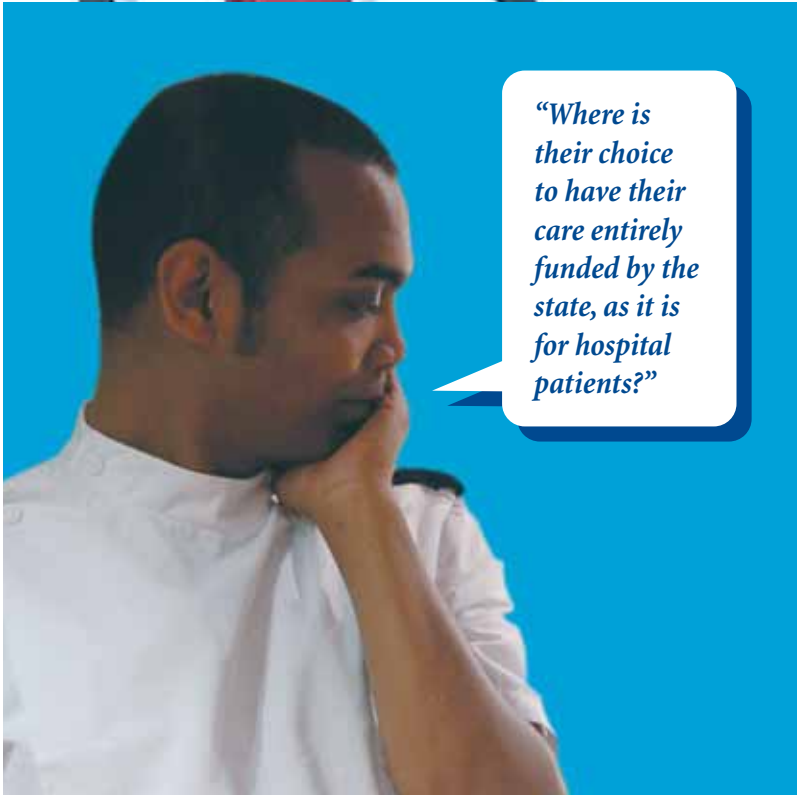




*“In the social care environment there remains no choice.”*



*“Changing the health choices people make is more complicated than simply educating them about healthy and unhealthy lifestyles.”*



*“Where is their choice to have their care entirely funded by the state, as it is for hospital patients?”*



*“Where is the choice to design packages of care according to individual needs?”*

# Real choice in the health service

**An RCN discussion document**



Royal College  
of Nursing

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## Introduction

As nurses, we know that the principles of individual, holistic, patient-centred care and patient choice and empowerment inform what thousands of us do, every single working day. We are in no doubt that the patient is at the centre of nursing practice and nursing theory.

So why are nurses and the RCN cautious about the introduction of the Government's Choice agenda? Because it appears that only a limited form of patient choice is being introduced with the aim of creating a *market* in the National Health Service (NHS). For example, Health Secretary John Reid says that if patients don't choose to use their local hospital, this will be an incentive for that hospital to improve its services. But what if the hospital is unable to improve quickly, will Mr Reid allow it to go bust, leaving an area without easily accessible health services? Conversely, why can't a group of patients *choose* to have a health centre providing a range of services located in the heart of their community?

This publication unpicks what some of the key issues will be for nurses, and the patients in their care, as the Government's Choice initiative is rolled out. It presents a challenge to all of us to begin to think about the implications of this policy on the future funding and delivery of health care services in the NHS over the next few years.

### Why enter the debate?

The Choice initiative is a key policy in the Government's NHS modernisation agenda, and the central plank of public services reform. But what does *choice* for the NHS really mean?

At RCN Congress 2003, members passed a resolution calling on the RCN to reject the creeping privatisation of the NHS. There was no doubt from the tone of the debate that nurses' representatives at Congress were uneasy about the pace of change and the lack of public discussion.

The RCN Policy Unit took forward this Congress resolution and undertook to provide members with opportunities for debate, to supply informative briefings and to create a new RCN policy position that addressed members' concerns about the pace and direction of the modernisation agenda. We have talked to RCN members in workshops and other collaborative events to review the issues, including public-patient involvement, so inextricably linked to the Choice agenda.

Since Congress 2003, the RCN has also responded formally on choice, consumerism and the *marketisation* of health care to the English Department of Health and the Public Administration Select Committee.

