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## 8 Local implementation of New Labour's market reforms

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Theories of policy process recognise that policy implementation is as important as, if not more important than, policy design in determining the impact a policy has in practice. Unfortunately, policy-makers often do not pay adequate attention to implementation, considering it the responsibility of others, such as managers, and assuming that implementation is simply 'a matter of carrying out that which has been decided upon' (Grindle and Thomas 1991). Studies of policy implementation have highlighted how policies are mediated by features of the local context (Pawson and Tilley 1997). The views and actions of local actors involved in implementation, in particular, have been found to influence the impact of policies (Lipsky 1980).

Policy-makers and politicians tend to focus on the grand ideas, often failing to acknowledge that, although they have the power to enact policies and legislation, they have much less control over how these are put into practice, or the fact that the results of implementation are often quite different from those that were intended or anticipated.

A useful analogy is that policy-makers sit in the control room (Westminster and Whitehall) pulling levers (making policy), but failing to notice that not all the wires are connected (there are no or few mechanisms to make change happen) and that, even where they are, it takes longer than they expect before the mechanisms act (there are lags between the introduction of national policy and local action).

This makes evaluating health reforms all the more challenging. Attributing any observed effect to a particular policy is difficult, especially when reforms are often multifaceted, operate at multiple levels (system, local, organisational, clinical and service), are 'entangled in complex, inherently political processes', and subject to frequent change (Van Eyk *et al* 2001).

Previous research on the internal market during the 1990s found that despite large-scale structural reforms, the measurable impact was modest, partly because the system was constrained by pre-existing institutions, and partly because the 'dose' was too small to have had a marked effect (Le Grand *et al* 1998). Other observers have suggested that the lack of effect is to be expected in a 'complex system' such as the National Health Service (NHS) (Davies 2002).

Previous chapters in this book have discussed briefly the process and extent of the implementation of particular policies. This chapter considers in more detail how the market reforms introduced by the Labour government were implemented locally. Specifically, it discusses the following questions:

- Was there a grand policy design or blueprint for the reforms?
- Was implementation 'big bang' or more gradual and incremental?
- Did these policies replace previous policies or did they add to pre-existing ones?
- Were the policies implemented as intended?
- What was the impact of context on implementation?

This chapter is intended to complement the other chapters in this book by focusing on the contexts and mechanisms that influence the outcomes and impact of policies. The evidence is drawn from studies that have included qualitative methods of data collection, such as ethnographies and extended case studies. One of the particular strengths of qualitative methods in policy evaluation lies in revealing the experiences and views of local actors, and thereby contributing directly to understanding the nature of policy implementation. Crucially, the inclusion of qualitative methods enables evaluations to consider not just 'does the policy work?' but also 'how does it work (or not)?' (Pawson and Tilley 1997).

## **An emergent reform package**

Although the *NHS Plan* (Department of Health 2000b) was heralded as a 10-year plan for the NHS, it did not set out a blueprint for the market reforms that were to follow. Instead, it was very largely an old-style input plan for the NHS, concentrating on increasing staffing and the capacity to provide services. The details of the market-related policy emerged only gradually. Indeed, the policies were not articulated as a 'package' until 2005 (Department of Health 2005a).

The gradual emergence of the market reforms as a package can partly be explained by the shifting objectives and goals among senior policy advisers and politicians, particularly in the run up to and after the 2001 election. In the second term of the Labour government, it was clear that the priority was to reduce waiting times for elective surgery, but despite spending more on the NHS, the system was not responding commensurately, causing frustration (Le Grand 2007; Powell *et al* 2011). Some of the proposals, such as giving control of budgets to primary care trusts (PCTs) and establishing independent-sector treatment centres (ISTCs), were in the 2001 Labour manifesto, but the more radical ideas for market reform had to wait for the innocuously titled *Delivering the NHS Plan* (Department of Health 2002a). The title suggested that it was simply another post-NHS Plan implementation document, although the new policy package was described by one policy maker as 'the internal market with knobs on' (Powell *et al* 2011, p 87).

It was not until as late as 2005 that the market-based policies were presented explicitly as 'a coherent and mutually supporting set of reforms, which together provide systems and incentives to drive improvements in health and health services' (Department of Health 2005a, p 9). The logic was that the impact would result from the combined effects of the different policies – the benefits would be 'realised through the interactions between all four elements' (Department of Health 2005a, p 12), namely changes to commissioning and patient choice, provider diversity, Payment by Results (PbR), and quality and financial regulation.

