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Comparative case
studies of health reform
in England

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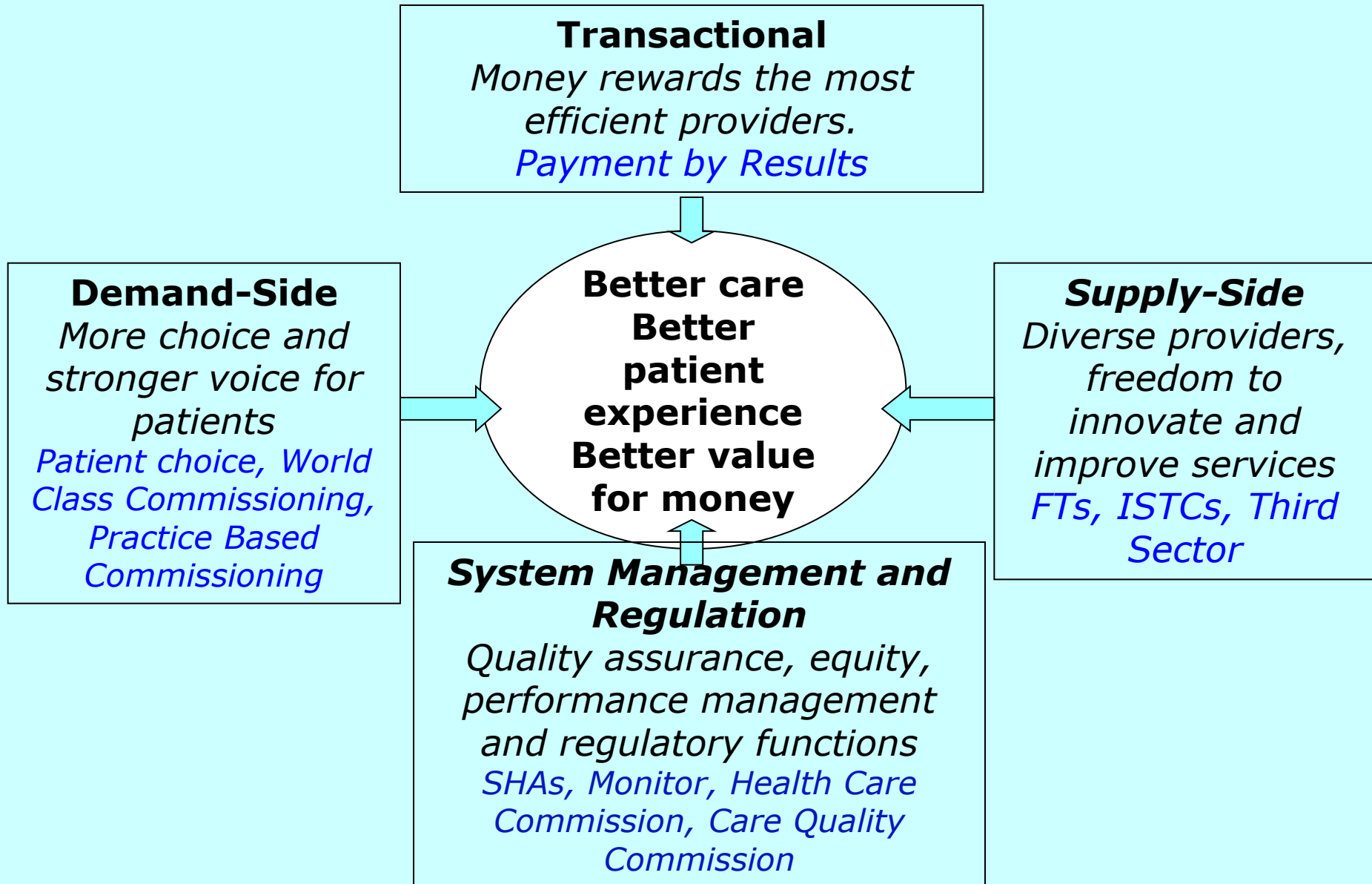
Health Economics Unit*

The Kings Fund**

Introduction

- National evaluation on health reform: 3 tracer conditions - orthopaedics, diabetes, and EIMH - in 6 Case Study Areas
- Background to evaluation: comparative case study design
- Realistic Evaluation (Pawson and Tilley 1997) 'What works for whom in what circumstances'

Framework for health reform in England



Theory: 'mutually supporting' reforms

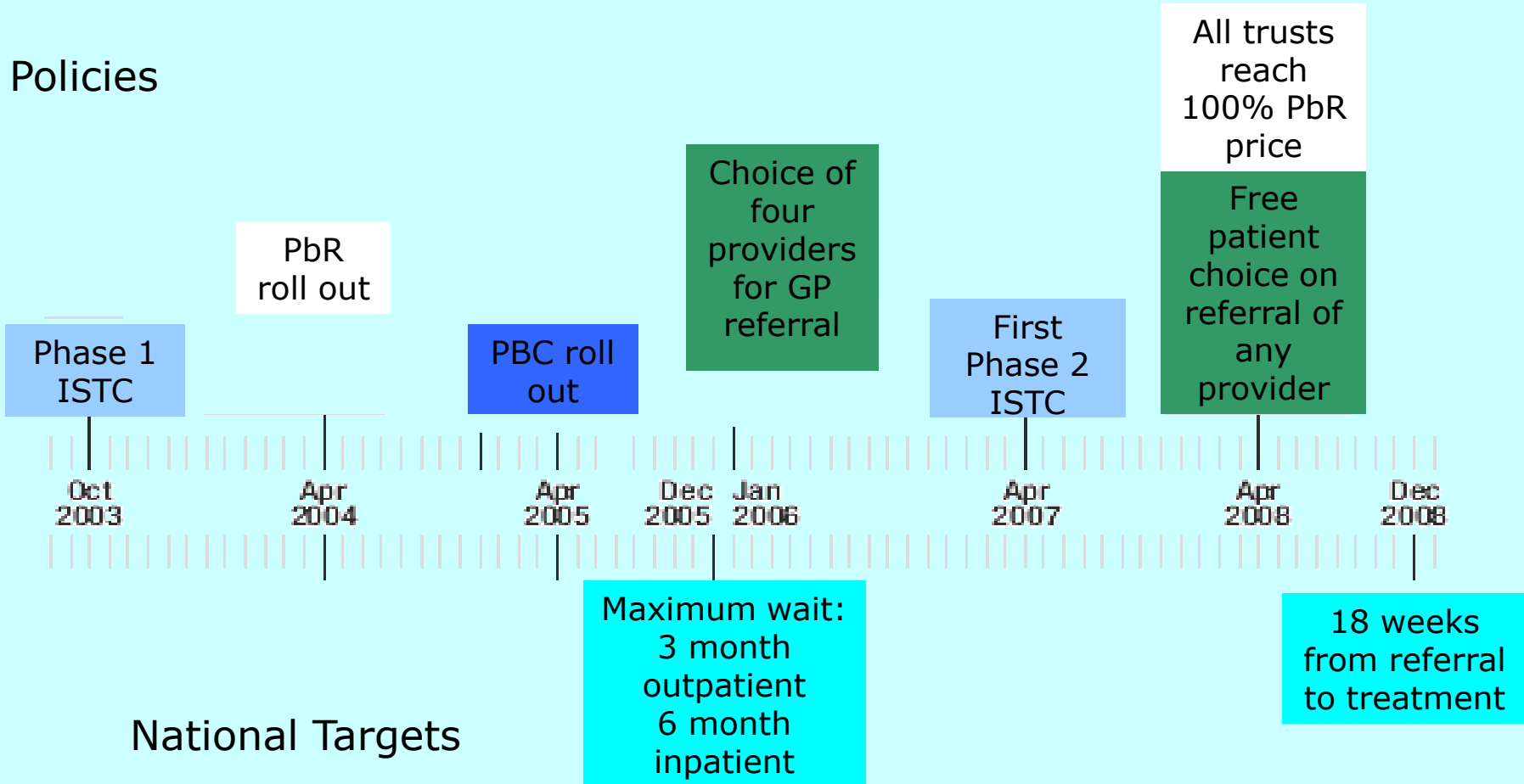
'a coherent and **mutually supporting** set of reforms, which together provide systems and **incentives** to drive improvements in health and health services, increase responsiveness to patients and help to achieve reductions in health inequalities...