During this time there have been other significant changes in the structure of health and social care services. These include the setting up of foundation trusts, independent sector treatment centres (ISTCs), and reforms of mental health and learning disability services. All these have put extending and improving patient choice even more firmly at the centre of the debate.

### This publication

This publication consists of four essays from the RCN Policy Unit and Professional Nursing Department. They examine some of the key issues for nurses and patients as the Government rolls out its Choice initiative. The essays challenge us all to think through the implications of the policy for the way a national health service is funded and delivered.

The essays are not intended to be exhaustive accounts of the debate. Each stands alone, connected by their theme. They represent current RCN thinking on the issues of choice and consumerism, and pull the debate back to the reality of nurses' experience by highlighting the issues brought to our attention by our members.

### Your response

You are invited to respond to this issues raised in some or all of the essays. We'd like to hear your views and the experiences of your colleagues. We want to find out how choice and consumerism really works in practice in the NHS.

You can respond to us by:

- visiting the RCN Discussion Zone online at [www.rcn.org.uk/members/dz/](http://www.rcn.org.uk/members/dz/)
- emailing the Policy Unit at [choice@rcn.org.uk](mailto:choice@rcn.org.uk)
- writing to the Policy Unit, The Real Choice Debate, 20 Cavendish Square, London W1G 0RN
- joining us at the Policy Unit Fringe Event at Congress 2005 (for details see Congress brochure).

We look forward to joining in the Real Choice debate with you!

**Howard Catton**  
RCN Head of Policy Development and Implementation

# Patients, clients, citizens or consumers?

**Tim Curry, RCN South East Regional Officer and Policy Adviser**

## Public expectation

The language and behaviour of Government gives us no doubt that reform in public services, particularly the NHS, is a matter of do or die:

“Public services can either be renewed, which is what we want, or dismantled, which is what parts of the right want, but they will not stay with public support unreformed,” according to the Prime Minister in 2004.

The need for reform is not in question; society has moved on dramatically from the 1950s consensus, away from one idea of welfare to another, in quite startling fashion. While some sections of our society appear committed to maintaining the status quo, the majority are unwilling to be dictated to or patronised by providers of their health and social care services.

One of the architects of New Labour public service reform, Alan Milburn, was unambiguous in his defence of the reform agenda: “We are in a consumer age whether people like it or not. What will destroy the public services is the idea that you can retain the ethos of the 1940s in the 21st century.”

Faced with a new generation of consumers with rising demands and expectations, the Government has described choice as the cornerstone of the reform of public services (Reid, 2004). However, while we must surely welcome choice over what we receive in health and social care services, we must also be clear that this is not a straightforward matter, nor one without cost.

Public expectation is a very powerful agent for change and one could view the use of the word *choice* as a clever, if somewhat cynical, move on the part of the Government – a move that promises much to an impatient electorate, but which is sufficiently broad to allow for negotiation and limitation. More choice is hard to argue against!

## A consumer market place?

People clearly want choice in many aspects of their life – home, leisure, work, goods and services. In order to enter a market for services or goods, you need clear and timely information, the ability to take your money elsewhere, and the ability to express a clear preference. However, health care is not like buying shoes, or purchasing any other service (Dixon, 2004).

As far as the NHS is concerned, it is not hard to see how some areas of NHS reform such as the IT strategy, funding flow reform and foundation trusts are clearly tied into the notion of mobility, information and purchasing power for patients. The Government has also made much of the ability to choose the *location* in which you receive your treatment and how such choices will deliver a new partnership in care. Anything than genuinely extends choice and involvement for patients should be welcomed.

But in responding to the reform of public services, we must be careful not to miss other points of this reform or other features of choice. Real choice is not simply about giving patients choices

over where they receive their treatment. The current policy shift could also be considered as abandoning the traditional model of welfare in favour of a relationship with the state that is based on consumerism, aimed at a population whose political preferences are thought by policy makers to be revealed mostly by economic decisions. In essence, it would seem the Government wants public services to be provided more like privately supplied goods. By overlaying a market-based mechanism – choice – they believe people will gain more control over their lives.

The opposing view suggests that good public services foster a sense of community through collective provision of services, and in that sense help define the nature of the community itself. To abandon the idea of collective provision of services, and with it any notion of solidarity, is to abandon an element of community living. An element that should be supported through genuine involvement and power sharing, not undermined through individualism and consumerism.