This *post hoc* description appears to have been driven by the needs of a new Secretary of State, Patricia Hewitt. The Department of Health was struggling to give a clear and cogent account of the reforms and what they were aiming to achieve (Powell *et al* 2011), and one senior policy-maker admitted that the lack of a unified narrative earlier in the reform process had hampered implementation: 'Not enough thinking had been done about how it all fits together and therefore the right sequencing, pace of development and implementation. So it did feel a bit like a rescue act' (Powell *et al* 2011, p 89).

Thus although presented as a package of mutually reinforcing policies, the market reforms in fact emerged gradually under the Labour government and a succession of secretaries of state for health. As others before have described it, policy-making is not a logical or rational process of decision-making but a much messier process (Hecló 1974). This has repercussions for implementation, to which we now turn.

## The sequencing of implementation

Partly due to the evolution of the policy proposals, different elements of the reforms were implemented at different times, and implementation of the specific policies was also staggered.

Demand-side reforms (PCTs and practice-based commissioning [PBC]) were introduced after supply-side reforms, and their implementation was significantly delayed by the 2006 restructuring of PCTs, which reduced their number from 300 to 152 (Exworthy *et al* 2009).

The consequences of the sequencing of the reforms were acknowledged by policy-makers involved in the 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' (policy-maker). (Powell et al 2011, p 102)*

*'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' (policy-maker). (Powell et al 2011, p 103)*

While some felt that commissioning should have been developed and strengthened before giving the provider-side greater autonomy by establishing foundation trusts and stronger incentives through PbR, others felt that this was an important first step in order to address the pressing political problem of waiting times.

The implementation of the individual elements was also phased. Patient choice was the first element to be introduced, largely as a response to long waiting times for elective surgery. It was first piloted in 2002 among cardiac patients in London who had been waiting for more than six months. In 2006 'choice at the point of referral' extended choice to all planned care, although it was not until 2008 that 'free choice' of provider was introduced, which enabled patients to choose any eligible provider.

Similarly, PbR was introduced initially for a small number of elective procedures in foundation trusts. In 2006, it was extended to elective care in all NHS hospitals, and in 2007 to include non-elective outpatient care and treatment in accident and emergency departments.

The phasing of policy implementation has two important implications. First, it provides an opportunity to refine and adjust policies during implementation. Although there were formal evaluations of patient choice pilots, the government did not wait for the results of these before announcing the extension of choice. In a more technical area, such as PbR, learning from the early implementation was used to inform technical refinements of coding and price-setting. The timing of evaluation is therefore important. For example, the effects of competition were only apparent towards the end of the study period, ie, it took three to four years for the combined impact of the market-related policy instruments to have their predicted effect (by about 2007/8) but not before (Cooper et al 2011; Gaynor et al 2011). If the evaluation had been carried out too soon, the reforms would have been thought to have had no impact.

Second, it means that not all the elements of the market reforms were operating simultaneously or to the same extent throughout the period of implementation. This can have advantages for evaluation, as it allows the impacts of specific elements of the reforms to be isolated to some extent (eg, using interrupted time series analysis and comparative study designs). However, when considering the overall impact of the reforms, it means that there is only a relatively short period for the reforms as a whole to have had an effect. The impact of policy depends on the dose of the mechanism required to effect change. As one policy-maker interviewed in the study by Powell et al (2011, p 99) observed: "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" (policy-maker).

This quote also suggests that policy-makers were frustrated at the time it took and the speed of change. Even when a policy has officially been implemented, it may not have taken full effect because the dose is weaker or variable between areas. An evaluation of patient choice (Dixon *et al* 2010a) found that only about half of patients recalled being offered a choice, concluding that choice had not been fully implemented, at least not as reflected in government targets, eg, that 90 per cent of referrals should be booked via Choose and Book (dropped from the 2011/12 operating framework). Providers interviewed in the study thought it would take time for choice to develop and that things might change in future, particularly as patients became more aware of choice, more information on the quality of providers became available, and a tighter funding environment heightened competition between providers (Dixon *et al* 2010a). It is therefore possible that the evaluation was not able to detect much impact, not because it was not having any but because the dose was too small.

## Layering

As well as the issue of phasing, another complication for any evaluation of reforms is that new policies are often overlaid on existing policies. This was recognised by one of the chief architects of the market-based reforms, who described three overlapping phases of New Labour's reforms: increased supply of staff and modernised infrastructure; national targets and performance management from 1998 onwards; and the reintroduction of competition from 2002/3 (Stevens 2004).

