

**THE IMPACT OF THE MARKET
ORIENTED REFORMS IN THE UK AND
SWEDEN: CASE STUDY CATARACT
SURGERY**

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To my mother and father

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Abstract

In the early 1990s, a set of market oriented reforms was introduced into health care systems of the UK and Sweden, two exemplary cases of the reliance on planned budgeting and integrated provision of services. In the pursuit of increased efficiency, several County Councils in Sweden have followed public competition model while in the UK internal market reforms were introduced. It was expected, that the separation of functions of planners and purchasers from those of providers, would achieve higher allocative efficiency but it would also enhance users' satisfaction with care.

This thesis used cataract surgery as a case study to trace the impact of competition among providers and the separation of purchasers' functions from the former on the set of selected indicators: choice, information, quality, responsiveness and efficiency.

Qualitative research methods were employed to record the perception of changes of those indicators for patients, primary care providers, eye surgeons, managers and purchasers. A set of open ended and standardised questionnaires was designed to elicit the views of all actors involved and to measure the likely transformations. These data were then compared with quantitative figures obtained from hospital registers and national league tables where numbers of operations performed as day/inpatient cases, prices for service and waiting times for the first specialist appointment and cataract surgery were examined. Four study sites from outer London and the only existing large provider of eye services to Stockholm County Council were selected and used for the purpose of international comparison.

The analysis of the data showed that the quasi-market reforms have resulted in a change of the attitude of secondary providers, which had some positive influence on quality of care expressed in reduction of waiting times at the outpatients' department and as tailored appointments for the surgery. Some improvements in the amount and type of information given to purchasers and patients could be detected, although as far as direct users were concerned, the demand for it has not been fully satisfied.

However, the impact on choice available to patients and purchasers alike seemed to be adverse, an effect that was particularly strong in the UK case and which was precisely the opposite of what reforms proclaimed. This was partly a result of disincentives introduced by the reforms but it also reflected the ambivalence that patients had towards enacting their choices. Another finding was that General Practitioners were on the whole poorly informed about the changes and were unable to comment on many of the issues asked. This raises questions about the uncritical endorsement of vast responsibilities into the hands of intermediaries alongside the recent changes of the NHS.

Responsiveness measured as changes in the waiting times for the first specialist appointment and for the cataract surgery itself showed an uneven trend. Both decreased in the short-term and then increased to the pre-reform levels after this issue ceased to be the priority on the governments' agendas, implying that these short lived effects must have been rather a result of specific interventions and not the consequence of the market's work. It was also demonstrated that those providers who successfully responded to the market incentives and delivered services of high quality efficiently, were also more keen to shift to the technologies with cost-saving potential. However, there was no clear evidence of the impact of those changes on the prices of service despite the increases in the numbers of operations.

The overall conclusions are that market reforms even in its modest form were hardly allowed to work and when they worked they did not always produce what theory predicted. This was a result of the half-hearted belief in their effectiveness, the lack of clarity in policy formulation and conflicting objectives being pursued simultaneously, which possibly explains why most respondent groups could not see any major changes.

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I. BACKGROUND

CHAPTER 1

INTRODUCTION

Many countries in Europe faced the problem of the escalating cost of health care expenditure during the 1960s and 1970s. However, only the protracted period of slow economic growth combined with inflation in health costs in the 1980s, known as “stagflation”, prompted most of them to embark on a search for different ways of improving the efficiency of health care delivery. This trend was seen in the UK and Sweden, and also in many other countries throughout the world.

Market-oriented reforms introducing competition into both the demand and supply side (New Zealand and part of the Netherlands), and internal market reforms dealing only with improving efficiency of supply, were introduced during this period (in the UK and Sweden). In each case, the reforms adopted reflected the traditions and aspirations of the country. Thus, for example, in the UK it resulted in a centrally initiated and directed large scale overhaul of the system, while in Sweden different models of public competition were introduced in a limited way at the regional level.

The health care systems of the UK and Sweden were chosen for the purpose of this comparative analysis, because they share a number of common features, both when their vertically integrated structures are examined, and when the strengths and weaknesses resulting from these are considered. In addition, the solutions proposed for overcoming the deficiencies of their systems, while not being identical, follow a similar market-oriented pattern.

In both cases, the reforms can be summarised as the rejection of the model of rational planning in social policy, present throughout most of the time during their post-war history, on the grounds of its limitations in achieving micro-efficiency gains and in meeting the increasing expectations of its users. Thus the top-down bureaucratic structure was deemed as too inflexible to promote the systems'

responsiveness to the population's needs and the command economy was recognised as creating obvious disincentives in terms of enhancing providers' productivity. But did these market-oriented reforms in the UK and Sweden bring about the desired outcomes? Did they increase the responsiveness and efficiency of the health care systems concerned? It is these questions that this thesis, in a small way, attempts to answer.

1.1 Research Question

The fundamental research question that this study considers is: what was the impact of the internal market reforms in the UK and Sweden on a set of indicators related to explicit criteria used to evaluate the redesign of the system such as choice, information, quality, responsiveness and efficiency.

All of these criteria are important. First, the availability of choice and information are essential conditions for both quasi- and full internal markets to work properly (Le Grand and Bartlett, Chapter Two, 1993). If there is no choice, there can be no competition and, hence, little incentive to increase efficiency, quality or responsiveness. If there is little information, purchasers and users will be in a poor position to judge quality, and hence, again, incentives for improvements will be blunted. In addition, they are worthy and welcome outcomes in and of themselves because they empower patients and may also be regarded as broader aspects of the quality of care (Ovretveit, 1992; Maxwell, 1990).

Second, quality standards are important in controlling undesirable effects, which may result from public services being provided in a market environment. From the start of the reforms, fears were raised that the likely micro-efficiency gains could be achieved only at the expense of quality of care (Boufford, 1993; Le Grand et al 1994; Roberts, 1995). "Quality" in health care is, of course, enormously difficult to define and for the purpose of this study, it was necessary to narrow to a range of possible interpretations of the concept. Accordingly quality was defined primarily in "process" terms: specifically, in terms of changes in satisfaction with the technical aspects of care, changes in waiting times at

outpatients' clinics, some aspects of information, and changes in the attitudes of providers.

Third, responsiveness to users' needs is seen as an important attribute of modern health care systems whose absence in the pre-existing health care systems of both the UK and Sweden created dissatisfaction and which reforms aimed to address. Changes in the waiting times for both cataract surgery and the first specialist appointment were used as a proxy measure of responsiveness to patients' needs on the assumption that waiting times must represent some estimate of the need for service provision.

Fourth, the above changes were interpreted in the context of efficiency gains that might have been achieved, and an attempt was made to outline the trade-offs involved with other policies that were simultaneously being pursued. The search for higher efficiency was arguably the most important driving force behind the reforms in both countries and it justifies its central role against which the other indicators are considered in this evaluation.

Reforms' impact on equity, which is possibly the second most important objective of publicly financed health care systems, is not addressed in this study. This is because of two reasons. First, improving equity was not the intention of the reforms in the UK; to the contrary as one researcher noted it "*was conspicuously absent from the reforms agenda*" (Whitehead, 1992). In Sweden the government was more preoccupied with maintaining the equity but there were no specific references on how reforms could affect it.

Second, the attempt to measure the differences in waiting times for cataract between fund-holders' and non fund-holders' patients, produced results that were inconclusive despite the anecdotal evidence of the alleged negative impact, which came mostly from the health professionals interviewed in this study. For these reasons and for the matter of space equity is not part of this study.

It was also decided that the outcomes of the reforms were to be measured using the example of cataract surgery as a tracer condition. Cataract surgery is a

procedure well suited to reflecting the likely changes in delivery of service that could be attributed to the reforms. Cataract surgery is an elective procedure, with increasing worldwide demand and relatively well-established effectiveness (Williams et al, 1994). It was also widely used by market supporters as one of the cases that would illustrate the likely gains that could accrue in the aftermath of the introduction of the reforms.

Furthermore, the choice of this particular service was also influenced by the fact that the diffusion of certain technologies, which resulted in efficiency gains, such as day-case surgery, might have been significantly speeded up by the organisational incentives brought about by the reforms.

The principal methodology involved qualitative interviews. The views of the main participants, such as the health professionals, purchasers, managers and patients, were sought in order to draw conclusions on the impact of the reforms. Observations from each perspective - professional, patient or organisation of the service under assessment - were made. These observations were broken down into components. Each perspective concentrated on some further sub-components, which attempted to capture the specific perception of the key players in the system, reflecting the different priorities attached by the observer and the objectives of their assessment.

1.2 Addressing gaps in previous research

This study attempted to address some of the gaps in these aspects of health care delivery which, while considered important, have been very little evaluated, if at all. These concerned, primarily, the likely changes in the level of choice and information and the changes in attitude of the main actors. The study's focus on these aspects of care is justified, because they represent the values that users increasingly expect health services to deliver, and also because the markets are seen as instrumental in bringing about these differences.

A particular service was used to serve as the tracer condition to illustrate some effects of the market-oriented reforms on the set of indicators selected. Cataract

surgery was used as a case study for the evaluation of the reforms, and it was hoped that it would provide an insight into an area that was relatively under-researched. There was little published research that provided evidence of the impact of the changes introduced into specific treatments. An additional aspect this study attempts to address by means of an international comparison was the response to a similar set of reforms introduced into distinct cultural environments, which shared a number of common characteristics in the pre-reform organisation of their systems and in the type of reforms adopted.

Despite the limitations involved in international comparisons, important conclusions about the interrelation between the different elements of chosen policies, the methods of their implementation and their final outcome, as well as internal and external determinants of their success, could be reached. Also, quite often the context of international comparisons that allows for a better understanding of the specific features of each system and of the factors that led to their establishment, may also help to explain their individual differences.

1. 3 Plan of the thesis

The thesis is divided into four major parts. Part I provides background information and outlines the purpose and scope of the research. Chapter Two compares the similarities and differences of the pre-reform health care systems of the UK and Sweden and briefly outlines the design and objectives of the reforms in both countries. Chapter Three discusses the concepts and framework of the indicators that were selected to show the market's impact and attempts to provide some justification for their use. Chapter Four summarises previous attempts to evaluate market-oriented reforms revealed in the literature and identifies the existing gaps in research. Some of these, such as the relative absence of evaluations dealing with particular services, and also the limited number of international comparisons, are addressed in this study.

Part II provides the research methodology of the study and Part III its results. Chapter Five presents the research methodology, including a detailed description

of the sample, the procedures and the tools used. The methodological limitations of the project are also discussed here.

Part III of this thesis is concerned with data analysis and the presentation of results with regard to all indicators (where their different aspects are highlighted) and the perspectives of all involved actors. Chapter Six presents the results of the research with respect to choice, Chapter Seven aspects of information, Chapter Eight aspects of quality, Chapter Nine aspects of responsiveness and Chapter Ten aspects of efficiency. In each case, a comparative analysis between the UK and Sweden is carried out. The analysis is densely interspersed with large amount of quotations and consists of a fairly detailed reference to the material from transcribed interviews. For a quick review of the principal results the reader should refer to the end of each chapter.

The final part of the thesis, Part IV, consists of Chapter Eleven, which is devoted to an interpretation of the findings and Chapter Twelve, which concludes the thesis and delineates some of the policy implications that could be drawn from the results. Chapter Twelve also presents some recommendations as to how the lessons from the experience of market -oriented reforms might be incorporated in future developments in the UK and Sweden.

The appendixes consist of tables summarising the research methodology (Appendix I) the questionnaires used (Appendix II) and characteristics of the samples of respondents (Appendix III). The detailed findings of the audit on clinical outcomes in hospital P in the UK are presented in Annex I, and indicators of clinical outcomes used in Sweden in Annex II. The copy of publications that have so far resulted from this research project can be found in Annex III.

CHAPTER 2

BACKGROUND

This chapter is divided into two major parts. The first part discusses the health care systems of the UK and Sweden. It provides some background information and serves as a justification for their selection for the purpose of this comparison. In the second part, the rationale for the introduction of the reforms is outlined and the major points of content of the reforms, in both the UK and Sweden, are presented.

2.1 Health care systems in the UK and Sweden

The health care systems of the UK and Sweden were chosen for comparison in this study, as they share a number of common features in their pre-existing structure and in the content of the reforms introduced in the late 1980s (the UK) and the early 1990s (Sweden). Despite important similarities, the differences in historical origin and organisational aspects of the two systems have determined the model of reforms adopted in each case; they would also eventually shape the outcome of the reforms.

2.1.1 Similarities and Differences

The principles behind the inception of both health systems and their organisation of health care were similar in many respects. These were almost equally mirrored in their achievements and also in the problems and challenges they faced. For a long time, both countries served as model health care systems - to be emulated in many less developed and developing countries. Their success was internationally recognized when the social, demographic and clinical dimensions of the performance of the systems were taken into account. Both countries perform relatively well in international comparisons where conventional

indicators, such as life expectancy at birth for females and males, infant mortality rate per 1,000 live births, and low weight at birth for hospital deliveries, are used (See Table 2.1).

Table 2.1 Life expectancy, infant mortality and low weight at birth in selected OECD countries, 1997

	Life expectancy at birth – Females (Years)	Life expectancy at birth – Males (Years)	Infant mortality rate/1000 live births	Low weight at birth Hospital deliveries (%)
Australia	80.9	75.0	5.7	6.3 ^b
Canada	81.3	75.3	6.0	—
Czech Republic	76.9	70.0	7.7	6.0 ^a
Denmark	77.8	72.5	5.5	5.2 ^a
Finland	80.2	72.8	4.0	4.1
France	81.9	73.9	5.0	6.2
Germany	79.5	73.0	5.3	6.1
Ireland	78.5	72.9	6.3	—
Iceland	80.6	76.4	6.1	3.2 ^b
Italy	80.8	74.4	6.2	6.0 ^a
Japan	82.8	76.4	4.3	7.1 ^a
Netherlands	80.4	74.6	5.5	—
Norway	80.8	74.8	4.0	5.3
Poland	76.4	67.6	13.6	7.9 ^b
Portugal	78.6	71.5	7.4	6.0
Spain	81.2	73.2	5.5	5.4 ^b
Sweden	81.0	76.7	4.0	4.4
Switzerland	81.7	74.3	5.0	5.2 ^a
United Kingdom	79.5 ^b	74.3 ^b	5.9	7.0 ^a
United States	79.2	72.5	8.0	7.2 ^b

^a 1995

^b 1996

Source: OECD Health Data 99

The table demonstrates that, overall, Sweden's outcomes are superior to many and among the best of the industrialized countries. On the whole they, can indeed only be compared to those of Japan that has higher life expectancy for females than Sweden which is even a little bit lower than in Switzerland and Spain. The UK's outcomes, on the other hand, are comparable to those of Italy and the Netherlands, but are slightly worse than the indicators of some countries with a lower income, such as Spain, and also of some countries with a higher

income, such as Germany. In addition to a weaker performance when compared to most Scandinavian countries (except for Denmark), the UK's overall indicators are also worse than those of Canada, Australia and Switzerland and most of the indicators for France; but they are better than the outcomes of Ireland, the United States and Portugal.

