How should we evaluate the impacts of policy?: the case of Payment by Results and the 18 Week Patient Pathway in English hospitals

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Today, qualitative researchers are framing the relationship between qualitative case studies and quantitative evaluation research in positivist terms, seeking dialogue with quantitative researchers on the basis that qualitative case studies hold the potential to develop theory for evaluation programmes and to improve the quality of quantitative research. In the UK health policy literature, however, recent evaluations of major government programmes of reform have been conducted under largely quantitative and econometric strategies involving baskets of indicators, or routinely collected hospital statistics, set against the central stated aims of the programme: namely, to improve quality, efficiency, responsiveness, output and equity. For the wider evaluation literature, we detail the results of a qualitative case study of the impact of two key reforms, the 18 Week Patient Pathway and Payment by Results, on four English hospitals, demonstrating the value of the positivist frame to evaluation research based on its capacity to improve understandings of cause and effect and to direct quantitative researchers towards better measures and data sets. For the UK health policy literature, we demonstrate the value of qualitative case studies to the policy process in terms of their potential to reduce the risks for serious policy mistakes.

Keywords: evaluation research; policy analysis; patient waiting times; Payment by Results; National Health Service; healthcare

1. Evaluating public policy

The National Health Service (NHS) is Europe's largest organisation (NHS 2009). It employs more than 1.3 million people and offers publicly funded health care free at the point of access for the entire population of the UK. While the NHS is a collective term that refers to the four publicly funded healthcare systems of England, Wales, Scotland, and Northern Ireland, each system operates independently, and is accountable to the respective devolved government (Wright 2009, 2011). During its second term in office, the former UK Labour Government introduced a wave of decentralised policy mechanisms that aimed at improving service delivery via familiar notions of competition and choice in public services, among the most important of which are considered Payment by Results (PbR) and the 18 Week Patient Pathway (18 Weeks; Le Grand 2007).

Recent evaluations of these key initiatives have been conducted under largely quantitative and econometric strategies involving baskets of indicators, or routinely collected hospital statistics, set against the central stated aims of the wider policy programme: to improve quality, efficiency, responsiveness, output and equity (Mays and Dixon 2011a, 124–125). Knowledge matters in the policy process and a good deal of the knowledge utilised in public policy emanates from evaluation research. Evaluation is a means for establishing the effectiveness or non-effectiveness of policy. In short, policy evaluation measures policy impacts (Radaelli 1995), and a key question for evaluators is how best to go about this task. The consensus in the evaluation literature is that policy research should integrate quantitative and qualitative perspectives (Bryman 2006). The consensus regarding mixed methods has been hard won. In political science, at least, comparing differences between quantitative and qualitative approaches traverses highly sensitive ground. In the past, the distinction between the two traditions has even led some analysts to invoke religious metaphors. If qualitative researchers were, like the ancient Hebrews, the people of the book, then quantitative researchers were the people of the model (Heckman 2000, 46).

But, in the new millennium, these metaphors, and even the distinction between quantitative and qualitative research itself, are considered unhelpful (Onwuegbuzie and Leech 2005). Better distinctions are thought to include: statistics versus logic, effect estimation versus outcome explanation and population-oriented versus case-orientated approaches (Mahoney and Goertz 2006, 245).

Based on these distinctions, quantitative and qualitative styles of policy evaluation are often considered the logical consequences of the alternate foci and interests of policy researchers. Where qualitative researchers seek to explain individual cases under a 'causes-of-effects' approach; quantitative researchers attempt to estimate the average effect of independent variables under an 'effects-of-causes' approach. Where qualitative methodologies tend to adopt a narrow scope, with less emphasis on causal generalisation; quantitative methodologies adopt a broader scope to maximise statistical leverage and generalisation. And where qualitative researchers suggest that the evaluation of theory must be sensitivity to observation, and that, exceptions can have important impacts; quantitative researchers suggest that all observations are equally important and that overall pattern-fit is critical (Patton 2002; Mahoney and Goertz 2006). As a result, qualitative researchers are sometimes considered more analogous to detectives, who solve puzzles and explain outcomes via experience, detailed fact gathering and general causal principles (George and Bennett 2005). By contrast, quantitative researchers are often considered analogous to natural scientists, who analyse sets of data with a view to establishing a pattern of conforming observations against a null hypothesis (Mahoney and Goertz 2006, 229). Under the consensus, these metaphors and distinctions are also put with the intention of promoting dialogue and understanding between different types of researchers, with the hope that neither tradition will use explications of difference to point out where the assumptions of the other are deeply flawed.

Recently, some qualitative researchers have taken a stronger position, suggesting that a 'negative framing' of the consensus via notions of equilibrium and the balance of approaches runs the risk of missing the important contribution that each tradition can make to the evaluation literature (Yin 2003; George and Bennett 2005). Taking a stronger position, these analysts seek a more sophisticated and collaborative dialogue between qualitative and quantitative approaches based on a recognition of the complementary nature of each approach. And in some areas of social science, this stronger position is already taking hold and the respective ambitions of each tradition are being scaled back. For example, the proponents of case studies, of statistics and formal modelling are becoming more circumspect about the kinds of knowledge and theories they aim to produce (George and Bennett 2005, 4–5). Within each tradition, analysts are improving their techniques and making significant advances towards mitigating many of the problems identified by their critics (Mays and Pope 2000). Based on an appreciation of the epistemological strengths and weaknesses of alternative foci, students of policy evaluation are also gaining exposure to multiple approaches and movement across the frontiers is becoming more common. Consequently, analysts themselves are becoming more aware of the limitations of their favoured methods and more secure about their own ability to make contributions to theoretical progress. In turn, they are also more anxious to pursue collaborations with practitioners in other fields for the purpose of improving the quality of policy evaluations (George and Bennett 2005, 4–5). Grounded in a more solid appreciation of the strengths and limitations of various evaluation methodologies, this more sophisticated dialogue has encouraged qualitative researchers to eschew the negative frame of pursing a balance and equilibrium between different research methods in favour of a much more positivist construction of the relationship (Stake 1995; Yin 2003; George and Bennett 2005).

