with the NHS. If hospitals lose staff they jeopardise their ability to offer the full range of services.

There has not been a relative increase in rehabilitation provision in line with the expansion in elective capacity in the private sector and out sourcing of work to other areas. If resources are not available in the community patients are at risk of being re-admitted, possibly as an emergency, or there will be increased pressure on emergency response hospital-at-home schemes. There has been evidence of increased 999 calls and care pathways being inadequate. It is feared that competition will destroy the spirit of collaboration within the NHS where resources are shared. Collaboration is vital to improve emergency care, services for people with chronic conditions and for highly specialist services.\textsuperscript{18} Whole system planning is required to ensure an integrated service across secondary, primary and community services.

Primary care may be negatively affected by choice. Some main concerns include: practice capacity, workload, consultation length and quality and fears that existing health inequalities will be exacerbated. The choice system
transfers all of the administration over into primary care without the transfer of funds from the secondary care sector into primary care to actually account for that. Some participants feared that the system would increase bureaucracy and administration, although new employment opportunities would be created and/or changing job roles. Nevertheless, through the original referral system a patient could technically be sent anywhere in the country and a few have been granted operations abroad. Also, if a patient has previously had an operation they may prefer to see the same consultant again for a similar problem, but under “choose and book” this may not be possible. The policy could also take resources away from the traditional Cinderella services such as mental health, district nursing for older people and public health because there are few targets. Furthermore, psychological support for the patient and family is not being considered in relation to access.

Conversely, patient anxiety would be reduced through knowing when and who they are going to be seen by and being seen quickly could reduce worries about a medical condition. Reduced waiting time is associated with improved quality of life and health in patients. Furthermore, patients going to a private provider can be confident that an appointment is not going to be cancelled because of an emergency admission. They can provide appointments with an NHS consultant in the evening or weekend which is more convenient to people in employment and allows relatives or friends to attend giving social support. In the private sector, psychologically, patients will feel better if in a pleasant, quiet environment where they appear to have the undivided attention of health professionals. If more people are going to go into the private sector waiting times will be reduced in the local NHS hospital. Indeed the numbers of people waiting for hospital treatment and the length of time waiting is reducing.

The private sector considers that it can complement NHS provision and there has developed a deeper understanding of each other’s pressures and the NHS now has an appreciation of the roles and skills that are available in the private sector. Also, they could be seen as taking the pressure off the NHS Trusts, rather than creaming off the low risk patients. The NHS could be seen as devouring the private sector as the number of self-pay operations fall, as patients can be seen quicker. Choice could actually drive up standards particularly for cleanliness as providers will want to attract patients to their establishments. Private providers were considered to be particularly expert for routine operations where they have specialised in these procedures. It provides a rational system of referral stopping differential waiting lists for comparable consultants

Professional training of medical and nursing staff may be compromised as it is envisaged that the case mix in the acute NHS Trust hospitals will not be sufficiently varied to provide good training. The loss of routine operations to the private sector is already disturbing teaching. Furthermore, ITCs also have no responsibilities for research.

There were major concerns around hospital viability if money follows the patient through payment by results. This is already pushing some trusts into
deficit and services are threatened particularly by the transfer of operations from NHS hospitals. Objections have been raised that new providers will be paid more over the first five years to offset the extra costs they incur plus a guaranteed level of provision. Choice may provide an incentive to improve services, but hospitals that lose patients will go into financial decline. There could be a “sink” sub-section within disadvantaged areas where providers are under performing, unable to attract good staff, with falling demand contrasted with prosperous leafy areas where there is high demand but not enough places and in effect the provider selects the consumers. An alternative view is that the NHS would not be destabilised as private providers could only take limited numbers, and some patients would still prefer their local hospital. Competition could be seen as healthy as skill levels of staff would be consistently at a higher level, if a provider was constantly busier.

Discussion also took place on whether patients actually value choice. The evidence from the pilot choice projects may not offer much light on this because the patients, procedures and financial arrangements were not representative of how choice is going to operate in practice. Evidence suggests that patients favour choice if they do not have to consider its relative value. Recent surveys confirm that choice is not seen by the public as the greatest NHS priority and the vast majority put a good local hospital ahead of choice of provider.
Recommendations

It is recommended that a working group be appointed to consider the recommendations of this HIA. The working group should identify: the feasibility of the recommendations, how they might be acted on and lead people or organisations that might implement them.

To raise awareness
- Raising awareness about “Choose and Book” amongst the general public through different media formats.
- To inform the general public in all residential areas that it will be their right to choose.

Help in making a choice
- If GPs were moved to larger practices then someone could be employed at health care assistant level for all of the GPs to sort out booking arrangements for the patients. Also in the NHS drop-in centres an individual could organise the “Choose and Book” for that area. These arrangements would ease the administration of the choice agenda.
- The decision to refer could be done by a GP and then have a patient advisor who would go through all the options outside the practice. However, not all were in agreement with this as it puts reliance on the patient to contact an outside agency, which from experience some would not do.
- More resources for primary care if booking to take place in general practice with the training of staff in dealing with patients and protecting confidentiality.

Information requirements
- Require more transparent, sophisticated data on the performance of hospitals that takes into account the differences in case mix, and to make this data available to patients in an easily understood format. This is particularly pertinent for people with poor literacy and numeracy skills so they can make a fair comparison.

Maintaining standards
- For all providers to be independently assessed to the same standards.
- Need assistance with the journey for ethnic minorities and families if travelling distances.
- Monitoring needs to take place of any problems that are occurring with the implementation of the “Choose and Book” taking into account the point of view of staff and patients.
• Continued monitoring of what providers patients are going to – for instance whether choice is being skewed because of loyalty to a particular provider.

• Two patient/carer representatives at all levels of the NHS for instance on the PCT Board, the Strategic Health Authority, select committees, scrutiny committees and the oversight Committee.

**Reducing inequalities in health**

• Require interpreters to be booked for all consultations within primary and secondary care for non-English speaking patients.

• Resources provided to primary care to employ people to go through the choice options with them in an advocacy role, taking into account any other needs they may have such as carer responsibilities for a child or elderly person or any medical issues they may have. The same person could be involved in the discharge of that patient as well as providing continuity of care, ensuring that all the necessary services have been identified on admission such as the patients' home helps. The more deprived the ward where the surgery is the more intensive the resources to be allocated. That role would take the onus off the doctor.

• In NHS Centres – an individual available to organise “Choose and Book” for people who felt they could not organise an appointment themselves

• Need to run a course for would be patients and tell them all the questions they should be asking about “Choose and Book”.

• Support at point of choice for disadvantaged people such as those with communication difficulties. A pilot could be instigated in a general practice using specialist workers e.g. people able to communicate with ethnic minorities and understand their culture.

• To be fair to local people, a person’s first option has to be to go local. In 2008 you could go anywhere but if the patient was not local they would be further down the list. There would have to be quotas from certain areas.

• To avoid a postcode lottery, need targeted community education programmes, for disadvantaged people such as those with communication difficulties to explain that it is their right to choose between alternative providers. Could use local radio channels, television and local newspapers.

• Need good information, perhaps a leaflet campaign on how to make a choice in simple, plain English and in the main foreign languages spoken on Merseyside. This to be provided in a variety of venues: for instance schools, libraries, doctors surgeries, and chemists. Healthcare staff such as district nurses, practice nurses could talk it through with patients. Some information should be in large print format, simple pictorial language for people with a learning disability and British sign language. “Readspeaker” could be used on “Choose and Book” websites to help dyslexics or others with low literacy skills, a learning disability, with English as a second language, or the elderly with impaired vision. When the icon is clicked the text on the page or highlighted word is spoken. Coloured paper can be used to aid word perception for dyslexics.
• There needs to be a clearly defined advocate for people who have no capacity, or little capacity to deal with their own affairs. It would be helpful if there was some scrutiny that could be done on those advocates or family members to make sure that they are acting in the patients best interests.

• Feedback when the choice agenda is operational on where the monetary resources are going throughout the country.

• Ensure that choice of providers is local so it is easily accessible for people without their own transport.

• If the cost of travel is restricting access to services then free transport should be provided not just for the patient but the relatives of the elderly and the young and for other vulnerable groups.

• For the physical and mental well-being of the vulnerable and frail patient, where possible, hospital hotels should be developed to accommodate relatives, particularly of the young, old and the critically ill patients.

• Providers to take into account culturally specific needs such as availability of prayer mats, modesty gowns.

Aftercare

• Investment in primary care should go hand in hand with the expansion of elective care.

• Imperative that the information flow is good between the place where the elective service is and where the rehabilitation is being provided.

• Need to establish proper care pathways and links. Community support should be totally linked to elective care provider.

