

Implementation and the impact of reforms

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Outline

- › Phasing
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- › Unintended consequences
- › Mutually reinforcing or conflicting

Phasing

- › Patient choice: pilots (2002), 4-5 providers at point of referral (2006), free choice (2008)
- › Commissioning: PCT reorganisation (2006), PCT PBC (2005), provider split (stop-start, final deadline 2011)
- › Tariff: initially elective and selective FTs, all trusts & wider range of procedures, CQIN, never events and best practice
 - *Because of the time delay in getting the market based reforms in place, you wouldn't expect them to have had the same degree of impact, nor have they done so in my view. (Policymaker)*

Phasing

- › Recognition that policies needed refinement and adjustment
 - *The decision to have fixed prices was in part recognition of weak commissioners and was expected to drive technical efficiency within the acute sector. However the original tariff was a beta release 0.1. ...we were clear the tariff was not fit for the long term purpose. (Policymaker)*

Phasing

- › Uneven implementation between demand side and supply side reforms
 - *There is a real risk in uneven or very differently paced developments. My perception was that supply side reforms had been more advanced and were picked up more quickly than the demand side, which would have been reversed in an ideal world (Policymaker)*
 - *One of the well rehearsed criticisms is that one should have sorted out commissioning before doing any of the supply side stuff. In the abstract one can see the attractions of that argument. In practice there are a series of political problematics... and the first was around waiting times (Policymaker)*

Layering

- › Market reforms were added to existing layers of policy initiatives and local structures
- › Targets and performance management
 - Elective surgery: 18 week waiting time target
- › Incentives and clinical strategies
 - Diabetes and LTCs: QOF and NSFs
- › Locally existing institutional structures, relationships and values
 - Availability and location of acute capacity
 - GP referral relationships with consultants
 - mission focused on patient-centred care

Dissonance

- › Disconnect between national policy intent / rhetoric and local interpretation and experience
 - Rhetoric of choice: equity enhancing
 - Theory of choice: quality improving
 - Aims of PBC: demand management
- › Commissioners' and providers' perspectives differed but agreement on reforms 'focusing minds'
 - Commissioners not positive about PBR
- › Local response to re-label existing initiatives as new policy

Context

- Impact and perceived impact varied across sites & specialties (cf. Audit Commission (2008), King's Fund (2008))
 - Specialty: elective vs chronic/ emergency /MH
 - Locality: competition not where expected, local market structure and relationships
 - *So I think they made some contribution around improving access, reducing waiting times, the planned care objectives as they were designed to address. I think they've made life more difficult in delivering some of the other priorities, whether it's around prevention (Policymaker)*

Dose

- › How many patients need to be offered choice and then exercise it by attending non-local provider?
 - *“you didn’t need that many patients to actually switch as long as it was a credible enough threat that would produce some kind of behavioural effect on the part of the hospitals and surgeons” (Policymaker)*

Dose

- › Purchaser power weak
 - *“I found a weak spot in the setup was commissioning... I think the people that introduced them hoped that Primary Care Trusts were going to have the best of health authorities and the best of GP fundholding, you know, they were in a sense GP-led health authorities. Actually I think they had the worst of both.” Policymaker*

Unintended consequences

- › Both positives and negative impacts that were not foreseen by those designing the policies but were identified by implementers
- › PBC resulting in peer review of practice performance and hunger for data (Coleman 2009; Curry et al 2008)
- › Tariff fuelled activity growth in emergency admissions (combined with targets) and barrier to pathway redesign (shift care to community)

Mutually reinforcing or conflicting

- › Policy documents suggested that the reforms were 'mutually reinforcing'. Coherence understood by few key policy advisers
 - *choice was the primary driver for a better patient experience, regulation as a primary driver for better quality; tariff as a primary driver for better value for money. So they operated an interlinked set but some of them were more important in certain aspects (Policymaker)*

Understanding by officials

- › But not more widely embrace by officials at DH
 - *There was an implementation failure throughout the system. I think that great chunks of the DoH has never bought into the reforms and therefore never used them as levers to deliver stuff. As soon as you wanted something else to happen, you created a new set of targets and a new set of instructions. (Policymaker)*
 - *The DoH never concentrated on making the reforms fit for the purpose they wanted. They were just something that were left behind because Ministers asked for them. (Policymaker)*

Mutually reinforcing or conflicting

- › Competition believed to conflict with maintaining sustainable health economy
- › Commissioning through selective contracting and tendering vs 'free' choice / all willing provider market
 - *'Commissioning is about getting the best for our patients, but then we ask them what they want?' PCT manager*
- › Referral management and patient choice (Imison 2010)

Insights for future reforms

- What needs to be in place first? Identify key building blocks
- Recognise the need to refine the policies and adapt to changing context and feedback from implementers
- Stripping away of performance management may mean providers look out not up
- Is the narrative about the reforms and their purpose clear
- Limited application beyond elective - different approaches and new currencies for LTCs, MH.

Insights for future reforms

- Geography may be less of a problem. Need to understand current market structure
- Expect the reforms to be 'diluted' during implementation and therefore give them chance to 'work'
- Expect there to be unintended consequences and amplify the positive and try to mitigate the negative
- Recognise where the inherent tensions and points of conflict are and try to resolve them at least in the minds of those on the ground