There are three principal areas of similarity. First, the health care systems of both the UK and Sweden shared the characteristic of being relatively cost-effective, although a different amount of GDP was spent on health care in each case. The UK devoted, and still devotes, a lower percentage of GDP to its health care expenditure than Sweden - around 6.7% and 8.4% respectively; although this persists, whether expressed in real prices or purchasing parities, it is not as great as it used to be (Getzen et al, 1991; Schieber et al, 1993; OCED, 1999).

For instance during the 1970s Sweden and the UK occupied the second and fifteenth place in spending among the OECD countries which in the late 1990s was respectively the twelve and eighteenth. Similarly there is a tendency towards a narrowing the gap in the percentage of GDP that was devoted to health care in the 1970s and 1990s, which for Sweden increased only from 7.1% to 8.4% but for the UK the increase was from 4.5% to 6.7% (for details, see Table 2.2 and Table 2.3).

Table 2.2 Total expenditure on health per capita (PPP in US\$) and as % of GDP in the UK and Sweden in 1970, 1980, 1990 and 1995 and their ranking against other OECD countries

	1970	1980	1990	1997
Sweden	458 (7.1%)	1145 (9.4%)	1571 (8.8%)	1762 (8.4%)
United Kingdom	296 (4.5%)	848 (5.6%)	1042 (6.0%)	1391 (6.7%)
Ranking in comparison with OECD countries	2 and 15 (respectively)	2 and 20 (respectively)	7 and 18 (respectively)	12 and 18 (respectively)

Source: OECD Health Data 99

The international comparisons that relate spending to the outcomes of health care have been questioned and criticised, especially because, apart from the

usual problem of the reliability of data and the same indicators being measured differently (Ruble and Schneider, 1991), there is another equally fundamental problem. This relates to the use of non-standardised and internationally agreed definitions of different components of health (Schieber et al, 1993). In this case, the significant reduction of the difference in the amounts spent, which has occurred during recent years between the two countries, reflects wider economic trends and corresponds with Sweden's decline in economic growth. It also confirms what has been known for quite a long time, that spending on health care is strongly correlated with the size of GDP, and also more importantly, with the pace of economic growth (Newhouse, 1977; Parkin et al, 1987; Hakansson, 1999).

Nonetheless, there are also less obvious reasons that may influence this outcome. In Sweden, for example, the dramatic reduction in spending which occurred from 1990 to 1995 and which, according to the data presented, may be as high as 1% of GDP, has coincided with the shift of social care from the county councils to the municipal government, introduced in 1992, known as the Adel reform (named after the minister that passed it).

Thus, by not appearing on the balance sheets of the county councils, whose principal responsibility is the financing and provision of health services to their populations, it is also no longer calculated as part of health care expenditure. In reality, however, if the amount subtracted from spending on social care is added to what is currently spent on health, the figures demonstrate that there has been no great curtailment in the money devoted to health (see Table 2.3).

Table 2.3 Spending on health care in Sweden in the years 1990-1996, including adjustment for the consequences of the Adel reform

<i>Year of measurement</i>	<i>Expressed as current prices (in bln SEK)</i>	<i>Expressed as fixed costs (in bln SEK)</i>	<i>Expressed as the percentage of GDP</i>
1990	119	119	8.8
1991	125	118	8.7
1992	112	103	7.8
1993	114	103	7.9
1994	118	102	7.7
1995	123	102	7.5
1996	128	101	7.6
1996*	145	114	8.6

*Including the amount spent on social care, which after the Adel reform is in not calculated as health care expenditure

Source: Eckerlund et al (1998), Socialstyrelsen (National Board of Health and Welfare)

Although both systems are financed from a single source, there are, nevertheless, some differences in this respect between the two countries. The UK's health care is almost solely financed out of general taxation, while in Sweden a large proportion of health care expenditure is covered through a regionally determined level of taxation. In both systems, however, strong control of overall spending was one of their predominant features, which in the UK was, and still is, decided at the central government level, while in Sweden it is determined by the various regional governments.

Success in controlling the overall cost of health care is widely attributed to the mode of financing of the health care system (Abel-Smith, 1992a). Another factor, also seen as contributing to the relative cost-effectiveness of a health system's delivery, are the incentives for health professionals reflected in the methods of remuneration (Barr, 1992). In both countries, these are characterised by the absence of third party payments and/or fee-for-service provision, which is known to place inflationary pressures on health care expenditure (Evans, 1974; Abel-Smith, 1992a; Abel-Smith, 1992b) and rely on payment methods that are predominantly salary-based.

The second similarity is in their low administrative costs when compared to other industrialized countries (the USA being the most extreme example), which enable most of the resources to be spent on direct care for patients (Ham, 1993; OECD, 1994). This could probably be regarded as a result of the relative centralisation of decision-making in health care delivery (either by regional or central government) resulting in vertical integration that is a characteristic of some publicly funded and operated health systems (Anell, 1996). The absence of a competitive environment, which, in itself, creates a multiplicity of agents and intermediaries in the contracting and commissioning procedures, might have also contributed to the efficiency of the systems.

Third, the concept of equity is an important component pertaining to the philosophy of both systems (Whitehead, 1994a; Whitehead, 1994b; Garpenby, 1992; Berleen et al, 1994). In this respect they are quite favourably placed in the context of international comparisons and are, by most criteria, evaluated as providing relatively equitable access to comprehensive services. However, when regarding the concern for equity, important distinctions that exist between the two countries have to be taken into account for a better understanding of the system. These, together with some other key differences, are analysed below and summarized in Table 2.4.

Table 2.4 Key features of the two health systems: the UK and Sweden

UNITED KINGDOM	SWEDEN
MAIN SOURCE OF FINANCE: central taxation	MAIN SOURCE OF FINANCE: Local taxation
ORGANISATION highly centralized	ORGANISATION decentralised to the County level
REFERRALS TO HOSPITALS - tightly controlled by primary care doctors	REFERRALS TO HOSPITALS - largely uncontrolled, patients' self-referrals common
SPENDING AS % OF GDP - app. 6.0%	SPENDING AS % OF GDP - app. 8.0%
HEALTH OUTCOMES Very good	HEALTH OUTCOMES Excellent
EQUITY OF ACCESS very high	EQUITY OF ACCESS very high
SATISFACTION OF USERS – high	SATISFACTION OF USERS - very high

Source: Various (Ham, 1993, Le Grand, 1994; Saltman, 1990) compiled by the author

When discussing the differences, one of the most important is the pronounced contrast in the perception of the equity concept and the place it occupies in the policy agendas of the two countries. While in the UK it is more often declared as a political statement, in Sweden it seems to be more a case of actively sought policy, and this is reflected in agendas of each government (Garpenby, 1992; Berleen et al, 1994; Bergman, 1994). Thus, in Sweden there is an absence of major political overtones attached, in contrast to the UK where, equity seems to be an important concern and a subject of debates while the expression of equity or even equality as a policy goal is carefully omitted. There are also some further differences, which have their foundations in the inception of the system and in the political origins of the idea.

In the UK, equity can be undoubtedly regarded as one of the founding principles of the NHS, and it has shaped and justified the broad vision and scope of the system. Its roots, as explained by Klein, can be sought in the long nurtured social expectations which, before 1948, were not properly reflected in the health care system of the country, and which the NHS came to fulfill (Klein, 1989). Klein regards the origin of the NHS as the result of political boldness that was eventually diluted by a series of political compromises (Klein, 1995), one may argue also with respect to its dedication to equity.

The same does not seem to hold true for Sweden, where there is a longer and more continuous tradition of commitment to equity principles. In this context, the Swedish health care system should be viewed more as the final result of incremental advancements in social policy, which have been taking place over the last century (Garpenby, 1992; Rhenberg, 1990; Culyer, 1991).

In addition, as a large trans-national comparative study demonstrated the implications for the equity of access may not be the same in both countries. One of the criteria used in this study, in which both the UK and Sweden were included, measured the income-related inequalities that were expressed as self-assessed health. It demonstrated that, although in all countries there were inequalities in health care in favour of higher income groups, these were most pronounced in the UK and least pronounced in Sweden (van Doorslaer et al, 1993).

Even more of a contrast is the kind and degree of commitment to democratic participation that is present in each system. In the case of Sweden, there is a long and strong tradition of local participation as a result of the decentralised structure of the decision-making processes (Garpenby, 1992; Rhenberg, 1990). This is retained and developed further in more than one of the models of reforms and even more in the proposals preceding the actual introduction of the reforms where elected city councilors were considered as the only purchasers of health care services (Anell et al, 1993).

By contrast, the UK can be characterised by policy-making based on negotiation among representatives of different pressure groups carried out at the central level and then only followed by direct participation at many other levels, including local ones, whose influence is much more diffuse (Jones and Cavannagh, 1991). This probably becomes more clearly illustrated through examining the position that health care reforms occupy in the political discussion in both countries.

As pointed out by Garpenby in Sweden, reforming health care has, so far, never been an issue for national debate whether in parliament or during electoral campaigning (Garpenby, 1992), probably because all the power, in terms of managing and financing health care, is delegated to the regional governments. In the UK, by contrast, any major restructuring of the NHS constitutes a highly sensitive topic on each government's agenda and is a subject of public debate. At the end it is usually negotiated through a long process, involving different representatives and pressure groups (Hogwood and Gunn, 1984; Jones and Cavannagh, 1991).

Also, the pace of the reforms and the way that they were implemented in both countries highlights important differences that are typical of the UK and Sweden. In the case of the former, the initiative came from central government and was aimed at nothing less than the wholesale redesign of the system. This was clearly demonstrated when arguably rather simplistic market mechanisms were phased into complex and intricate environments throughout the country, without any previous experience or evidence of their chances of success or failure. The anticipated changes were dressed up in rhetoric and were heavily charged with

political overtones, which often obscured the real content of the intended reforms.

In Sweden, in the true spirit of decentralised decision-making, twelve counties gradually adopted different types of market-oriented reforms between 1991 and 1995; this roughly constituted half of the total number of counties (for details, see Fig. 2.1). Their initial introduction was on a limited scale, which allowed for evaluation and modifications where needed. The set of reforms was not uniform either, varying from quite radical arrangements (Dalarna) to cautious experiments with elements that suited local needs (Stockholm, Bohus). Also, the Swedish policy makers were not reluctant to learn from the experience of others, including British academics and politicians, which according to some might even have seriously influenced the policy choices adopted (Whitehead et al, 1997).

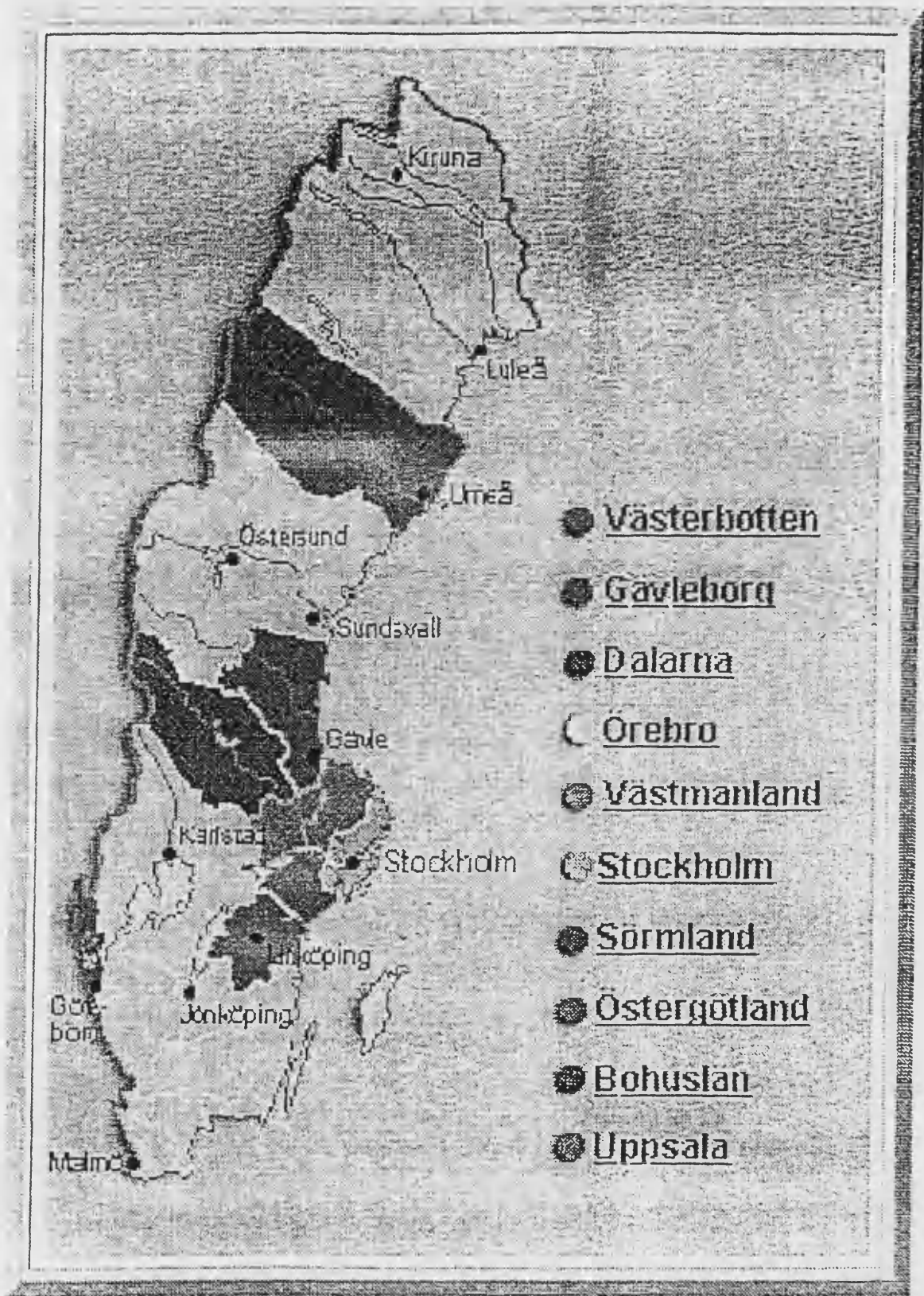


Figure 2.1 Counties in Sweden that have adopted different forms of market-oriented reforms (coloured and shaded) from SPRI

The other distinct feature of the two systems is the organisation of primary health care delivery. The British system has a well-functioning GP 'gate-keeping' device, which, in fact, constitutes the backbone of the NHS and contributes highly to its efficiency (Glennerster et al, 1994a; Glennerster et al, 1994b). The Swedish system, together with a number of other European countries like France, Germany and Belgium, allows patients to refer themselves for specialist care at their own discretion (Abel-Smith, 1992a; Giraud 1992). However, despite the relatively lesser importance attached to the primary care gate-keeping function in Sweden, primary care network schemes operate in the health care centres, with multidisciplinary staff employed to secure provision of a comprehensive range of primary care services.