Manpower and training

• Cheshire and Merseyside Workforce Development Confederation will need to consider the impact on manpower and training of the choice agenda. Private providers will need to be included in the rotation of junior doctors.
### Appendix 1:

**Table 1: Key areas influencing health**

<table>
<thead>
<tr>
<th>Categories of influences on health</th>
<th>Examples of specific influences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological factors</td>
<td>age, sex, genetic factors</td>
</tr>
<tr>
<td>Personal / family circumstances and lifestyle</td>
<td>family structure and functioning, primary / secondary / adult education, occupation, income, risk taking behaviour, diet, smoking, alcohol, substance misuse, exercise, recreation, means of transport (cycle / car ownership)</td>
</tr>
<tr>
<td>Social environment</td>
<td>culture, peer pressures, discrimination, social support (neighbourliness, social networks / isolation), community /cultural / spiritual participation</td>
</tr>
<tr>
<td>Physical environment</td>
<td>air, water, housing conditions, working conditions, noise, smell, view, public safety, civic design, shops (location / range / quality), communications (road / rail), land use, waste disposal, energy, local environmental features</td>
</tr>
<tr>
<td>Public services</td>
<td>access to (location / disabled access) quality of primary /community /secondary health care, child care, social services, housing / leisure / employment / social security services, public transport, policing, other health-relevant public services, non-statutory agencies and services</td>
</tr>
<tr>
<td>Public policy</td>
<td>economic / social / environmental / health trends, local and national priorities, policies, programmes, projects</td>
</tr>
</tbody>
</table>
Key Informants

Interviewees:

Choice Manager
2 GPs Central Liverpool PCT
GP Everton
GP Sefton
Senior Manager, Ambulance Service
BMA Representative
Non-Executive member of PCT Board
Community Physiotherapist
Private Hospital (2 representatives)
Social Inclusion Unit
Translation Service

Focus Groups:

Public Health Professionals
Cardiothoracic Centre Service Users Group
Liverpool Choice Board
Patient Forum in Sefton
Patient Forum in Liverpool
Practice Nurses
Wirral Service Redesign Group
District Nurses
Local Authority Scrutiny Committee
Expert Patients
Patient Care Advisors

Contacts

The following were invited but were unable to participate in the HIA:

Director of Public Health
Senior Public Health Professional
Secondary Care Providers: NHS Consultants; Other private providers
PCT Chair
Social Services
Information Analysts
Planned Care Lead
Rehabilitation at home team
Refugee Action
Appendix 2:

Profile of health service provision in Merseyside, November 2005

1. PCTs
The 9 Primary Care Trusts across Merseyside (see Figure 3) are responsible for managing primary care services, providing community health care services and commissioning hospital services for their local population:

2. GPs
Figure 3 shows how many GP surgeries there are in each of the 9 Merseyside PCTs.

Figure 3: Number of GP surgeries in each PCT in Merseyside

<table>
<thead>
<tr>
<th>PCT</th>
<th>Number of GP Surgeries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bebington &amp; West Wirral</td>
<td>17</td>
</tr>
<tr>
<td>Birkenhead &amp; Wallasey</td>
<td>45</td>
</tr>
<tr>
<td>Central Liverpool</td>
<td>60</td>
</tr>
<tr>
<td>Knowsley</td>
<td>39</td>
</tr>
<tr>
<td>North Liverpool</td>
<td>24</td>
</tr>
<tr>
<td>South Liverpool</td>
<td>21</td>
</tr>
<tr>
<td>South Sefton</td>
<td>39</td>
</tr>
<tr>
<td>Southport &amp; Formby</td>
<td>19</td>
</tr>
<tr>
<td>St Helens</td>
<td>44</td>
</tr>
</tbody>
</table>

3. NHS Trusts

5 Boroughs Partnership NHS Trust: Hollins Park House, Warrington.

Aintree Hospitals NHS Trust: Aintree House, Fazakerley Hospital, Liverpool. Sites: Fazakerley Hospital, Walton Hospital. Note - the Walton Centre for Neurology and Neurosurgery NHS Trust is based at Fazakerley.

Cardiothoracic Centre – Liverpool NHS Trust: Liverpool.

Clatterbridge Centre for Oncology NHS Trust: Bebington, Wirral. Sites: Macclesfield General Hospital, Congleton War Memorial Hospital, Knutsford Community Hospital.

Liverpool Women’s NHS Foundation Trust: Crown Street, Liverpool.

Mersey Care NHS Trust: Princes Dock, Liverpool. Sites: Ashworth Hospital, Broadoak MH Unit, Mossley Hill Hospital, Rathbone Hospital, Scott Clinic, Windsor Clinic.

Mersey Regional Ambulance Service NHS Trust: Liverpool.

Royal Liverpool & Broadgreen University Hospitals NHS Trust: Sites: Broadgreen Hospital, Liverpool Dental Hospital, Royal Liverpool Hospital.
Royal Liverpool Children’s NHS Trust: Alder Hey Hospital, Liverpool.

Southport & Ormskirk Hospital NHS Trust: Southport. Sites: Ormskirk & District General Hospital, Southport & Formby District General Hospital.

St Helens & Knowsley Hospitals NHS Trust: Sites: Whiston Hospital, St Helens Hospital, Newton Community Hospital.

The Walton Centre for Neurology & Neurosurgery NHS Trust: Liverpool.

Wirral Hospital NHS Trust: Arrowe Park, Wirral.

4. NHS Walk-in Centres

NHS Walk-in Centres are nurse-led services which provide minor treatments, health information and self-help advice. No appointments are needed.

The Centres are open throughout the year from early in the morning to late in the evening 7 days per week. There are 5 in Merseyside (Liverpool City Centre; Liverpool Old Swan; St Helens; Wirral Arrowe Park; Wirral Victoria).

5. Treatment Centres

In Merseyside, there are 3 fully operational NHS Treatment Centres (Southport and Ormskirk, Clatterbridge, and Aintree). There is also one scheme under development (Royal Liverpool and Broadgreen). At present, there are no independent sector Treatment Centres on Merseyside (as at September 2005).

Treatment Centres may be housed in purpose-built facilities, innovative mobile units (currently for cataract surgery and MRI scanning and reporting) while others will use hospitals, refurbished to suit their needs. Some Treatment Centres are ‘virtual’ centres, making use of existing facilities in a new way, not necessarily all in the same location.

6. NHS Foundation Trusts

Liverpool Women’s Hospital is the only NHS Foundation Trust on Merseyside at present. Aintree Hospital is currently under consideration for foundation status.

7. Private Hospitals

There are seven private hospitals in and around the Merseyside area:

Lourdes Hospital, Liverpool

*Inpatient beds:* 51
*Number of consulting rooms:* 9 + ENT Suite
*Number of theatres:* 2 + Endoscopy
Abbey Sefton Hospital
situated within University Hospital Aintree, in Liverpool.

BUPA Murrayfield Hospital, Wirral.
*Inpatient beds:* 45  
*Outpatient beds:* 12  
*Number of consulting rooms:* 12  
*Number of theatres:* 3

Fairfield Hospital, nr. St.Helens
*Inpatient beds:* 43  
*Outpatient beds:* 4  
*Number of consulting rooms:* 9  
*Number of theatres:* 2

Capio Renacres Hospital, nr. Ormskirk
*Inpatient beds:* 30  
*Number of consulting rooms:* 6  
*Number of theatres:* 2

The Grosvenor Nuffield Hospital, Chester
*Inpatient beds:* 35 inc 2 beds in HDU  
*No of consulting rooms:* 7  
*No of theatres:* 2

BUPA North Cheshire Hospital, Warrington
*Inpatient beds:* 40  
*Outpatient beds:* 10  
*Number of consulting rooms:* 12  
*Number of theatres:* 3

Information sources:
*Information on private hospitals:* [http://www.privatehealth.co.uk](http://www.privatehealth.co.uk)  
*Other information obtained from Cheshire & Merseyside SHA website (http://www.cmha.nhs.uk/), and DoH website (http://www.dh.gov.uk/assetRoot/04/12/07/57/04120757.pdf).*
Population profile: Merseyside PCTs

Age/sex structure

Of all the Merseyside PCTs, Southport and Formby and Bebington and West Wirral PCTs have the highest proportion of retired residents 65 years and over (21.8% and 20.4% respectively) (Chart 1). Knowsley and North Liverpool PCTs have the highest percentage of children less than 15 years. For all Merseyside PCTs, under 16 year olds make up 20.7% of the total population; 62.7% are of working age and 16.7% are 65 and over (see Table 2 below for more details).

Chart 1: Age structure in PCTs

Table 2: Age structure of the Merseyside PCTs

<table>
<thead>
<tr>
<th>PCT</th>
<th>All Ages</th>
<th>Children 0-15 No. (%)</th>
<th>Children 0-15 No. (%)</th>
<th>Working age 16-64 No. (%)</th>
<th>Working age 16-64 No. (%)</th>
<th>Retired 65+ No. (%)</th>
<th>Retired 65+ No. (%)</th>
<th>Mean age of population</th>
<th>Median age of population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bebington &amp; West Wirral</td>
<td>121614</td>
<td>23322 (19.2)</td>
<td>73508 (60.4)</td>
<td>24784 (20.4)</td>
<td>41.9</td>
<td>36.8</td>
<td>36.8</td>
<td>36.8</td>
<td>35.0</td>
</tr>
<tr>
<td>Birkenhead &amp; Wallasey</td>
<td>190679</td>
<td>41226 (21.6)</td>
<td>117663 (61.7)</td>
<td>31790 (16.7)</td>
<td>38.7</td>
<td>39.7</td>
<td>39.7</td>
<td>39.7</td>
<td>39.0</td>
</tr>
<tr>
<td>Central Liverpool</td>
<td>233141</td>
<td>45304 (19.4)</td>
<td>154608 (66.3)</td>
<td>33229 (14.3)</td>
<td>36.6</td>
<td>36.6</td>
<td>36.6</td>
<td>36.6</td>
<td>34.0</td>
</tr>
<tr>
<td>Knowsley</td>
<td>150459</td>
<td>34517 (22.9)</td>
<td>93646 (62.2)</td>
<td>22296 (14.8)</td>
<td>37.0</td>
<td>37.0</td>
<td>37.0</td>
<td>37.0</td>
<td>36.0</td>
</tr>
<tr>
<td>North Liverpool</td>
<td>104986</td>
<td>23456 (22.3)</td>
<td>66197 (63.1)</td>
<td>15333 (14.6)</td>
<td>36.8</td>
<td>36.8</td>
<td>36.8</td>
<td>36.8</td>
<td>35.0</td>
</tr>
<tr>
<td>South Liverpool</td>
<td>101346</td>
<td>19745 (19.5)</td>
<td>63005 (62.2)</td>
<td>18596 (18.3)</td>
<td>39.7</td>
<td>39.7</td>
<td>39.7</td>
<td>39.7</td>
<td>39.0</td>
</tr>
<tr>
<td>South Sefton</td>
<td>167626</td>
<td>35995 (21.5)</td>
<td>103199 (61.6)</td>
<td>28432 (17)</td>
<td>38.9</td>
<td>38.9</td>
<td>38.9</td>
<td>38.9</td>
<td>39.0</td>
</tr>
<tr>
<td>Southport &amp; Formby</td>
<td>115332</td>
<td>21126 (18.3)</td>
<td>69098 (59.9)</td>
<td>25108 (21.8)</td>
<td>42.7</td>
<td>42.7</td>
<td>42.7</td>
<td>42.7</td>
<td>43.0</td>
</tr>
<tr>
<td>St Helens</td>
<td>176843</td>
<td>36597 (20.7)</td>
<td>112665 (63.7)</td>
<td>27581 (15.6)</td>
<td>38.7</td>
<td>38.7</td>
<td>38.7</td>
<td>38.7</td>
<td>38.0</td>
</tr>
<tr>
<td>Total</td>
<td>1362026</td>
<td>281273 (20.7)</td>
<td>853541 (62.7)</td>
<td>227149 (16.7)</td>
<td>38.0</td>
<td>38.0</td>
<td>38.0</td>
<td>38.0</td>
<td>38.0</td>
</tr>
</tbody>
</table>

Source: 2001 Census, ONS
The highest proportion of the population in Merseyside PCTs falls within the 25-44 age band. This age-band shows more females, which is sustained into the older age bands (Chart 2).

