Evaluating current market reforms in the English NHS

Nicholas Mays
Professor of Health Policy
Department of Public Health & Policy, London School of Hygiene & Tropical Medicine, University of London

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Outline

- What do we mean by ‘reforms’ & ‘evaluation’?
- NHS reforms since 1991, nature of evaluation & findings
- 2002 reforms – reintroduction of market
- Health Reforms Evaluation Programme
  - rationale, features, governance, process, progress
- Challenges ahead

What do we mean by ‘reforms’ and system level changes?

- Major changes to system incentives, governance, organisation, payment or financing

What is ‘evaluation’?

- Ultimately normative, depending on value placed on particular effects by different actors
- Usually research to see whether a policy achieved objectives set by its proponents and/or its effects on wider system goals
  - e.g. equity, efficiency, responsiveness, acceptability, humanity, sustainability, economy
  - range of goals means that onlookers can usually find some aspect to confirm their prejudices

What are the particular challenges of system level policy ‘evaluation’?

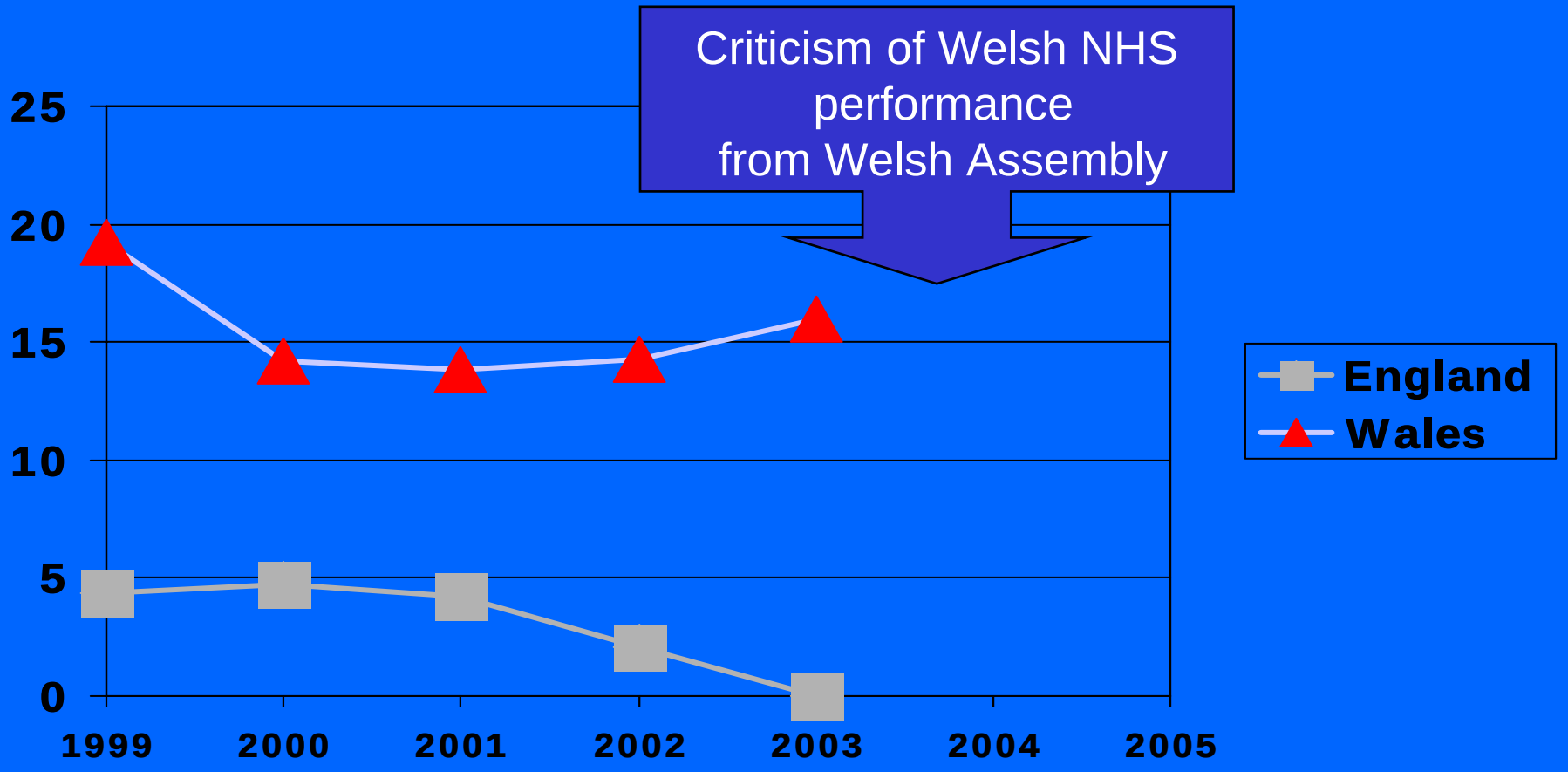
- ‘Reforms’ are seldom fixed, tend to be ‘emergent’
- Difficult to define focus & disentangle effects from previous, overlapping & subsequent changes
- Context matters
- ‘Reforms’ tend to be politically & intellectually controversial
  - Public tends to have a negative view unrelated to performance
- ‘Reforms’ are rarely introduced with an eye to evaluation
- ‘Reforms’ tend to have multiple, broad objectives
- Measurement is problematic because no simple ‘bottom line’ (e.g. productivity in public services)