This explains why the particular model of market-orientated health care reforms that gave a unique power to family doctors, enabling them to become competing health care providers and purchasers at the same time, was implemented only in the UK, despite the similar proposals being voiced in Sweden. What was suggested in the latter's case would, according to some researchers, have largely resembled the GP fund-holding scheme if implemented (Le Grand, 1993; Rhenberg, 1990). There were also others who thought that the experiment in Dalarna County, where general practitioners were given more power, with the purpose of ultimately assisting city councilors in decision-making processes, was already a movement in this direction (Glennerster et al, 1994b).

2.2 Market-oriented reforms in the UK and Sweden

The search for higher efficiency, prompted by an apparently limitless increase in demand for health care, has been a driving force behind the changes introduced into many health care systems during the last decade (Abel-Smith, 1992b; Bennett, 1991; Hurst, 1991; OECD, 1992; Glennerster and Le Grand, 1995). In the case of publicly operated health systems, such as those in the UK and Sweden, this reform process has often been initiated as organisational restructuring, aimed primarily at achieving better value for money and promoting users' satisfaction with the health care service. Global trends and internal fiscal pressures had led to the realisation that provision of health care, in respect of its

efficiency, responsiveness and choice, were in need of improvement, both in the UK and Sweden.

2.2.1 Rationale of the reforms

The common features of the pre-reform systems in both the UK and Sweden were public financing and ownership of production, coupled with central planning of the delivery of services. Although their respective structures produced remarkable achievements, whether measured in terms of health care indicators, universality and equity of access, or technical efficiency (Saltman, 1994), at the same time, they were subject to persistent criticism for their poor management and low responsiveness to the needs and wants of users (Enthoven, 1985). As market proponents argued, the very same payment methods that kept the cost of the system down had, at the same time, acted as disincentives for increasing productivity and improving quality of the care provided (Enthoven, 1985; Enthoven, 1988).

Set against the strengths of both health care systems, a number of commonly shared weaknesses became increasingly apparent. These shortcomings and the shift in the public mood in favour of the market's potential were the factors that created an environment conducive to change and which eventually found their way on to the reforms' agendas. Although the reforms reflected a perception that seemed principally confined to interventions aimed at a micro-efficiency level, the organisational changes intended for correcting pre-existing deficiencies had also, in fact, diffuse effects at the macro-level, expressed in both economic and social terms.

As a result, the reformers intentionally or unintentionally prompted a whole-scale shake up of the welfare state philosophy that had formed the foundations of the systems. According to the categorization of the reform processes, proposed by Ham, the UK, together with Israel and New Zealand, followed a 'big bang' reform, while Sweden pursued its own bottom-up and an incremental path of reform (Ham, 1997). This typology in a way confirms that, regardless of the approaches to the processes of the reforms and the different mechanisms of their initiation,

the content of the reforms chosen was quite similar despite the differences in expectations placed upon them.

The internal problems that were at the root of the restructuring of the health systems in both countries were the existence of long waiting lists for some hospital procedures (mostly for elective surgery), a lack of patient choice and responsiveness, as well as evidence of inefficiency in the use of resources which was loudly articulated in the UK (Ham, 1993).

One of the best-documented examples was the huge variation in operating rates among consultants in the UK. Cataract surgery, used as the tracer condition in this study, illustrated this phenomenon: the differences in operating rates were as much as three times between the bottom and the top values (Drummond et al, 1991). This was amplified even further when variations in length of stay and operating rates per 100,000 resident populations, between different providers units in the same area for the same procedure, were examined. For instance, a study examining the rates of cataract surgery in the Southwest Thames Region, found that operating rates among consultant eye surgeons varied by as much as three times (Williams et al, 1993).

Similar evidence from Sweden suggested that there were variations in operating rates between different regions of the country. Not only were huge differences reported in the use of procedures but also were significant differences in waiting times between urban and rural areas and between the Southern and Northern parts of the country (Eckerlund et al, 1992; Swedish Ophthalmology Association Registers, 1993, 1994, 1995). In Sweden, the waiting times, although not as long the British ones, contributed to widespread dissatisfaction with system's performance, and the conservative government saw it as an important issue to be addressed.

The unmet demand for cataract surgery in both countries, which was estimated at 65,000 cases awaiting surgery in 1991 in the UK (Thomas et al, 1992) and to 50,900 patients on waiting lists in 1991 in Sweden (a similar figure despite the enormous difference in population) prompted the debate towards the search for more effective ways of service provision. The culprit, in the latter case, was found

to be the low productivity and measures reflected in the reforms' agenda were primarily aimed at tackling this problem (Charpentier and Samuelson, 1994).

All these happened against the backdrop of the realisation that long waiting lists were not necessarily a true reflection of demand for care (Frankel, 1991); in fact many questioned the direct relation between the two. For example Goldacre et al suggested that there is little correlation between increased throughput and the length of waiting lists in case of cataract surgery (Goldacre et al, 1987). Others found that the way that lists were constructed and updated did not reflect the real number of people in need of the particular service (Davidge et al, 1987; Radical Statistics Group, 1992).

Furthermore, poor co-ordination between primary and secondary care units and a relatively low priority attached to primary health care, were important factors prompting the re-examination of the systems. Poor co-ordination was not only apparent for different tiers of health care but also for social care in the UK, and between health and social forms of insurance in Sweden. Meanwhile, the services remained traditionally too much hospital-oriented despite the differences existing between the two countries. In the UK, this was demonstrated, among others, in the King's Fund report devoted to this issue, which advocated for a shift in priorities and resources allocation in favour of primary care in the London area.

Despite the many political statements about commitments to the promotion of primary care proffered at different times, the ultimate proof of the honesty of politicians' intentions, as reflected in resources allocated for the cause they championed, was invariably modest. When examining the pattern of the resource allocations for different tiers of care, it could be legitimately doubted whether primary health care had ever constituted a real priority in the health policy agenda in either of the two countries.

Analysing these factors and ranking them according to their priority, the long waiting-lists phenomenon seemed to be an important preoccupation on policy makers' minds, although the users' reaction to this was less known. These were the source of lasting embarrassment for the liberally-minded government in the UK

whose image was tarnished by the evidence of unresponsive services being tolerated at the heart of the public sector, something skillfully exploited by the media and the political opposition. For example, in 1986 over 600,000 patients were on waiting lists in the UK, a quarter of whom remained there for more than a year (Davidge et al, 1987). Again in the UK, in 1986 the waiting time for a first appointment with a specialist consultant was around 16 weeks (Goldacre et al, 1987). The liberal government astutely recognized it as a sign of inefficiency resulting from lack of incentives.

In Sweden, long waiting lists for elective procedures also constituted a serious problem that resulted in dissatisfaction among users and pointed at the system's low productivity. Although the rates of cataract surgery of 4.5 operations per 1,000 inhabitants were among the highest in the world (Courtney, 1992; Desai, 1993), there were long waits in County Council owned hospitals in which, in 1992, 92% of all cataract operations were performed (Lundstrom et al, 1996). During the time of the UK's reforms, in Sweden a conservative government came to power in the early 1990s, after a long monopoly presence of the socialists in office. Possibly following the UK's suit and in reflection of the *zeitgeist*, it made introducing more consumerism into health care (by offering choices to patients) and creating a service that would be more responsive to the users' needs as some of its aims.

Consequently, and apart from systemic causes there was also a range of factors influencing and shaping the form of the response to internal challenges. The roots of these should be sought in the wider changes that were either outside the health sector or outside the internal affairs of each country or both. Thus the convergence in the timing of the response and the form of the major restructuring of the health care systems of the industrialised world (Ham, 1990), without being solely confined to it (World Bank, 1987; World Bank, 1993), was, to an important degree, conditioned by global events.

These were primarily related to the major political changes in Central and Eastern Europe, which were precipitated by a complete failure of the alternative economic models and which resulted in a unanimous consensus about the

superiority of the market economy as the most efficient way of delivery for both economic and social goods.

Coincidentally, while Enthoven laid the framework for changes in Western Europe, the first experiment with a purchaser-provider split actually took place in Leningrad and other places in the Soviet Union (Hakansson et al, 1989, Hakansson et al, 1991). This was conducted as part of the wider attempt by Gorbachev's administration to use incentives for stimulating performance of the ossified economy and, in 1988, experiments with new methods of payment for hospitals and fund-holding for primary care providers were already being tried within the framework of "new economic mechanism" (Sheiman, 1994; Fotaki, 1999).

Another important factor in the search for efficient ways of providing services that had been traditionally confined to the domain of the state, was the economic slowdown that was present in most of the developed countries for at least a decade. The use of market means to improve efficiency, responsiveness and the quality of services provided, but also to assert the users' autonomy, was a part of a broader trend present in other spheres of social policy. This was especially evident in the UK and it led some of the researchers there to define it as the revolution in social policy (Bartlett et al, 1998).

2.2.2 Objectives of the market-oriented reforms

The promotion of effective services of high, or at least acceptable, quality reflected in users' satisfaction, produced and allocated in a more efficient manner, became a priority issue for policy-makers in the UK (by the end of the 1980s) and in Sweden (at the beginning of the 1990s). They believed that the introduction of market elements into health care would enhance efficiency and would simultaneously tackle the main shortcomings of the former systems, such as rigidity, bureaucracy and unresponsiveness. Therefore, it was decided to introduce market forces in such a way as to achieve the complex task of stimulating organisational innovation within the publicly planned and financed

health systems, without sacrificing overall cost control or equity of access (Ham, 1997). The reasons why the reforms were introduced are outlined in Box 2.1.

Box 2.1 Rationale for the introduction of pro-market reforms in the UK and Sweden

In the United Kingdom

- ❖ Maximising efficiency of service delivery within given budgetary constraints
- ❖ Tackling the issue of low responsiveness to patients' needs
- ❖ Stimulating patients' and buyers' choice
- ❖ Improving accountability

In Sweden

- ❖ Introducing efficiency incentives while increasing productivity
- ❖ Answering the need for implementation of systematic cost containment mechanisms
- ❖ Responding to the demand for more personalised services

Source: Various (Ham, 1993, Le Grand, 1994; Saltman, 1990) compiled by the author

In the early 1990s, governments in both countries decided that these objectives were best served by the incorporation of market elements into the existing framework of public ownership and financing. In both cases, a transformation of integrated systems of budgetary control into pluralistic contractual arrangements, based on purchaser-provider exchange, was used as means to achieve it (Le Grand et al, 1993; Ham, 1997; Saltman and van Otter, 1992a).

The reliance on market features, manifested in the introduction of competitive incentives for stimulating micro-efficiency of production and freedom of choice in the allocation of resources, was determined by the policy-makers' belief in their proven suitability and superiority to the structures that they replaced. The pre-reform organisation of these two health systems, involving a command-led, top-down systems of production and delivery of services owned by the central (UK) or regional government (Counties in Sweden), were regarded as ineffective, costly and inadequate (Enthoven, 1985; Anell, 1995).

The introduction of a competitive market ethos into health care delivery was expected to realize efficiency gains, improve choice and increase users'

satisfaction with health care delivery. The central government in the UK and the regional governments in Sweden would, nevertheless, still retain control over policy decision-making. It could be argued that this was an attempt to reconcile the traditional public health system goals, such as, for example, universality of access, with the potential virtues and gains that the market might deliver.

Over the same period, many countries have attempted different experiments in terms of separating purchasers and providers as a means of improving efficiency on their supply side, although, in some cases, competition was also used to create an alternative financing structures within a predominantly publicly funded system. This, for example, was the gist of the reforms introduced in New Zealand and of those that were planned in the Netherlands during the late 1980s and at the beginning of the 1990s. Many countries, however, including the two that are the principal source of concern in this study, decided to maintain a single source of finance and directed their efforts at influencing supply side mechanisms, by means of other sets of changes introduced simultaneously with market reforms.

One of the most important structural reorganizations in the UK were the strengthening of the managerial orientation of the NHS that preceded the internal market reforms, which were the first attempt to hold the medical profession accountable for the decisions related to the utilisation of resources (Relman, 1988). The other important change that followed the introduction of the purchaser-provider split in the UK were the definition of priorities in the form of public health targets through the document published by the government "*Health of the Nation*" (DoH, 1991b), and more closely related to the spirit of the reforms, the formulation of the entitlements of patients in "*The Patient's Charter*" (DoH, 1991a; DoH, 1995b).

In Sweden, the shifts that occurred simultaneously were quite significant and were tightly linked to the purchaser-provider split introduced into many counties including Stockholm. The pivotal change was the establishment of the care guarantee for four and half (only cataract surgery in ophthalmology) surgical specialties initially, which outlined an explicit time frame for provision of certain services. Another change that facilitated the shift of the so called "social patients"

from the hospitals to nursing homes was the separation of financing between hospitals and the former, which was known as Adel reform. The set of reforms that were introduced in the UK and Sweden, alongside the market reforms, some of which could have had synergy effects on the health care reforms, are outlined in Table 2.5.

Table 2.5 Health reforms introduced in the UK and Sweden in the late 1980s and at the beginning of the 1990s

Sweden	Main points of reforms	United Kingdom	Main points of reforms
Adel Reform (1992)	Shift of responsibilities for financing and provision of social care from regions (county councils) to the municipalities	Griffith's reform (1983)	Introduction of the concept of professional management and financial accountability into the health service
Family doctor reform (1992)	Family doctors are qualified general practitioners who can be freely chosen by patients, with money following their choices regardless of the patients' residence or catchment area	White Paper <i>Working for Patients</i> (1989) Implemented in 1991 (Market reform)	Creation of two types of purchasers, HAs and GPFHs, who contract competing providers for services for their population Introduction of GP fund-holding scheme Freedom of choice to choose GP Hospitals become trusts
Minimum waiting guarantee (1992)	No patient has to wait for more than three months for the treatment (for five procedures initially then extended to all ranges of treatment)	White Paper <i>Health of the Nation</i> (1991)	Targets for national health policy and the time-frame for their achievement are set Consolidation and co-operation is proposed to achieve health policy goals
Changes in the payment methods	Performance-based payment using DRG instead of budgeting Internal pricing instead of free use of prices	<i>The Patient's Charter</i> (1991)	No waiting time longer than 18 months for elective procedures No waiting time for the first specialist appointment beyond defined limits No waiting time at the outpatients' clinics beyond 30 min. Right to information and second opinion Setting out of the procedure for complaints
Purchaser provider split (1992) (Market reform)	New forms of financing and organisation Purchasing committees formulate requirements for the service provided to their population and conclude contracts with the providers		
Freedom of choice of provider (1992)	Choice of primary care providers and wide range of specialist services from public or private sector		

Source: Various (DoH, 1989; 1991, 1995; Griffith, 1983; Berleen et al 1994; Hakansson et al; 1997; Hakansson, 1999) compiled by the author

Despite the introduction of market reforms, however, in all cases, including the UK and Sweden, state regulation turned out to be more indispensable than ever (Gustafsson, 1995; Klein, 1995). On the one hand, it was necessary in order to maintain the systems' compatibility with the overall strategic goals of public health policy. These could broadly be defined as securing a position in which consumption of health services is sustained at socially desirable levels, it is relatively equitably distributed, and the principle of allocative efficiency is maintained.