In this paper, we present the results of a qualitative case study of 18 Weeks and PbR on four English hospitals, demonstrating the value of this positivist frame based on its capacity to provide useful tools with which to develop theory for the evaluation of policy

interventions and wider programmes of reform (Stake 1995; Yin 2003, 2006; Baxter and Jack 2008, 544). We demonstrate the potential of qualitative research to facilitate close collaboration between the participant and the researcher, enabling the former to describe their views of reality, and the latter to fashion improved understandings of participant actions and the causes behind them (Crabtree and Miller 1999; Lather 1992; Baxter and Jack 2008, 544–545). We show that qualitative case studies hold the capacity to answer the 'how' and 'why' of policy impacts by allowing researchers to understand how actions are influenced by the contexts in which they are embedded (Baxter and Jack 2008, 556). We establish that qualitative case studies are able to improve the quality of quantitative research by providing better constructions of cause and effect, enabling quantitative researchers to develop better evaluation strategies and to target more relevant concepts, measures and data sets. Ultimately, we conclude that the conduct of policy evaluations in the absence of a sophisticated and collaborative dialogue with qualitative research not only risks delivering crude and unsophisticated evaluations of major programmes of policy reform; but, where such evaluations are permitted to feed back into the policy process, they also heighten the potential for serious policy mistakes.

2. The evaluation of UK healthcare reform

In the UK, reducing patient waiting times has been a longstanding policy goal towards which a succession of governments have experimented with a variety of mechanisms. In 2006, however, the former UK Labour government published an implementation framework for an 18 Week Patient Pathway [Department of Health (DH) 2006]. Whereas earlier efforts to reduce waiting times had emphasised institution-based waiting time targets that focused on specific elements of the patient journey: referral, diagnosis, treatment, outpatient consultation; 18 Weeks addressed waiting times from a patient perspective by focussing on the entire patient journey. Under the new approach, the 18 Week pathway commenced when the patient received general practitioner (GP) referral for diagnostics and concluded when the patient was admitted for treatment. Consequently, 18 Weeks did away with the entire notion of institution-based waiting lists and targets, requiring primary and secondary care providers to work in close collaboration to deliver the new patient-based target.

In the UK health policy literature, evaluations of waiting time targets have been undertaken largely from a quantitative frame against 'quality indicators', primarily hospital mortality rates. Typically, evaluators see small difference between 18 Weeks and the older institution-based waiting time targets. 18 Weeks is conceived as another policy instalment in an ongoing government project for tackling excessive hospital waiting times through target regimes, in which the key issue has been concerns regarding reactive gaming (Dimakou et al. 2009). Typically, evaluators express fears that the use of waiting time targets could create a culture in which there is little but hitting and missing targets to distinguish successful from unsuccessful organisations (Bevan and Hood 2006a, 2006b; Lewis and Appleby 2005; Francis 2010). Other evaluators have worried that target regimes might contribute to the commodification of healthcare and lead hospitals to prioritise some parts of the care pathway at the expense of other parts (Dimakou et al. 2009; Harrison 2009; Appleby et al. 2005).

Evaluations of waiting time targets have often focussed on quantitative output indicators to establish impacts such as: before and after analyses of average waiting time distributions (Harrison and Appleby 2005); duration analysis of Hospital Episode Statistics (Dimakou et al. 2009); hospital level admissions data and mortality rates (Propper et al. 2010). Assessing older institution-based targets, evaluators found that these had successfully decreased patient waits without having significant impacts on quality indicators (Propper et al. 2010). On this basis, they offered suggestions regarding actor behaviours. For example, where institution-based targets were found to have achieved their aim without reactive gaming and negative impacts on quality indicators, one study suggested that NHS employees may have been on 'a mission', that waiting

time targets may have induced 'additional effort at no cost', or that the lengthy roll out of the target regime may have encouraged NHS employees to recognise and support the policy as a long term solution rather than a short term fix (Propper et al. 2010, 332). More recently, evaluators have begun tracking hospital performance against the 18 Week target by measuring the waiting times of patients still waiting for treatment, those who attended outpatients for treatment, and those who were admitted to hospitals as inpatients. The strategy established success against the target, on a monthly basis, by tracking the median patient waiting time – the time waited by the person halfway between the shortest and longest wait along the referral to treatment pathway (King's Fund 2010; Appleby 2011). Broadly, evaluation strategies for 18 Weeks and other waiting time targets establish impacts by measuring, analysing and reporting changes to baskets of routinely collected output indicators. However, the problem is that in lieu of a collaborative dialogue with qualitative research, there is no indication that these indicators are either appropriate for assessing impact or even reflective the landscape in which they are located. Put simply, how do evaluators know that they are looking for impacts in the right places? Indeed, quantitative researchers experience difficulty explaining cause and effect, which also complicates the task of establishing actor motivations and actions. The point is that qualitative case studies have the capacity to highlight the impacts and underlying processes that 18 Weeks initiates within organisations, and how these both enhance and undercut organisational performance, which can help evaluators target better concepts, measures and data-sets.

Similarly, reducing service costs and improving efficiencies within the system have also been long standing policy goals towards which both UK Labour and Conservative governments have set a variety of new policy mechanisms. Introduced in 2002, PbR replaced the earlier Conservative Government's market-based instrument, commonly termed 'the internal market', which established a system of healthcare purchasers and providers that functioned on the basis of legally binding contracts between general practice fundholders, who received budgets from the DH, and public and private sector hospitals, which competed with each other on prices for individual services in order to secure contracts from purchasers. But, the experiment was a failure: transaction costs were high and smaller organisations were unable to engage in the market resulting in systemic service variations (Wright 2011).

Taking office in 1997, Labour abolished both the internal market and GP fund holding. In 1999, it established primary care trusts (PCTs), freestanding statutory bodies responsible for contracting health services with provider organisations in their local areas. Under the new system, PCTs and provider organisations negotiated contracts on the basis of a national schedule of prices for healthcare services, known as PbR. Introduced in 2002, PbR provides fixed tariffs for commissioning Healthcare Resource Groups: essentially, a range of clinical procedures, treatments, and diagnoses (DH 2002). By 2006–2007, PbR covered all non-elective, accident and emergency and outpatient admissions, effectively £22 billion worth of services (DH 2006, 2007). With individual tariffs calculated according to an average national cost for services, PbR solved many of the problems of the old internal market. By removing the ability of purchasers and providers to negotiate prices, PbR reduced complexity in the system. By fixing the price, it offered a solution to the problems of systemic service variability by requiring providers to monitor the costs of their activity and pursue reductions against the average national price.