Throughout the period of the market reforms analysed in this book (2002/3–2009/10), the machinery of government and the NHS (eg, strategic health authorities) was still geared towards ensuring that nationally defined targets were met. This was reflected at the highest level in the public service agreement targets negotiated by the Department of Health with the Treasury and monitored by the Prime Minister's Delivery Unit; as well as, at the Department of Health, in the annual operating framework, which was used by strategic health authorities (and Monitor for foundation trusts) to manage the performance of boards and chief executives. Local accounts of the reforms reflect this layering of policies.

A study of two local health economies (Exworthy *et al* 2009) found that managers were working in a context of multiple policies. The result was a dilution of managerial energy and a diversion of attention to the most pressing concerns, which, for all the organisations involved was achieving national targets, especially those with regard to financial balance, waiting times and infection control.

Exworthy *et al* (2009) found that the prioritisation of national targets not only diverted attention away from implementing market-based policies, but in some cases directly impeded them. For example, the menu of possible choices setting out where patients could opt to receive care was restricted to those providers that

were compliant with the 18-week access target. One clinician in the study admitted that in these circumstances the clinicians involved simply reverted to the previous system of manual referrals:

*'We will offer a patient five places to go and appointment times at those five places. That's what it says. It doesn't mean it's going to be within your county, or within your district, it's anywhere within the country. So all [the general practitioners seeking to refer a patient] does is she logs out of the Choose & Book screen and writes me a letter and sends it in... so that's all that's happening. There is no choice. Patients don't want choice, patients want to be treated in their local hospital' (Clinical director, Hospital). (Exworthy et al 2009, p 127)*

Similar findings have been reported elsewhere (Dixon et al 2010a; Powell et al 2011). When asked what drove service improvements within their organisations, providers mentioned a wide array of factors, but choice appeared to have played a relatively minor role (Dixon et al 2010a, p 134). Powell et al, for example, reported that 'access targets were perceived as the highest priority' (Powell et al 2011, p 133). For those working in particular clinical areas, national policies such as national service frameworks were seen to be more influential than the market reforms (Powell et al 2011).

## **Dissonance**

The package of reforms (Department of Health 2005a) was not always well understood at local level (Powell et al 2011). Studies of the local implementation of the market-based policies revealed an unsurprising disconnect between national policy rhetoric, and local experience and interpretation. For example, an ethnographic study by Newman and Vidler found that while individual patient choice of place of care was presented as equity-enhancing in national policy documents, this was 'not convincing for those who have to deal with the reality of resource decisions on the ground' (Newman and Vidler 2006, p 205). In this study, commissioners believed that local strategies aimed at reducing health inequalities, either by encouraging people to adopt healthier lifestyles or by targeting resources at particular groups, were undermined by the emphasis on consumer choice in national policy documents.

Newman and Vidler also found that local clinicians interpreted national policy according to their professional values and aims. Thus, patient choice was reconceptualised by local clinicians as involving patients in decisions about their treatment in the interests of more effective health outcomes. This is illustrated in the following extract from one of the interviews in the study:

*If you talk about choice, how a lot of people will think is that it is about choosing whether you go to this hospital or that hospital. But from my point of view it is around choice right down to the patient level, and it is a bit greater than what*

*hospital you go to, it's around how do you want the service delivered to you... There are options available for treatment; which one fits you best?* (Newman and Vidler 2006, p 205)

With regard to their overall findings, Newman and Vidler commented:

*This is not a case of professional refusal or resistance to the government imperative, but can be understood as a more positive attempt to appropriate elements of consumerist discourse in order to secure the professional goals of improved health outcomes. Such outcomes were to be supported through enabling patients to make informed treatment choices, enhancing their expertise and finding ways to make them more 'responsible' for their own health.* (Newman and Vidler 2006, p 205)

Similar findings have been reported elsewhere. For example, Powell *et al* found that commissioners and general practitioners (GPs) had interpreted patient choice policy in terms of 'redesign programmes and services based more on "personalisation", self management and coproduction' rather than as a means of promoting competition (Powell *et al* 2011, p 107).

One way in which local actors respond to a rapidly changing policy environment is by relabelling existing initiatives as new policy (Curry *et al* 2008). Relabelling enables local actors to demonstrate that their plans are consistent with national policy direction while meeting local objectives and ensuring the continuation of pre-reform initiatives. Curry *et al* (2008), for example, found that service developments already under way had been reclassified as resulting from PBC, which made it difficult to attribute any developments specifically to PBC.

In a study of PBC, Coleman *et al* (2009) identified two different views of what PBC was intended to achieve:

- for groups themselves to redesign services
- or to encourage use of a wider range of providers.

It was the first interpretation that was the most widespread among local actors. This is perhaps not surprising as the original aims were ill-defined, although Curry *et al* summarised them as:

- to encourage clinical engagement in service redesign and development
- to bring about better, more convenient, services for patients
- to enable better use of resources (Curry *et al* 2008, p viii).