On the other hand, regulation acted as a safeguard, ensuring that the reforms complied with the overall framework of policies aiming at macro-economic stability. In short, its purpose was to correct for the "market failure" (McGuire et al, 1987) which can occur when public goods are attempted to be freely traded, just as, conversely, the introduction of market-oriented reforms into publicly operated welfare systems was to correct for government failure, resulting from its position as a monopolistic provider (Le Grand, 1995; Snower, 1993).

Arguably, the policy choices incorporated in the health care reforms in the UK and Sweden also reflected wider trends, such as economic retrenchment and decreased confidence concerning the effectiveness of central planning, although modified and shaped by the political traditions of each country (Garpénby, 1992; Anell, 1995, Ham et al 1994). Therefore, the attempt at introducing planned or managed markets into health care took the form of internal or quasi-markets in Britain (Le Grand et al, 1993; Le Grand et al, 1994) while the public competition model was followed in Sweden (Saltman and van Otter, 1992a; Saltman and van Otter, 1992b). This was an example of how global trends were mediated by the national state policies or in another words how the macro-effects of changes beyond the control of a single country were modified by the middle level transformations such as national policy making according to Mohan (Mohan, 1996).

According to Saltman and van Otter, the internal market constitutes an example of a regulated market where competition takes place between agents in an internal environment that is publicly operated, regulated and monitored by central

government. Public competition model on the other hand, is an example of a planned market where external agents compete with each other and regulation is at the responsibility of publicly elected boards operating on the local level (Saltman and van Otter, 1992b).

2.2.3 Content of the reforms

On the organisational level, the reforms resulted in a split between the roles of providers of secondary care (hospitals and health centres) and those of purchasers (County Councils in Sweden, and District Health Authorities and the fund-holding General Practitioners in the UK). Large provider units were given the option of changing their status from government-administered organisations to self-managed competitive entities and renaming themselves as trusts (the UK) or, occasionally, limited companies (Sweden).

Primary care doctors were also given opportunities to participate in the restructuring of the system. Thus, in the UK, general practices which fulfilled certain criteria (appropriate size of the patients' list and adequate premises) became holders and managers of the budget designated for their patients, on behalf of whom they would purchase elective care and by whom they could be freely chosen (Glennister et al, 1994a). Those who enrolled in this scheme were given explicit incentives (the freedom and the means to purchase elective care for their patients, together with the possibility of reinvesting any surplus of their budget within the practice) to provide the best quality of care for their patients within their own practice capacities, and also to choose for them the best deals from competing secondary care providers (see Box 2.2).

Box 2.2 Key features of the reforms in the UK – the internal market model

1. Separating of the functions of the providers of services:

- *Hospitals*
- *and primary care doctors*

from buyers:

- *The District Health Authorities, which allocated money both to primary care doctors and to hospitals*
- *and primary care doctors, acting as budget-holders, buying elective services from hospitals on behalf of their patients (up to a given amount). The surplus could be retained and reinvested freely for patients care.*

2. Introduction of competition among providers:

- *Hospitals (self-managed trusts) have to win contracts from the District Health Authorities and primary care doctors act as budget-holders*
- *Primary care doctors have to attract patients*

3. Freedom of choice for buyers but also for patients - "the money follows the patient"

Sources: various (Le Grand, 1994; Glennerster et al, 1994a; DoH, 1989a) compiled by the author

In Sweden, whilst fund-holding experiments were implemented to a very limited degree, the free choice of a family doctor constituted a welcome novelty (Saltman, 1990; Rhenberg, 1997). The free choice of provider was to be applied to all levels of care in Sweden (see Box 2.3), but only at the primary care level in the UK, where maintaining the already efficient and well-established gate-keeping role performed by General Practitioners was seen as a priority (Glennerster et al, 1994a; Glennerster et al, 1994b).

Box 2.3 Key features of the reforms in Sweden - the public competition model

- 1. Different forms of purchaser-provider split take place in half of the 26 Counties (regions)*
- 2. Competition between providers (which may or may not be self-managed) in public care delivery and, occasionally in the private system, is encouraged*
- 3. County Councils monitor the delivery of "care agreements" with providers within set DRG prices and quality specifications*
- 4. Change of control system over providers: global budgets replaced by prospective payments to stimulate productivity*
- 5. In many regions, a scheme of the freely chosen family doctor is established, one of whose main duties is to refer patients to hospitals*

Sources: various (Saltman and Van Otter, 1992a; Berleen et al, 1994) compiled by the author

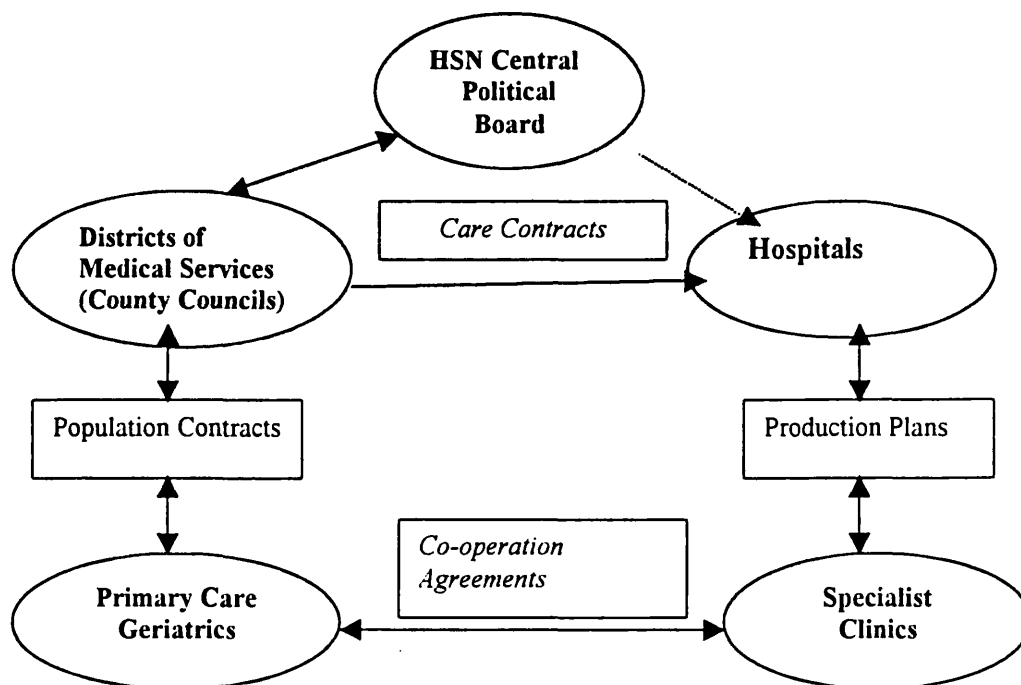
These models were first proposed by Enthoven for the UK, and were subsequently modified and then adopted under the NHS and Community Care Act of 1990 (Enthoven, 1985). The experiments with market elements introduced in Sweden drew, to various degrees, on the theory of public competition as well as on Enthoven's model of the "mixed" or "managed market".

In both countries, an internationally influenced and politically informed design process was attempted, on the macro- and the micro-scale, only in the UK this was tried on a national level, while in Sweden it was left to the discretion of the regions. In the latter case, initially only the counties of Dalarna and Stockholm responded, but gradually different forms of the purchaser-provider split were introduced by many other County Councils.

This was first done at the system level, where selected market-type incentives aimed at improving the performance of the system were introduced within the framework of public accountability (Saltman and Van Otter, 1992a). Simultaneous changes on the institutional level were centred on devising an organisational scheme through which the "planned market" would come to life. In Stockholm, this involved a separation of purchasers and providers whose exchange was based on contracts, which was quite incomplete and illusory,

however, as the latter were in most if not all the cases owned by the former. The whole system operated under the aegis of a powerful HSN (Central Political Body), which had vast responsibilities and extensive powers (see Fig. 2.2).

Figure 2.2 The structure of the Stockholm Model



Source: Jonsson, R. (1994) Stockholm County Council

The role of the HSN was to set the rules, which involved needs assessment of the hospitals' network and/or personnel, and licensing, including medical accreditation. The former function was shared with a professional body (The National Board for Health and Welfare). The HSN also assessed the financial viability of the firms that intended to operate in the market. It was involved in the "products' definition" and in setting prices using the DRG system, which also meant negotiations with providers and the setting of budgetary ceilings. It allocated resources to the purchasers on the basis of an index that was calculated using size, age, sex and socio-economic status indicators. At the same time, the HSN was responsible for issuing planning and strategic directives, in accordance with the defined priorities.

Despite their limitations, the promise of these changes in both countries was considerable. Health planners at the District Health Authorities and County Councils could, for the first time, focus exclusively on identifying and meeting the needs of their populations and on using their purchasing power to shape the provision of services accordingly. For Health Authorities to fulfill their new role in an adequate manner, they had to become involved in activities such as appraising service options, specifying a chosen pattern of service provision, placing contracts and monitoring the provision of contracted services. Most importantly, they would eventually have to assess the impact of health service activities on the health status of their populations.

Patients were to be given support to act as informed consumers and to choose providers, which through their exposure to competition, were, in turn, given incentives to provide higher quality services and responsive care. Thus, in Sweden, they were, for the first time, to act as informed customers/users, with money following their choices (Anell, 1995; Rhenberg, 1997). In the UK, this role was assigned either to the Health Authorities or to the primary care providers known as GP fund-holders, who were regarded as the patients' closest and best informed representatives (Glennister et al, 1994a; Glennister et al, 1994b; Ham, 1997).

The implementation of the set of market-orientated reforms in the British NHS is seen as the first successful attempt at shifting power away from the doctors, the most powerful group of health professionals, into the hands of the purchasers (Klein, 1995). As the freedom of decision-making of the latter was, in turn, significantly curtailed, and as they are largely subordinate to the NHS Management Executive and the Department of Health, this, in the UK's case, meant a transfer of power to central government. What happened in Sweden, though, was quite different, because decentralised decision-making at the county councils' level would not allow for even limited centralisation. Yet the set of market-oriented reforms introduced at the beginning of 1990s, according to some authors, constituted the first attempt of national health policy formulation (Garpenby, 1992).

2. 3. Conclusions

The UK and Sweden, two countries with integrated systems of financing and provision of health care and conspicuous examples of reliance on planned budgeting, have, for similar reasons, embarked on the course of market-oriented reforms. These were to stimulate competition at the supply level and to enhance productivity (in Sweden) and efficiency (in the UK), while improving some aspects of the quality of care and enhancing responsiveness to users' needs and wants (in both countries).

The analysis presented in this chapter has demonstrated that two countries sharing important similarities in their structure, philosophy and values pertaining to their health systems, while yet retaining distinct characteristics of their own, opted for a set of comparable tools for achieving goals that were not dissimilar. It was also argued that the outcomes in each case are likely to reflect the also the differences in policy-making and political culture, in addition to the universality and generic attributes that are often associated with market instruments. This outline has also provided the background information for positioning the purpose and scope of this evaluation.

CHAPTER 3

INDICATORS OF THE MARKET'S IMPACT AND JUSTIFICATION FOR THEIR USE

As was argued in previous chapters, the market-oriented reforms in Sweden and the UK were aimed at achieving a wider choice for patients in service delivery, an increased level of responsiveness to their needs and greater efficiency often expressed as better value for money. In this chapter, the meaning of each of these objectives is explained with the focus placed on separating out the political overtones and translating the objectives into workable research definitions. In addition, to the purported objectives declared by the reformers, it was decided that other parameters needed to be included such as the impact of the reforms on information and quality of health care delivery so as to delineate fully the consequences of the reforms. The comprehensive set of indicators used for measuring the reform's impact, using a tracer-condition service, is presented in Table 1 of the Appendix I.

In the first part of this chapter, the essential preconditions for the market to operate are briefly outlined. This is followed by a presentation of the selected indicators, which sets out the background and justifies their use for the purpose of measuring the market's impact.

3.1 The pre-requisites of markets in health care

This part examines the theoretical preconditions that must exist in the market environment to enable it to work effectively. In both the UK and Sweden, reforms introduced planned markets in an attempt to combine the best elements of two worlds: efficiency and equity. These planned markets are positioned in the mid-point of the continuum, which ranges from pure, neo-classical, private markets for health care to the models in which health care provision is part of the planned economy. However, the pre-requisites that are analysed below are essential for either pure or quasi markets if they are to deliver efficient results within given quality specifications.

The first essential condition deals with competition. This must exist on both the demand and supply sides and it is usually secured by a sufficient number of providers and purchasers. However, economies of scale favour comparatively large units of providers and purchasers at the expense of the number of players. That this is a problem in the case of health care is supported by evidence from the literature, at least for the American market where the large HMO-type providers operate (Propper, 1992). The trend for health authorities and hospitals to merge has already been seen in both the UK and Sweden, with consequent problems in establishing mutually beneficial arrangements often at the expense of quality and the price of services provided to the user.

Second, if competition is to be promoted, free entry and exit from the market or at least the possibility of participating without the high costs that restrict entry, must realistically exist. This means that markets must be contestable and must stimulate efficient behaviour by at least posing the threat of competition (Le Grand and Bartlett, Chapter Two, 1993; Roberts, 1989; Roberts, 1993). The evidence drawn from examining providers' behaviour in the USA has shown that new players are prevented from entry to the market by the existing providers, who are in a privileged position and therefore capture a bigger share of the market (Propper, 1992).

The reasons for this barrier to entry are again related to the size of the incumbent providers and the high capital costs that are required during the initial stages of investment. In this way, an environment for monopoly/oligopoly conditions on the providers' side is created, which, when coupled with monopsony/oligopsony on the purchaser's side, can lead to bilateral arrangements at the expense of efficiency and quality (Propper, 1992; Roberts, 1989). In the case of geographic isolation quality can also be affected by the natural monopoly phenomenon - always a plausible possibility in health care provision.