Establishing impacts for PbR, evaluations have been conducted under a quantitative econometric frame, which measures the introduction of PbR against changes to baskets of routinely collected quality indicators: primarily, length of stay, post-surgical readmission and hospital mortality rates (Propper, Burgess, and Green 2004; Gaynor 2006a, 2006b; Cooper et al. 2009; Farrar et al. 2009). The strategy holds that PbR is representative of a 'second phase of provider competition', the central aim of which was to increase quality

and efficiency through choice and competition (Propper and Dixon 2011, 83; Propper, Burgess, and Green 2004; Gaynor 2006a; Cooper et al. 2009). Analysing impacts, the chief interests of the strategy lie in regard to economic theory, competition and the impacts of markets with fixed prices on quality improvements (Gaynor 2006b; Miraldo, Goddard, and Smith 2006; Propper, Burgess, and Gossage 2008).

Earlier evaluations of the old internal market found a negative relationship between competition and changes in hospital mortality rates (Propper, Burgess, and Green 2004, 1247; Propper, Burgess, and Gossage 2008). Evaluators agreed: where providers set both the price and the quality of services, 'the positive and normative impacts of competition are ambiguous' (Gaynor 2006a, 441). Alternatively, where prices were regulated or fixed above the marginal cost, evaluators in the US suggested that competition should improve quality: 'economic theory for markets with regulated prices predicts such a result' (Gaynor 2006b, p. 27). However, findings in the UK disappointed. Analysts found that PbR's fixed regime of prices had increased levels of activity and reduced costs, but produced little measurable change in mortality indicators (Farrar et al. 2009). In response, they offered a variety of explanations. Where 'competition and choice' failed to deliver marked impacts on mortality rates, some suggested that incentives for hospitals to increase quality may depend on both their geographical location and the precise mix of payers in their local area (Propper, Wilson, and Burgess 2006; Miraldo, Goddard, and Smith 2006). Alternatively, where other analysts put the question differently, asking whether competition had 'saved lives' to find that "mortality fell more quickly (i.e. quality improved) for patients living in more competitive markets after the introduction of hospital competition in January 2006" (Cooper et al. 2009); they concluded that it had; and consequently, that competition had worked.

The problem is that these evaluations focus on measurable output data in the wider service of economic theory. Indeed, PbR is conceived as part of a wider government programme to increase quality and efficiency through choice and provider competition (Propper, Burgess, and Green 2004; Gaynor 2006a; Cooper et al. 2009). By packaging PbR within an econometric frame, evaluators can provide little insight regarding the impacts of PbR on the delivery of healthcare services within organisations. Again, lacking a collaborative dialogue with qualitative research, there is no guarantee that that these evaluations are looking for impacts in the right places. Moreover, with their primary focus on the concepts of choice and competition, the case can also be put that these studies are not even evaluating the impacts of PbR at all.

The more serious problem, however, is that some of these evaluations are feeding directly back into the policy process for healthcare reform. On 7 June 2011, Prime Minister David Cameron delivered a key speech on UK healthcare in which he referenced an evaluation carried out at the London School of Economics and Political Science. Facing intense pressure to abandon the government's controversial Health and Social Care Bill, Cameron claimed that 'competition is one way we can make things work better for patients. This isn't ideological theory. A study published by the London School of Economics found hospitals in areas with more choice had lower death rates. And there's now real evidence that England is delivering more for its money than any of the devolved nations, in part because of the competitive reforms initiated by Tony Blair and Alan Milburn' (Cameron 2011).

Conversely, a lack of thorough evaluation research arguably contributed to the demise of 18 Weeks. While evaluators have some insight to when and where breaches against waiting time targets occur, they have been unable to help policymakers understand how and why the 18 Weeks target actually works within hospitals. The problem is also a serious one. In June 2010, UK Health Secretary Lansley (2010) abolished 18 Weeks as an official government target, aiming to 'free the NHS from bureaucracy and targets that have no clinical justification…doctors will be free to focus on the outcomes that matter –

providing quality patient care… the NHS will no longer be accountable to ministers or the Department for its performance in these areas'. However, in June 2011, with concern from inside the NHS building that hospital waiting times were on the rise, Prime Minister David Cameron subsequently reintroduced the commitment to 18 Weeks (BBC News 2011; Triggle 2011).

In the UK, these evaluations have also captured the attention and, to some extent, the agenda of the wider research community. Summing up the government's reforms, key analysts recently noted 'on the face of it, the most striking finding' from all the evidence collected regarding the introduction of 'the market to the English NHS was that higher levels of potential inter-hospital competition appeared to be associated with a faster reduction in hospital mortality rates' (Mays and Dixon 2011a, 135). Assembling the findings of a wide range of studies, analysts suggested that the effects of Labour's NHS reforms 'were not dramatic', that they 'had only a small, sometimes imperceptible, impact in the desired directions', and that, therefore, a major issue for policymakers is whether the costs, both financial and political, were 'worth the effort' (Mays and Dixon 2011b, 159–160).

These examples point to a wider problem in the UK health policy literature: namely, the lack of sophisticated dialogue between qualitative case studies and quantitative evaluation research. In the remainder of this paper, we detail the results of a qualitative case study of the impact of 18 Weeks and PbR on four English hospitals with a view to demonstrating the importance of such a dialogue to the evaluation of these mechanisms. For the evaluation literature, our point is a general one: that a positivist framing of the relationship between qualitative case studies and quantitative techniques holds a useful capacity to improve understandings of cause and effect, and thereby, to direct quantitative researchers towards better strategies, measures and data sets. For the UK health policy literature, our point is more direct: the absence of a dialogue with qualitative research, and the wider failure to appreciate developments in the evaluation literature, risk the production of crude and unsophisticated evaluations of UK healthcare reform which heighten the potential for serious policy mistakes.

3. Methods

The methods used in this study have been described elsewhere (Allen et al. 2010; Dempster, Woods, and Wright 2013). Four hospitals were purposively selected to reflect a range of factors including: specialist hospitals and district general hospitals, degree of market competition and geographical settings: for example, rural and urban settings and South and North areas of England with a maximum of three hours travel from major population centres. The aim was to have maximum variation. Only foundation trusts (FTs) were included in the study.