... while it is useful to categorise the reforms into these four strands, in practice the benefits will be realised through the **interactions between all four elements'** (*Health reform in England: update and next steps* DH 2005: 9)

Impact of health reforms

- Reforms have not been implemented uniformly (Audit Commission 2008; King's Fund 2008)
- The King's Fund:
 - 'All the various elements of the reforms are working somewhere, although not always as intended. None is working everywhere' (Kings Fund *Making it Happen* 2008: ix).
- Reform **mechanisms** contingent on context: temporal and geographical

The temporal dimension



The geographical dimension

- Case study areas reflecting differences in the reform mechanisms
- Demand - Monopoly vs. contestability
- Supply - 'old' NHS monopoly vs. Foundation Trusts and ISTCs
- Transactional – cost linked to location and specialisation
- System Management & Regulation 'constant'

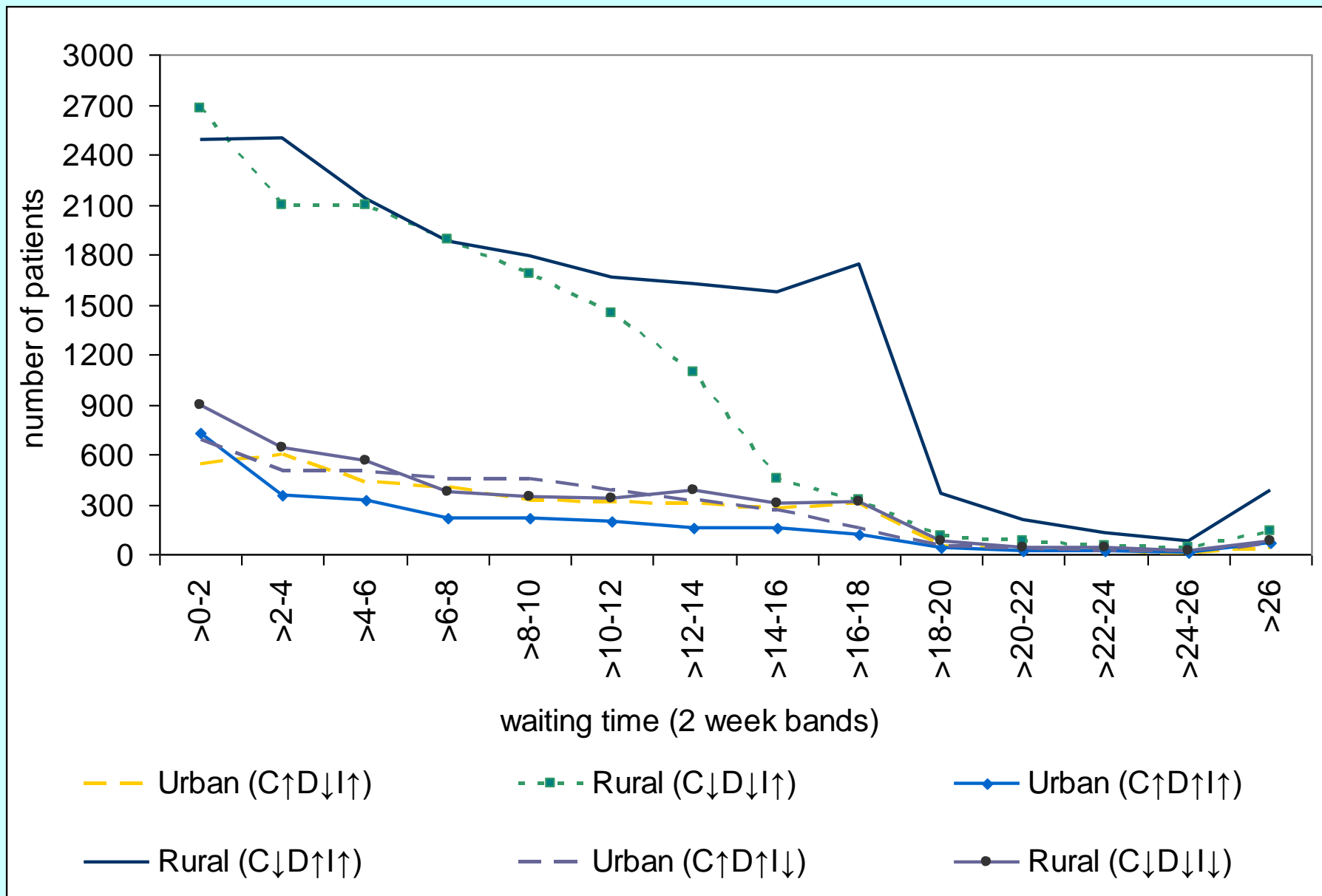
Case study 1: Rural PCT (C↓D↓I↑):

- Predominantly rural location
- Limited provider competition
- Limited independent provider presence
- Contextual factors negative to reform mechanisms

Case study 2: Urban PCT (C↑D↑I↓)