English NHS ‘reforms’, 1991-

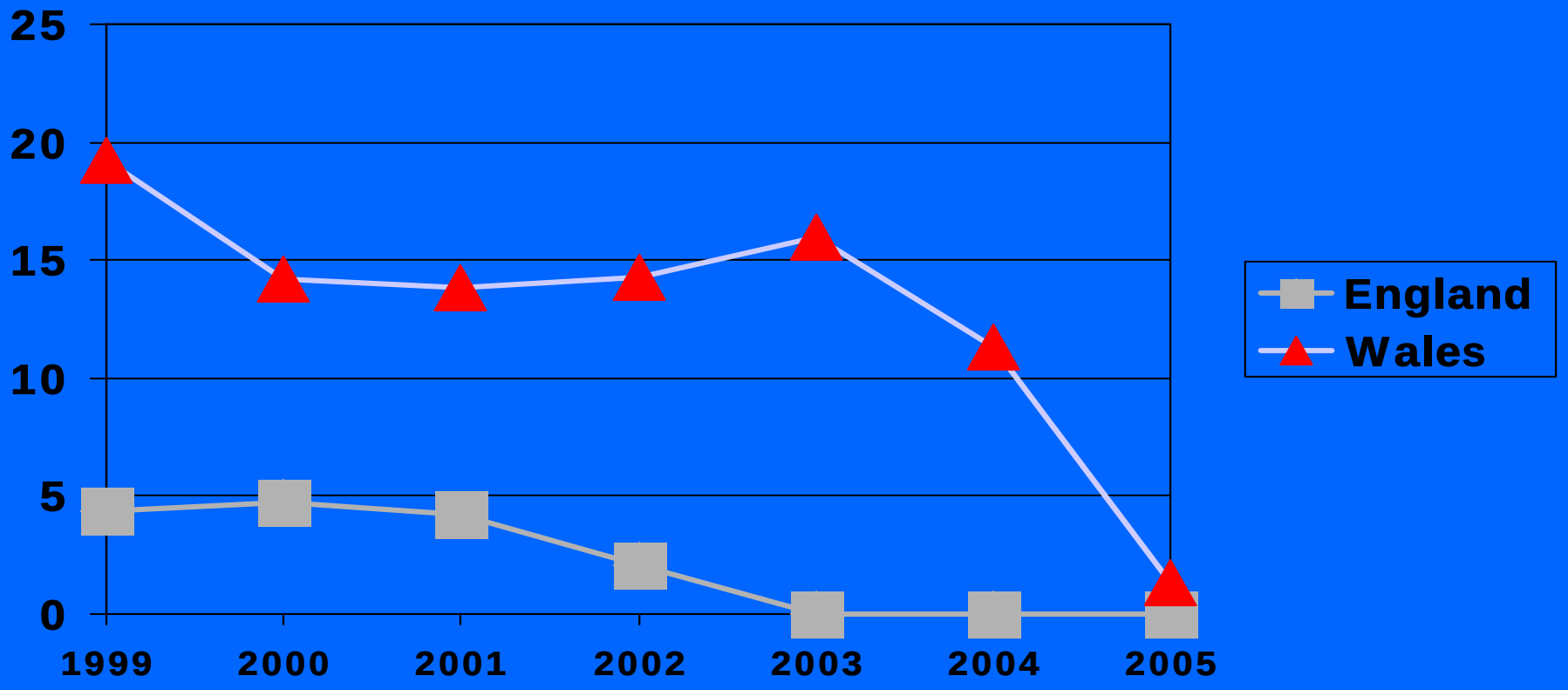
Three main phases:

- 1991-1997
  - Predominantly ‘internal market’, supply side competition
- 1997-2002
  - ‘Command and control’, targets, performance management, investment in return for ‘modernisation’
- 2002-2007
  - Market for NHS services, including private & Third Sector
  - Gradual shift towards a ‘self-improving’ NHS

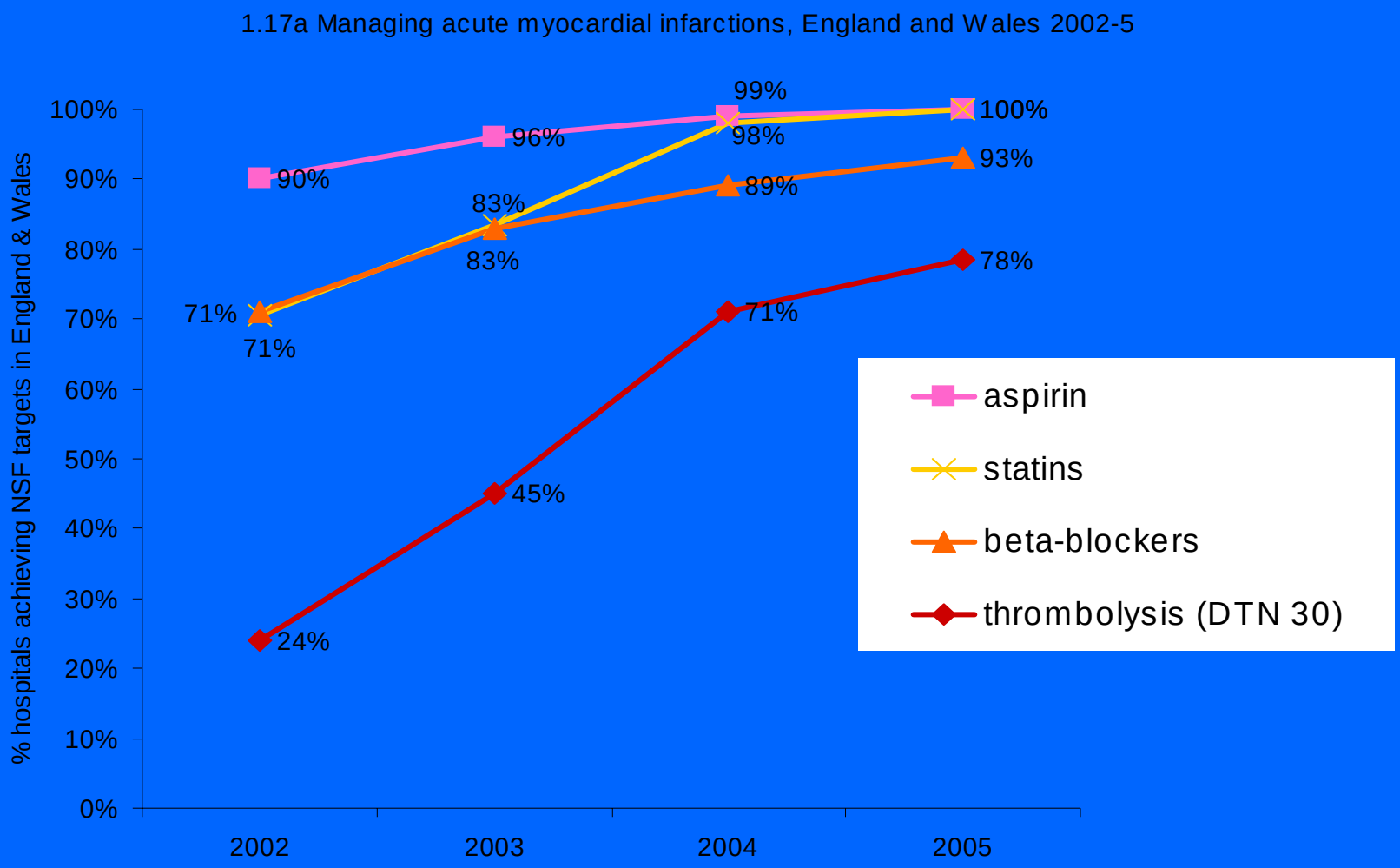
% waiting > 12 months England & Wales: 1999 - 2003