The research questions explored (1) how, and at what level, have PbR and 18 Weeks influenced processes and the roles of actors within organisations; (2) where and how have these instruments delivered improvements, (3) where and why have they failed to deliver improvements.

Primary data collection included conducting interviews, observation of meetings, documentary analysis, and the exploration of governance through focus on services for two distinct tracer conditions: people with diabetes and orthopaedic surgeries. The tracers provided a case study overview of the different aspects of hospital service, and how these integrate in terms of governance and production processes. It also provided accounts of the decision-making processes of various actors exploring their experiences, in light of 18 Week targets and PbR. Each tracer was managed by different divisional specialities within the hospital that is, medicine and surgery. For example, diabetes is an ongoing long-term condition, often managed in the community, with only severe cases being seen at the hospital. By contrast, orthopaedics usually involves a short concentrated use of

services within the hospital and has less of an infrastructure based in the community. More importantly, the 18 Week target applies to much non orthopaedic surgery while PbR applies to both services.

Personnel were selected to reflect a range of views within the organisation (Miles and Huberman 1994; Patton 2002). The aim was to solicit views and experiences of people involved from the executive level to those engaged with providing services. The sample of interviews was stratified across the structure of the hospitals. Within the clinical directorates, consultants and nursing staff reported to a general manager and a clinical director, who held responsibility for managing the budget, quality control and the provision of services and were often key gatekeepers. In turn, the general manager and the clinical director reported to the Board of Directors, who held overall responsibility for the performance of the Directorates and the Trust. The Board of Directors reported to, and consulted with, the Board of Governors on hospital performance and its future strategies. Governors reported consultations to their various constituencies.

Interviews were conducted in two six-month periods of fieldwork, from February to July in 2008–2009. By this time, the selected hospitals had been pushing to meet the 18 Week target for almost two years and had recently become FT hospitals. At all levels, staff were firmly focussed on delivering 18 Weeks and achieving the pathway had become the dominant influence on the internal organisation of all hospitals. Similarly, by 2006–2007, PbR covered all non-elective, all accident and emergency, and all outpatient and emergency admissions, requiring all hospitals to review the actual costs of their activity against income derived from the national price (DH 2007).

In total, 111 interviews were conducted across the four locations, by a team of five researchers. Transcripts were typed verbatim, proof read and corrected, while notes and comments were collected and made into gisted memos (Dempster and Woods 2011; Evers 2011; Paulus, Lester, and Dempster 2013). In order to ensure validity, at least three members of the research team read all the data and contributed to the production of themes for the analysis using an agreed framework (Dempster, Woods, and Wright 2013). A similar process was used for collected documents (other than purely financial documents), all of which was imported into NVivo8 (QSR International 2008) for analysis. Examples from the analysis are included below to explain or illustrate key points. While retaining anonymity the speakers have been identified by their position within the organisation for example, clinician, clinical director, director of commissioning, executive and manager.

4. Results

4.1. Enlisting clinicians: intrusions on professional discretion

18 Weeks and PbR function within hospitals via intrusions on professional discretion, associated with the national price and the 18 Week target. Both instruments structure an environment in which clinicians must modify clinical decision-making processes in order to deliver the time and cost-based targets set under each instrument. In the main, clinicians were supportive of the enhanced responsiveness to patients achieved under 18 Weeks. However, support for PbR was more equivocal. While clinicians welcomed the potential for efficiency gains, profit retention and investment in services within their directorates, they were concerned about negative impacts on quality.

Under 18 Weeks, clinicians noted improvements in the care pathway: patients were seen more quickly, their journey through the hospital was better mapped, and clinicians were able to observe their progress much more easily. However, clinicians were critical that the target gave them ‘no choice but to treat that patient within 18 weeks’ (Executive). 18 Weeks was an arbitrary target. It had been ‘plucked out of the air at random’ according to one clinician. It bore no relation to the patient or their ailment. And it also required clinicians to structure treatments arbitrarily. ‘It’s been decided that you have to have four

weeks lead in time at most to the consultation, four weeks to investigate and decide, and then you've got another six weeks to do any operation. So you've got to have completed the episode within 18 weeks' (Clinician). Under 18 Weeks, professional discretion suffered because 'sometimes a disease doesn't change fast enough in-between and so you're making a decision based on not that much in fact…you try to make an assessment of how bad things are going to be and use your best guess' (Clinician). Or, in other words, 'stick your finger up in the air…lick it to see where the wind's blowing. It's as unscientific as that' (Clinician). Where clinicians thought that some conditions might improve outside the 18 Week window, the pressure to push patients through the system often sent patients to clinics unnecessarily. And for their part, some patients did not wish to be sped through the system. They preferred to have treatments at self-selected times (or places). 'Patients say, I don't want an operation now. I want my operation in the summer, during the holidays when I've got childcare and things like that' (Executive). In general, clinicians acknowledged and supported enhanced responsiveness to patients achieved under the target; but they also resented the loss of professional discretion. 'They (the government) would possibly justifiably say this is what's made things better, but it (18 Weeks) creates some very strange drivers in the hospital, this idea that it's not always clinically appropriate what you do when you're just chasing a target, and it just makes life very unpleasant' (Clinical Director).

But PbR intruded on clinical decision making too. Under PbR, clinicians felt pressure to reduce costs by admitting patients only where absolutely necessary. They made more use of outpatient, primary care, or even community care settings. 'We do a lot of education and try to equip primary care staff to take on the patients that we'd like to discharge… we do look at it more as a business in that we do have to meet hospital targets' (Clinician). For some clinicians, reducing costs and generating profits was important to the development and viability of their directorate. 'If we can get our hands on some of the income that comes in, then we could be able to use that money to invest in the Directorate. I think it's more what happens if you… didn't have PbR and then you just get what the Strategic Health Authority gives you, which some of the other Trusts around you have suffered, and financially that's been really bad for them' (Clinician). But efficiency and cost savings also came at the expense of professional discretion. In particular, clinicians were concerned that PbR might deliver lower quality services. By moving patients between primary and secondary care, clinicians claimed that the relationship between the patient and the consultant became less trusting and less close. 'We don't treat a condition, we treat a patient, and I think people seem to think it's a bit like, you need a particular job done on your car, so you can go to any Peugeot dealer who will ring around and see if he can get the part sent in, and it doesn't matter which garage he goes to…but I think it's very different having an operation, because surgery's not like putting a bit on a car…the skills of surgeons vary tremendously' (Clinician).