Third, for a competitive market in health care, one of the most crucial factors is an improvement in the supply of information about the cost and outcomes of services; information that must be accessible to all the parties involved: users, purchasers and decision makers. However, securing a free flow of information is

not an easily attainable goal in health service provision (indeed, if it can be attained at all). This is due to the peculiarities of health care as a commodity and to the asymmetry of information between purchaser and provider, which operates to the disadvantage of the former (Evans, 1974).

Fourth, transactions costs have to be low. This may conflict with the investment for attaining better information as well as for monitoring the quality of service. As predicted by Le Grand and Bartlett, General Practitioners will usually have lower ex-post and higher ex-ante costs, which are the expenditure incurred before and after the transaction respectively. In contrast, the ratio of the ex-ante to ex-post costs for collective purchasers is most likely be the reverse of the former (Le Grand and Bartlett, Chapter Two, 1993). There are also problems related to the increased costs that are, at least initially, required for the implementation of the reforms, as has been the case for the British NHS during its continuous reform process. In addition, constant increases in the cost of operating the system can be expected, because of the contracting and commissioning procedures, which by their nature are not cheap (Hutton, 1993).

Fifth, in any market self-interest is one of the motivating forces. Given the peculiarities of health care as a commodity, the impact of imperfect information and the ill established criteria for quality control pose the risk that the whole system might be permeated by crude self-interest. While the relevant agents must be motivated to respond to market incentives, this motivation may cause problems if other conditions for a successful market are not fulfilled (Roberts, 1993). For instance, where there is poor information, unscrupulous providers may engage in opportunistic behaviour (Williamson, 1975). This could then not only lead to greater and unintended inequalities, but also to social inefficiency which would be the precise opposite of the goals originally intended by the reformers.

3.2 The indicators selected and justification for their use

This section outlines the framework for an analysis of the concepts of choice, information, quality, responsiveness, equity and efficiency, in order to validate their use for tracing the changes resulting from market-oriented reforms. It also provides a detailed discussion of how different aspects of each of these indicators were adopted and used for measurement of the market's impact.

3.2.1 Choice – concept and framework

The importance of choice based on appropriate information, the underlying precondition for effective choice, as a feature of health systems, derives from two sources. It has its origins in the application of the industrial model of Total Quality Management to health services (Berwick, 1992) and also has its roots in the consumers' movement (Winkler, 1987). It is usually presented in the context of market liberalism and is thus associated with the political and economic mode of thought known as neo-classical libertarianism.

The introduction of market features into the wider public sector (Glennerster et al, 1995; Le Grand et al, 1993) and, in this case, into the health care service of the UK and Sweden, was also viewed by many (Garpenby, 1992; Gustafsson, 1995; Ovreteit, 1994a) as the result of a resurgence of conservative ideology. The prominent features of this philosophy, such as property rights, individual freedom and personal responsibility (manifested in a strong reliance on the private provision of services, competition and freedom of choice as opposed to collectivist values such as equity and the supremacy of community-defined needs) were rediscovered and relied upon as a broad policy framework.

This return to conservative ideology may well prove the case when the origin of the implementation of the quasi-markets is traced since it reflects the decisions of the respective liberal-minded governments of the day. Nonetheless, the notion of users' autonomy, which underpins the market philosophy, also derives from the theory of the social rights of citizenship (Marshall, 1950; Alinsky, 1960).

According to this theory, policy imperatives aimed at the promotion of the concept of the well informed patient, who is able to choose from a range of available alternatives, are not necessarily bound to serve the individualistic attributes of an increasingly business minded society (Gustafsson, 1995; Ovretveit, 1994a).

In this context, the expansion of patients' rights in choosing the providers of services could also be used to reinforce the true empowerment of citizens, if properly linked to their direct participation in the decision-making processes (Saltman, 1994a; Winkler, 1987). As elaborated by Saltman, this extension of choice may involve influence over modalities of treatment and higher accountability by providers and by those acting on the patients' behalf for budgetary allocation; it may also extend to their participation in election of health-related politicians (Saltman, 1994a).

There is also another conceptual problem often manifested as an artificial dichotomy of two, mutually exclusive concepts: those of choice and citizen participation. In libertarian philosophy, the ultimate consequence of choice is manifested by 'exit' from the system, while citizen participation is an expression of 'voice' and implies some acceptance of the rules of the system with an attempt geared towards changing them from within. This derives from Hirschman's conceptual analysis, which considered exit and voice as antithesis of each other. He argued that choice (exit within the publicly financed and provided services) was possible only at the margins of the system (for those who could pay and usually also the articulate ones). If fully exercised it could lead to diminishing the elements of voice in the system (Hirschman, 1970).

However, this analysis is valid only in a collectivist mindset as Skidelsky correctly remarked. He pointed out that the articulate users have not only the ability to exercise their power by means of exit but tend even more often to capture a public monopoly for their own needs (Skidelsky, 1995). The latter is supported by empirical evidence that Goodin and Le Grand have presented in his early work by demonstrating the middle classes' aptitude and ability in obtaining more benefits from the NHS (Goodin and Le Grand, 1987) which was even more

visible when contrasted with the prevalent inequalities for those who might have higher needs (The Black Report, 1982).

Thus the division between citizens' participation as a means of democratising a system regarded as a public utility that is driven by users' needs and choice being a manifestation of the consumers' sovereignty relegated to the sphere of wants appears to be a relatively linear construct (Calnan et al, 1998). This is because it reflects only the traditional political concepts that used to underpin the philosophies of the health care systems and fails to capture the complexities involved in the concept of choice and its specific dynamics within the health care context. Arguably it also fails to take into account the expectations of users that might have occurred in recent years.

The view argued here lends support to the proposition put forward by Saltman who regarded choice not as a necessary expression of consumerism but as a means for increasing the democratic participation by the users (Saltman, 1992). It is suggested here, that examples from different health care systems imply that citizen participation (voice) and individual choice (exit) are complementary, rather than alternative, modes of ensuring citizens' influence over health services.

When analysing the content of some of the typologies suggested by researchers who have attempted to categorise the degree of empowerment given to users in different systems, one is confronted by overlaps between the concepts of choice and participation. According to these typologies, the means of empowerment range from mild to strong measures. These measures involve moral persuasion expressed in complaint procedures and appeals; gradually increase to freedom of choice of the physician and the insurer as well as the modalities of treatment given to users. They are at their strongest when users have control, either delegated or direct, over the resources spent on health (Amstein, 1966; Saltman, 1994a).

If the British and Swedish pre-reform systems are positioned within this typology, only the weakest elements in the form of moral persuasion can be found in the former, while the Swedish system seems to empower citizens significantly by

enabling them to elect local politicians responsible for the health decisions. However, doubts have been expressed as to how far decentralized decision-making promoted direct participation in reality. The evidence suggests that when this happened at regional (Sweden) or even at municipal level (Finland) power was still retained in the hands of the administrators (Vienonen, 1994).

On the other hand, the example of granting citizens free choice between competing sickness funds in health insurance systems (Israel, Germany) has spawned new legal, institutional and political frameworks, as well as significant interest group activity, all aimed at increasing public input into the processes of health policy-making and implementation (Chinitz, 1995). The question put forward by Chinitz when analysing these developments, is whether the development of multiple avenues for citizen involvement represents disarray or a healthy social learning process regarding the running of the health system. The conclusion expressed is a cautious optimism that the latter is the case and suggests directions for public policy in order to encourage this outcome (Chinitz, 1995).

Therefore, the freedom of choice of provider (with all its consequences for resource allocation) that was introduced into integrated, publicly funded systems and initiated by market oriented reforms, seems to constitute an attempt to combine the best of the two approaches in practice. In other words, market elements can be used to strengthen the voice element in the system and, through enhancing direct participation in decision-making at an individual level, to increase the accountability of elected politicians and, ultimately, to provide more democratic legitimacy to the governance processes in health care systems.

However, later on some of the defendants of choice in health care have argued that individual choice is not an adequate policy objective as it could prove to be highly destructive if taken away from the broader context of the institutional guidance and regulatory framework and have disastrous effect on growth of health care costs (Saltman, 1999).

Choice as an indicator of the impact of the reforms

Choice is the ultimate objective in the set of reforms promoted by libertarians whose theories profoundly influenced the policies adopted by the conservative governments of both countries. According to these beliefs, choice is best served through the development of the concept of the consumer. As with the other concepts, the notion of the consumer/user exercising choice is differently translated according to the reality and tradition of each respective health care system.

In the UK, the collective approach, which is traditionally associated with the NHS, has arguably continued unchanged despite the market rhetoric and the adoption of the concept of consumerism. It appears as if the policy makers were hesitant about using market means to further their aims in full and, as a consequence, have conveyed the message of a half-hearted belief in the market's effectiveness as the sole means of achieving those aims.

In addition, the values that underpin solidarity are at odds with self-interest and the individualistic mentality that the proponents of the reforms seemed to be advocating as a means for increasing the operational effectiveness of the system and the result is an attempt to reconcile two mutually exclusive sets of values. The tension created is clearly reflected, for example, in the way in which a measure of "democratisation" aimed at users was introduced into the system, with health professionals and managers being urged, by means of administrative measures, to take users' views into account (Joule, 1993).

Another example of diluting the principle of consumers' sovereignty is the issue of patient choice, which is seen as being best promoted by intermediaries such as the General Practitioner fund-holders or the managers of the reformed District Health Authorities. As a result, there is little or no space for individual decisions to be left to the patients. In addition, for the UK patients the place of residence seems in most cases to determine who will represent them in these decisions hardly linking up with the concept of patient choice. It is also accepted that no health care reforms addressed the issue of patients' choice of different forms of

treatment although this can be very important for some patients (Ovretveit, 1994a).

In Sweden, the majority of the models of public competition that were discussed prior to the introduction of the reforms advocated the direct involvement of users in exercising choice. This is in stark opposition to the delegation of decision making to agents, which has always been used in the UK and continues to be the case in the reformed NHS (Saltman and Van Otter, 1992b; Saltman, 1990). Even in Sweden, though, proposals have been voiced for replacing patients' direct control, a relatively well-entrenched feature of the Swedish health care system, by emulating the British example of General Practitioner fund-holders acting as informed intermediaries on patients' behalf.

The different aspects of choice for the selected service can be regarded as an important indicator of the market's effectiveness and, for this reason; the study adopted a two-pronged approach. First, it was aimed at eliciting patients' points of view, reflecting their needs and preferences, which might be different from those of other actors, thereby providing a more thorough insight into the concept of choice. Second, in the UK in particular the extent of choice that is given to patients by their closest intermediaries, the General Practitioner fund-holders, who were regarded as the most flexible decision-makers able to promote the choices of their patients, was also measured in order to assess how far this was happening in reality. The latter was attempted through an examination of the changes in the degree of choice available to patients in the pre and post-reform periods in such aspects of care as the choice of primary care provider and the choice of the hospital site to which they were referred for surgery.

3.2.2 Information – concept and framework

The role that information plays in health care services provision is multifold. First, if health care is assumed to possess some characteristics of a commodity that can be exchanged in a regulated market environment, information about the service's specifications is essential. For users and/or buyers to exercise effective choice, the provision of sufficient and good quality information is a precondition

that must be fulfilled. Informed choice is one of the market mechanisms that secures technical and allocative efficiency and brings about utility gains to users.

Second, despite the multitude of models of gaining information, which may or may not be based on the previous experience of service, the key aspect is how to protect consumers from providers' opportunistic behaviour. In order to secure provision of reliable information, means for documentation and reporting back on the quality of services offered are required. This, on the one hand entails that patients must be guaranteed the right of access to information about the quality of the service and, on the other hand, that the service providers are obliged to document and publish relevant information. Third, the ultimate and arguably the most worthwhile purpose, that provision of appropriate information could and should serve, is the empowerment of users through enabling them to make an intelligent use of health care systems.

The last conviction rests on the belief that users are also important co-producers of care. As long as the quality of the ever-growing number of health services is not adequately documented and the results are not made available in plain and comprehensible language to citizens, consumers can hardly be expected to make more meaningful and effective use of what is offered to them. One such example is the poor quality of hospitals and of doctors in private practice, which is one of the best-kept secrets in many countries where it exists alongside the usually predominant, publicly owned system (Badura, 1999).

Yet the question of greatest concern to patients who decide to seek care outside the public health system is where to find appropriate high quality services. They and their families can rely on little support in their attempts to find answers from within the health system. For this to be achieved, changes in communication techniques between users and professionals and the health care system in its entirety are not sufficient, as there is a need for more structural change to effect fundamental shift in power to the user (Ovretveit, 1994b; Silverman, 1987).

Most recently, there seems to be unanimous agreement in most industrialised countries on the need to shift the relationship to one of partnership instead of the

paternalism that pertained to most aspects of health care provision so far. The impetus for change has been motivated by several considerations: clinical, financial and political.

First, it has increasingly been recognised that if the core therapeutic processes are to be successful, patients' active participation is needed in addition to evidence-based procedures and highly qualified professionals with adequate experience. It has been proven that, not only does the involvement of users' in their course of treatment have a positive effects on its outcomes, the mere possession of information about it does as well: it increases compliance but also speeds up recovery (Stewart, 1995; Balas et al, 1996).

Second, when patients are fully informed about the risks involved in procedures and their preferences are taken into account, the number of procedures, especially interventions, is lower; so are the costs involved, both in terms of direct expense and in terms of those resulting from litigation (Richards, 1998). Finally, patients are increasingly less prepared to tolerate provision of information that is "excessive, clumsy and bent" as noted in one of the BMJ's editorials (BMJ, 1997). They are becoming more and more interested in different forms of participation in their treatment, which they see as a means of asserting their autonomy.

For many years, both the politicians involved and the third-party payers have failed to take any serious interest in this matter even though the problem of asymmetry of information between the providers, purchasers and/or users has been a well known phenomenon from the 1970s (Evans, 1974). This has been the case despite the fact that differences in the perceptions and perspectives of users and professionals, and difficulties in communication arising from these, are well documented (Luker et al, 1995; Luker et al, 1996).

There have also been numerous views expressed as to the role of health professionals (mainly doctors) in cultivating and fostering this phenomenon, which eventually became accepted as an inherent attribute of health service provision. In addition, the imbalance of power between the profession, on the one

side, and the users and payers on the other, was the very factor that constrained the possibility of change, because it served the interests of the profession. Some authors thought that this, together with the assumption that medical ethics were the best device for safeguarding quality, of care might also be a manifestation of protectionism by the profession because of their unprecedented ability to erect powerful barriers that restricted entry into the market. This was precisely the thesis that was first argued in a seminal paper by Arrow (Arrow, 1963).