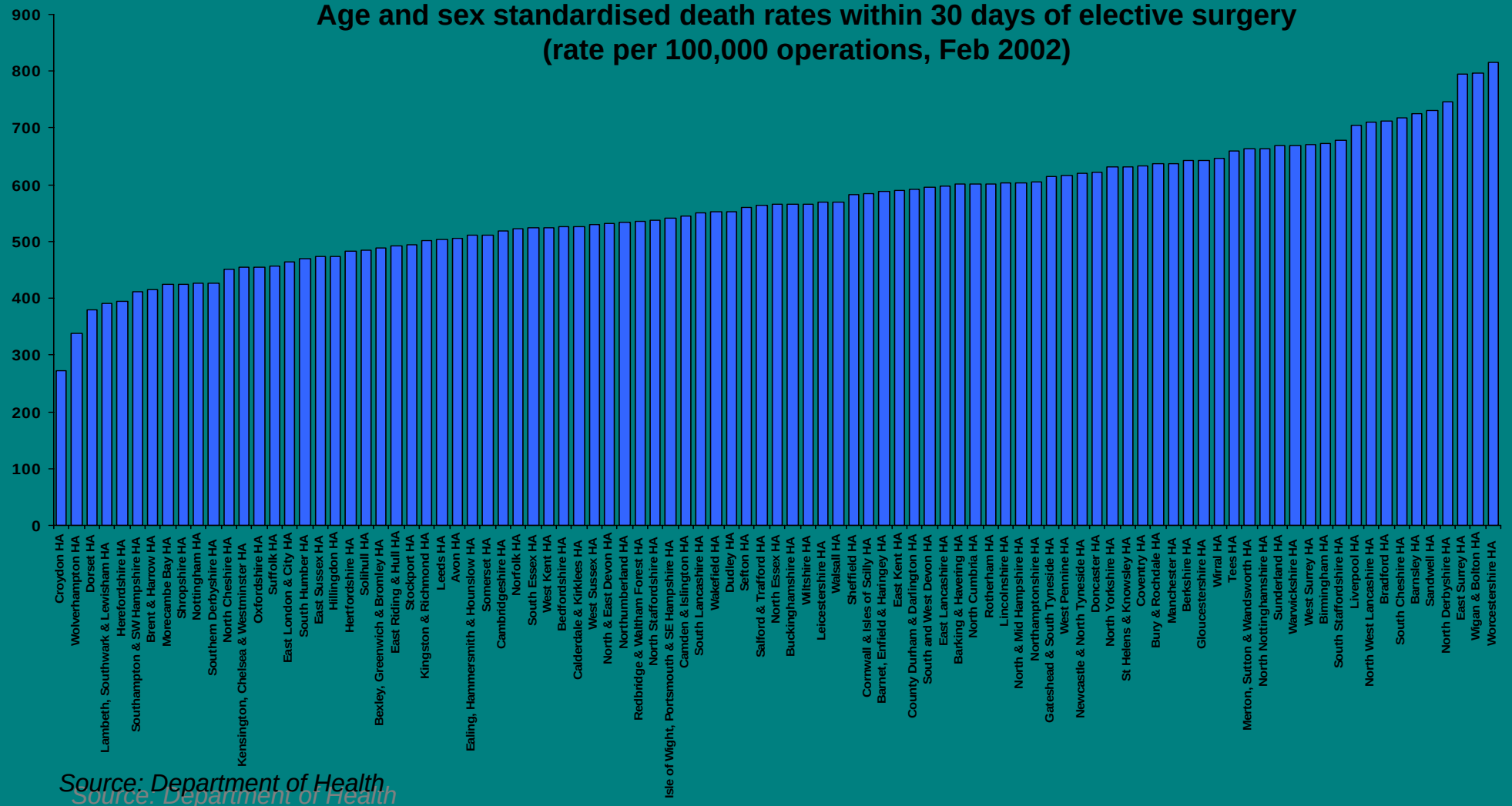
% waiting > 12 months England & Wales: 1999 - 2005