4.2. Enlisting clinical teams: pressure from the executive

18 Weeks and PbR also allowed hospital executives to exert pressure on clinical teams. In exerting pressure, executives were concerned to deliver more efficient services and cost savings without negatively impacting on service quality. Significantly, executives did not exert pressure via emphasis on delivering quality improvements. In some cases, they were even prepared to subordinate innovation and improvement within directorates to achieve waiting time targets and cost reductions.

Executives were highly supportive of 18 Weeks. They wanted the target 'delivered' and had put considerable pressure on clinical teams to achieve it. At the time of interview, executives were more interested in their clinical directorates achieving the 18 Week target than in delivering innovations and improvements within service lines. 'At the moment we're trying not to distract them by anything other than delivering the 18 week target (Executive). 18 Weeks opened the activities of clinical teams to executive scrutiny. Under both 18 Weeks and PbR, clinicians felt the presence of the hospital executive much more acutely. 'We have Consultant staff meetings with the Chief Executive…they

usually say unless we hit the targets one way or another, we will lose so much money or we won't get the contract for such and such… I think clearly one feels that the employer is a little bit closer than previously' (Clinician). Executives held regular meetings with clinical directorates to assess and plan how specialities could deliver the target. 'There is a lot of pathway work going on, and there needs to be because of the eighteen week[s]…we need to understand the pathways and we need to remove the blocks, and we need to be working together' (Executive). Executives exerted pressure via engagement. 'We've had quite a lot of discussions and debates both with individuals and with groups about the waiting list and 18 weeks and ….I have to say they've all behaved brilliantly around that, now I would say a few years ago we would have had no chance of doing that' (Manager).

Executives were also supportive of PbR and put considerable pressure on clinical teams to deliver cost reductions and efficiency gains in some areas. 'I hope…that they understood why it's necessary for them to make a surplus. But…we're not saying, okay, if you don't make a surplus, then we're going to close you down. Because, obviously… it's a little bit more complicated than that' (Executive). PbR enables the Executive to engage with clinical directorates regarding the way they provide their services. 'Where it's made an impact, service leads [have] actually said 'Gosh, are we really making a loss of that amount?' Well…you did two things, check the coding, the coding was wrong. And one more operation per list, which wasn't too onerous, and it got up to a contribution of nought. Well, they've only got to get to 11% to make their surplus that we want them to make. So they're on their way' (Executive). Clinical teams document procedures via coding returns, which attract payment under PbR. With accurate knowledge regarding the activity and performance of clinical directorates, hospital executives were able to enforce accountabilities by pursuing service efficiencies, remapping the pathway and delivering profits.

Some executives reported major successes in using PbR to deliver service improvements and to increase care quality. But the major emphasis was on cost reduction. 'It's been particularly successful in Ophthalmology, 'cause they looked at their data, and looked at their profit, and looked at the process, so it's not just a financial model, it's a care model, and…looked at the number of steps. As a result of doing the process mapping, they've been able to cut out a number of steps, significantly shorten the Care Pathway, and thereby you generate more surplus, because it costs you less. And as you know… everything's on a PbR, a tariff….so if you can do the same thing in a shorter amount of time, you'll generate more surplus' (Executive). Again, executives exerted pressure via clinical engagement. But, in terms of PbR, some clinicians responded and others did not. 'Some (Clinicians) don't get it… I have no patience with that. I say, 'You want to do interesting things, play with the toys, do interesting medicine, you've got to do the boring stuff well, efficiently and make a return, 15%, whatever we mandate it to be, so that we can do the interesting things, invest in research, invest in the add-ons. But if you can't do the basics, we won't be in business!' (Executive).

4.3. Enlisting managers and clinicians: coding and data collection

In the face of executive pressure, 18 Weeks and PbR also structure an environment in which clinicians and their managers become jointly accountable for operationalising each instrument. In terms of PbR, joint working involves new responsibilities for accurately coding episodes of care, which render the cost-based implications of clinical activity more transparent to both managers and the executive. Under 18 Weeks, joint working involves new responsibilities for collecting data and tracking the progress of patients through clinical directorates, which render the time-based implications of clinical activity more transparent both to the executive and to a much wider array of other actors within the hospital. Interestingly, quality improvement did not feature as a means for recruiting managers and clinicians to deliver either instrument.

PbR puts pressure on clinical directorates to code episodes of care accurately, or to risk receiving less money. Under PbR, clinicians and managers must work much more closely in order to attract the appropriate levels of payment. 'I can't code. I can't put an operation down. If you were to come back in a year, I would hope that we were further forward. if we had a much better Coding Department in this [hospital], I imagine we would make so much more money' (Manager). At the time of interview, most managers reported that their directorates were not accurately coding procedures. 'I'm not convinced that within this Directorate…that we are coding accurately for the investigations activity that's coming through the door so that we get the right sum of money attached to that spell, because if you get the wrong code it can make a huge difference' (Manager). In some hospitals, the need for better coding had increased the importance and profile of 'coders' within clinical directorates. Traditionally, NHS coders have not been paid much. However, under PbR, a great deal of the hospital's income depends on coders doing their job correctly. 'I was in the States visiting a hospital, and the second person after the Chief Executive that I met was the Coding Manager.… because you have to make sure that your income is reflective of what you've done' (Manager). In order to make their clinical directorates more profitable, hospitals have improved their coding departments and also the relationships between coders and clinicians. 'We've had many battles about why we wanted the surgeons to sit with the clinical coders, to make sure that we're coding appropriately for income' (Manager). However, most Directorates reported that 'they (clinicians) don't really like this very much' (Manager).