## Listening to patients

The RCN believes that the public want personal *relationships* with the services they receive, not just personalised services. People want a sense that they have real influence over the nature of the care they receive. This relationship is at the core of nursing, and nurses have always been aware of this dynamic and have often called for more time to care for and make contact with the public they serve.

Delivering health and social care is not simply about an individual relationship with a consumer, but an activity that connects with individuals, couples, families, communities, schools and workplaces. To treat this as merely a buyer-seller relationship is to characterise caring as a crude exchange of currency between self interested parties – this is not what nurses believe and experience every day.

If we are to genuinely enhance the patient experience, the RCN believes that we need to spend much more energy in improving, delivering and evaluating strategies to raise the voice of patients in every area of the service. Have we really embedded an effective patient voice in service delivery and redesign? Have disenfranchised people in society been given the due concern and consideration to equip them for a new consumerist relationship with providers? This would have the added benefit of enhancing patient involvement before a further shift in the relationship between users and providers occurs.

## Conclusion

The RCN considers that the *real choice debate* should concern how we provide genuine patient choice over a range of safe, effective and accessible local services, delivered by appropriately qualified health care professionals, regardless of patients' ability to pay.

The current presentation of choice seems to suggest that choices are unlimited – but the RCN believes there should be more honesty in the public debate about the limitations of choice. We have repeatedly pointed out that unconstrained choice in a constrained health and social care budget is undeliverable. Where decisions are made to provide services, resources should continue to follow increased expectations for delivery.

If your response to this is ‘so what?’, then consider the relationship between buyers and sellers – is this a good place to take the nurse-patient relationship? Is it sophisticated enough to

allow compassion, empathy, supported decision-making and care? When was the last time you felt like revealing your deepest fears to the checkout assistant in the supermarket? When was the last time that a poor purchasing decision cost you your health?

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Rt Hon Tony Blair's speech to the Institute for Public Policy Research August 2004 for an example of the Prime Minister's belief system. [www.pm.gov.uk](http://www.pm.gov.uk)

## Health choices

### Jane Naish, RCN Policy Adviser

#### Introduction

Recent Government initiatives and the direction of the debate about choice in health have primarily focused on health *services*: the *what*, *where* and *by whom* factors in choosing health care. However, those aspects do not easily transfer to making choices about *health* itself, and particularly choice in public health. This paper outlines some of the tensions between choice of health care and choice in public health.

#### Health as a commodity

Some aspects of health care can be defined in terms of a commodity or package, with a definite beginning and end for provision and treatment, for example, hip replacement, cataract removal or hysterectomy. Health status and public health are much more complex concepts. They are formed from a number of factors, many of which are outside the remit of the health service, such as a person's socio-economic status, level of educational attainment and the location of their home. These factors are known to inter-relate and impact on health status at both individual and population level. They contribute directly to inequalities in health between sections of the population. For instance, mortality rates: workers classified as unskilled have a mortality rate three times higher than workers classified as professionals. Choice in health and public health cannot therefore be defined in simple terms as a commodity or episode of care.

## Exercising choice in health

For an individual to *exercise* choice about their health is also more complex than exercising choice over health care. Health status is shaped by a range of factors, some of which are outside the direct control of individuals. For example, the socio-economic status of the family into which an individual is born has a relationship with, and subsequent impact on, geographical location, nursery and school education, transport and leisure facilities, and so on. All these in turn impact on the health status of families and the future health status of their children as adults.

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*“Changing the health choices people make is more complicated than simply educating them about healthy and unhealthy lifestyles.”*

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Individuals, of course, have free will to make healthy choices and can exercise choice in areas such as smoking, diet, exercise and sexual activity. Socio-economic status and other social risk factors do not necessarily determine individual health destiny. But there is a significant body of evidence that suggests that health behaviour is shaped by social and environmental circumstances, and changing the health choices people make is more complicated than simply educating them about healthy and unhealthy lifestyles.

## Individual choice and public benefit

There is a third dimension to choice and public health. This is the relationship between individual choice, public benefit and improved population health, and those who work in public health who must balance individual rights and choices with the greater public health benefit. For example, some legislation affecting public health is accepted and not controversial, such as making it compulsory for people to wear car seat belts. Other legislation may be seen to impact on individual rights, for example, proposals to fluoridate domestic water supplies. Some people feel fluoridation interferes with their right to drink unfluoridated water, despite evidence that shows it has a beneficial effect on population health.