**Chart 2: Age sex distribution for all Merseyside PCTs**

![Chart 2: Age sex distribution for all Merseyside PCTs](image)

Source: 2001 Census, ONS

**Ethnic minority groups**

As Chart 3 illustrates, Central Liverpool has the highest proportion of residents belonging to ethnic minority groups in Merseyside (more detail in Table 3 below).

**Chart 3: Percentage of population in each ethnic minority group**

![Chart 3: Percentage of population in each ethnic minority group](image)

Source: 2001 Census, ONS
### Table 3: Percentage of population in each Ethnic Group

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Beb. &amp; West Wirral</th>
<th>Birkenhead &amp; Wallasey</th>
<th>Central L’pool</th>
<th>Knowsley</th>
<th>North L’pool</th>
<th>South L’pool</th>
<th>South Sefton</th>
<th>Southport &amp; Formby</th>
<th>St Helens</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>98.54</td>
<td>98.15</td>
<td>92.00</td>
<td>98.42</td>
<td>97.92</td>
<td>95.94</td>
<td>98.63</td>
<td>98.15</td>
<td>98.84</td>
</tr>
<tr>
<td>Of which White Irish</td>
<td>0.86</td>
<td>1.06</td>
<td>1.48</td>
<td>0.58</td>
<td>0.71</td>
<td>1.15</td>
<td>0.90</td>
<td>1.00</td>
<td>0.60</td>
</tr>
<tr>
<td>Mixed</td>
<td>0.52</td>
<td>0.60</td>
<td>2.46</td>
<td>0.83</td>
<td>0.68</td>
<td>1.42</td>
<td>0.53</td>
<td>0.61</td>
<td>0.38</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>0.38</td>
<td>0.45</td>
<td>1.48</td>
<td>0.24</td>
<td>0.36</td>
<td>0.98</td>
<td>0.35</td>
<td>0.57</td>
<td>0.38</td>
</tr>
<tr>
<td>Indian</td>
<td>0.22</td>
<td>0.19</td>
<td>0.52</td>
<td>0.15</td>
<td>0.16</td>
<td>0.53</td>
<td>0.18</td>
<td>0.27</td>
<td>0.23</td>
</tr>
<tr>
<td>Pakistani</td>
<td>0.04</td>
<td>0.03</td>
<td>0.30</td>
<td>0.05</td>
<td>0.11</td>
<td>0.23</td>
<td>0.06</td>
<td>0.08</td>
<td>0.06</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>0.03</td>
<td>0.17</td>
<td>0.21</td>
<td>0.01</td>
<td>0.02</td>
<td>0.04</td>
<td>0.05</td>
<td>0.15</td>
<td>0.04</td>
</tr>
<tr>
<td>Other Asian</td>
<td>0.09</td>
<td>0.06</td>
<td>0.45</td>
<td>0.03</td>
<td>0.07</td>
<td>0.18</td>
<td>0.06</td>
<td>0.07</td>
<td>0.05</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>0.14</td>
<td>0.20</td>
<td>1.95</td>
<td>0.22</td>
<td>0.27</td>
<td>0.54</td>
<td>0.13</td>
<td>0.20</td>
<td>0.09</td>
</tr>
<tr>
<td>Caribbean</td>
<td>0.05</td>
<td>0.06</td>
<td>0.38</td>
<td>0.08</td>
<td>0.06</td>
<td>0.14</td>
<td>0.04</td>
<td>0.09</td>
<td>0.03</td>
</tr>
<tr>
<td>African</td>
<td>0.07</td>
<td>0.09</td>
<td>1.14</td>
<td>0.08</td>
<td>0.15</td>
<td>0.26</td>
<td>0.06</td>
<td>0.09</td>
<td>0.04</td>
</tr>
<tr>
<td>Other Black</td>
<td>0.02</td>
<td>0.05</td>
<td>0.43</td>
<td>0.06</td>
<td>0.06</td>
<td>0.14</td>
<td>0.03</td>
<td>0.02</td>
<td>0.02</td>
</tr>
<tr>
<td>Chinese or Other Ethnic Group</td>
<td>0.43</td>
<td>0.60</td>
<td>2.11</td>
<td>0.30</td>
<td>0.77</td>
<td>1.11</td>
<td>0.37</td>
<td>0.48</td>
<td>0.31</td>
</tr>
</tbody>
</table>

Source: 2001 Census, ONS
Car or van ownership

Bebington and West Wirral PCT and Southport and Formby PCT have the highest percentage of households with one or more cars and vans (Chart 4 and Table 4). Central Liverpool has the lowest percentage of car and van ownership on Merseyside, followed by North Liverpool. Central Liverpool PCT also has the highest number of full-time students, as shown in Table 5, which may partly explain the low number of car owners.

Table 4: Percentage of Cars or Vans per households

<table>
<thead>
<tr>
<th>PCT</th>
<th>Number of HHs</th>
<th>none</th>
<th>One</th>
<th>two</th>
<th>three</th>
<th>four or more</th>
<th>Number of cars or vans in the area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bebington &amp; Wirral</td>
<td>50816</td>
<td>20.19</td>
<td>44.96</td>
<td>28.28</td>
<td>5.30</td>
<td>1.27</td>
<td>62468</td>
</tr>
<tr>
<td>Birkenhead &amp; Wallasey</td>
<td>82529</td>
<td>36.60</td>
<td>43.90</td>
<td>16.26</td>
<td>2.56</td>
<td>0.68</td>
<td>71868</td>
</tr>
<tr>
<td>Central Liverpool</td>
<td>100585</td>
<td>51.66</td>
<td>36.36</td>
<td>10.09</td>
<td>1.47</td>
<td>0.42</td>
<td>63161</td>
</tr>
<tr>
<td>Knowsley</td>
<td>60553</td>
<td>41.76</td>
<td>40.87</td>
<td>14.77</td>
<td>2.10</td>
<td>0.50</td>
<td>47773</td>
</tr>
<tr>
<td>North Liverpool</td>
<td>44034</td>
<td>49.63</td>
<td>39.09</td>
<td>9.89</td>
<td>1.16</td>
<td>0.23</td>
<td>27896</td>
</tr>
<tr>
<td>South Liverpool</td>
<td>43246</td>
<td>39.03</td>
<td>41.55</td>
<td>16.11</td>
<td>2.56</td>
<td>0.74</td>
<td>36649</td>
</tr>
<tr>
<td>South Sefton</td>
<td>67891</td>
<td>35.68</td>
<td>43.12</td>
<td>17.6</td>
<td>2.98</td>
<td>0.62</td>
<td>61090</td>
</tr>
<tr>
<td>Southport &amp; Formby</td>
<td>48956</td>
<td>24.50</td>
<td>45.34</td>
<td>24.77</td>
<td>4.24</td>
<td>1.15</td>
<td>55164</td>
</tr>
<tr>
<td>St Helens</td>
<td>72697</td>
<td>30.48</td>
<td>43.34</td>
<td>21.50</td>
<td>3.76</td>
<td>0.92</td>
<td>73871</td>
</tr>
</tbody>
</table>

Source: 2001 Census, ONS
Socio-economic classification

Table 4 is based on the National Statistics Socio-economic Classification [NS SEC]. This has been developed to replace social class and socio economic group. In the [NS SEC] all full-time students are recorded in the 'full-time students' category regardless of whether they are economically active or not.

Of the PCTs on Merseyside, Bebington and West Wirral has the highest percentage of residents between in the managerial and professional occupations (31.2%), followed by Southport and Formby (28.8%). North Liverpool PCT has the lowest percentage in these occupations (14.9%).

Within North Liverpool PCT, nearly a quarter of the population (24.5%) are employed within semi-routine and routine occupations. This is the highest proportion for all Merseyside PCTs.