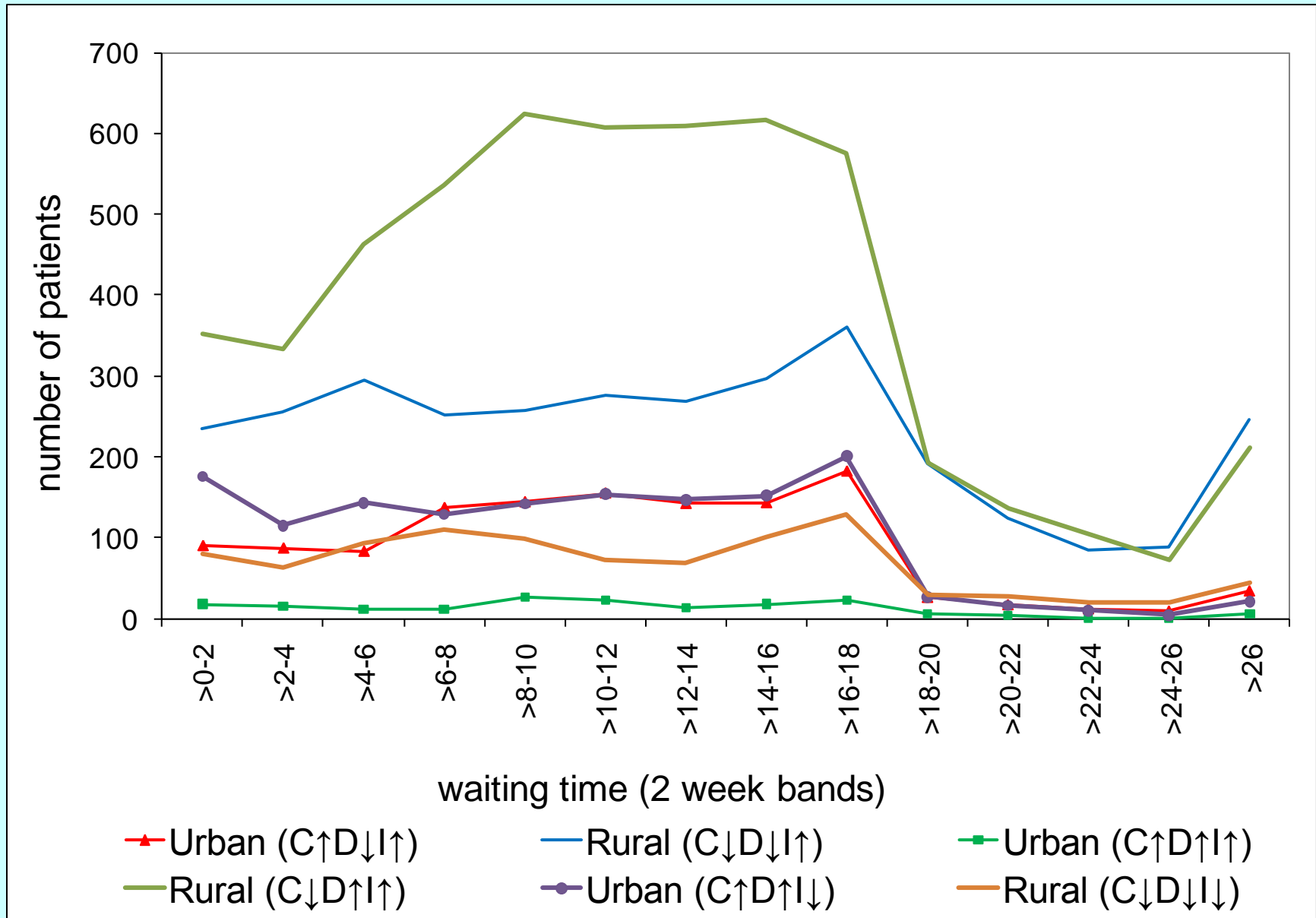
- Inner-city/central urban location
- A high degree of provider competition
- A high degree of provider diversity (plurality)
- Limited presence of independent providers
- Contextual factors positive to reform mechanisms

Waiting time for all elective admissions excluding orthopaedics: number of cases in the three months to March 2009



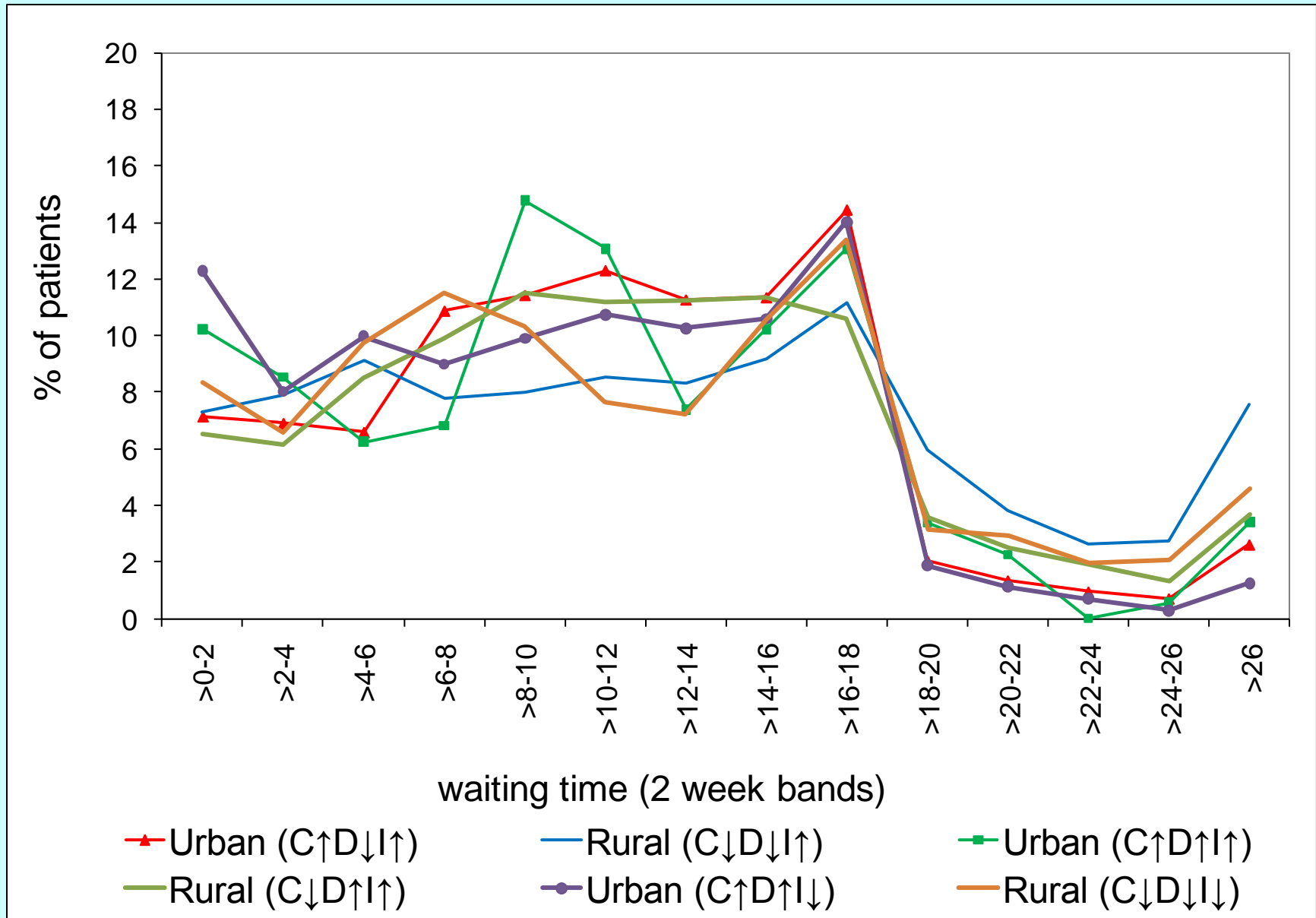
Waiting time for elective orthopaedics:

number of admitted cases in the three months to March 2009



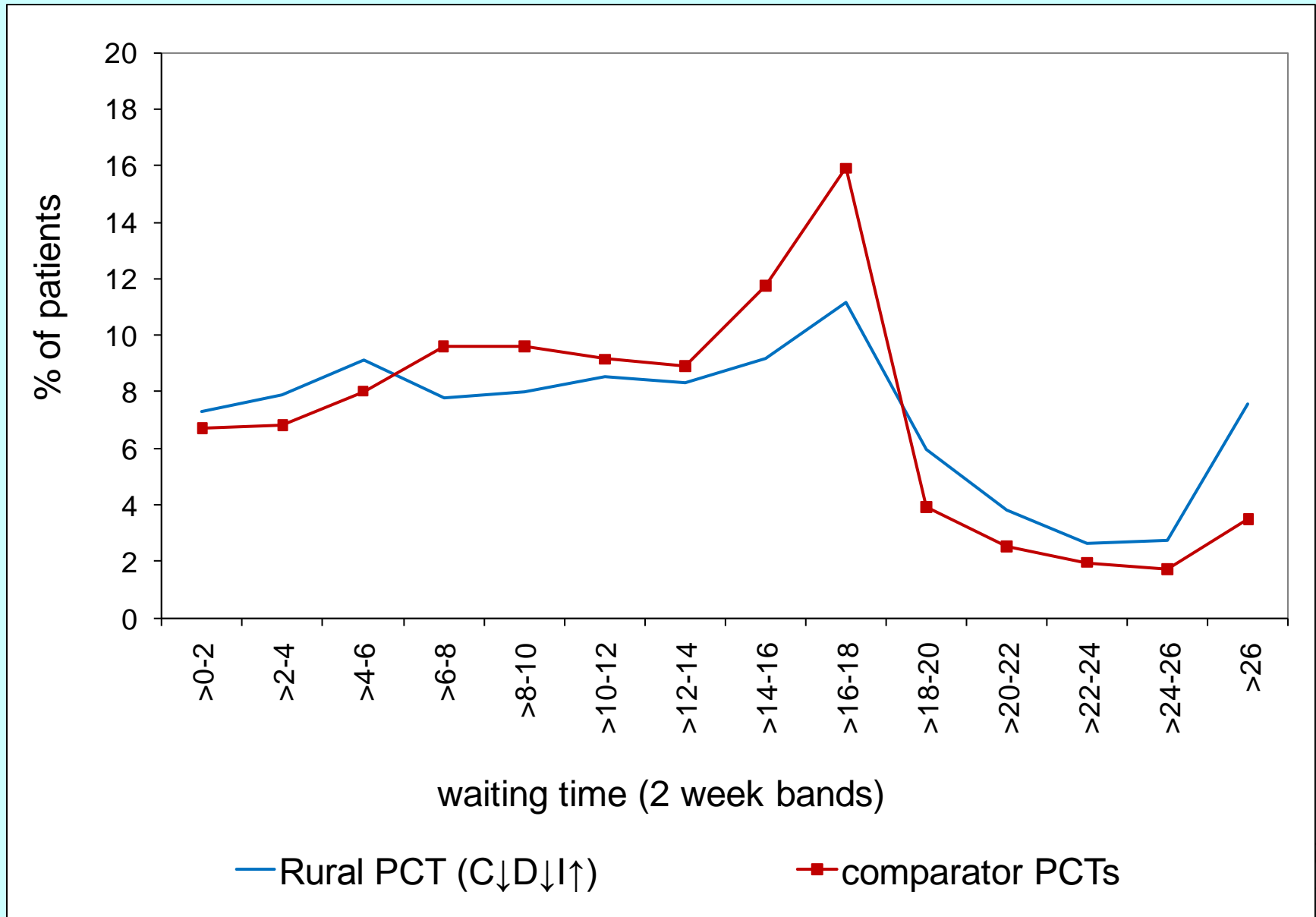
Waiting time for elective orthopaedics:

percentage of admitted cases in the three months to March 2009

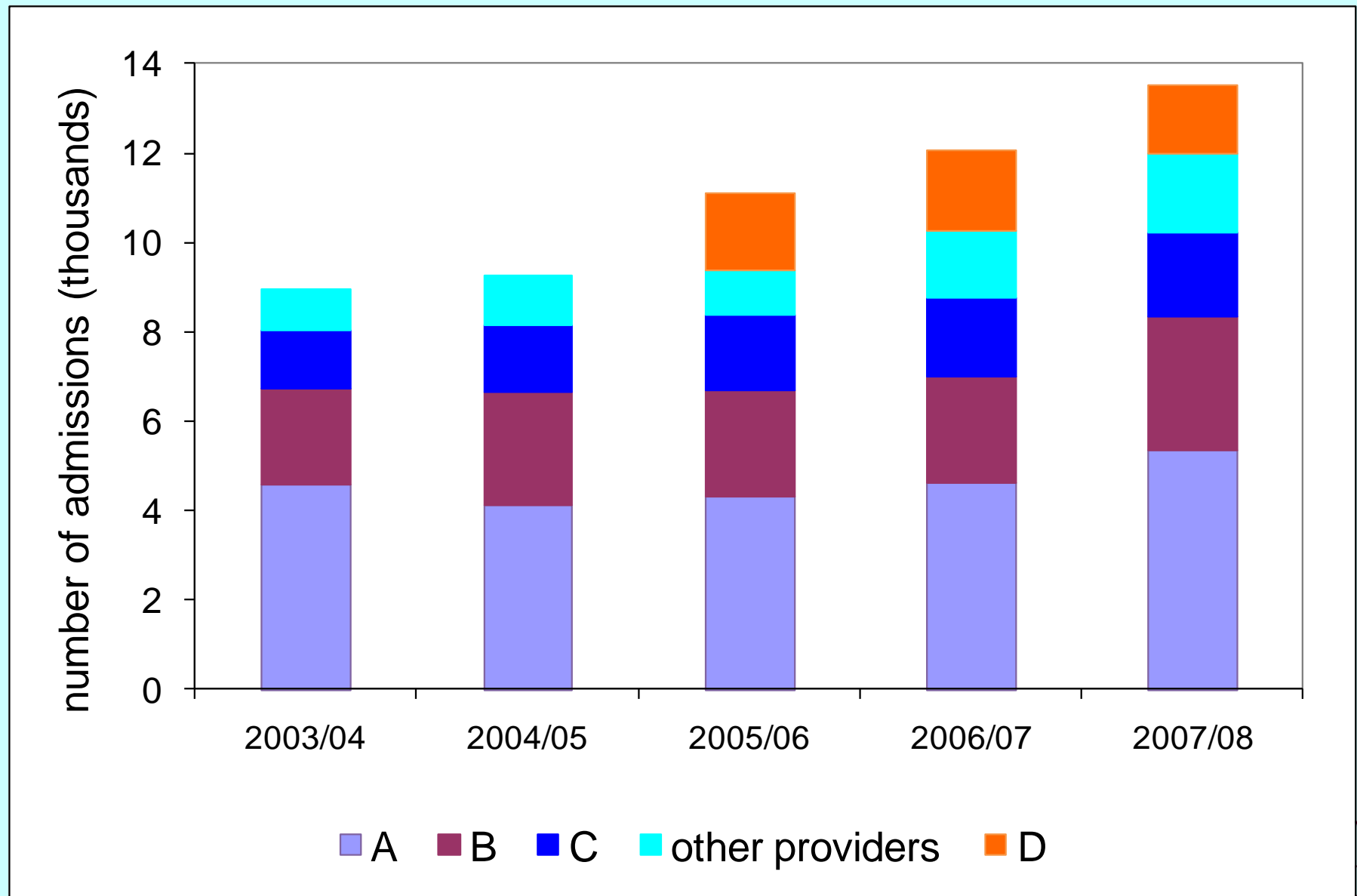


Waiting time for elective orthopaedics:

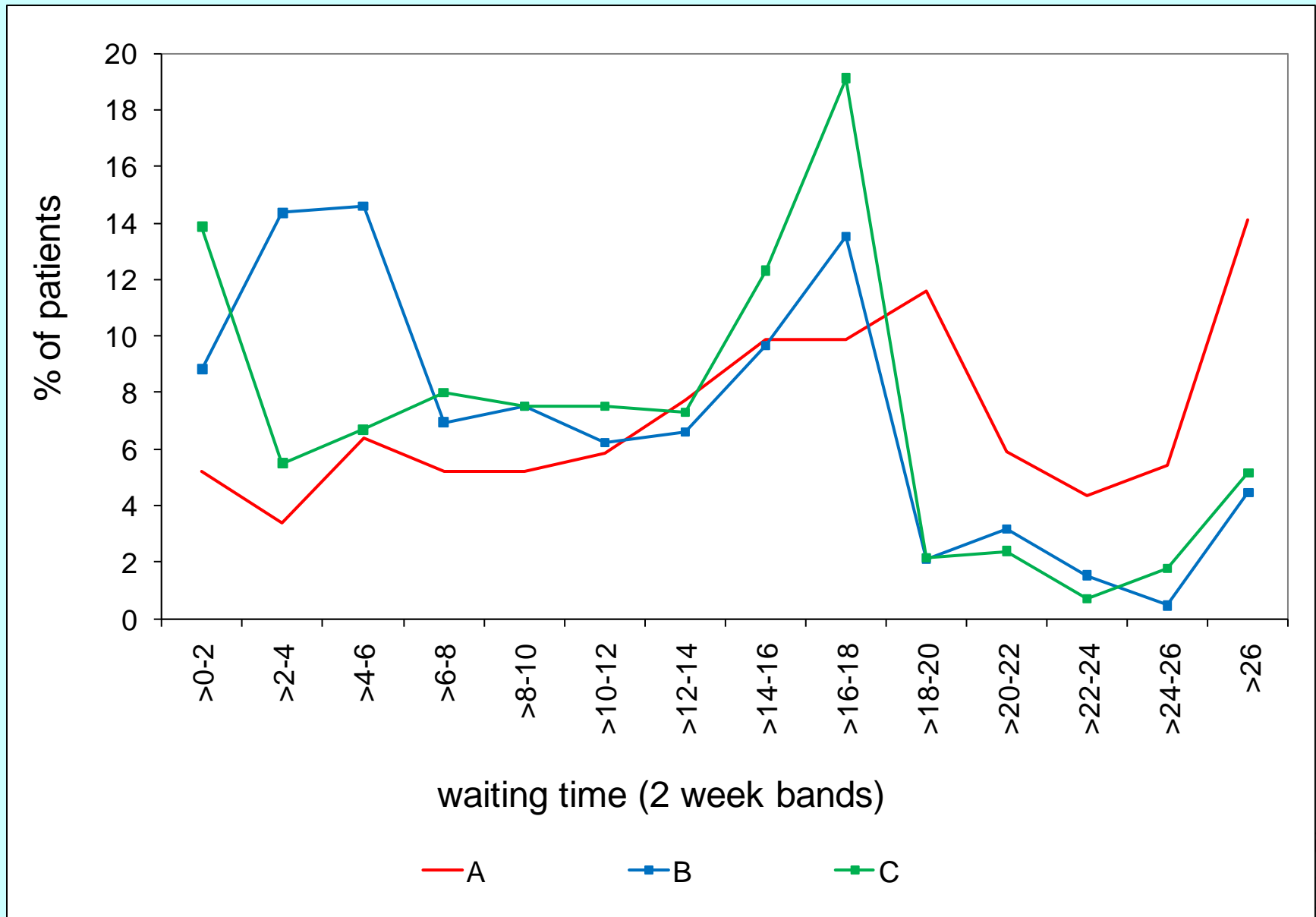
percentage of admitted cases in the three months to March 2009



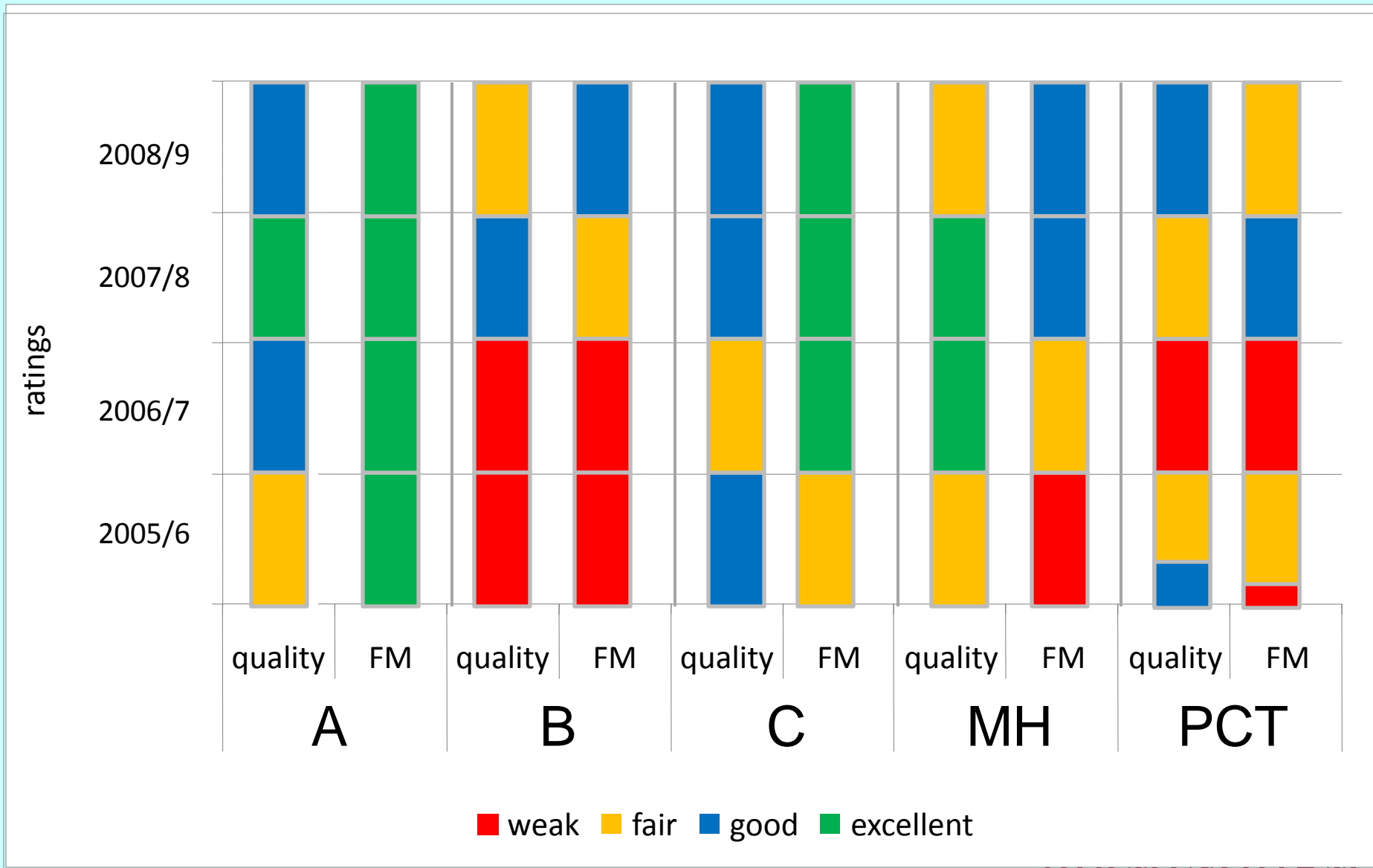
Rural PCT (C↓D↓I↑): elective orthopaedic admissions by provider