Trends in NSF clinical targets

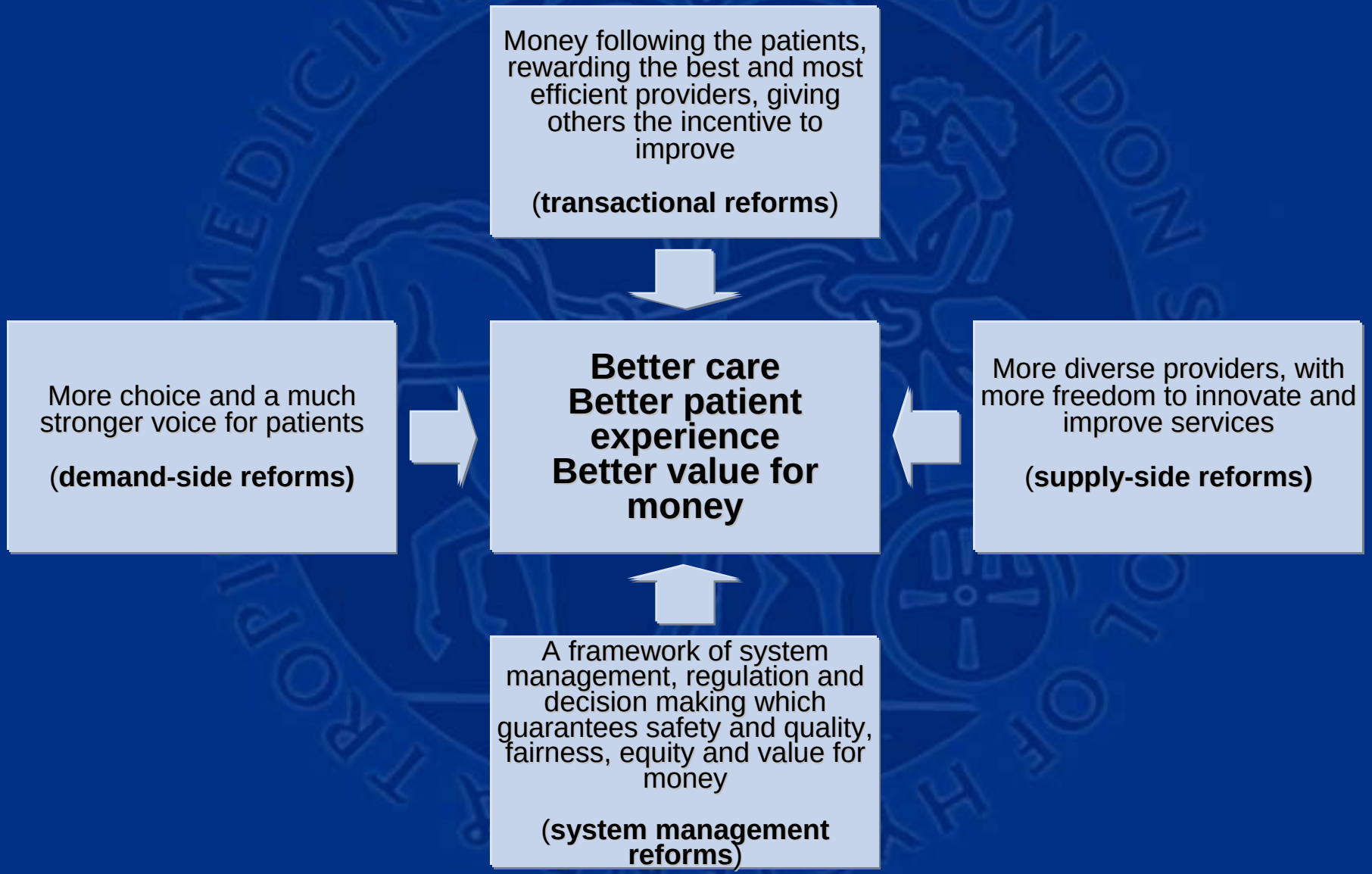


Variation in clinical outcomes