Table 5: Socio-economic classification

<table>
<thead>
<tr>
<th>PCT</th>
<th>Percentage of people aged 16-74</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Higher managerial/</td>
</tr>
<tr>
<td></td>
<td>Higher professional occupations</td>
</tr>
<tr>
<td></td>
<td>Lower managerial &amp;</td>
</tr>
<tr>
<td></td>
<td>professional occupations</td>
</tr>
<tr>
<td></td>
<td>Intermediate occupations</td>
</tr>
<tr>
<td></td>
<td>Small employers &amp; own account</td>
</tr>
<tr>
<td></td>
<td>workers</td>
</tr>
<tr>
<td>Bebington &amp; West</td>
<td>9.95</td>
</tr>
<tr>
<td>Wirral</td>
<td>21.22</td>
</tr>
<tr>
<td>Birkenhead &amp;</td>
<td>5.31</td>
</tr>
<tr>
<td>Wallasey</td>
<td>14.94</td>
</tr>
<tr>
<td>Central Liverpool</td>
<td>5.09</td>
</tr>
<tr>
<td>Knowsley</td>
<td>13.06</td>
</tr>
<tr>
<td>North Liverpool</td>
<td>3.24</td>
</tr>
<tr>
<td>South Liverpool</td>
<td>7.39</td>
</tr>
<tr>
<td>South Sefton</td>
<td>5.29</td>
</tr>
<tr>
<td>Southport &amp;</td>
<td>8.16</td>
</tr>
<tr>
<td>Formby</td>
<td>20.67</td>
</tr>
<tr>
<td>St Helens</td>
<td>5.20</td>
</tr>
<tr>
<td></td>
<td>15.70</td>
</tr>
<tr>
<td></td>
<td>8.86</td>
</tr>
<tr>
<td></td>
<td>4.72</td>
</tr>
<tr>
<td></td>
<td>Lower supervisory</td>
</tr>
<tr>
<td></td>
<td>and technical occupations</td>
</tr>
<tr>
<td></td>
<td>Semi-routine occupations</td>
</tr>
<tr>
<td></td>
<td>Routine occupations</td>
</tr>
<tr>
<td></td>
<td>Full-time students**</td>
</tr>
<tr>
<td>Bebington &amp; West</td>
<td>6.74</td>
</tr>
<tr>
<td>Wirral</td>
<td>9.86</td>
</tr>
<tr>
<td>Birkenhead &amp;</td>
<td>7.69</td>
</tr>
<tr>
<td>Wallasey</td>
<td>13.71</td>
</tr>
<tr>
<td>Central Liverpool</td>
<td>5.16</td>
</tr>
<tr>
<td>Knowsley</td>
<td>10.41</td>
</tr>
<tr>
<td>North Liverpool</td>
<td>7.00</td>
</tr>
<tr>
<td>South Liverpool</td>
<td>13.39</td>
</tr>
<tr>
<td>South Sefton</td>
<td>6.75</td>
</tr>
<tr>
<td>Southport &amp;</td>
<td>10.37</td>
</tr>
<tr>
<td>Formby</td>
<td>6.47</td>
</tr>
<tr>
<td></td>
<td>11.52</td>
</tr>
<tr>
<td>St Helens</td>
<td>5.93</td>
</tr>
<tr>
<td></td>
<td>11.16</td>
</tr>
<tr>
<td></td>
<td>6.07</td>
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<td></td>
<td>5.92</td>
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<td>7.82</td>
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<tr>
<td></td>
<td>12.82</td>
</tr>
<tr>
<td></td>
<td>11.62</td>
</tr>
<tr>
<td></td>
<td>5.65</td>
</tr>
</tbody>
</table>

**A full-time student is a person of any age who has indicated that they were a schoolchild or student in full-time education. 
Source: 2001 Census, ONS
Unemployment

As illustrated in Chart 5, North Liverpool PCT has the highest percentage of people who are unemployed (6.79%). Table 6 shows that North Liverpool also has the highest proportions of people who are long-term unemployed (2.67%); economically inactive through being permanently sick or disabled (13.01%) and unemployed aged 16-24 (31.41%). Central Liverpool PCT has the highest proportion having never worked (6.57%). Bebington and West Wirral and Southport and Formby PCTs have the highest percentage of unemployed aged 50 and over (26.9% and 24% respectively), but the lowest proportions of unemployed (2.8% and 3% respectively) (Chart 5 and Table 6).

Table 6: Unemployment

<table>
<thead>
<tr>
<th>PCT</th>
<th>Unemployed</th>
<th>% of unemployed Aged 16 - 24</th>
<th>% of unemployed Aged 50 &amp; over</th>
<th>Long-term unemployed*</th>
<th>Never worked</th>
<th>Economically inactive: Permanently sick/disabled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bebington &amp; West Wirral</td>
<td>2.83</td>
<td>23.81</td>
<td>26.96</td>
<td>0.90</td>
<td>1.54</td>
<td>5.73</td>
</tr>
<tr>
<td>Birkenhead &amp; Wallasey</td>
<td>5.21</td>
<td>26.77</td>
<td>18.38</td>
<td>1.92</td>
<td>3.86</td>
<td>10.64</td>
</tr>
<tr>
<td>Central Liverpool</td>
<td>6.12</td>
<td>28.87</td>
<td>14.79</td>
<td>2.46</td>
<td>6.57</td>
<td>11.41</td>
</tr>
<tr>
<td>Knowsley</td>
<td>5.87</td>
<td>30.41</td>
<td>13.92</td>
<td>2.24</td>
<td>6.02</td>
<td>12.15</td>
</tr>
<tr>
<td>North Liverpool</td>
<td>6.79</td>
<td>31.95</td>
<td>13.36</td>
<td>2.67</td>
<td>6.10</td>
<td>13.01</td>
</tr>
<tr>
<td>South Liverpool</td>
<td>5.08</td>
<td>29.81</td>
<td>16.77</td>
<td>1.99</td>
<td>4.45</td>
<td>9.86</td>
</tr>
<tr>
<td>South Sefton</td>
<td>4.58</td>
<td>27.18</td>
<td>16.40</td>
<td>1.73</td>
<td>3.41</td>
<td>9.40</td>
</tr>
<tr>
<td>Southport &amp; Formby</td>
<td>3.04</td>
<td>22.69</td>
<td>24.30</td>
<td>1.00</td>
<td>1.73</td>
<td>6.26</td>
</tr>
<tr>
<td>St Helens</td>
<td>4.15</td>
<td>26.77</td>
<td>18.45</td>
<td>1.52</td>
<td>3.11</td>
<td>10.09</td>
</tr>
</tbody>
</table>

*For Long-term unemployed; year last worked is 1999 or earlier.
Source: 2001 Census, ONS
Chart 5: Percentage of people unemployed

<table>
<thead>
<tr>
<th>Location</th>
<th>Unemployment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wirral</td>
<td>2.83</td>
</tr>
<tr>
<td>Bebington &amp; Wirral</td>
<td>5.21</td>
</tr>
<tr>
<td>Birkenhead &amp; Wallasey</td>
<td>6.12</td>
</tr>
<tr>
<td>Central Liverpool</td>
<td>5.87</td>
</tr>
<tr>
<td>Knowsley</td>
<td>6.79</td>
</tr>
<tr>
<td>North Liverpool</td>
<td>5.08</td>
</tr>
<tr>
<td>South Liverpool</td>
<td>4.58</td>
</tr>
<tr>
<td>South Port &amp; Formby</td>
<td>3.04</td>
</tr>
<tr>
<td>St Helens</td>
<td>4.15</td>
</tr>
</tbody>
</table>

Source: 2001 Census, ONS

Qualifications

Qualification levels in the 2001 census are as follows:
- Level 1: 1+ ‘O’ level passes, 1+ CSE/GCSE any grades, NVQ level 1, Foundation GNVQ
- Level 2: 5+ ‘O’ level passes, 5+ CSEs (grade 1). 5+ GCSEs (grades A-C), School Certificate, 1+’A’ levels/ AS levels, NVQ level 2, Intermediate GNVQ
- Level 3: 2+ ‘A’ levels, 4+ AS levels, Higher School Certificate, NVQ level 3, Advanced GNVQ
- Level 4/5: First degree, Higher degree, NVQ levels 4 and 5, HNC, HND, Qualified Teacher status, Qualified Medical Doctor, Qualified Dentist, Qualified Nurse, Midwife, Health Visitor.

North Liverpool PCT and Knowsley PCT have the highest proportion of residents with no qualification (Chart 6). These PCTs also have the lowest proportion of residents with Level 4/5 qualifications.
**Chart 6: Percentage of residents aged 16-74 with highest qualification obtained**

<table>
<thead>
<tr>
<th></th>
<th>Bebington and West Wirral</th>
<th>Birkenhead and Wallasey</th>
<th>Central Liverpool</th>
<th>Knowsley</th>
<th>North Liverpool</th>
<th>South Liverpool</th>
<th>South Sefton</th>
<th>Southport and Formby</th>
<th>St Helens</th>
</tr>
</thead>
<tbody>
<tr>
<td>No qualifications</td>
<td>22.71</td>
<td>33.68</td>
<td>36.62</td>
<td>43</td>
<td>44.26</td>
<td>34.04</td>
<td>34.53</td>
<td>25.72</td>
<td>35.36</td>
</tr>
<tr>
<td>Level 1</td>
<td>15.75</td>
<td>17.66</td>
<td>13.32</td>
<td>16.76</td>
<td>17.38</td>
<td>14.38</td>
<td>17.84</td>
<td>16.53</td>
<td>17.21</td>
</tr>
<tr>
<td>Level 2</td>
<td>22.09</td>
<td>20.91</td>
<td>15.5</td>
<td>17.89</td>
<td>17.72</td>
<td>17.06</td>
<td>20.1</td>
<td>21.6</td>
<td>19.57</td>
</tr>
<tr>
<td>Level 3</td>
<td>7.95</td>
<td>6.91</td>
<td>12.95</td>
<td>5.93</td>
<td>6.16</td>
<td>8.93</td>
<td>7.08</td>
<td>7.7</td>
<td>6.12</td>
</tr>
</tbody>
</table>

Source: 2001 Census, ONS

**General health**

Even though Bebington and West Wirral PCT and Southport and Formby PCT have a higher percentage of older residents (Chart 1), they have the lowest percentage of households with one or more persons with a limiting long-term illness (Chart 7). North Liverpool and Knowsley PCTs have the highest proportion within this category (47.3% and 46.7% respectively).
Chart 7: Percentage of households with one or more person with a limiting long-term illness

As Chart 8 shows, most people described themselves as having good health, however more people did so in Bebington and West Wirral PCT and more people in North Liverpool PCT described their health as not good.