Rural PCT (C↓D↓I↑): Waiting time for elective orthopaedic admissions by main provider

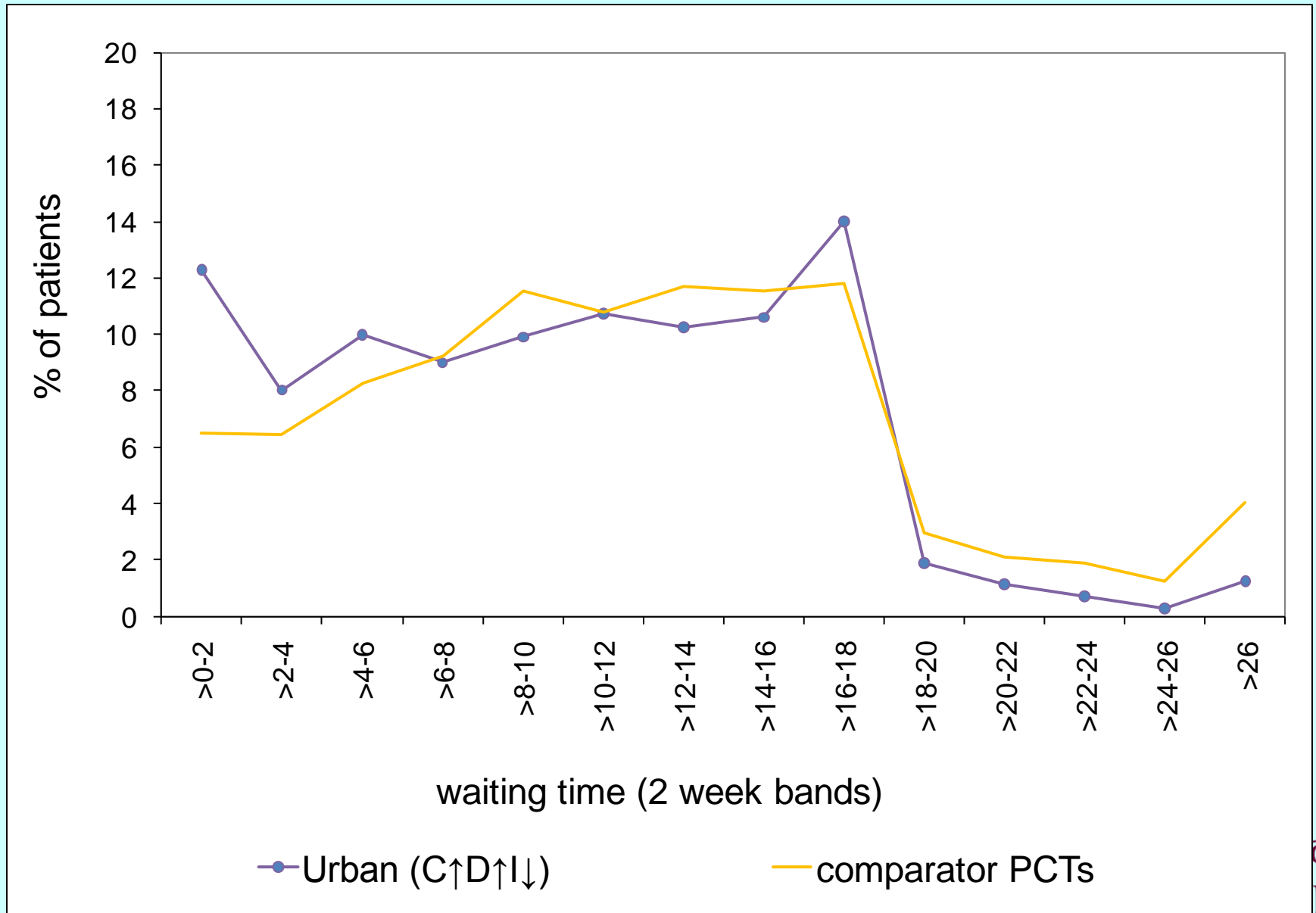


Rural PCT (C↓D↓I↑): CQC ratings

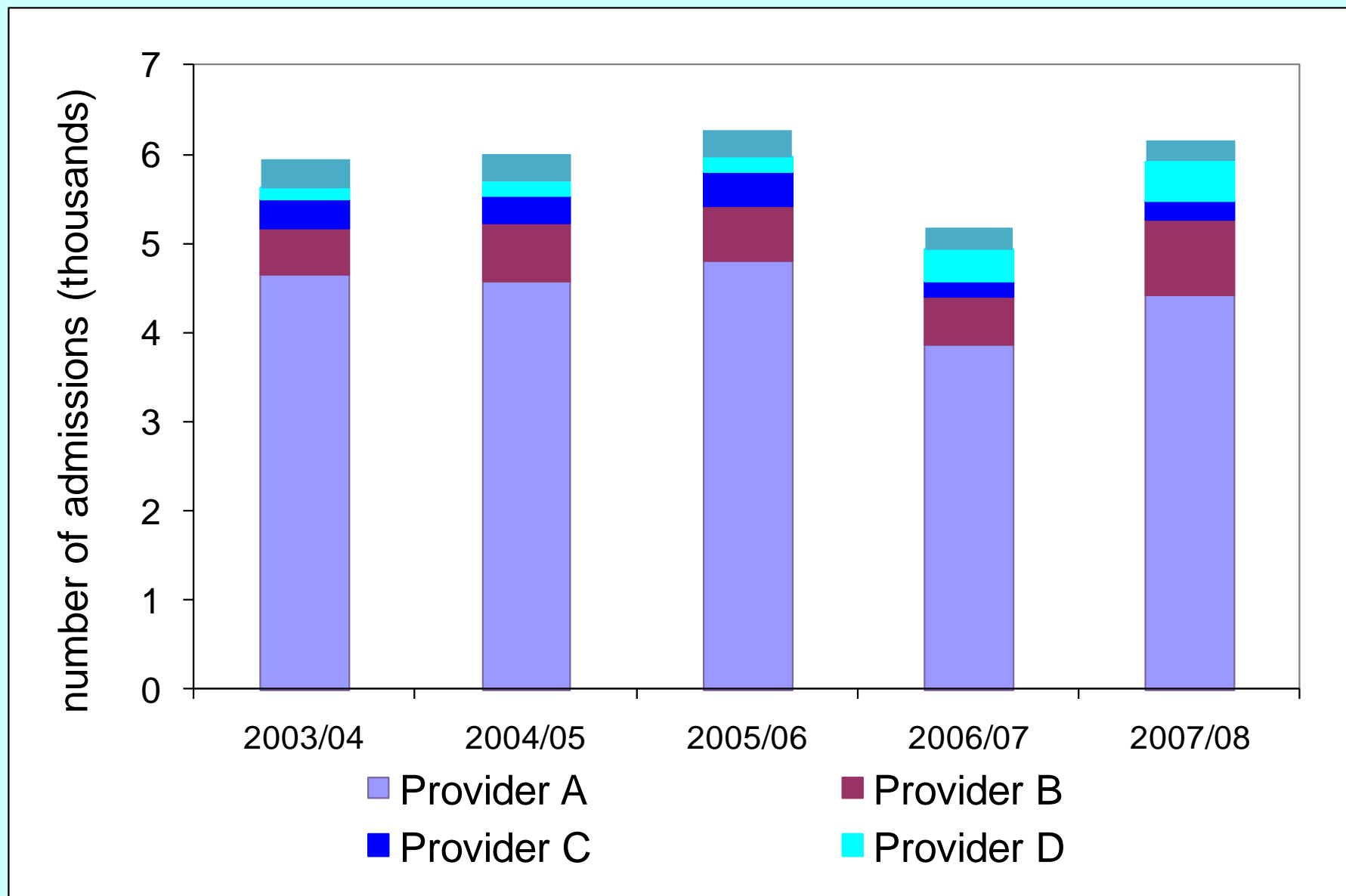


Waiting time for elective orthopaedics:

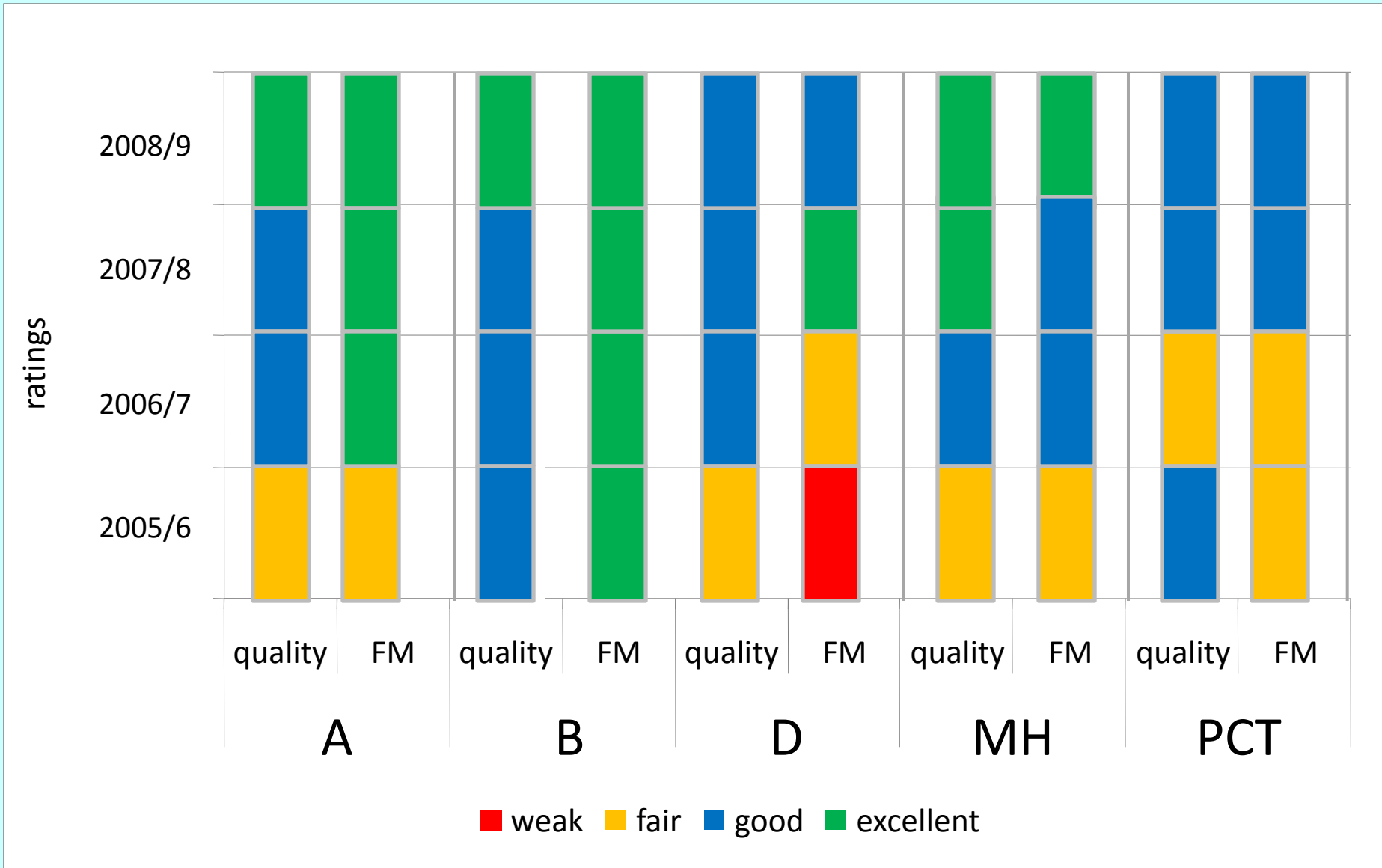
percentage of admitted cases in the three months to March 2009



Urban PCT (C↑D↑I↓): elective orthopaedic admissions by provider



Rural PCT (C↑D↑I↓): CQC ratings



Results: Urban and Rural System Perspectives

- **Demand side reform**
- Rural case study: reorganisation distracted PCT from DSR.
- Urban case study: DSR reforms
- BUT limited impact of ‘choice’ due to location, history, identity, GP influence and ‘Brand loyalty’.
- **Supply side reform**
- Rural case lacked competition and diverse providers however progress towards 18 weeks helped by referral management, limited ISTC (reducing demand) and subcontracting to private sector (increasing capacity)
- Urban case developed collaborative approach in market ‘full of FTs’, but limited independent sector to subcontracting- plurality but little competition.
- In both sites, FT status brought governance and accountability reforms but regulatory reforms (Monitor) stifled innovation.