Source: Department of Health

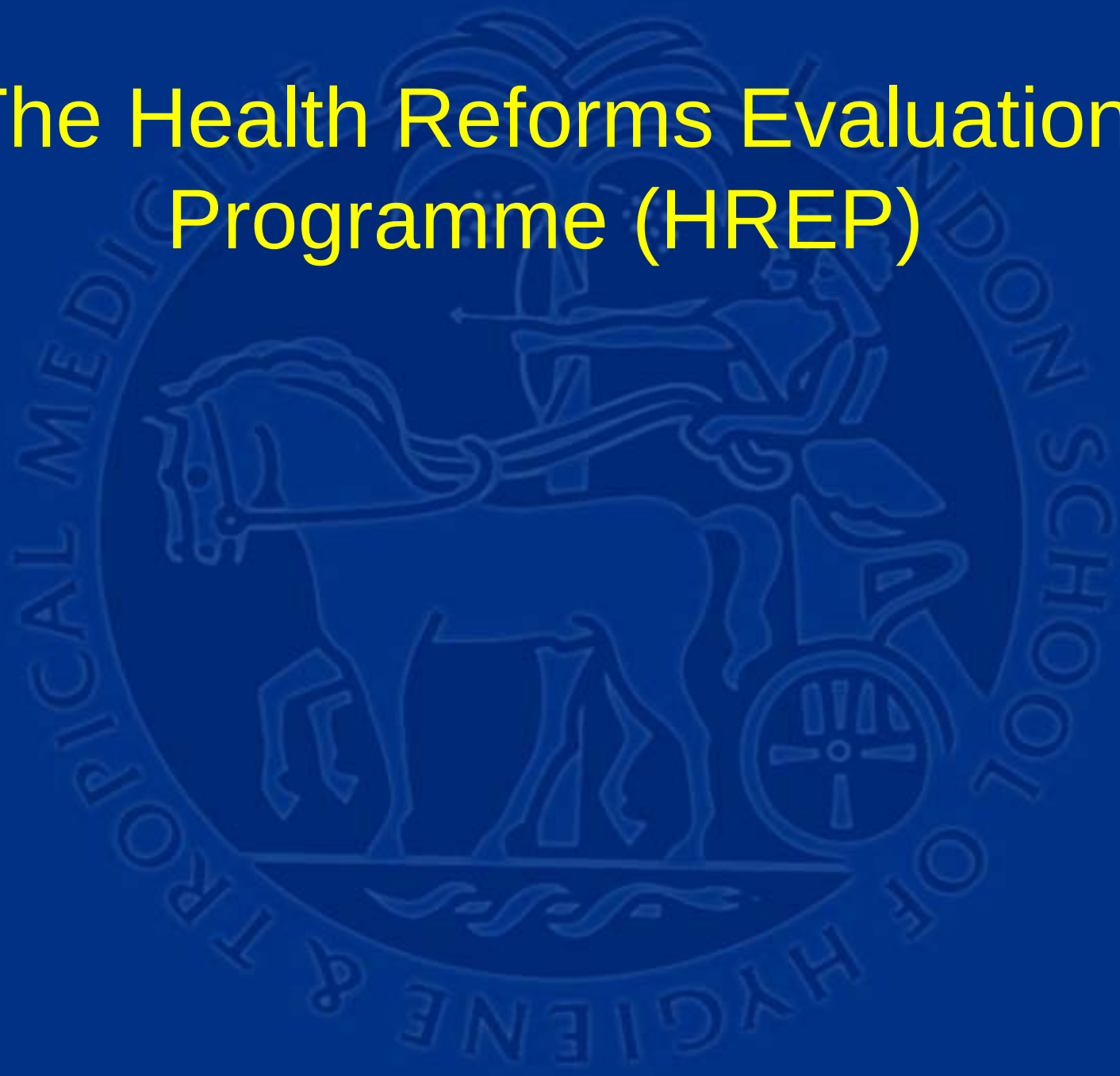
The re-invented NHS market in England, 2002-