For clinicians, coding was an unwarranted intrusion on their time. Some admitted trying to avoid doing any coding at all, or even making legible notes for the coders to use. 'Apart from in A&E, a lot of Doctors will…try to avoid having to code 'cause it's quite tedious … people would just say they didn't have the time to do it, and it's bureaucracy and they're too busy… a lot of them will try, then they just get it wrong because they lose interest' (Clinician). Under PbR, however, coding has become much more important within clinical directorates. 'I was working in hospitals before PbR came along, nobody in hospitals gave a moment's attention to somebody from the Health Authority asking, 'where are you with your coding returns'' (Director of Commissioning).
Similarly, 18 Weeks also required managers and clinicians to work much more closely. Managers reported that developing a sense of ownership of the target was critical to achieving clinical buy-in on 18 Weeks. At the time of interview, the 18 Week target was placing considerable pressure on managers. '[18 weeks] nothing else. Here and now, it's the absolute; it's the number one drive' (Manager). Managers regularly iterated the importance of 18 Weeks: '18 weeks is a massive, massive, massive part of my life at the moment, and as a specialty we are struggling at the moment to achieve it' (Manager). Strategic planning within clinical directorates revolved around short-term projects aimed at delivering 18 Weeks. Primarily, projects involved improving data collection and data sharing. For managers, this translated as 'doing a lot of our own manual data collection, which is very very time consuming…' (Manager). For clinicians, it translated as 'a lot of persuading to get people to fill in the forms correctly' (Clinician). Data collection consisted of tracking incoming referral data and assessing the capacity of the directorate to manage referrals. But, 18 Weeks also required input from support staff. 'It's clerks and people like that who have been doing seven days a week. You've got to go through every record, because we don't have the information systems' (Executive). At the time of interview, managers and clinicians had weekly activity meetings to improve data collection and patient monitoring. 'It took us over 6 weeks to actually get our data to a point where we thought we believed it' (Clinician).

In the face of executive pressure, clinicians also were sensitive to pressures on managers associated with 18 Weeks. 'There's quite a lot of fairly tough business type management of the managerial staff from the central office in the hospital… being aware of the anxiety and stress levels in meetings with management, I'm aware that they're under enormous pressure from the centre' (Clinician). Some clinicians responded by

conducting extra clinics and performing theatre work outside regular hours. 'Lots of people have been asked to do extra clinics and we've put in extra doctors to try to get the backlog of work down' (Clinician). But other clinicians were less responsive to such entreaties. 'I've refused' (Clinician).

For their part, managers reported closer relationships with clinicians. 'In the areas which have embraced it, there's clinical buy-in' (Manager). But, some managers reported that many clinicians still did not think 18 Weeks had anything to do with them. Where clinicians had bought-in to the target, they increasingly viewed the directorate as 'part of a team', and 'management' as the hospital executive rather than managers within the directorate. 'When things aren't going so well… it's senior management, what do management know, and I say 'Well, I'm management', [they say] 'Yeah but we don't mean you, we mean them up there'' (Manager).

Other managers reported that clinicians needed to feel that they owned the 18 Week target. 'I've been saying to them for the last two years, the 18 week target is… not my target, it's ours, you can't walk away from it; and boy have they tried' (Manager). Managers improved accountability by engaging clinicians and other staff members. 'If you go and talk to them and explain why you have to do things then nine times out of ten they'll [Clinicians] do it, it's when you don't tell them what's going on and things start disappearing off the waiting list and you're doing this and that and the other that they don't like it….things like that would have happened in the past…I think it's the level of engagement we have with them now and the relationships that you build up with them' (Manager). And certainly, all clinicians welcomed the opportunity to improve patient experiences even if they held residual concerns about targets. 'I don't think it's wrong to look at how long patients have waited on waiting lists…. I think there was inequity in the way that the Health Service was provided…unfortunately, the ones who shouted the most, usually got the most rapid service… poor little old ladies who didn't stand up for themselves might be rather neglected and suffer' (Clinician).

In addition, managers also had to work more closely with nursing staff and administrators. Senior nurses were highly receptive to the target, but 'it's a bit more difficult to get that culture and that across to nurses lower down' (Manager). Again, reaching the lower grades was about engagement, ensuring that all members of the directorate understood their role in delivering the target. 'Medical secretaries… another group of staff…they're normally a law unto themselves but we've done a lot of work with them and I would say now that the vast majority of mine anyway are onboard, they understand about 18 weeks' (Manager).

4.4. Service facilitators: cooperation, integration and learning

18 Weeks and PbR also created new roles and accountabilities across different clinical directors. Specifically, hospitals created Service Facilitators for the purpose of enhancing cooperation, learning and integration across clinical directorates. In this respect, we also found that actors worked against some of Labour's more widely stated policy aims. For example, where 'competition' threatened to influence actor behaviour, both managers and executives were concerned to check its influence.

In order to deliver PbR and 18 Weeks, hospitals created new managerial roles across directorates for the purpose of coordinating activity. Essentially, delivering each policy required a diverse range of clinical directorates to become accountable to each other in terms of the resources they consumed and the lengths of time in which they completed different episodes of care. 18 Weeks required directorates to assess their internal capacity, their available beds, the number of nursing staff and clinics. It also required better coordination between directorates in terms of theatre access, physiotherapy and community care. 'Its massive… you've got to think of everybody around the table … everybody kept saying 'have you included me?' …then you've got to look at the actual

non-stock things. If you put more patients through you use more bandages, you use more prosthetics … ' (Manager).

Some hospitals appointed Service Improvement Facilitators to review and improve co-ordination between clinical directorates. 'We've had to review every speciality within Medicine, to make sure from referral to treatment, patients are going through within 18 weeks' (Manager). Facilitators enhanced integration by reviewing processes and identifying potential blockage points. They mapped the patient journey and linked up the clinical directorates and the various GPs. 'On the 18 weeks stuff…how do we do it… by an incredible amount of attention to detail… there's an enormous amount of micro management going on with every single general manager and the trackers, day in, day out' (Manager). Facilitators streamlined the pathway to achieve 4 weeks to an appointment, 4 weeks for diagnostics allowing 10 weeks for surgical procedures if required. '[18 Weeks] makes you look at your Patient Pathways, how you communicate… and it leads you into the GPs and other services. So it goes back to business planning and that brings you back to the whole governance cycle really' (Executive). At some point, there was always a person in the hospital who could identify the whereabouts of the patient along the journey. 'We've gone from, kind of, three separate waiting lists, for want of a better word, to one amalgamated one' (Manager). The result had been a major improvement in moving patients along the care pathway. 'It's been a fabulous improvement in Diagnostics, people used to wait forever, ludicrous amounts of time' (Executive).