Curry *et al* (2008) found that GPs were more interested in using their budgets to bring about small-scale changes to services rather than commissioning services from different providers.

In a number of studies (Farrar *et al* 2007; Exworthy *et al* 2009; Dixon *et al* 2010a; Powell *et al* 2011), the market-based policies were perceived by local actors as conflicting with the local objective of maintaining a sustainable health economy. For example, the national evaluation of PbR found that:

*...issues of NHS culture and behavioural norms were raised by the interviewees, as affecting their responses to the incentives of the new system. For instance, a number of interviewees would not pursue greater revenues through increased supply if this was an action considered detrimental to the financial status of the commissioner and the local health economy as a whole. (Farrar et al 2007, p 15)*

Concern for the viability of other organisations and the health economy as a whole also led to agreements between organisations not to compete for services but rather to 'carve up' the market so that they were offering different but complementary services (Exworthy *et al* 2009; Dixon *et al* 2010a).

Powell *et al* (2011, p 139) found that the economic downturn had resulted in a shift away from competition to a renewed emphasis on collective action between organisations to ensure a sustainable health economy. One PCT, for example, was refusing to pay using tariff and had told the acute trusts:

*"whatever the level the activities are, we cannot afford to pay you, so we're not going to pay you." ...once it becomes clear that they're not going to get paid anymore it then becomes "how do we work with you in order to minimise financial pressure and minimise demand?" (PCT director).*

## **Unforeseen consequences**

Studies of implementation of the market reforms have revealed both positive and negative impacts that were unforeseen by those who designed the policies (*see* Chapter 9). At least some of this is a consequence of how the policy was interpreted and implemented locally. For example, PbR has been blamed for a number of negative consequences, including:

- a growth in emergency admissions (although the empirical evidence does not support this view)
- so-called upcoding of procedures
- preventing the transfer of care to community settings (Audit Commission and Healthcare Commission 2008; Blunt *et al* 2010; Powell *et al* 2011).

Although PbR was originally designed to increase activity in an effort to reduce waiting times, its extension from elective to emergency admissions, and to medical as well as surgical admissions, created incentives for hospitals to increase activity

in areas where this might not be desirable from a quality perspective. At least part of the effect is attributable to the way in which local organisations responded to policies and the incentives they created, and individual behaviours within those organisations.

The way patient choice was implemented was also not as intended. Greener and Mannion (2009b) found that one trust's perception of the Choose and Book computerised booking system was that it was useful not so much to help it compete for business within the new economy of care, but rather as a way of dealing with excess demand for its services.

Some commissioners introduced referral management centres, partly in order to support the delivery of patient choice targets (that all patients should be offered a choice of at least four or five providers and that a specific proportion of referrals be made through Choose and Book). Ironically, referral management centres have also been found to restrict patient choice by directing referrals to particular providers, for example, to make use of local ISTCs when their capacity had already been paid for by the PCT (Imison and Naylor 2010; Co-operation and Competition Panel 2011).

Although few patients used published information to make a choice of provider, and few providers reported competing directly for patients, the threat that patients could go elsewhere did seem to stimulate a greater focus on the patient experience (Dixon *et al* 2010a). This effect was not created, however, by choice but rather stemmed from providers' concerns about their reputation and a desire to retain the loyalty of local patients.

Other policies had unintended benefits. For example, an unexpected finding from a study by Coleman *et al* (2009) of PBC was a new willingness among GPs to undertake peer review and performance management of each other's work. This took the form of practice visits to discuss performance, publication of named performance data, open discussion of performance data in meetings, and the use of PBC as a mechanism to implement an unrelated performance assessment framework.

Interestingly, the coalition government now plans to strengthen GP involvement in commissioning. At least one of the explicit intentions behind this policy is to promote peer scrutiny of performance in general practice (Goodwin *et al* 2011).

## **Local context**

The extent to which market-based policies were implemented varied across sites and specialties. Contextual features influencing implementation included the local configuration of providers, their proximity to each other, the type of services they provided, and the nature of pre-existing relationships. The reforms were not painted on to a blank canvas, but implemented where there were existing local structures, relationships, values and aims.