Chart 8: Perception of General Health

Lone Parents
Female lone parents greatly outnumber male lone parents (Chart 9). For every male lone parent there are thirteen lone female parents.
In all PCTs, male lone parents are more likely to be in full-time employment than female lone parents (Chart 10). Conversely, female lone parents are more likely to be employed part-time. Lone parents living in the PCTs of Bebington and West Wirral and Southport and Formby are more likely to be in employment. The highest number of lone parent households is in Central Liverpool PCT (Appendix Table E). However, as a percentage of the total number of households in a PCT the highest percentage of lone parent households are found in North Liverpool (13.2%) followed by Knowsley (11.8%) and Central Liverpool (11.7%).
Indices of multiple deprivation

The Indices of Deprivation 2004 (ID 2004) have been constructed by the Social Disadvantage Research Centre at the University of Oxford on behalf of the Office of the Deputy Prime Minister ODPM.

There are seven domains, each in turn based upon a range of indicators. Each domain measures different aspects of multiple deprivation, which make up the overall Index of Multiple Deprivation 2004:

- Income deprivation;
- Employment deprivation;
- Health deprivation and disability;
- Education, skills and training deprivation;
- Barriers to Housing and Services;
- Living environment deprivation and
- Crime.

There are more details of how the ID is constructed in Note 1 of the Appendix.

Chart 11 shows that North Liverpool has the highest scores for four out of seven domains and the multiple deprivation index. Central Liverpool PCT, closely followed by North Liverpool PCT, has the highest scores for the health domain. Knowsley scores the highest on ‘barriers to housing and services’. Bebington and West Wirral is the least deprived PCT on Merseyside followed by Southport and Formby.
Life expectancy

Life expectancy at birth (2000-2002) is highest in Bebington and West Wirral PCT and lowest in North Liverpool and Central Liverpool PCTs (Chart 12). The average life expectancy for residents of Bebington and West Wirral PCT is over four and a half years longer than the North Liverpool PCT average for males and females.

*Deprivation*: For all PCTs, life expectancy for males and IMD score has a significant correlation coefficient ($r_s = -0.88$, p <0.01). Life expectancy at birth for females and IMD score has a highly significant correlation coefficient: ($r_s = -0.97$, p <0.001). (See Note 2 in Appendix for explanation of r value).
Chart 12: Life Expectancy at Birth 2000-2002

<table>
<thead>
<tr>
<th>PCT Name</th>
<th>Observed deaths</th>
<th>Expected deaths</th>
<th>SMR</th>
<th>SMRLL</th>
<th>SMRUL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bebington &amp; West Wirral</td>
<td>7360</td>
<td>7914</td>
<td>93</td>
<td>90.89</td>
<td>95.15</td>
</tr>
<tr>
<td>Southport &amp; Formby</td>
<td>8463</td>
<td>8136</td>
<td>104.02</td>
<td>101.81</td>
<td>106.26</td>
</tr>
<tr>
<td>North Liverpool</td>
<td>6010</td>
<td>4549</td>
<td>132.11</td>
<td>128.79</td>
<td>135.49</td>
</tr>
<tr>
<td>Birkenhead &amp; Wallasey</td>
<td>12035</td>
<td>10163</td>
<td>118.42</td>
<td>116.31</td>
<td>120.55</td>
</tr>
<tr>
<td>Central Liverpool</td>
<td>13899</td>
<td>10380</td>
<td>133.91</td>
<td>131.69</td>
<td>136.15</td>
</tr>
<tr>
<td>South Liverpool</td>
<td>6626</td>
<td>5807</td>
<td>114.11</td>
<td>111.38</td>
<td>116.89</td>
</tr>
<tr>
<td>St Helens</td>
<td>9679</td>
<td>8493</td>
<td>113.96</td>
<td>111.7</td>
<td>116.26</td>
</tr>
<tr>
<td>Knowsley</td>
<td>7943</td>
<td>6336</td>
<td>125.36</td>
<td>122.62</td>
<td>128.15</td>
</tr>
<tr>
<td>South Sefton</td>
<td>9504</td>
<td>8608</td>
<td>110.41</td>
<td>108.2</td>
<td>112.65</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics, Small area data base 2004

Mortality

Standardised mortality ratios (SMRs) for the following tables are based on five years’ deaths data applied to population counts from the 2001 national census (see Note 3 in Appendix for explanation of SMR calculations and confidence intervals).

All causes

In Table 7, the all cause SMR for Bebington and West Wirral was 7% less than the standard for England and Wales. All other PCTs were above the standard.

Deprivation: SMRs for all cause mortality correlated with the multiple deprivation index (IMD) scores for PCTs, showing a strong positive linear relationship ($r_s = 0.97$, $p<0.001$). Therefore there was a positive association, but not necessarily a causal one, between these two variables: the higher the level of multiple deprivation the higher the SMR.

Table 7: Mortality from all causes - persons, all ages 1998 - 2002

<table>
<thead>
<tr>
<th>PCT Name</th>
<th>Observed deaths</th>
<th>Expected deaths</th>
<th>SMR</th>
<th>SMRLL</th>
<th>SMRUL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bebington &amp; West Wirral</td>
<td>7360</td>
<td>7914</td>
<td>93</td>
<td>90.89</td>
<td>95.15</td>
</tr>
<tr>
<td>Southport &amp; Formby</td>
<td>8463</td>
<td>8136</td>
<td>104.02</td>
<td>101.81</td>
<td>106.26</td>
</tr>
<tr>
<td>North Liverpool</td>
<td>6010</td>
<td>4549</td>
<td>132.11</td>
<td>128.79</td>
<td>135.49</td>
</tr>
<tr>
<td>Birkenhead &amp; Wallasey</td>
<td>12035</td>
<td>10163</td>
<td>118.42</td>
<td>116.31</td>
<td>120.55</td>
</tr>
<tr>
<td>Central Liverpool</td>
<td>13899</td>
<td>10380</td>
<td>133.91</td>
<td>131.69</td>
<td>136.15</td>
</tr>
<tr>
<td>South Liverpool</td>
<td>6626</td>
<td>5807</td>
<td>114.11</td>
<td>111.38</td>
<td>116.89</td>
</tr>
<tr>
<td>St Helens</td>
<td>9679</td>
<td>8493</td>
<td>113.96</td>
<td>111.7</td>
<td>116.26</td>
</tr>
<tr>
<td>Knowsley</td>
<td>7943</td>
<td>6336</td>
<td>125.36</td>
<td>122.62</td>
<td>128.15</td>
</tr>
<tr>
<td>South Sefton</td>
<td>9504</td>
<td>8608</td>
<td>110.41</td>
<td>108.2</td>
<td>112.65</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics, Small area data base 2004

All cancers

Table 8 includes deaths from all cancers, and other related conditions (ICD10 C00-D48, equivalent to ICD9 140-239). A reduction in mortality rates for persons under 75 due to cancer is a target indicator in the ‘Saving Lives: Our Healthier Nation’ strategy. Bebington and West Wirral PCT and Southport and Formby PCT had
SMRs below the standard for England and Wales, however the confidence levels, as expressed in the last two columns of the table, fall below and above the standard for England and Wales. Therefore, the true SMR may be above or below the standard. All the other PCTs have SMRs significantly higher than England and Wales. The SMR for North Liverpool PCT was just over 50% higher than the standard population, followed by Central Liverpool PCT, with an SMR of 141.

**Deprivation:** A highly statistically significant association was found between IMD scores for PCTs and their SMRs for cancer deaths in persons under 75 years. ($r_s=0.91$, p<0.001)

### Table 8: Mortality from cancers, persons, <75 1998 - 2002

<table>
<thead>
<tr>
<th>PCT Name</th>
<th>Observed deaths</th>
<th>Expected deaths</th>
<th>SMR</th>
<th>SMRLL</th>
<th>SMRUL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bebington &amp; West Wirral</td>
<td>508</td>
<td>528</td>
<td>96.16</td>
<td>87.97</td>
<td>104.89</td>
</tr>
<tr>
<td>Southport &amp; Formby</td>
<td>508</td>
<td>509</td>
<td>99.86</td>
<td>91.37</td>
<td>108.94</td>
</tr>
<tr>
<td>North Liverpool</td>
<td>563</td>
<td>374</td>
<td>150.46</td>
<td>138.29</td>
<td>163.42</td>
</tr>
<tr>
<td>Birkenhead &amp; Wallasey</td>
<td>930</td>
<td>710</td>
<td>130.92</td>
<td>122.64</td>
<td>139.61</td>
</tr>
<tr>
<td>Central Liverpool</td>
<td>1143</td>
<td>808</td>
<td>141.47</td>
<td>133.39</td>
<td>149.92</td>
</tr>
<tr>
<td>South Liverpool</td>
<td>464</td>
<td>400</td>
<td>115.98</td>
<td>105.67</td>
<td>127.03</td>
</tr>
<tr>
<td>St Helens</td>
<td>799</td>
<td>692</td>
<td>115.51</td>
<td>107.64</td>
<td>123.8</td>
</tr>
<tr>
<td>Knowsley</td>
<td>735</td>
<td>548</td>
<td>134.03</td>
<td>124.51</td>
<td>144.08</td>
</tr>
<tr>
<td>South Sefton</td>
<td>811</td>
<td>650</td>
<td>124.82</td>
<td>116.38</td>
<td>133.72</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics, Small area data base 2004

**Lung cancer**

Table 9 shows SMRs for lung cancer. North Liverpool PCT had an extremely high SMR of 219 (95% confidence interval of 197 – 243). When this was broken down for males and females, the male SMR was 196 (Cl: 170-225); and the female SMR was 257 (Cl: 218-301) (Charts 13 & 14).