It was this unchecked power and the lack of accountability of the profession for the rapidly growing share of public resources devoted to health on the one hand, and the tremendous variation in practice and outcomes of care on the other, which led to the questioning of the supremacy of professional authority. The growing scepticism started from the areas traditionally considered as more peripheral such as health care management and the efficiency of health service provision, but gradually came to involve all matters of health, including the most sacred taboos of clinical practice (Relman, 1988, Klein, 1995).

Information as an indicator of the impact of reforms

The market place requires good and usable information for the consumer/user if it is to work properly. Thus, processes for attaining better information were promoted through various initiatives, with service providers being made responsible for correcting the asymmetry of information between the patient and the professional (McNicol, 1992). One of the measures aimed at its achievement was the delegation of the role of purchasers to suitable agents or intermediaries, such as, for example the GP fund-holders in the UK.

The reforms also highlighted the need for improved information on costs and outcomes and mechanisms were put in place accordingly. One such measure was the attempt by the NHS to produce information on costs by speciality from 1988. Since the introduction of the internal market, all clinical work at hospitals, and all clinical work by GP fund-holders and all extra contractual referrals have also been priced on the basis of the episode of care. In Sweden, a

system of costing services using the modified Diagnosis Related Groups (DRGs) was devised, known in Sweden as the KOKS system.

As a result of the reforms, the collective type of purchasers in the UK and Sweden were to be, respectively, the District Health Authorities and county councillors. Individual purchasers in the form of GP fund-holders were introduced only in the UK. Primary care providers in Sweden would have played the same role as the fund-holding General Practitioners in the UK had a similar model been adopted (Glennerster et al, 1994a; Glennerster et al, 1994b). The determining factor in deciding on their suitability, especially in the case of Sweden, was the possession of appropriate information about patients' needs and the capability of assessing the outcome of treatment and care procedures.

The newly created purchasers' schemes in both countries (fund-holders in the UK and house or family doctors in Sweden) were expected to correct the existing imperfections of information supply. The assumptions on which these expectations rested were two-fold: first, that if purchasers were given financial incentives to attract patients, their number would be sufficient to make competition work. Second, because General Practitioners were the best-informed representatives of the patients, they would be automatically predisposed to act not only as judges, but also as promoters, of the quality of care received by their patients.

As a consequence, General Practitioners in the UK, and less so the primary providers in Sweden were to be responsible, at least in theory, for diminishing the imperfection of information supply. The collective purchasing agents were not to be excluded from this process either. The new role of the reformed Health Authorities was to assess the health needs of their populations, for which relevant information would also be required.

Traditionally, health professionals have acted as agents for the patients. This element seems to be heavily retained in health systems, underpinned by collectivist values in welfare provision, such as, for example, the NHS in the UK. On the contrary, in countries with a health insurance system, patients are

formally treated like autonomous market partners. Traditionally, patients have the right to choose their physician as long as the physician has a contract with the social health insurance system. In addition, patients have the right to full information from their physician and also have the right of access to their own medical history. However, in reality even in these systems patients are not better informed than those in other health systems, nor are they independent partners in the system; they seem to need agents who can decide and act in their interest.

In spite or maybe because of this, this principal agent relation is heavily questioned in the current debates within the insurance-based systems. For example, in Germany the sickness funds increasingly act as purchasers of services and by doing so are trying to take on the role of the patient's agent. In the German hospital system, the federal states ("Bundeslander") also act as agents.

Some believe that patients' interests are probably best served by independent patients' organisations. Community Health Councils in the UK are a diluted version of these organisations and were set up to deal with the democratic deficit in the British health care system. The most prominent example of this trend is the case of the Netherlands where the patients' organizations play a strong role and are equal partners enjoying support from the government.

In other European Union countries the representatives of self-help groups, independent consumer societies and independent counseling centres are seen to be capable of offering assistance and form the nucleus of patients' organizations. However, it is not fully clear how the observed tendency of shifting the vote from health professionals towards health insurance or less often to the patients' organisations will develop which might be one of the causes of tension in the system (Badura, 1999).

This research examines the effectiveness of incentives introduced into the system by a means of reforms stimulating the activity on the side of the patients' agents (mainly GPs in the UK) to obtain and use information for the benefit of their patients. Information provided to patients about procedures or the options

concerning their treatment (given to them by providers such as primary care doctors and hospital units) were examined. The information was tested against the views of other participants in the system, especially, the providers, and their perception of the type and quality of information was compared with that of the users. Finally, conclusions were drawn about the changes that could be attributable to the reforms in the context of the perspectives of the different actors.

3.2.3 Quality of care – concept and framework

Quality is a multi-dimensional concept with a number of meanings that may be differently highlighted according to the purpose of its use (Ovretveit, 1992; SPRI's Report, 1990). It is, therefore, important to define clearly the perspectives adopted. The essential precondition, before assessing the quality of health care, is to define the meaning of the term "quality" itself, as has been repeatedly stressed by Donabedian (Donabedian, 1966; Donabedian, 1980).

As often happens in practice, concepts that are underpinned by value-laden judgements become muddled with generalities, making the task of handling them for any concrete, evaluative purpose unmanageable. At first, the concept of quality in terms of care seemed to be quite similarly treated by health care practitioners and academics alike (Brook, 1973). The recognition that it was difficult to define quality in terms of a single attribute, or even as a catalogue of functionally related attributes, led to the establishment of a comprehensive platform for assessment.

Different views were put forward as to what dimensions and perspectives might be regarded as inherent parts of a broader concept of quality of care, some of them extending to all-encompassing notions and some referring to elusive concepts of need, equity and accessibility (Maxwell, 1992). According to others, efficiency defined as *"fully meeting requirements at the lowest cost"* should constitute the foundation of a comprehensive quality model (Ovretveit, 1992). Quality is defined by International Standard Organisation norms as *"the degree to which all characteristics of a product, process or service meet the requirements that originate from the goal of use"* (ISO, 1991).

Many concepts of quality are concerned with efficacy, effectiveness and appropriateness. The first is viewed as the ability of a health care service to produce the desired outcome in a defined population under ideal conditions, and the second as the extent to which the same outcome can be achieved under usual conditions where skills and resources are different from the experimental ones. These two dimensions form the foundation on which quality standards are established and correspond with the technical or operational notion of quality.

The third is appropriateness, which basically equals health gain, where the expected health benefits exceed the expected negative consequences by a sufficiently wide margin to make the procedure worthwhile (Buchan, 1993; Butler, 1994). This aspect of quality is still treated more as a research question and not used as a policy making instrument in health care services in Europe, possibly with the exception of the Netherlands, where it is implemented to some extent (Buchan, 1992). Coulter et al argued that the lack of scientific evidence on which to base the decisions about the appropriateness of treatments is one of the main factors responsible for this situation (Coulter et al, 1995).

It is accepted that there are several definitions of quality, or several variants of the single definition, and each of them is legitimate and valid in its appropriate context. One of the fundamental, and most widely accepted, definitions and systems for assessing quality of care is that provided by Donabedian (Donabedian, 1966; Donabedian 1980). It is based on the measurement of structure (defined as broad mix of inputs), process (the way the activity is carried out) and outcome of care (the results of the former two) using as an example the initial condition of service (see Fig 3.1).

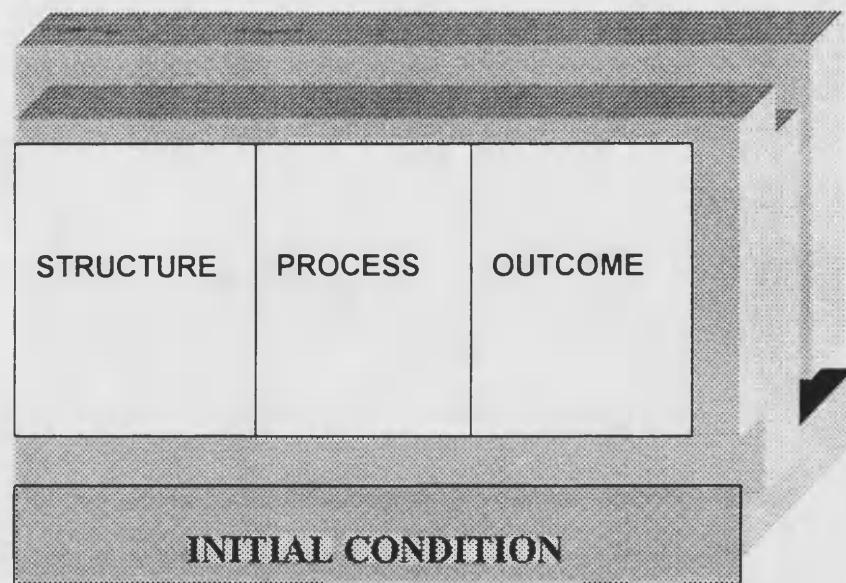


Figure 3.1 Quality stages according to Donabedian (Donabedian, 1966)

However, the classic production model where this concept originated has only a limited application for health care provision. This is mainly due to the difficulties encountered when establishing a relationship between the structural mix of inputs and the outcomes that result from carrying out a health care related activity; the difficulties arise because of the number of influences related to the processes of care (Donabedian, 1966; Ovretveit, 1992).

Quality is not necessarily an analysis of activity but a comparison with something else, which could be another similar activity or an identical one; it is a multi-dimensional issue (Calman, 1992; Donabedian, 1980). Even in the early analytical studies in the quality literature, the views of practitioners, consumers, administrators and policy-makers were given equal attention (Donabedian, 1966). This useful division (including the points of view of all parties involved in defining quality) was also adopted for the evaluation purposes of this study (Fig. 3.2).

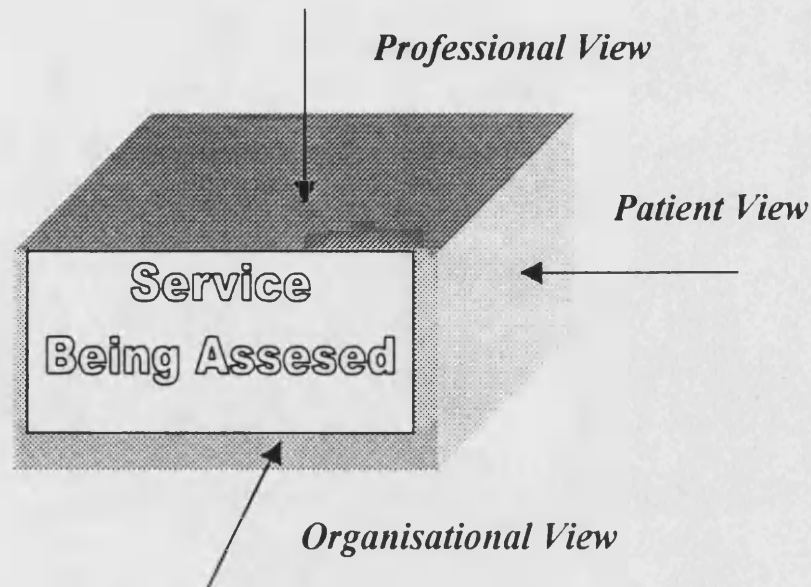


Figure 3.2 Different perspectives when service outcomes are evaluated

Quality as regarded by patients

Acceptability of the service, expressed in technical, social and cultural terms is probably the first consideration for patients and also for staff. Relevance or responsiveness understood as catering primarily for the needs of the patient and not of health professionals, is probably the patients' second consideration. Information about the components of treatment, likely outcomes and the form in which the patient can use it, is another area for consideration, as is respect for patients choice, based on adequate information for enabling them to make decisions about treatments.

Technical competence or the quality of the process itself and the improvement of the methods of measurement, ensuring confidence about the outcome, is equally important. Cost-effectiveness, seen from the social viewpoint and regarded, as the involvement of the wider public in choices about the type and level of provision of health services could also be an issue of interest to patients. Users of services, apart from being patients, are at in the same time taxpayers and indirect contributors to the funding of health care.

Quality as regarded by health professionals

Health care professionals are traditionally taught an individualistic logic, which has its historical roots in the doctrine of empiricism on which scientific inquiry is based (Russell et al, 1992). This individualistic logic is, moreover, buttressed by the notion of absolute clinical freedom traditionally entrusted to doctors who then use medical ethics to safeguard the quality of care. It is argued that the former might have been invented not only to counteract the inherent market failure that occurs when health care is traded as a commodity but also as a barrier to limit entry into the market (Arrow, 1963).

For these and other reasons doctors and other health-related professionals are accustomed to acting in isolation. It means that the concept of quality is also not immune from the fragmentation that is characteristic of complex and labour-intensive systems like the health care system. As a result, more often than not, health care professionals usually equate the concept of quality with clinical efficacy/effectiveness.

Quality as regarded by funders/direct payers

Efficiency is the most important consideration for funders, which is expressed as a preoccupation with targeting scarce resources to the most worthwhile activities. These are usually defined as the capacity to benefit most, when viewed from both a societal and medical point of view. It also deals with determining the appropriate level of provision of a particular intervention but less so with the appropriateness of the services despite the widespread evidence that a high percentage of inappropriate interventions in the health care provision (Chassin et al, 1987; Chassin et al, 1989). Care is also made inappropriate through failure to adopt interventions with demonstrated effectiveness (Sheldon et al, 1993).

Although quality is considered as a matter of primary importance, on which decision-making about services should be made, it has been argued that health care policy is

being deflected towards simple issues such as the most efficient financing systems and cost-containment (Maynard, 1993a). Some argue that if procedures of proven appropriateness/effectiveness had been adopted, there would probably be no need for implicit or explicit rationing (Frankel, 1991; Frankel and West, 1993; Maynard, 1993a). Coulter et al put forward a hypothesis that until the appropriateness of treatments and a more universally accepted concept of need is established it will be difficult to incorporate these aspects of care into the decision making processes and purchasing activities (Coulter et al, 1995).

The organisational concept of quality

In the 1980s, the concept of quality broadened from professional activities towards including the organisation of care at the institutional level, the performance of specific departments extending to the integration of consumers'/patients' preferences and choices. It was also redirected from merely improving quality towards assessing and assuring it, which was described by Relman as the era of assessment and accountability (Relman, 1988).

Some of the proposed initiatives as to how to achieve the quality objective in the UK were included in the Department of Health's recommendations, that formed part of the White Paper and initiated the 1991 market reforms (DoH, 1989a). These could be briefly outlined as the introduction of continuous postgraduate education, a quality assurance system for all health professionals and the introduction of the medical audit. Another measure was work on guidelines and care protocols, which were expected to develop into anticipated recovery pathways and purchasing protocols and accreditation for all levels of specialisation for all categories of health professionals.

Quality as regarded by the government

The government's role is even broader than that of the funders'. Traditionally, it was concerned more with taking measures that would in the first instance, assure provision of high quality care and not necessarily with the assessment of the quality of the care itself (Casparie, 1993).