Evaluation and impact of reintroduction of competition, 2002-

- Implemented over time
- Some piloting of reforms (e.g. London patient choice pilot showed patients would take up choice)
- Limited signs so far of increased output or quality directly related to market reforms
- Revealed excess hospital provision in some parts
- Tension between competition (electives) & collaboration (chronic disease care)
- Importance of regulation emerging

The Health Reforms Evaluation Programme (HREP)



DH Rationale for HREP

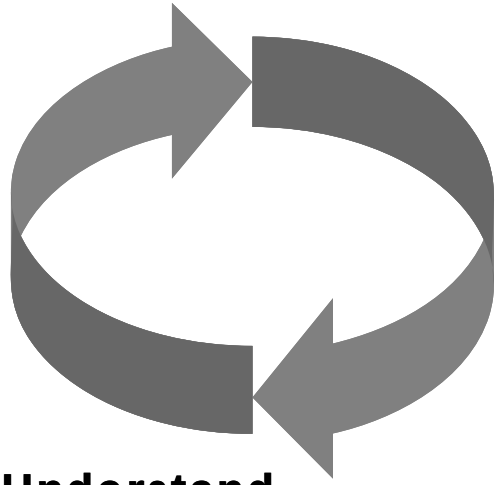
- Extent and potential significance of changes
- Desire to be able to adjust reform implementation in light of better understanding about how reforms are being implemented (mainly ‘formative’ evaluation)
- Desire to leave a legacy of knowledge for future policy development on impact (‘summative’ evaluation)

Features of HREP

- Independent, commissioned, peer reviewed research
- Subject to usual DH research contract
  - expectation of publication of findings
- Coordinated from outside the DH (NM), but part of long established DH PRP
- £3.5m over 3.5 years including coordination costs
- Aim: a coherent, ‘managed’ programme, not stand-alone projects, contributing to policy development

The aspiration: evaluation guides policy adaptation

3. Respond appropriately including by adjusting policy



1. Drive and support effective implementation of health reform

2. Understand quickly and accurately, to an appropriate degree of detail, what is happening and why - locally and nationally