**Deprivation:** The correlation coefficient for lung cancer and IMD was highly significant ($r_s=0.96$, 0.001). For males, the coefficient was $r_s = 0.91$, (p <0.001); and for females, $r_s = 0.95$ (p < 0.001).
Table 9: Mortality from lung cancer, <75 1998 - 2002

<table>
<thead>
<tr>
<th>PCT Name</th>
<th>Observed deaths</th>
<th>Expected deaths</th>
<th>SMR</th>
<th>SMRLL</th>
<th>SMRUL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bebington &amp; West Wirral</td>
<td>226</td>
<td>234</td>
<td>96.42</td>
<td>84.26</td>
<td>109.85</td>
</tr>
<tr>
<td>Southport &amp; Formby</td>
<td>220</td>
<td>227</td>
<td>97.04</td>
<td>84.64</td>
<td>110.75</td>
</tr>
<tr>
<td>North Liverpool</td>
<td>354</td>
<td>161</td>
<td>219.3</td>
<td>197.05</td>
<td>243.38</td>
</tr>
<tr>
<td>Birkenhead &amp; Wallasey</td>
<td>521</td>
<td>312</td>
<td>167.17</td>
<td>153.13</td>
<td>182.17</td>
</tr>
<tr>
<td>Central Liverpool</td>
<td>648</td>
<td>346</td>
<td>187.45</td>
<td>173.29</td>
<td>202.45</td>
</tr>
<tr>
<td>South Liverpool</td>
<td>255</td>
<td>176</td>
<td>144.68</td>
<td>127.47</td>
<td>163.57</td>
</tr>
<tr>
<td>St Helens</td>
<td>366</td>
<td>297</td>
<td>123.04</td>
<td>110.76</td>
<td>136.32</td>
</tr>
<tr>
<td>Knowsley</td>
<td>434</td>
<td>242</td>
<td>178.98</td>
<td>162.54</td>
<td>196.64</td>
</tr>
<tr>
<td>South Sefton</td>
<td>414</td>
<td>289</td>
<td>143.15</td>
<td>129.69</td>
<td>157.63</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics, Small area data base 2004


Source: ONS, Small area data base, 1998-2002
A Health Development Agency study found that in England, the area with the highest proportion of smoking-related deaths was North Liverpool PCT, where 43% of deaths in people over 35 were due to smoking (Table 10). This was followed by Knowsley PCT, which was ranked 2nd in the country.

Table 10: Proportions of smoking related deaths amongst ages 35+

<table>
<thead>
<tr>
<th>Ranked (England)</th>
<th>PCT</th>
<th>male</th>
<th>female</th>
<th>persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>North Liverpool</td>
<td>47</td>
<td>40</td>
<td>43</td>
</tr>
<tr>
<td>2</td>
<td>Knowsley</td>
<td>47</td>
<td>37</td>
<td>42</td>
</tr>
<tr>
<td>6</td>
<td>Central Liverpool</td>
<td>45</td>
<td>34</td>
<td>40</td>
</tr>
<tr>
<td>33</td>
<td>St Helens</td>
<td>42</td>
<td>30</td>
<td>36</td>
</tr>
<tr>
<td>35</td>
<td>South Sefton</td>
<td>42</td>
<td>30</td>
<td>36</td>
</tr>
<tr>
<td>40</td>
<td>Birkenhead and Wallasey</td>
<td>42</td>
<td>30</td>
<td>36</td>
</tr>
<tr>
<td>59</td>
<td>South Liverpool</td>
<td>40</td>
<td>29</td>
<td>34</td>
</tr>
<tr>
<td>216</td>
<td>Bebington and West Wirral</td>
<td>34</td>
<td>22</td>
<td>28</td>
</tr>
<tr>
<td>257</td>
<td>Southport and Formby</td>
<td>34</td>
<td>21</td>
<td>27</td>
</tr>
</tbody>
</table>

Source: HDA 2004

Colorectal, prostate and breast cancer

For colorectal cancer, all 9 Merseyside PCTs had SMRs above the standard for England and Wales. In 4 PCTs, SMRs were significantly higher (Table 11). There were no significant differences between the 9 Merseyside PCTs and England and Wales in mortality from prostate or breast cancer (Tables 7 and 8).

Deprivation: There was no significant relationship between IMD and mortality from colorectal cancer ($r_s = -0.1$); prostate cancer ($r_s = 0.55$); or breast cancer ($r_s = -0.43$).
Table 11: Mortality from colorectal cancer, Aged <75 years all persons, 1998 - 2002

<table>
<thead>
<tr>
<th>PCT Name</th>
<th>Observed deaths</th>
<th>Expected deaths</th>
<th>SMR</th>
<th>SMRLL</th>
<th>SMRUL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bebington and West Wirral</td>
<td>100</td>
<td>97</td>
<td>103.05</td>
<td>83.84</td>
<td>125.33</td>
</tr>
<tr>
<td>Southport and Formby</td>
<td>129</td>
<td>94</td>
<td>137.68</td>
<td>114.95</td>
<td>163.6</td>
</tr>
<tr>
<td>North Liverpool</td>
<td>80</td>
<td>67</td>
<td>119.14</td>
<td>94.47</td>
<td>148.28</td>
</tr>
<tr>
<td>Birkenhead and Wallasey</td>
<td>160</td>
<td>130</td>
<td>123.42</td>
<td>105.03</td>
<td>144.09</td>
</tr>
<tr>
<td>Central Liverpool</td>
<td>177</td>
<td>144</td>
<td>123.07</td>
<td>105.6</td>
<td>142.59</td>
</tr>
<tr>
<td>South Liverpool</td>
<td>78</td>
<td>73</td>
<td>106.31</td>
<td>84.43</td>
<td>133.3</td>
</tr>
<tr>
<td>St Helens</td>
<td>134</td>
<td>124</td>
<td>108.33</td>
<td>86.62</td>
<td>135.25</td>
</tr>
<tr>
<td>Knowsley</td>
<td>107</td>
<td>101</td>
<td>106.07</td>
<td>86.93</td>
<td>128.18</td>
</tr>
<tr>
<td>South Sefton</td>
<td>156</td>
<td>120</td>
<td>129.85</td>
<td>110.27</td>
<td>151.9</td>
</tr>
</tbody>
</table>

Table 12: Mortality from prostate cancer, males aged <75, 1998 - 2002

<table>
<thead>
<tr>
<th>PCT Name</th>
<th>Observed deaths</th>
<th>Expected deaths</th>
<th>SMR</th>
<th>SMRLL</th>
<th>SMRUL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bebington and West Wirral</td>
<td>36</td>
<td>38</td>
<td>94.6</td>
<td>66.26</td>
<td>130.97</td>
</tr>
<tr>
<td>Southport and Formby</td>
<td>35</td>
<td>37</td>
<td>93.97</td>
<td>65.45</td>
<td>130.69</td>
</tr>
<tr>
<td>North Liverpool</td>
<td>30</td>
<td>27</td>
<td>112.03</td>
<td>75.62</td>
<td>159.99</td>
</tr>
<tr>
<td>Birkenhead and Wallasey</td>
<td>56</td>
<td>50</td>
<td>112.05</td>
<td>84.64</td>
<td>145.51</td>
</tr>
<tr>
<td>Central Liverpool</td>
<td>64</td>
<td>57</td>
<td>111.84</td>
<td>86.13</td>
<td>142.82</td>
</tr>
<tr>
<td>South Liverpool</td>
<td>31</td>
<td>29</td>
<td>106.5</td>
<td>72.36</td>
<td>151.17</td>
</tr>
<tr>
<td>St Helens</td>
<td>46</td>
<td>48</td>
<td>95.82</td>
<td>70.15</td>
<td>127.81</td>
</tr>
<tr>
<td>Knowsley</td>
<td>34</td>
<td>39</td>
<td>86.5</td>
<td>59.9</td>
<td>120.87</td>
</tr>
<tr>
<td>South Sefton</td>
<td>45</td>
<td>46</td>
<td>96.94</td>
<td>70.71</td>
<td>129.71</td>
</tr>
</tbody>
</table>

Table 13: Mortality from breast cancer, females aged <75, 1998 - 2002

<table>
<thead>
<tr>
<th>PCT Name</th>
<th>Observed deaths</th>
<th>Expected deaths</th>
<th>SMR</th>
<th>SMRLL</th>
<th>SMRUL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bebington and West Wirral</td>
<td>104</td>
<td>93</td>
<td>111.73</td>
<td>91.29</td>
<td>135.38</td>
</tr>
<tr>
<td>Southport and Formby</td>
<td>99</td>
<td>89</td>
<td>111.32</td>
<td>90.47</td>
<td>135.53</td>
</tr>
<tr>
<td>North Liverpool</td>
<td>69</td>
<td>65</td>
<td>106.87</td>
<td>83.15</td>
<td>135.25</td>
</tr>
<tr>
<td>Birkenhead and Wallasey</td>
<td>144</td>
<td>127</td>
<td>113.8</td>
<td>95.97</td>
<td>133.98</td>
</tr>
<tr>
<td>Central Liverpool</td>
<td>140</td>
<td>137</td>
<td>102.35</td>
<td>86.1</td>
<td>120.78</td>
</tr>
<tr>
<td>South Liverpool</td>
<td>63</td>
<td>69</td>
<td>90.98</td>
<td>69.91</td>
<td>116.4</td>
</tr>
<tr>
<td>St Helens</td>
<td>132</td>
<td>119</td>
<td>111.02</td>
<td>92.89</td>
<td>131.65</td>
</tr>
<tr>
<td>Knowsley</td>
<td>80</td>
<td>99</td>
<td>81.2</td>
<td>64.39</td>
<td>101.06</td>
</tr>
<tr>
<td>South Sefton</td>
<td>102</td>
<td>117</td>
<td>86.91</td>
<td>70.86</td>
<td>105.5</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics, Small area data base 2004

**Circulatory diseases**

Circulatory diseases include coronary heart disease (CHD), stroke, and other related conditions (ICD10 I00-I99, equivalent to ICD9 390-459). A reduction in mortality rates for persons under 75 due to circulatory diseases is a target indicator in the ‘Saving Lives: Our Healthier Nation’ strategy.¹⁸⁵
All but two PCTs, (the two least deprived), had significantly excess deaths compared to the national standard. In Central Liverpool PCT there was a raised SMR of 156 and in North Liverpool PCT an SMR of 147 (Table 14).

**Deprivation**: There was a significant relationship between SMRs for circulatory disease and IMD ($r_s = 0.87$, $p<0.01$).