The means that are available to each government may differ in the extent of its executive power over health issues. Nevertheless, they basically include the same broad tools such as legislation, regulation of the provision of health care facilities, planning and financing. A government's objectives, moreover, while overlapping with those of the founders in terms of financing, especially when the source of finance is general taxation, are also oriented towards assuring the safety of health care intervention both for the users and for the health professionals. This must also be regarded as being within the framework of the environmental perspective.

Accessibility, both in terms of geographical access and equity of access for different socio-economic groups, is another of a government's concerns. Availability of information is also an aspect of access. This is because it has been proven that access to health care is related to socio-economic and educational status (Goodin and Le Grand, 1987; O'Donnell et al, 1991), which is also what makes access one of the objectives of a more global approach to quality.

Finally, a government needs to secure compatibility of a chosen health policy with the overall framework of macroeconomic stability. It is known that social and health policy both follow the general trends of a country's economy, whether the trend is of rapid growth or recession, thus serving as one of the tools and a counter-vailing power in balancing the economy through retrenchments in social policy spending (Culyer, 1991; McGuire et al, 1987).

Quality as an indicator of the impact of reforms

Although White Paper has stated that competition would drive up quality (DoH, 1989), quality of care itself was not regarded directly as one of the objectives of the reforms but in the words of Donabedian, "*quality, while not being a primary goal of the reforms, comes rather in a guise of value for money*" (Baker, 1993). It can be found, to some extent, in all the other components of the reforms that were articulated and it was for this reason incorporated as one of the key indicators for evaluating their impact.

While recognising the important implications that all factors have on the quality of care delivery in general, the perspective adopted here is modest in scope and uses the above only as a broad framework for interpretation of the results of this study. These are primarily concerned with the changes in attitude of the health professionals and adoption of more user-friendly forms of service provision, such as reducing waiting time at outpatients' department and some aspects of service provision that would increase patients' well being (i.e. setting a date for an operation).

It can be argued that, in addition to the traditional players in health care, patients are uniquely well placed to assess most if not all aspects of care especially when they have had previous experience of good care. This can even be extended to the technical aspects of the quality of care and can be defined by what is accomplished and not by what is simply done (Donabedian, 1992). It can in addition, serve as a useful source for providing information about public priorities and the public perception of the services (Richardson et al, 1993). It also enables conclusions to be drawn on how far the direct objectives of the reforms, such as responsiveness to need and increased choice for the patient, have been fulfilled in practical terms. Hence in this study, patients' views and their satisfaction level with different aspects of service were elicited.

3.2.4 Responsiveness – concept and framework

Another proclaimed objective of the reforms was to enhance responsiveness to patients' needs. In the UK, this was promoted in part by empowering the General Practitioners, who were seen as spokespersons on behalf of the patient (Glennister et al, 1995; Matsagannis et al, 1993). The role of the District Health Authorities was also radically changed: their new (and sole) responsibility was to organise provision of health services in accordance with the assessed needs of their populations.

In Sweden, the earliest reforms were implemented in Stockholm and in Dala County, where city councilors, the elected local politicians, were given a higher profile in the role of representing their population on health care issues. The

innovation in the form of a more active role that was given to primary health care providers in the Dala County experiment was still aimed at increasing their advisory role by providing inputs to the decisions that were to be made by the county councilors. This solution also had its proponents in the UK (Graffy et al, 1994).

Waiting times for access to hospital, either for specialist consultation and/or the performance of an elective procedure (diagnostic and/or surgical), have a long history within the publicly operated and funded health care systems. Explanations for their genesis and persistence were sought in economic, organisational and sociological theories alike. Economists argued that, in the absence of pricing mechanisms and zero cost at the point of use of services, demand was bound to outstrip any reasonably defined level of supply (Cullis and Jones, 1983; Cullis, 1985).

In this context, waiting lists were considered to be a desirable rationing tool for distributing limited resources, as they would ensure access to services for those who might benefit most. Thus social considerations were, in this context, closely related to equity-creating conditions, fulfilling both objectives at the same time. However, in practice this theoretical tenet seemed to have several imperfections. Waiting lists reflected rather large geographical differentiations (Davidge et al, 1987; McPherson et al 1981; Williams et al 1993) including both inter- (Goldacre et al, 1987; McPherson et al, 1981) and intra-specialty practice variations (Drummond et al, 1991; Williams et al, 1993). There was considerable doubt whether they contributed to the principle of equity.

The other main argument for the inevitability of waiting lists in publicly provided health systems put forward by economists dealt with the lack of efficiency in the allocation of resources and the perverse effects of incentives resulting in technical inefficiency; the latter according to many is inherent in non-market systems. This has been the subject of vigorous and lengthy debate on the desirability and optimal level of the state involvement in the provision of public goods.

The evidence available suggested that pure market provision of health care in the form of private insurance leads to the "invisibility" of waiting lists. However, some doubted whether their real measure was not correctly expressed, as the uninsured were not included on them (Cullis et al, 1985). Others argued against pure market on the grounds of social inefficiency, which would be created through the denial of an appropriate level of services to a significant part of the population (Saltman, 1994b). In essence, this was an argument supporting pleas for greater equity.

Whatever the efficiency merits or demerits of the sole reliance on a pure market or on state provision of health care, these seemed not to apply to the social insurance model with universal entitlements to care and non-existence of waiting lists, as could be seen in the example of Germany. The success of the latter could be attributed to the different incentives for providers present in the compulsory health insurance systems reflected in remuneration schemes (Schwartz & Busse, 1997) but also pointed towards differences in the level of supply, manifested in higher manpower and activity rates (McPherson et al 1981) which according to some has provided an incentive to oversupply services (Freeman, 1998).

The role of allocative mechanisms and, in particular, the reimbursement system in promoting or, in the case of rigidly planned health systems, impeding technical efficiency is widely accepted. Yet the positive relationship between the level of funding and related inputs and the success of systems in dealing with demand, and furthermore, in meeting health care needs within a reasonably defined level, is much less acknowledged.

On the other hand, waiting lists were, and still are thought to be a characteristic of health systems where the allocation of resources is unrelated to productivity and the incentives, which would stimulate it. Examples from European pre-reform systems, such as Sweden (Charpentier and Samuelson, 1994), and the UK (Frankel & West, 1993) and elsewhere in the world, as in New Zealand (Buchan, 1993) to mention but few, seem to confirm this conventional wisdom. The effects of the incentives must not be overestimated, though, and need to be disentangled from the effects that are the result of a greater amount of resources

devoted to this purpose, which is characteristic of most of the insurance-based systems in Western Europe (OECD, 1999).

Changes in waiting times - an indicator of the impact of the reforms on responsiveness

The NHS review that began in 1988 was, to an important degree, prompted by a response to widely exposed individual, and usually extreme, cases of waiting times (Dixon, 1998). The government of the day committed itself, in a highly publicised undertaking, to abandoning the culture that fostered and supported the acceptability of waiting list mentality within the NHS. As things were at that time, the requirement to deliver high standard professional services was contradicted by perverse incentives for upholding them because they were perceived as necessary for securing not only funding but also reputation. It was argued that the purchaser/provider split would reconcile the conflicting objectives and that the disincentives for maintaining long waiting lists by specialist providers would cease to exist.

In addition, power for influencing providers' behaviour was decentralised into the hands of individual (GP fund-holders) and collective purchasers (District Health Authorities). A similar situation was developing in Sweden, where the politicians of the County Council of Stockholm decided to provide a health care guarantee, initially for the five elective surgical procedures for which waiting times were demonstrably the longest. In this context, the quasi-market reforms in the UK and Sweden were both directed at changes on the supply side (Maynard, 1993a; Rhenberg 1997) while maintaining the predominantly public and single source of funding which seemed to be in line with these concepts.

At the same time, views were expressed that the interpretation of waiting times could not be relegated solely to the demand side as the traditional approach to this issue had suggested (Goldacre et al, 1987; Cullis et al 1983), and that it had to be sought on the supply side (Iverson, 1993) and the factors related to professional decisions (Morgan et al, 1987). It is beyond the scope of this study, however, to provide further elaboration on the complexity and

comprehensiveness of issues involved in the persistence, succinctly labelled the “perdurance”, of the waiting list phenomenon (Frankel and West, 1993) and to examine closely the validity of these claims.

What is attempted in this research is to discover whether or not the decrease of waiting times advocated by the market proponents for elective procedures - like for example cataract surgery actually took place in practice and how significant were the changes. These were analysed in the context of efficiency gains and their impact on quality. Following the analysis of evidence, some explanations of the changes, which have taken place, is proposed (see Chapter Eleven, Discussion).

In addition, this study looks into the phenomenon of waiting for treatment and the presence or absence of incentives promoting organisational innovation within the system. The aim was to evaluate the impact of improvements on the dynamics of waiting times that might have occurred on the micro-efficiency level. The internal market reforms, which were aimed at achieving higher allocative and technical efficiency, are thus well suited to an examination of the validity of this claim.

More specifically, changes in waiting times, from before and after period of the reforms were used as the main indicator of responsiveness to patients’ needs and as one of the indicators of change in service delivery. Responsiveness to need, expressed as changes in waiting times, was, for the purpose of this study, based on the assumption that, if properly measured, the level of unmet demand could be regarded as a proxy for need. A further assumption was that it could be relatively safely employed as a proxy to measure the unmet demand, one of the commonly accepted definitions of need (Bradshaw, 1972).

The limitations of waiting lists, such as the inaccuracy of registers (Davidge et al, 1987; Goldacre et al, 1987), and perverse incentives for keeping them long (Beech et al, 1992) were taken into account, to counteract the many arguments raised against the correlation of the length of waiting lists with the unmet need. Despite these reservations, the length of the waiting lists was used as the substitute and/or tracer of demand. Waiting times, that are usually expressed as

figures on waiting lists, are the only available indicators of the demand and need for cataract surgery (Williams et al, 1992; Williams et al, 1994). Bearing these reservations in mind, meaningful conclusions about responsiveness to need may be inferred following an analysis of changes in waiting times.

3.2.5 Efficiency - concept and framework

The set of quasi-market reforms introduced in the UK in 1991 and in Sweden in 1992 had achieving improvements in the efficiency of service delivery as its most important aim. This concept of efficiency encompasses both technical and allocative efficiency. The former meant either the decrease of the cost of inputs for a given outcome or the increase of outputs produced at the same cost (this notion of efficiency derives its origins from the industrial production process). The latter should occur when the benefits gained from the use of given resources are maximised and it is more often used within the domain of public policy. Although it was not explicitly articulated in government manifestos, either in the UK or in Sweden, it could be assumed that the purpose of the reforms were to tackle both aspects of efficiency.

Until now, the efficiency issue has been addressed by purchasing authorities in terms of activity indicators (throughput or volume/cost ratio). Even in such a narrowly defined concept of efficiency, a considerable uncertainty about the amount of care purchased in comparison to the previous year and, in consequence uncertainty about the so-called efficiency outcomes, was widespread (Appleby, 1994; Epstein, 1990). The evidence provided served as a sufficient argument for developing a concept of efficiency in a more pertinent and relevant manner and for establishing adequate systems for monitoring its development.

During the late 1980s, the focus was placed on introducing policies and methods that would contain the rapidly growing expenditure of health care. These developments had to deal with demographic trends and the increased availability of

biomedical technology, as well as the increases in real income (Barr, 1992; OECD, 1985). The factors that were responsible for the growth of the real cost of health care provision during the 1970s and 1980s were largely beyond the control of national health policy makers, either in the UK, Sweden or in any other health care system. It was also increasingly recognised that the only power government had to influence the rise in the cost of health care in practice, was by making choices and an explicit setting of priorities that would be based on evidence of the procedures (Dixon et al, 1991; Heginbotham, 1992; Maynard, 1993a).

Therefore a distinction between efficiency and cost containment is seen as a necessary one to be made. Although they may under some circumstances overlap, conceptually they constitute a different level of approach. While cost containment is a rather straightforward policy, which is largely related in a linear way to its aim, efficiency can be interpreted at many levels and, in some cases, may even contradict the former. That is probably why some health economists do not consider that cost containment can itself serve as a sensible policy goal and, for this reason, argue that it should not be considered as a driving force of the reforms, at least in the British case (Barr, 1992; Culyer, 1991).

Efficiency as an indicator of the impact of the reforms

The notion of efficiency was formulated only at a relatively late stage as a direct objective of the reforms in the UK. It initially took the form of a demand for and pursuit of greater public accountability in the use of resources and choices made in the health care services, before being articulated as a search for greater efficiency later. This pressure was mainly directed towards the medical professionals who were regarded as commanding and deploying resources according to their own priorities, and it was initially manifested in the introduction of control over the medical body in the form of external management (Griffiths, 1983).

By contrast, in Sweden the central aim of the reforms, which had begun to take shape already in the early 1980s (Health Act 1982), was to align financial responsibility with operational control (Saltman and Van Otter, 1992b). This was again placed within the responsibility of elected councilors, whose most important

responsibility, for which they were directly accountable to their constituencies, was the performance of the County's health system.

When the attainment of greater efficiency was eventually defined as an explicit goal of the reforms, the introduction of a market ethos into health care was proposed as the means of achieving it. This reflected the renewed confidence in the beliefs of the neo-classical school that internal competition among providers would result in better management of the existing capital resources, which would, in turn create higher productivity gains. In order to achieve a more effective structural mix, both primary and secondary health care providers were given performance-related incentives.

In the UK *in lieu* of the performance-related incentives, a fund-holding scheme was proposed for general practitioners and trust status was offered to hospitals, which wanted to participate in the scheme. Thus, the concept of at least two types of purchaser was developed, one being the District Health Authorities and the other the GP fund-holders. There was an apparent departure from the neo-classical model of a private market for health care that was reflected in extensive regulation and which was carried out in a strictly centralized manner in the UK in contrast to a more decentralized fashion in Sweden, though the option of introducing a central regulatory body was also extensively discussed in the latter case.

This study is concerned with the aspects of quality, choice, information and responsiveness that might have been influenced by the reforms and their links to efficiency. Efficiency is one of the indicators of the market impact and it is therefore examined for at least two reasons. First, it is important to ascertain whether improvements in quality, choice, information and equity were achieved at the expense of efficiency or vice versa, if at all. As Propper et al suggests, in her reference to the USA's health market purchasers, those who do not face hard budget constraints tend to compete on quality rather than on price, which nevertheless results in higher costs (Propper et al, 1998).

Second, there were also arguments voiced whether reforms driven by efficiency considerations would, if they were successful, have a positive or rather negative effect on the quality of care. In short, there seemed to be a disagreement as to the impact on different aspects of quality, which was voiced in the aftermath of the introduction of the reforms in both countries.