Where directorates experienced difficulty meeting the target, they often cited a lack of co-ordination. 'We are the only department in the hospital that is having trouble hitting their 18 weeks target…we were having a ridiculous situation a couple of months ago where …certain surgical specialists which have got no waiting list would have anaesthetists and we were getting lists cancelled 'cos there were no anaesthetists…instead of saying, actually… the first thing we need to supply is anaesthetists for the Orthopaedic department' (Clinician).

Under PbR, clinical directorates had also became accountable to each other, but in terms of costs and efficiency gains. In some hospitals, competition became an issue at this point. 'It's got quite competitive. If medicine are doing really well, they… jeer a bit at Surgery. We look at it more as in winners and losers, so there's a bit more open competition between the doctors' (Manager). Typically, directorates reported their profitability at joint meetings with the executive. In these forums, executives were concerned to manage levels of competition. 'I think if you can do it in an environment where people don't feel threatened… you can learn from each other so that you're a learning organisation, then that's a good thing (Manager). Others, however, tried to eliminate competition and pursue collaborative arrangements. '[name] got the Surgical Directorate and I've got Medicine, and we've very much tried to work together, to try and stop that competitiveness. So we've got a really good understanding of how each other works, and we tend to support each other' (Manager).

4.5. Enlisting outside organisations: capacity, quality and accountability failure

18 Weeks and PbR had mixed success influencing actors from outside organisations. For its part, PbR failed to influence behaviour outside the hospital. Conversely, 18 Weeks enrolled the private sector in the regulatory regime on pragmatic grounds: primarily, a lack of service capacity in public hospitals. Again, we found no evidence that 'provider competition' played any role in recruiting actors to either regime.

The 18 Weeks required hospitals to forge new relationships with the private sector. 'I don't really like to use the private sector, but we're being pragmatic because of just the sheer volume of work that we've had to do in terms of 18 weeks' (Manager) If hospitals were unable to treat patients within the time frame; they often turned to the private sector for help. 'We deal with private hospitals…we've got good relationships with them… it's

just like an extension really of the hospital and they help us, they've helped us deliver eighteen weeks to be honest' (Manager). For their part, some clinicians reported that improvements in service quality were also a motivating factor, suggesting that reducing the Patient Pathway and working with private providers had bettered tailored services towards patients. 'Unless we can discharge our patients, and unless we can design the care that we're going to provide in a better way and a more timely way, then we're not going to reach our targets because… we're just going to be swamped with patients who are not really appropriate for our service' (Clinician).

Conversely, PbR failed to deliver accountability between hospitals and outside organisations, particularly PCTs. The NHS is a cash limited system and PCTs have fixed budgets. Essentially, PCTs expressed anxieties that hospitals were up-coding services. 'When PbR first came along, I thought fantastic…this is going to take away all the grief we had about the contracting negotiations 'cause the price is fixed and all we're talking about is volumes, but it hasn't turned out to be like that at all' (Executive). Under PbR, relationships between hospitals and PCTs lack transparency because commissioners lacked the means to verify coding returns. Put simply, hospitals and PCT didn't trust each other. As a result, PbR involved vagary and negotiation. As one executive outlined, 'if you're a PCT, say, 'Hang about, we've spotted that perhaps we shouldn't be paying for this quite in this way' and, of course, as soon as we look at it, we say, 'Well yeah, you're probably right, but we've just spotted that we're not charging for all these things over here that we've never counted in coding'. So there's this constant vagary about whether you've coded correctly' (Executive). At some hospitals, the vagaries associated with PbR had strained relations to near breaking point. PCTs reported that some hospitals were significantly less transparent than others about the accuracy of their coding. 'The view from a lot of PCTs is that [name of hospital] is far less transparent about those sort of things, and trying to dig through the… volumes of information that comes out of [name of hospital]' (Commissioner). Where PCTs lack the institutional resources to verify coding returns, commissioners and providers were forced to operate PbR on a deliberative basis. 'We clearly record things more diligently now…we don't necessarily charge for everything, but what we do is we use them as bargaining chips. So the PCT has often come in with a query that says, 'You know, you seem to be doing an awful lot of Haematology work, what's going on?' And we go, 'Yeah, that's fine, but did you know that actually we've looked at Community Midwifery and you haven't been paying for that at all and we're not charging you for that'' (Manager).

5. Discussion

The broader advantage of exploring the relationship between qualitative case studies and quantitative research methods is the potential to develop theory for the evaluation of policy mechanisms like PbR and 18 Weeks. This potential is a direct result of close collaboration between participants and researchers, under which the former describe their views of reality, thereby enabling the latter to fashion improved understandings of participant actions and the causes behind them. Armed with better theory and better conceptions of cause and effect, qualitative case studies have the capacity to enhance the sophistication and quality of quantitative research by directing researchers towards better strategies for evaluating impacts and to the use of more relevant concepts, measures and data sets.

In terms of theory development, our analysis suggests that 18 Weeks and PbR have had multiple impacts, perhaps the most important of which has been to alter the ways in which power is allocated, negotiated and operationalised within hospitals. The 18 Weeks delivers impacts at a number of levels. It intrudes on clinical decision making via healthy concerns for responsiveness. It exerts executive pressure on clinical teams, particularly managers. It places increased emphasis on data collection. It produces co-ordination and integration between clinical directorates. It involves healthy concerns for quality improvements. And, it also delivers closer working relationships between clinicians,

managers and the private sector.