Table 14: Mortality from circulatory diseases, persons, <75 1998 - 2002

<table>
<thead>
<tr>
<th>PCT Name</th>
<th>Observed deaths</th>
<th>Expected deaths</th>
<th>SMR</th>
<th>SMRLL</th>
<th>SMRUL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bebington &amp; West Wirral</td>
<td>754</td>
<td>912</td>
<td>82.68</td>
<td>76.88</td>
<td>88.8</td>
</tr>
<tr>
<td>Southport &amp; Formby</td>
<td>878</td>
<td>883</td>
<td>99.48</td>
<td>93.01</td>
<td>106.29</td>
</tr>
<tr>
<td>North Liverpool</td>
<td>931</td>
<td>635</td>
<td>146.55</td>
<td>137.28</td>
<td>156.27</td>
</tr>
<tr>
<td>Birkenhead &amp; Wallasey</td>
<td>1449</td>
<td>1219</td>
<td>118.91</td>
<td>112.86</td>
<td>125.19</td>
</tr>
<tr>
<td>Central Liverpool</td>
<td>2116</td>
<td>1357</td>
<td>155.88</td>
<td>149.31</td>
<td>162.67</td>
</tr>
<tr>
<td>South Liverpool</td>
<td>794</td>
<td>693</td>
<td>114.64</td>
<td>106.81</td>
<td>122.9</td>
</tr>
<tr>
<td>St Helens</td>
<td>1432</td>
<td>1154</td>
<td>124.06</td>
<td>117.71</td>
<td>130.65</td>
</tr>
<tr>
<td>Knowsley</td>
<td>1273</td>
<td>953</td>
<td>133.58</td>
<td>126.34</td>
<td>141.12</td>
</tr>
<tr>
<td>South Sefton</td>
<td>1311</td>
<td>1130</td>
<td>116.04</td>
<td>109.85</td>
<td>122.5</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics, Small area data base 2004

**Coronary heart disease**

SMRs for CHD were higher than England and Wales in all but one of the nine Merseyside PCTs, and significantly higher in seven PCTs (Table 15).

**Deprivation**: There was a significant correlation between CHD SMRs and IMD: ($r_s = 0.85$, $p < 0.01$).

Table 15: Mortality from CHD, <75 1998 - 2002

<table>
<thead>
<tr>
<th>PCT Name</th>
<th>Observed deaths</th>
<th>Expected deaths</th>
<th>SMR</th>
<th>SMRLL</th>
<th>SMRUL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bebington &amp; West Wirral</td>
<td>431</td>
<td>556</td>
<td>77.56</td>
<td>70.41</td>
<td>85.24</td>
</tr>
<tr>
<td>Southport &amp; Formby</td>
<td>544</td>
<td>537</td>
<td>101.21</td>
<td>92.88</td>
<td>110.09</td>
</tr>
<tr>
<td>North Liverpool</td>
<td>585</td>
<td>386</td>
<td>151.65</td>
<td>139.61</td>
<td>164.46</td>
</tr>
<tr>
<td>Birkenhead &amp; Wallasey</td>
<td>872</td>
<td>741</td>
<td>117.69</td>
<td>110</td>
<td>125.76</td>
</tr>
<tr>
<td>Central Liverpool</td>
<td>1333</td>
<td>825</td>
<td>161.51</td>
<td>152.96</td>
<td>170.42</td>
</tr>
<tr>
<td>South Liverpool</td>
<td>487</td>
<td>421</td>
<td>115.78</td>
<td>105.72</td>
<td>126.53</td>
</tr>
<tr>
<td>St Helens</td>
<td>923</td>
<td>705</td>
<td>130.84</td>
<td>122.54</td>
<td>139.56</td>
</tr>
<tr>
<td>Knowsley</td>
<td>841</td>
<td>578</td>
<td>145.61</td>
<td>135.94</td>
<td>155.8</td>
</tr>
<tr>
<td>South Sefton</td>
<td>863</td>
<td>686</td>
<td>125.77</td>
<td>117.51</td>
<td>134.44</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics, Small area data base 2004

**Stroke**

SMRs for stroke were higher than England and Wales in all but one PCT, and significantly higher in four PCTs (16).

**Deprivation**: There was a strong correlation with IMD: ($r_s = 0.93$, $p<0.001$)
### Table 16: Mortality from stroke, aged <75 all persons, 1998 - 2002

<table>
<thead>
<tr>
<th>PCT Name</th>
<th>Observed deaths</th>
<th>Expected deaths</th>
<th>SMR</th>
<th>SMRLL</th>
<th>SMRUL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bebington and West Wirral</td>
<td>156</td>
<td>170</td>
<td>91.53</td>
<td>77.73</td>
<td>107.07</td>
</tr>
<tr>
<td>Southport and Formby</td>
<td>167</td>
<td>165</td>
<td>101.1</td>
<td>86.35</td>
<td>117.65</td>
</tr>
<tr>
<td>North Liverpool</td>
<td>166</td>
<td>119</td>
<td>139.86</td>
<td>119.39</td>
<td>162.82</td>
</tr>
<tr>
<td>Birkenhead and Wallasey</td>
<td>302</td>
<td>228</td>
<td>132.57</td>
<td>118.04</td>
<td>148.4</td>
</tr>
<tr>
<td>Central Liverpool</td>
<td>399</td>
<td>252</td>
<td>158.03</td>
<td>142.9</td>
<td>174.32</td>
</tr>
<tr>
<td>South Liverpool</td>
<td>149</td>
<td>130</td>
<td>114.66</td>
<td>96.99</td>
<td>134.62</td>
</tr>
<tr>
<td>St Helens</td>
<td>239</td>
<td>213</td>
<td>112.04</td>
<td>98.29</td>
<td>127.18</td>
</tr>
<tr>
<td>Knowsley</td>
<td>223</td>
<td>179</td>
<td>124.52</td>
<td>108.71</td>
<td>141.98</td>
</tr>
<tr>
<td>South Sefton</td>
<td>225</td>
<td>212</td>
<td>106.22</td>
<td>92.79</td>
<td>121.04</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics, Small area data base 2004

### Respiratory disease

Table 17 shows that SMRs for respiratory disease were significantly higher in seven of the nine Merseyside PCTs.

### Deprivation

There was a very strong relationship with IMD, with $r_s = 0.98$ ($p < 0.001$)

### Table 17: Mortality from respiratory disease, aged <75 all persons, 1998 - 2002

<table>
<thead>
<tr>
<th>PCT Name</th>
<th>Observed deaths</th>
<th>Expected deaths</th>
<th>SMR</th>
<th>SMRLL</th>
<th>SMRUL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bebington and West Wirral</td>
<td>212</td>
<td>266</td>
<td>79.6</td>
<td>69.25</td>
<td>91.07</td>
</tr>
<tr>
<td>Southport and Formby</td>
<td>216</td>
<td>259</td>
<td>83.46</td>
<td>72.7</td>
<td>95.36</td>
</tr>
<tr>
<td>North Liverpool</td>
<td>349</td>
<td>186</td>
<td>187.82</td>
<td>168.63</td>
<td>208.6</td>
</tr>
<tr>
<td>Birkenhead and Wallasey</td>
<td>524</td>
<td>355</td>
<td>147.47</td>
<td>135.11</td>
<td>160.66</td>
</tr>
<tr>
<td>Central Liverpool</td>
<td>738</td>
<td>396</td>
<td>186.53</td>
<td>173.31</td>
<td>200.49</td>
</tr>
<tr>
<td>South Liverpool</td>
<td>289</td>
<td>203</td>
<td>142.03</td>
<td>126.13</td>
<td>159.39</td>
</tr>
<tr>
<td>St Helens</td>
<td>463</td>
<td>333</td>
<td>139.1</td>
<td>126.71</td>
<td>152.36</td>
</tr>
<tr>
<td>Knowsley</td>
<td>496</td>
<td>280</td>
<td>177.03</td>
<td>161.79</td>
<td>193.31</td>
</tr>
<tr>
<td>South Sefton</td>
<td>373</td>
<td>331</td>
<td>112.74</td>
<td>101.59</td>
<td>124.79</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics, Small area data base 2004

### Accidents and poisoning

SMRs for accidents and poisoning in the nine Merseyside PCTs were all higher than in England and Wales, and significantly higher in seven PCTs (Table 18).
Table 18: Mortality from accidents and poisoning, all ages 1998 - 2002

<table>
<thead>
<tr>
<th>PCT Name</th>
<th>Observed deaths</th>
<th>Expected deaths</th>
<th>SMR</th>
<th>SMRLL</th>
<th>SMRUL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bebington &amp; West Wirral</td>
<td>115</td>
<td>108</td>
<td>106.79</td>
<td>88.17</td>
<td>128.19</td>
</tr>
<tr>
<td>Southport &amp; Formby</td>
<td>173</td>
<td>109</td>
<td>159.2</td>
<td>136.36</td>
<td>184.77</td>
</tr>
<tr>
<td>North Liverpool</td>
<td>118</td>
<td>74</td>
<td>159.98</td>
<td>132.42</td>
<td>191.58</td>
</tr>
<tr>
<td>Birkenhead &amp; Wallasey</td>
<td>230</td>
<td>150</td>
<td>152.96</td>
<td>133.83</td>
<td>174.06</td>
</tr>
<tr>
<td>Central Liverpool</td>
<td>265</td>
<td>172</td>
<td>153.82</td>
<td>135.86</td>
<td>173.5</td>
</tr>
<tr>
<td>South Liverpool</td>
<td>119</td>
<td>84</td>
<td>141.38</td>
<td>117.12</td>
<td>169.18</td>
</tr>
<tr>
<td>St Helens</td>
<td>256</td>
<td>131</td>
<td>195.13</td>
<td>171.96</td>
<td>220.56</td>
</tr>
<tr>
<td>Knowsley</td>
<td>169</td>
<td>102</td>
<td>165.79</td>
<td>141.73</td>
<td>192.75</td>
</tr>
<tr>
<td>South Sefton</td>
<td>143</td>
<td>128</td>
<td>111.74</td>
<td>94.17</td>
<td>131.63</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics, Small area data base 2004

Deprivation: There was no significant relationship between accidents and poisoning and IMD ($r_s=0.45$).