Inequalities in health are another factor. To compensate for health inequalities, health services may be targeted or made more accessible or appropriate to sections of the population most likely to have poorer health and greater health needs than others. This principle is not generally contested (although that may be because the public are not widely aware of it), but in practice consequent provision of services will affect choices some individuals are able to make. For example, the *Surestart* programme for mothers with children under five operates strictly in areas that have high deprivation indices. This means that people who live outside those areas, who may well also be in poor circumstances, cannot access the programme or exercise their choice to attend or not attend it.

There is a stark question underlying the decisions about individual choice and public benefit. It is how far, and by what means should health services and practitioners restrict, penalise or reward health choices made by individuals in the pursuit of

improved population health? Also, how far should individual health and lifestyle choices then relate to access for health care and health treatment? The recent media debate has highlighted the issue. Some commentators have suggested that there should be restrictions on treatment for cardio-vascular disease for smokers. In practice, some health services are already restricted because of individual lifestyle. For example, patients with alcoholism who do not give up drinking are not candidates for liver transplants.

## Conclusion

We need a robust and honest debate between health practitioners, patients and the public about the meaning of choice in health and public health. How does individual choice relate to social circumstances and public benefit? Should lines be drawn where lifestyle choices and access to health care are concerned, and if so, where?

Evidence suggests that in health practice, a community development approach to working with local communities can make a real difference to health and influence health choices. This is not about working with individuals or telling people what they should do. It is about partnerships with local communities to find practical solutions to local problems that impact on health and provide support for the decisions that they make.

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*“How far, and by what means should health services and practitioners restrict, penalise or reward health choices made by individuals in the pursuit of improved population health?”*

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# Choice and nursing practice in services for people with learning disabilities

Colin Beacock, RCN Policy Adviser

## Introduction

How vital is choice in services for people with learning disabilities? It is so vital that it is one of the key factors, along with rights, independence and inclusion, in the English White Paper on the future of these services (DH, 2000). The Scottish Executive's review of the practice of registered nurses for people with learning disabilities (RNLD), and their nursing colleagues, has said that their future contribution must:

*"...foster a culture of choice and collaborative working with children and adults with learning disabilities, their carers and other agencies and services involved with their care and support."* (NHS Scotland, 2002)

## Service developments

A policy of maximising choice is not new in services for people with learning disabilities, but has become a central theme in all four UK countries over the last 20 years.

During this period, services have moved forward with great speed. A service that was almost entirely centred on NHS hospitals has become a diverse, community-based service, provided by a range of agencies in the state, independent and voluntary sectors. In some ways nursing practice has led the development of improved systems of health care for people with learning disabilities.

## Disenfranchised groups

One group of people, however, has been in danger of missing out on these exciting and principled developments. These are the men and women whose learning disability is further complicated by behaviour that is identified as *difficult to manage*, and who may pose a danger to themselves or others. Many people in this group have found themselves in secure services, often still a part of the NHS. The dilemma for the nurses, and multidisciplinary teams who care for them is how to maximise choice in the confines and restrictions of a secure service.

Person-centred planning is the basis for the future development of services, and is an aspirational format for individualised models of care. In these models the service user and their wishes form the central pillar on which the service rests and quality measured. They are models of care that promote choice as a driving force for sustained change. It is a real challenge to provide a level of engagement in the care process, and a degree of choice, for individuals whose primary wish is probably to be anywhere but in the service. But it is this very dynamic that provides the key for those nurses who act as facilitators of choice and engagement.

## Choice as an agent of change

Choice is a vehicle through which the service user can elect to participate in their own development, rehabilitation and social inclusion. The challenge for nurses is to develop a range of options within the limitations of the service through constantly challenging the boundaries of possibility. This can be achieved through advocacy and change agent behaviours. It requires nurses to extend their practice beyond clinical and direct care skills, to embrace the role of champion in promoting the ascendancy of the needs and rights of individuals over the restrictive practice of the organisation.

Fine words? They are more than that. In reality, this is exactly where leading-edge nursing practice is in secure and forensic services. The traditional role of nurses in these services has too often been focused on the maintenance of security at the expense of individualised care. Now, using the benefits of a values-based national policy to drive forward change can be the stock-in-trade of specialist RNLD in forensic services. The creation of a culture of choice, even in the most confining of services, has been encouraged by developments in nursing roles, through *Agenda for Change*, clinically-based service developments such as nurse consultants and modern matrons, and encouraging joint appointments to lecturer/practitioner roles.