Results: Urban and Rural System Perspectives

□ **Transactional reform**

- In rural case, PBR reinforced supply side activity by maintaining balance of power in acute sector.
- In urban case, PBR cited as 'the main catalyst for change' for FT providers. Strong informatics and leadership meant they were 'ahead of the game'.

□ **System Management Regulation**

- In rural case, strong SHA implementation of accelerated model for 18 weeks reduced waiting time, but at cost of strained relations.
- In urban case, broadly good relations across system but combined impact of Monitor and SHA create competing demands and duplication for FTs.

Other Tracer Conditions

□ **EIMH**

- Limited DSR and SSR. PBR to be implemented in 2014. The policy levers for EI centre on the NSF and the Policy Implementation Guide.

□ **Diabetes**

- Limited DSR in sense of choice of hospital, but choice and voice associated with moves from hospital to community (Care Closer to Home)
- Both sites found no evidence of competition or diverse providers. Rural system behaviour based on historical patterns; urban system driven by clinical and commissioning leadership.
- Both sites evidence that the combination of PBR and acute provider activity limited community based models of care
- Main policy levers were NSF, Care Closer to Home, evidence base/NICE guidance.

Results: Round Two Interviews

- Health reform in 'crisis'? System reassessment and retrenchment (realisation that system cannot sustain itself particularly in rural limited competition)
- Talk of moves from competition to 'cautious collaboration' in both areas, with rumours of block contracts in rural area.
- Caught between competing models: a fork in the road? (some advocates of integrated care/block contracts, but other advocates of more market (eg universal 'fundholding'). Middle or 'third' way may not be possible.

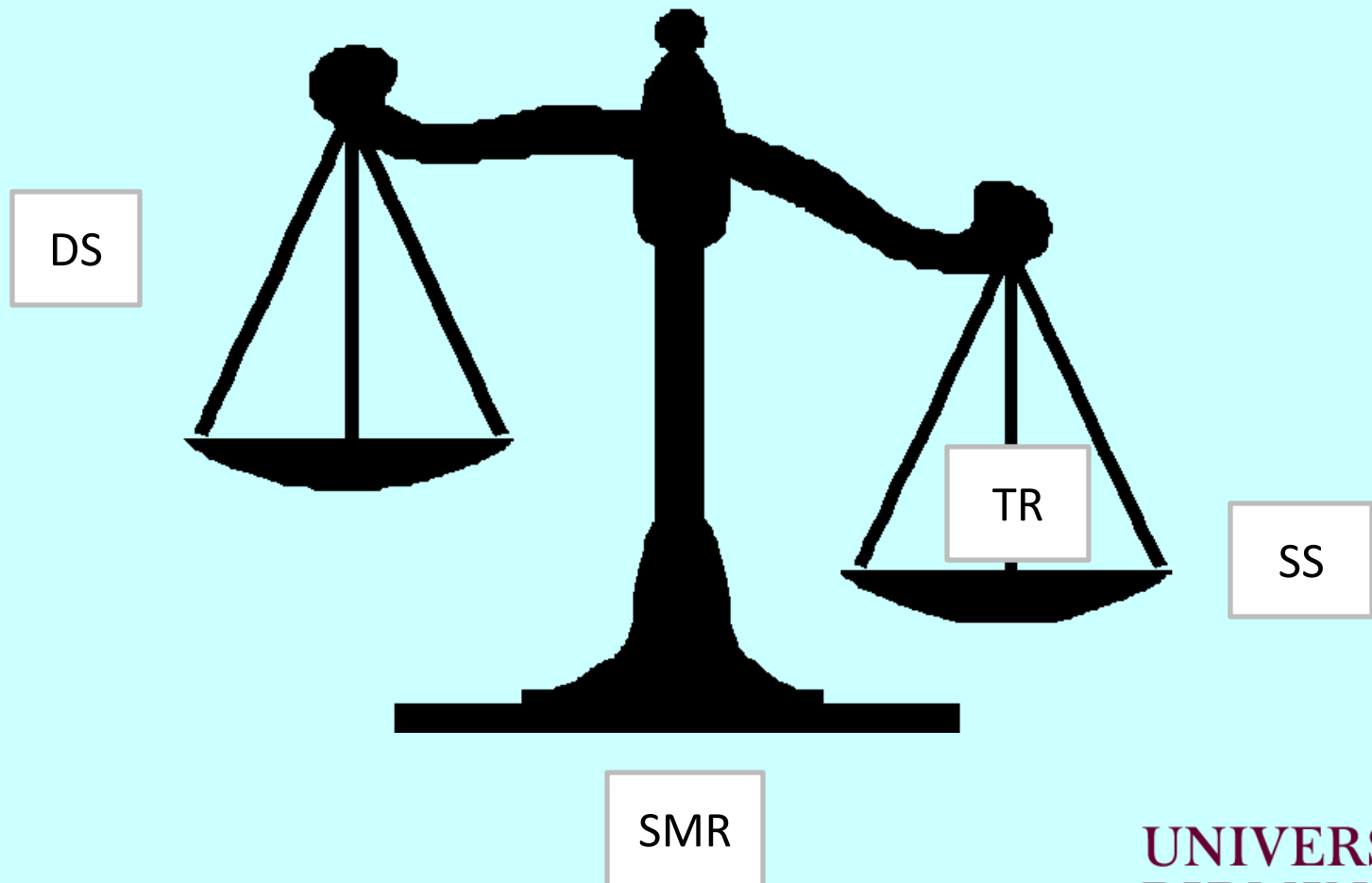
From Next Steps to Next Stage: High Care Quality for All

- 'from Aldi to M&S': welcome move from quantity or inputs to quality, experience and outcomes
- The Next Stage or going with the grain? Quality and Care Closer to Home already being implemented
- Clinical leadership has 'disenfranchised the commissioner'
- Integration or fragmentation? Polyclinics and continuity of care
- Review did not strike chords in EIMH: 'Darzi... who is Darzi?'

Discussion

- Significant differences of opinion on reforms, but they ‘focused the mind’
- *System* reforms: ‘Mutually reinforcing’ vs. post hoc rationalisation
- Tensions *across* the reform streams: the combination of Transactional and Supply has limited Demand side. Logic of reform in tension with collaborative, integrated models. 18w, FTs’ surpluses, and PBR have sucked money out of system. The reforms ‘are ‘out of kilter’, with centre of gravity on provider side (WCC should have preceded FT).
- Tensions *within* reform streams: For example, who are the WCC- PCT, PBC or individuals? What impact does everyone choosing the same supermarket till have on waiting?

The balance of system reform



Policy implications

- ❑ Does ‘one size fit all?’ An elective, London model?
- ❑ Demand and Supply varies geographically: ‘It might work in London but not here...’
- ❑ Next step reforms have provided levers for the NHS acute sector, but EIMH and Diabetes as ‘dogs that did not bark’ – change from other policy levers.
- ❑ Co-existence of different models: still elements of Command, Competition and Collaboration.
- ❑ ‘Take Home Messages’: ‘Steady State’ required; need to live in ‘less interesting times’; leave implementation to implementers, and do not micro manage