For all the above, p values are 2 sided, and uncorrected for multiple comparisons (see Appendix Note 4).
Summary of population profile

In Merseyside, North Liverpool, Knowlsey and Central Liverpool PCTs each tend to have more of the characteristics associated with deprivation and poor health. They are the top three ranked PCTs in Merseyside in the Index of Multiple Deprivation (IMD).

In Merseyside, **North Liverpool** has the highest proportions of:
- unemployment;
- long-term unemployed;
- people who perceive their health as ‘not good’;
- highest scores in 4 of the 7 deprivation domains, and the IMD.

**North Liverpool and Knowsley PCTs** have the highest proportions of:
- young unemployed;
- economically inactive due to permanent sickness or disability;
- people with no qualifications;
- households with long-term limiting illness;
- lone-parent households;
- population aged under 15;
- highest IMD scores (also Central Liverpool);
- smoking deaths (in England as well).

And **North Liverpool** has the lowest proportions of:
- people in managerial/professional occupations;
- people with level 4/5 qualifications (also low in Knowsley);
- and the lowest life expectancy (also low in Central Liverpool).

**Central Liverpool** has the largest proportion of residents from ethnic minorities; the highest proportion of people who have never worked; the highest number of lone-parent households; and the lowest car and van ownership on Merseyside.

**Bebington & West Wirral and Southport & Formby** are the least deprived PCTs. They have the highest proportions of:
- retired people;
- people with one or more car/van;
- people in managerial/professional occupations;
- unemployed aged 50+;
- highest proportions of people who perceive their health as ‘good’;
- highest life expectancy.

The same two PCTs have the lowest proportions of:
- unemployed;
- households with limiting long-term illness;
- and by far the lowest IMD scores.
The summary mortality table (Table 14) shows that North Liverpool, Central Liverpool and Knowsley PCTs had consistently high SMRs for most of the main causes of death.

**Table 19: Summary table: Mortality in Merseyside PCTs**

<table>
<thead>
<tr>
<th>SMR</th>
<th>PCTs with SMR below national average</th>
<th>PCTs with highest SMRs</th>
</tr>
</thead>
<tbody>
<tr>
<td>All causes</td>
<td>Bebington &amp; West Wirral</td>
<td>North Liverpool, Central Liverpool, Knowsley</td>
</tr>
<tr>
<td>All cancers</td>
<td>Bebington &amp; West Wirral, Southport &amp; Formby</td>
<td>North Liverpool, Central Liverpool, Knowsley</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>Bebington &amp; West Wirral, Southport &amp; Formby</td>
<td>North Liverpool, Central Liverpool, Knowsley</td>
</tr>
<tr>
<td>Colorectal cancer</td>
<td>none</td>
<td>Southport &amp; Formby, South Sefton</td>
</tr>
<tr>
<td>Prostate cancer</td>
<td>Bebington &amp; West Wirral, Southport &amp; Formby</td>
<td>North Liverpool, Birkenhead &amp; Wallasey, Southport &amp; Formby, South Sefton, St. Helens</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>none</td>
<td>Birkenhead &amp; Wallasey, Southport &amp; Formby, South Sefton, St. Helens</td>
</tr>
<tr>
<td>Circulatory disease</td>
<td>Bebington &amp; West Wirral, Southport &amp; Formby</td>
<td>Central Liverpool, North Liverpool, Knowsley</td>
</tr>
<tr>
<td>CHD</td>
<td>Bebington &amp; West Wirral</td>
<td>North Liverpool, Central Liverpool, Knowsley</td>
</tr>
<tr>
<td>Stroke</td>
<td>Bebington &amp; West Wirral</td>
<td>Central Liverpool, North Liverpool, Birkenhead &amp; Wallasey</td>
</tr>
<tr>
<td>Respiratory disease</td>
<td>Bebington &amp; West Wirral, Southport &amp; Formby</td>
<td>North Liverpool, Central Liverpool, Knowsley</td>
</tr>
<tr>
<td>Accident &amp; poisoning</td>
<td>none</td>
<td>St. Helens, Knowsley, North Liverpool</td>
</tr>
</tbody>
</table>

There were strong links between mortality and deprivation in conditions associated with circulatory and lung diseases (Table 15). There was also a strong correlation between IMD and life expectancy ($r_s$=-0.88, p<0.01 for males; $r_s$=-0.97, p<0.001 for females).

**Table 20: Summary table: Links with deprivation**

<table>
<thead>
<tr>
<th>Significantly strong correlation between IMD and SMR ($r_s$) (p&lt;0.01)</th>
<th>No strong correlation Between IMD and SMR</th>
</tr>
</thead>
<tbody>
<tr>
<td>All cause (0.97)</td>
<td>Colorectal cancer</td>
</tr>
<tr>
<td>All cancers (0.91)</td>
<td>Prostate cancer</td>
</tr>
<tr>
<td>Lung cancer (0.96)</td>
<td>Breast cancer</td>
</tr>
<tr>
<td>Circulatory disease (0.87)</td>
<td>Accidents and poisoning</td>
</tr>
<tr>
<td>CHD (0.85)</td>
<td></td>
</tr>
<tr>
<td>Stroke (0.93)</td>
<td></td>
</tr>
<tr>
<td>Respiratory disease (0.98)</td>
<td></td>
</tr>
</tbody>
</table>
Note 1
The Indices of Deprivation 2004 (ID 2004) have been constructed by the Social Disadvantage Research Centre at the University of Oxford on behalf of the Office of the Deputy Prime Minister ODPM.

The geography used is the lower level Super Output Area. These areas are based on groupings of Census Output Areas (typically 5) and represent approximately a minimum population of 1000 with a mean population of 1500. The boundaries are constrained to the wards used for 2001 Census.

There are seven domains, each in turn based upon a range of indicators. Each domain measures different aspects of multiple deprivation, which make up the overall Index of Multiple Deprivation 2004:

- **Income** – captures the proportion of the population experiencing income deprivation in an area, such as adults and children in income and support households.
  Includes two sub domains - the Income Deprivation Affecting Children Index (IDAC) 2004 and the Income Deprivation Affecting Older People Index (IDAOP) 2004
- **Employment** – measures employment deprivation conceptualised as involuntary exclusion of the working age population from the world of work.
- **Health Deprivation and Disability** – identifies areas with relatively high rates of people who die prematurely or whose quality of life is impaired by poor health or who are disabled.
- **Education, Skills and Training** – captures the extent of deprivation in terms of education, skills and training in a local area.
- **Barriers to Housing and Services** – this measures barriers to housing and key local services. Includes issues relating to access to housing, such as affordability and distance from services such as GP, supermarket etc.
- **Crime and Disorder** – Measures the incidence of recorded crime.
- **Living Environment** – focuses on deprivation with respect to the characteristics of the living environment such as quality of housing, air quality and road traffic accidents.

There are two additional indices - the Income Deprivation Affecting Children Index (IDAC) 2004 and the Income Deprivation Affecting Older People Index (IDAOP) 2004.

The Index of Multiple Deprivation 2004 (IMD 2004) is a measure of multiple deprivation at the small area level. The model of multiple deprivation, which underpins the IMD 2004 is based on the idea of distinct dimensions of deprivation which can be recognised and measured separately. These are experienced by individuals living in an area. People may be counted in one or more of the domains, depending on the number of types of deprivation that they experience. The overall IMD is conceptualised as a weighted area level aggregation of these specific dimensions of deprivation. Summary measures of the IMD 2004 for Merseyside PCTs are produced below.
Note 2

$r$ value (correlation coefficient):
A measure of the degree to which two variables have a linear relationship. The $r$ value can vary between +1 and –1. When $r= +1$ there is a perfect positive linear relationship, that is one variable directly increases as the other increases. When $r= -1$ there is a perfect negative linear relationship, that is one variable directly decreases as the other increases. When $r= 0$ there is no linear relationship between the two variables.

Note 3

Standardised mortality ratios (SMRs) for the tables are based on five year’s deaths data applied to population counts from the 2001 national census. The actual number of deaths (in the second column) for each PCT is compared to the number of deaths that would have been expected in that PCT, if its population had conformed to England and Wales age and sex specific death rates. The comparison is expressed as a ratio, where the ratio for England and Wales as a whole is 100. A ratio of 150 means that there were 50% more deaths than were expected. Conversely a ratio of 50 means that there were only half the expected number of deaths. The calculated SMR is an estimate; the true value is likely to fall within the 95% confidence interval for the SMR (indicated by the limits SMRLL and SMRUL). The confidence interval is a range of values that is normally used to describe the uncertainty around the standardised mortality rate. Therefore confidence intervals are a measure of the variability in the data. Generally speaking, confidence intervals describe how much different the SMR could have been if the underlying conditions stayed the same, but chance had led to a different set of data. Confidence intervals are calculated with a stated probability in this case 95%. Therefore, there is a 95% chance that the confidence interval covers the true value.

Note 4

Multiple comparisons.

A number of multiple comparisons have been used above (e.g. different causes of death and their relationship with deprivation). Multiple comparisons are associated with an excessive risk of false positive interferences (type I error), having a significant result happen by chance. For example, if using a $p$ value (probability/significance level) of 0.05 or 5% one in twenty tests could be significant purely by chance. Or put simply “if you torture the data enough it will confess!”. Significance level is the probability of making a type 1 error.

To correct for a type I error, Bonferroni correction can be used. The idea is that if one were conducting $n$ significance tests, then to get an over-all type I error of $ι$, one would only declare any one of them significant if the $p$ value was less than $ι/n$. Thus the $p$ value divided by the number of tests carried out.

$n$ (independent tests)
Probability that none of tests significant = $0.95^n$
Therefore the probability that > or = 1 significant is $1-0.95^n$. 
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