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*“How, and if, future legislation on mental health services and capacity should reflect the needs of people with learning disabilities.”*

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## Conclusion

Although these examples of nursing practice are becoming increasingly the norm in modern services, there are still obstacles to overcome. One of the main areas of concern is the continuing use of high security services for people with learning disabilities, and the question of how, and if, future legislation on mental health services and capacity should reflect the needs of people with learning disabilities. To achieve change, practitioners as advocates can focus on the fundamental force of choice as a driver for service development in individualised care, challenging the continuing suitability of services and legislation. RNLDs can, and do, face up to these dilemmas as part of their daily role. Choice has become one of their key allies in challenging the limitations created by the need for safety and security.

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# Long term care, short on choices

**Valerie Smith,**  
RCN Independent Sector Adviser

## Introduction

By 2008, the Government's patient choice initiative in England is expected to extend to the point where patients will be able to choose to go anywhere in the country for routine surgery. All the political parties agree that patients should have choice. While the main political parties vary in their approach to choice, there is one element on which they are in accord: they have chosen to bypass the social care sector in their deliberations. This paper outlines some of the implications of this for patients, and the challenges nurses face in supporting choice for residents of care homes.

## Background

Advances in technology and in the treatment of a range of conditions mean people now live longer and often have complex health care needs. As a result, the dependency level of residents in care homes has increased.

The implementation of the Health and Social Care (Community Health and Standards) Act (2003) introduced two new regulatory bodies. As a result, all care homes are now regulated as part of social care services, irrespective of whether they provide nursing care. The term social care encompasses a range of services that are provided by the local authority and the independent sector. Social care comes in many forms, such as day centres and care homes delivering both residential and nursing care. The term also includes providing meals on wheels, home helps and the fostering service.

## Accessing choice

A number of consultation processes have asked the public for their views about the provision of social care. These indicate that people's first choice is to remain in their own home, supported by a package of care. In some areas this has encouraged the development of a spectrum of care options, ranging from simple home support to sheltered accommodation and extra-care housing.

Even though many people may want to remain in their own homes, and the development of new support services supports this, the number of people requiring residential care is nevertheless rising. Given this, and the complexity of some older people's needs, there will always be a demand for residential care services (Wittenberg & Comas-Herrera, 2002 and 2003).

Funding for residential care has failed to keep pace with increasing care needs, rising costs, and the resource implications associated with legislation and regulation (Laing 2002 and 2004). Care homes cannot sustain this, and, as a result, an escalating number are closing, particularly those owned by individuals. Consequently, there is a shortage and lack of choice in a growing number of areas (Department of Health, 2002). While care home provision shrinks, indications are that the demand for it remains unchanged (Laing & Buisson, 2004).

The Government contributes to the cost of nursing care of people in care homes through the Registered Nursing Care contribution. There is considerable local variation in assessment and funding, and the supply of aids and equipment, access to medical care and public health surveillance are all inconsistent and poorly defined.

So, for service users, there remains limited choice. Given the numbers of care home closures, the reduced access to medical and support services, and the need in many cases for individuals to make a financial contribution, the questions we should be asking are:

- where is the ability for people to choose to go into a high quality care home, without having to sell the family silver?
- where is their choice to have their care entirely funded by the state, as it is for hospital patients?
- where is the choice to design care packages according to individual needs and not according to how much the local authority will pay?
- how do users exercise choice when selecting a general practitioner (GP) and ensure that their health needs are identified and addressed?
- how will residents of care homes exercise their right to access patient choice at the point of GP referral, when many will not have a regular GP?

## Conclusion

It seems that if you are a hospital patient, or even a hospital provider, the choice available will become greater. But in the social care environment there remains no choice, merely prescription.

By exercising choice, service users can influence the provision, planning and development of services. The challenge for nurses is to work within the current boundaries to provide quality care while continuing to challenge these boundaries through advocacy, and empowering service users to seek and exercise choice. There are a range of current and planned developments that could support nurses in this role. For example, the GMS (general medical services) contract provides greater opportunities for nurses to influence service delivery. While involvement in the local health economy, such as working with foundation trusts, could enable nurses to support vulnerable groups.

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