This is illustrated by the findings of a two-year ethnographic study that explored the local implementation of patient choice policy (Greener and Mannion 2009b). The study focused on an NHS trust that operated on the fringes of a conurbation where there was easy access to several providers of care and therefore considerable potential for a health care market to develop. The study found that existing referral patterns within the local area were extremely sticky (ie, resistant to change), even when they did not appear to be entirely rational. For example, referrals were not always to either the closest or the highest-rated local care provider. Instead, they were based on historical GP–consultant relationships. Patients were also ‘extremely loyal to the hospital, and believed that it was part of their community’ (Greener and Mannion 2009b, p 98), although a view prevailed among trust managers that it was the GPs, rather than patients, who were the real customers of the hospital, and this does appear to have been borne out by the evidence (Dixon *et al* 2010a).

Similarly, Dixon *et al* (2010a) describe a local health economy with one dominant trust to which patients were extremely loyal. It was primarily concerned with managing demand for its services and, rather than competing with other providers, it actively sought to encourage patients to go elsewhere to reduce pressure on its own facilities.

At other sites, Dixon *et al* (2010a) found that providers competed for patients at the boundaries of their catchment areas. These were often rural areas where patients were equidistant from several hospitals, and is consistent with the quantitative analyses reported in Chapter 6 that found the largest increases in competition to be in such areas. This study also found that some hospital providers felt threatened when local commissioners were tendering more aggressively for services and hospitals were having to compete with the private sector.

Exworthy *et al* (2009) concluded that the persistence of earlier social and institutional relationships meant that the market-based policies did not have their intended effects. For example, patient loyalty to the local hospital, and a reluctance to destabilise local organisations, meant that referral patterns were maintained and local providers negotiated market share. Conversely, market-based policies could also disrupt local social and institutional relationships and produce unintended consequences, such as by creating an adversarial environment that prevented necessary collaboration and produced inefficiencies by diminishing trust.

Market reforms were also not seen as appropriate to some specialties. Powell *et al* (2011) found that among both commissioners and providers, there was a commonly held view that patient choice did not have much relevance in long-term chronic conditions such as diabetes. In these conditions, greater value was placed on best-practice guidance, such as that contained in national service frameworks, as a lever for improving services; and the patient's voice, particularly in making decisions about treatment, was regarded as more relevant than choice of provider or place of care:

*In most sites it was acknowledged that the majority of patients would wish to choose their local hospital out of convenience. Where multiple entry points to diabetes care existed (particularly for secondary care) it was reported that this had the potential to fragment, or undermine, the potential to develop a pathway of care. (Powell et al 2011, p 182)*

## **Discussion and conclusions**

There was no blueprint for these reforms. Instead, the various elements of the reform programme emerged gradually, which meant there was some difficulty in articulating the reforms clearly and explaining how the different components interacted. This overarching narrative emerged relatively late in the day and may explain why local actors were often unclear about what and how the reforms were supposed to operate.

The staged approach to both the development and implementation of the market reforms by the Labour government meant that some aspects of the reforms moved ahead more quickly than others. Although this had some advantages – giving the opportunity to refine policies such as PbR in the light of feedback and the changing context – there were some down sides. Most critically, the providers were able to seize their new freedoms in response to stronger incentives before the commissioners had had time to develop their skills or approaches to manage demand. One consequence of the sequencing and layering described here is that it may have limited the extent to which any impact is observable – the full set of reforms were only in play for a relatively short period towards the end of New Labour's time in office as a result of the time-lag between policy enactment and implementation.

Despite a commitment to the market reforms among politicians and leading policy advisers, implementation of the reforms alongside existing top-down performance management of targets limited the extent to which they took hold locally. For local leaders, the imperative to meet national targets remained, and for clinicians working in areas outside elective surgery other policy initiatives appeared more salient.

In some localities, including urban areas, the market structure (eg, one dominant trust across several sites) and lack of population mobility meant that choice and competition were not seen to be relevant or did not amount to a significant change as there might well have been de facto a choice of hospital for many years. Prior assumptions that choice was not so relevant or feasible in rural areas were in fact found to be wrong. Surprisingly, the choice of provider and competition for patients was greater in rural areas where no single provider dominated and people were more used to travelling to access services (Dixon *et al* 2010a; Gaynor *et al* 2011).

The research studies reviewed here found a degree of dissonance between national policy rhetoric and its understanding by local implementers. As a result, policies conceived of nationally did not necessarily have the desired impact, indeed some

had unintended consequences, not all of which were negative. In line with much of the literature on policy implementation, local implementers had significant discretion to interpret the policies locally. Although some may argue that this is a good thing, allowing innovation and adaptation to local circumstances, in some cases people carried on as before, simply rebranding existing activities, or resisted them entirely.

The experience of market reforms points to a need for policy architects to recognise that local actors, context and institutions will mediate any changes. It suggests a need to pay more attention to the implementation phase of policy, and to identify what can be done to increase the chances of any policy having its intended impact.