Governance and organisation

- ‘Sponsor’ – DH’s DG, Policy & Strategy
- Oversight/QA – Reforms Evaluation Advisory Group of leading UK/international health service researchers & key policy-makers, chaired by coordinator (NM)
- Commissioning group – 2 UK external experts, DH policy ‘leads’, chaired by NM
- Day-to-day management – NM working with DH research liaison officer and 2 officials from PSU, Policy & Strategy Directorate

Role of the independent scientific coordinator

- Undertake periodic reviews integrating published research with internal analysis from DH & other agencies
- Gap analysis and specification of new research
- Chair the commissioning panel and direct peer review process
- Coordinate delivery of the programme, encourage cross-fertilisation between projects, develop overviews of the findings, and brief DH and other stakeholders on findings & their policy implications
- Chair REAP

Elements in HREP

- *Mechanism-specific projects*
- *Whole system studies of 'local health economies'*
- *Systematic reviews*

Innovative aspects of HREP I

- Successful proposals negotiated to finalise the research
- Attempt to keep researchers aware of shifts in policy thinking at an early stage
- Linking primary research to evidence syntheses
- Attempt to synthesise published & ‘grey’ literature with internal analyses from DH, PMSU, etc.
  - e.g. on extent of reform implementation

Innovative aspects of HREP II

- Exploitation of new routine datasets (e.g. Healthcare Commission's quality of care assessments)
- Use of maps to present some findings
- Projects to include some 'Reform Demonstration Systems' to get early insights into likely changes
- Encouragement to compare England with other parts of UK
  - to take advantage of 'natural experiments'

Progress so far: projects funded

- *How patients choose and how providers respond*
  - lead, Anna Dixon (King's Fund)
- *Competition under fixed prices*
  - lead, Carol Propper (University of Bristol)
- *Provider diversity in the NHS: Impact on quality and innovation*
  - lead, Will Bartlett (University of Bristol)
- *Comparative case studies on the impact of the health reforms in England*
  - lead, Martin Powell (University of Birmingham)
- *Effects of choice and market reform on inequalities of access to health care*
  - *Lead, Richard Cookson (University of York)*

Characterising the projects I

- Multi-disciplinary, though no active clinicians involved
- Variety of perspectives
  - some strongly economic, others more sociological, organisational
- Generally using ‘mixed’ methods
- Focus on impact and process
  - e.g. ‘context-mechanism-outcome’ configurations (Pawson & Tilley, 1997)
- Routine data (inc. GIS) and primary data collection
- Mix of ‘whole system’ and mechanism-specific studies
- National and local level studies

Wide range of impact measures across projects (‘tracer’ conditions)

- Death rates after AMI, aneurysm, stroke
- Revascularisation and colorectal cancer surgery rates
- Financial status of trusts and staffing indicators
- Inequality in age/sex standardised use rate ratios between top and bottom quintiles
- Patients’ experiences of quality
- Readmission rates/transfers to residential care

Characterising the projects III

- No bids won by management consultancies though not excluded
- Experienced teams with individual track records including prior collaborations
- Budgets of ~ £500k
- Projects already benefiting from one another
- Some projects have their own advisory, interactive panels (e.g. of managers)

Challenges ahead I

- Willingness & ability of DH policy leads to share early thinking with research teams
- Building mutual trust and relationships, especially when policy officials turn over
- Timely access to routine NHS information
- Obtaining & using ‘grey’ literature from within government
- Avoiding early feed back of findings prejudicing later analysis/conclusions

Challenges ahead II

- Managing unrealistic expectations
  - Most realistic product of evaluation is enlightenment, not simple answers, evaluation cannot look at everything
- Managing ‘bad news’ from the research
- Change of government and/or abandonment of key policies
- Ability of coordinator to ‘steer’ researchers
- Timing of findings to make a difference
  - risk of Buxton’s Law

    ‘*It’s too soon, until it’s too late’*

Further information on HREP and related research and evaluation

- http://www.lshtm.ac.uk/php/hrep
- http://www.lshtm.ac.uk/nccsdo

- NIHR