In terms of interventions, our analysis suggests that policymakers might have considered a number of means for refining 18 Weeks and improving its operation, rather than initially abandoning the policy on the basis of one among its many major impacts – the intrusion on clinical decision making – only to reintroduce the mechanism 12 months later. These means might have included: providing hospitals with better information systems to track pathways; providing managers with additional training for clinical engagement and possibly increased remuneration; and mechanisms for restraining executive enthusiasm regarding waiting time reductions. At the time of interview, clinical teams across hospitals were struggling to achieve the 18 Week target. And while it might be reasonable to assume that executive pressure on clinical teams would have eased as providers gained experience with the target; 18 Weeks' intrusions on clinical decision making would, in any case, always involve a potential for clinical revolt. Rather than relax the enforcement regime, government would have done better to manage this potential in the interests of the improved clinical responsiveness that 18 Weeks brought both to patients and to other actors within the hospital. For example, policymakers might have developed a taxonomy of conditions and illnesses that should aspire to the 18 Weeks target as opposed to those that would profit from longer, and perhaps even shorter maximum waiting periods. Consequently, potential responsiveness gains in select areas could thereby function as a unifying goal for enlisting clinical support, rather than remaining an arbitrary and widely divisive goal.

Alternatively, PbR has had mixed success influencing processes within hospitals. Consequently, there are some serious problems with PbR, which current policy reforms to NHS commissioning may even exacerbate (DH 2010). Like 18 Weeks, PbR delivers impacts at a number of levels. It intrudes on clinical decision making via healthy emphasis on cost-reductions and efficiency. It exerts executive pressure on clinical teams, and again, particularly on managers. It places significant emphasis on coding. And it also produces a healthy emphasis on learning and integration between clinical teams. However, it can also involve an unhealthy potential for competition. Finally, PbR requires deliberation and negotiation between providers and commissioners; but it can also involve bargaining and produce a broader lack of trust within the system. As a result, policymakers might consider a number of initiatives for improving the operation of PbR. Within hospitals, these might include: increasing training and remuneration for both coders and managers, training executives to promote learning and cooperation within organisations, and also to manage levels of competition. Possibly, they might even consider encouraging executives to ensure that cost savings and efficiency gains are reinvested in service lines in ways that do not compromise the autonomy of clinical directorates.

But, with respect to processes across organisations, the problems are much more serious. PbR aimed to solve many of the problems with the old internal market: complexity, service variability and efficiency and innovation. Certainly, PbR has encouraged innovation and efficiency within hospitals. But, by heightening the importance of coding, it has failed to reduce complexity in the system. Hospitals record more of their activity than ever before and some PCTs lack the capacity to verify coding returns. Moreover, hospitals are in a position to take advantage of this lack of capacity. Consequently, PCTs may need to become bigger and more capable organisations, especially in regard to commissioning services from larger hospitals. Most significantly, however, in the light of recent changes to NHS commissioning, the deliberation, bargaining and lack of trust that PbR generates between organisations has the potential to produce service variations. Currently, the government is engaged in replacing PCTs with smaller and leaner GP led Clinical Commissioning Groups (CCGs). But, if PCTs cannot manage coding returns from large hospitals, it is difficult to see how smaller CCGs will. Potentially, smaller CCGs might even increase the role of negotiation and bargaining in

the system and lessen the importance of coding. Not only could this produce the same systemic variations in service quality that PbR was intended to redress, it could also threaten the benefits of cost savings and efficiency gains already made under the policy. Indeed, if coding returns become less important to commissioners and providers, why should they remain important at the coalface of clinical directorates.

More generally, these kinds of insights into cause and effect highlight the dangers of conducting evaluation research in the absence of a sophisticated dialogue with qualitative case studies. On the basis of our analysis, the likelihood that faster reductions in hospital mortality rates are the most striking impact of Labour's reforms seems remote; and the observation that the programme itself has delivered minimal and sometimes imperceptible effects seems odd. In the first place, it is difficult to see why the literature would consider a reduction of hospital mortality rates at all as significant, because hospital mortality rates have very little relevance to the impact of either 18 Weeks or PbR on hospitals. In the second place, it is difficult to see how reductions in mortality rates could possibly evidence the success of 'competition policy' (Cooper et al. 2009), because 18 Weeks and PbR have failed to engender competition within hospitals. Indeed, competition plays little or no part in influencing actor motivations and roles, or even the institutional processes associated with either PbR or 18 Weeks. If anything, actors were prepared to work against the threat of competitively engendered impacts. As a result, it is difficult to understand why quantitative researchers are even interested in macroscopic concepts like 'competition', and in using measures like mortality rates to understand the impact of mechanisms like PbR and 18 Weeks. Indeed, recent initiatives for healthcare reform are related to the quality of health care rather than avoiding death, and it seems that quantitative measures ought to reflect this. And while concerns for quality improvements, in terms of responsiveness have some relevance to actor behaviour with regard to 18 Weeks, they have little or no relevance to roles and processes under PbR. If anything, actors voiced concerns that PbR might even reduce service quality. For PbR, the use of data sets regarding length of stay and post-surgical readmission rates seem appropriate, but they need to be combined with directorate level reports regarding profits and losses, coding returns, hospital level data about retained surpluses and re-investments in service lines, not mortality rates. With regard to 18 Weeks, quantitative researchers need to begin by distinguishing between institution-based waiting time targets and 18 Weeks, which has very different types of impacts. Arguably, the failure to evaluate 18 Weeks in terms of its own unique and complex impacts across the health service contributed to its demise, and is to some extent responsible for inhibiting its further refinement, because waiting time trackers that can only establish breaches of the target and median waits are of limited value. A thorough evaluation 18 Weeks would need to consider the use of private sector providers, the quality of internal monitoring and information sharing systems and, most importantly, the means by which actors within hospitals are recruited to the target.

6. Conclusion

One of the weaknesses of quantitative techniques for policy evaluation is the difficulty they experience describing cause and effect. And in the UK health policy literature, research questions to the effect 'does competition save lives', the results of evaluations involving broad brush indicators set against the central stated aims of major policy programmes and related assertions about small and imperceptible impacts cannot be taken at face value. Rather, they should be interpreted as being indicative of this weakness. Arguably, the fact some of these studies are feeding directly back into the UK policy process should spur qualitative researchers in a wide variety of fields and national contexts to take a stronger position with regard to framing the relationship between quantitative and qualitative techniques. What evaluation research needs is a sophisticated and collaborative dialogue between qualitative case studies and quantitative approaches based on a recognition of the complementary nature of each approach. And, in some fields more than others perhaps, the ambitions of quantitative researchers need to be scaled back. Proponents of econometrics, statistics and formal modelling need to become

more circumspect about the kinds of knowledge and theories they aim to produce, particularly considering the potential for evaluation research to influence policy.

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