Some claimed that the efficient provision of care would have a positive spillover effect and argued that it should, in fact, be considered as one of broader dimensions of the quality of care concept (Overtveit, 1992; Ovretveit, 1994b). Others thought that the priority given to budgetary considerations by the General Practitioner fund-holders might not only lead to under-referral and under-treatment but also to a conflict of interest between trusts (Keeley, 1993). These, taken together, could, in turn, adversely affect the continuity of patients' care (Wall, 1994).

The potential conflicts between efficiency and other objectives such as freedom of choice were identified already at an early stage and, accordingly, efficiency was used as a benchmark for the reforms' internal coherence. While all the detailed aspects and links between quality, choice, information and equity, on the one hand, and efficiency, on the other hand, were not investigated in this research, any changes that took place were interpreted in the context of the efficiency incentives introduced by the reform process.

For the purpose of this study, efficiency was measured as comparison of activity indicators and their relation to the cost of the service and to the clinical outcomes in selected providers' units. This enabled the drawing of conclusions on changes in efficiency and the links between efficiency the other objectives of the reforms. Also the adoption of cost effective procedures and in this case the shift to day care surgery as a likely result of pro-market reforms was investigated.

3.3 Conclusions

The discussion of indicators selected for examining the impact that the reforms had on concepts, which best reflected the spirit and aspirations of changes introduced, demonstrated how difficult, and sometimes impossible was the task of identifying measures for capturing these transformations. This was on the one hand, due to the complexity and compound meanings as well as the subjective and intangible nature of the goals that reformers aimed to further (such as were for example choice and quality).

An added difficulty in isolating particular effects was, on the other hand, caused by the close links and interdependency between some of the objectives of the reforms (choice and information is one such example). However, the conflicting character of the intended changes (increasing choice simultaneously with efficiency) complicated the task of identifying their impact yet further.

CHAPTER 4

THE IMPACT OF THE REFORMS AS REVEALED IN THE LITERATURE

In this chapter, the presentation of evidence of the impact of market-oriented reforms in the UK and Sweden follows the sequence of the indicators selected. The discussion of the findings, as revealed in the literature, is preceded by an outline of the constraints and limitations that the majority of evaluation studies face, including this one.

Market experiments introduced into planned health care systems, and their consequences for the transformation of health care provision, have attracted a great amount of interest from researchers, policy makers, the media, and even the wider public. The different effects of the reforms have been examined, with some of their aspects being at the centre of evaluation and debate, and others being virtually ignored. The former tendency is well illustrated by the numerous studies devoted to the effects of the General Practitioners' fund-holding scheme in the UK and its impact on the efficiency of care provision, on prescribing patterns and on equity of access. In Sweden, there was a similar focus on assessing productivity and efficiency gains, quality aspects accruing from the introduction of the Stockholm Model, and the purchaser-provider split reforms in general.

On the other hand, the reforms' effects on other important innovations introduced by means of market mechanisms, which may spell a transformation in the empowerment of users as a result of additional choice and information given to patients and purchasers, have attracted relatively less attention. Surprisingly, aspects of responsiveness and also the redefinition of the roles of the main actors, and the changes in their attitude expected to accrue from the new set of

incentives, were not given much prominence in the evaluators' agendas either. This may result from the fact that it was much easier to measure the most straightforward indicators and leave in the shadows those that matter equally or more, but which are less likely to be enumerated.

On the whole, however, there have been few systematic approaches to assessing comprehensive aspects of the reforms in the manner of a controlled study. Most of the studies, which have been completed in the UK, were either pieces of indirect research based on a review of existing literature, which was useful for identifying gaps in research but provided little hard evidence, or were retrospective descriptions and case studies. Very few used prospective methodology and even fewer included control groups for the purpose of comparison. In Sweden, the situation was similar, and a reliance on surveys of attitudes and evaluations within the area of gray literature was even more prominent. These were used for quite superficial purposes and, in the main, formed a vast body of non-refereed publications. The reasons for these limitations are discussed in more detail below.

4.1 Problems with the evaluation

A substantial body of evaluation research was accumulated during the several years that followed the implementation of the internal market reforms in the UK in 1991. Despite this, however, most of the evaluations conducted were fraught with a number of methodological problems. These are mostly related to the mode in which the reforms were introduced, but also to their content. In the case of the former, the main difficulty was the non-existence of comparable data from before the period of the reforms, against which to compare the performance of the reformed system. So, for example, there was a lack of reliable data on costs and prices of services before the reforms; and of course, there was no previous experience with purchasing schemes.

A further difficulty was also created by the purposeful obstruction of access for independent evaluators, which, according to many, was typical of the period preceding the implementation of the reforms and of the early stages of the

reforms (Dixon, 1998; Le Grand et al, 1998). In addition, the pace and the way that the changes were introduced transformed some structural aspects of service provision, making evaluation downright impossible or biased. For example, the massive change in the role of purchasers that occurred, without leaving control groups for the purposes of comparison, and the positive selection of participants, which happened at an early stage of the reforms (and was done on a voluntary basis), illustrates the difficulty of the task involved.

Meanwhile, in Sweden, even fewer attempts entailing systematic work have been made to measure the effects of the model(s). Although there have been many follow-up studies and evaluations of the effects of the market models in the Swedish health care system, very few were scientific in their approach and even fewer were grounded on proper evidence. Many of these evaluations were ordered by politicians of the county councils and were inevitably tainted by the political orientation of those who needed straightforward proofs of the reforms' success or failure, in order to support broader political agendas. This meant that the effects attributed to the different models of the reforms were not always based on solid empirical evidence.

The market experiment in Stockholm County Council was a notable exception in this respect. The effects of this experiment have been continuously studied and evaluated by independent researchers and auditors, and the results have been presented to the responsible politicians and administrators at the county council. These evaluations have given important feedback to the policy makers and also prompted subsequent modifications in the Stockholm model. But even in this case they were hastily discontinued after the ascension of Social Democrats and the explanation proffered was that there was no more interest in this matter.

The effects, or absence of effects revealed in the literature were derived from many different evaluations of purchaser-provider models in the Swedish health care system. One preliminary conclusion to be made is that the separation of the effects of the models from the effects of other developments in the health care system, that took place concurrently, proved even more difficult than in the UK's case. One reason for this was the degree of regional discretion in the

implementation of the reforms and the different time frames in which they were introduced in the separate county councils.

Besides this, in both countries there was a lack of reflection before the reforms were introduced, which impacted upon the ability to conduct proper evaluation afterwards (Dixon, 1998; Hakansson et al, 1997). Even when the effects of the reforms were investigated, there were only a few studies, which employed a systematic approach and, in most cases, only the short-term effects were the subject of evaluation.

Too many studies in both countries were preoccupied with the analysis of theoretical assumptions and too few provided evidence from direct research. The latter was especially pronounced in the first years of the implementation of the reforms. Many used methodologies that dealt only with simple surveys of the attitudes of different respondent groups. Studies that adopted a longitudinal approach and attempted to examine changes over time were few.

Last, but not least, was the problem of the confounding effects resulting from changes that happened simultaneously or directly beforehand, and which, while not being related to the particular set of reforms that this study examines, affected various aspects of care that the quasi-market reforms aimed to address. These confounding factors were linked both to other health and social care reforms and also to wider economic, technological and even social and political changes.

A set of important reforms that were simultaneously introduced had synergy effects with the objectives that the reforms sought to address. Additional difficulties arose from the fact that it was almost impossible to distinguish some reforms from others that might have been introduced earlier (UK and Sweden), simultaneously (Sweden) or soon after the reforms (UK and Sweden). The Adel reform of 1992 in Sweden, under which the responsibility for social care was shifted to the municipalities' budgets, led to a decrease in lengths of stay as well as to a decrease in the number of beds and was one of the most prominent examples of these effects.

Finally, the conflicting character of some of the important aspects of the reforms colluded with the aim of the evaluation at some of its stages, making the task of attributing specific effects to particular policies even more difficult. For instance the wider adoption of the cost-effective procedures such as the day care surgery could have been prompted by the incentives introduced by the reforms but their widespread diffusion could also be a result of the technological progress, which happened in the same time.

4.2 Choice

There are very few empirical studies examining the impact of the reforms on different aspects of choice and their relation with quality and/or efficiency in health care provision. The preliminary evaluation of reforms conducted in both countries (Mahon et al, 1994; Jones et al, 1994; Mays et al, 1996a; Anell, 1995; Anell, 1996; Rhenberg, 1997) provided some indications of their likely implications. One of the first studies conducted in the UK investigated the consequences of the reforms on the choice of hospital by patients and GPs for four specialties (Mahon et al, 1994). The findings from this piece of direct research conducted with samples of patients (approximately 300) and GPs in the UK found that, at the early stages of the implementation of the reforms, there was very little change in the choices exercised by either patients or GPs.

This view was also supported by the results of another study, where the evaluation of the reforms' effectiveness in promoting different quality aspects, including the choice of the hospital, involved a sample of elderly patients. Here again, no visible difference in patients' choice between 1990 and 1992 was observed, although some improvements in information provision were reported (Jones et al, 1994).

Moreover, as has been suggested by some preliminary studies evaluating the change in patients' and General Practitioners' choices that resulted from the reforms, there was potential for conflict between the differing objectives of reforms (Mahon et al, 1994). Mahon, in her research, stressed that the increased choice given to General Practitioner fund-holders in the market environment

might have been chiefly driven by efficiency considerations, which might not fully correspond with patients' choice if their preferences were to be taken fully into account (Mahon et al, 1994).

On the other hand, the first attempts at evaluating the fund-holding scheme and its impact on choice in the UK produced contradictory results. One group of researchers claimed evident improvements in choice and information, not only for the agents but also for their patients (Glennister et al, 1994a; Glennister et al, 1994b; Matsagannis et al, 1993) while other studies were less conclusive (Audit Commission, 1996; Dixon et al, 1996, Mays et al, 1996a). Another study, conducted at the early stage of the introduction of the reforms, which reviewed the practice patterns of 19 GPs in 10 fund-holding practices in the Northern Region of the UK, found no changes in the choice given to patients (Newton et al, 1993).

Similar evidence was provided by Swedish researchers, of whom a majority pointed out the conflicting nature of the reforms' objectives, expressed as increasing efficiency while promoting patients' choice (Anell, 1996; Rhenberg, 1997). These points were further elaborated in this study when analysing the effects of the reforms (for more details see the discussion section in Chapter Eleven). The outcomes of the Swedish reforms in stimulating patients' direct choice of both family doctors and secondary care providers (which, in some counties, also extended to the private sector), notwithstanding the geographical variations present (Anell, 1996), were more apparent.

In another study by Anell and Svarvar, it was reported that the freedom of choice for patients was quite significant in the areas with a high concentration of specialist facilities, which in some cases extended even across the boundaries of county councils, as was the case in Western Sweden. They nonetheless concluded that patients seemed to be making little use of it, as they preferred to be referred within their neighborhood (Anell and Svarvar, 1993).

Further evidence for patients' preference for closer and more familiar surroundings was presented in a Swedish study examining the changes in

waiting times that resulted from the reforms and introduced a care guarantee. It conceded that patients who were offered choices under the care guarantee, and could receive treatment at an alternative site, preferred instead to wait a bit longer instead of moving elsewhere (Hanning, 1996). Meanwhile, Rhenberg reported that currently in Sweden, the increase in patients' choice is responsible for 2-5% of total resource allocation (Rhenberg, 1997), which, however, remains to be substantiated by hard evidence.

On the whole, it seems that all the models of the purchaser-provider split introduced in different county councils in Sweden have implied a greater freedom of choice than any previous arrangements that existed in the Swedish health system. Besides introducing these models, the Swedish government also tried to increase freedom of choice by supporting private initiatives and establishing a system of family or house doctors who could be freely chosen by the patients, which sometimes appeared to be a confounding factor for the research hypothesis that this study examines.

Most studies pointed out some visible effects on the patients' influence and freedom of choice as their opportunity to choose a medical provider increased. Some studies have shown, however, that there have been no substantial changes in the consumption patterns after the introduction of the purchaser-provider models and the new government policies (Anell, 1996; Dahlström & Ramström, 1994); however, this claim is not unanimously supported (Jonsson, 1994; Bruce and Jonsson, 1996; Hakansson, 1999). Some others have hypothesised that the insufficient exercise of choice, wherever it occurred, could be due to a lack of information and knowledge about the new options (Anell, 1996; Bergman, 1998).

Researchers from both the UK and Sweden have acknowledged that the reforms were not followed by the creation of structures that would provide information on the availability of options to users. It was argued in both countries that the latter might have led to the underutilisation of their potential in making choices happen (Anell, 1996; Mays et al, 1996a). Recent research, conducted with a sample of 2,000 interviewees in Sweden, which although not directly related to market

reforms, provided some insight into the factors that influence patients' choices in different topics. These were found to be strongly dependent on age and educational status (Anell et al, 1997).

4.3 Information

Surprisingly, there has been very little investigation of the changes in the information aspects provided to both patients and purchasers. Yet the enhancement of information about service standards and specifications, while not being an explicit objective of the reforms in either of the two countries, is an indispensable tool for the market's success, on the one hand, and, on the other, a desirable outcome, considered by many to be a quality indicator in its own right (Ovrevit, 1992). In defiance of the national policy commitments to providing patients with relevant and appropriate information expressed in "The Patients' Charter" (DoH, 1991a; DoH, 1995b), surveys reveal that lack of information is the most common complaint voiced by patients in the UK (Bruster et al, 1994; Calnan et al, 1994; Stizia and Wood, 1997).

As there is no proper evaluation of the impact of the reforms on changes in quality and type of information provided, the evidence supplied was only indirect and inferred from studies that dealt with information aspects. One such was a study conducted by the King's Fund Institute in the UK, which aimed to assess the quality of written information provided to patients across a range of different specialties during the middle of the 1990s when the reforms were well embedded, although it was not directly concerned with the market reforms.

The findings of this research confirmed that the majority of patients wanted information about treatment options, even if they did not wish to be involved in decision-making about their treatments; but they usually did not receive it (Coulter et al, 1998). The study also acknowledged that the quality of written information provided was quite poor when measured against the patients' expectations and needs. There was, for example, very little information on a treatment's risks and side effects; the coverage of treatment options and

effectiveness was incomplete or missed out altogether; and uncertainties were ignored or glossed over (Coulter et al, 1998).

There are a few examples, which provide some evidence of improvements for at least one type of purchasers: the General Practitioner fund-holders in the UK. These claim that they were able to obtain better information from the providers, which, it was assumed, meant better information for patients (Glennerster, 1994; Glennerster et al, 1994a). Another study, conducted at an early stage of the implementation of the reforms and which examined the choices and information given to the elderly in the UK, indicated that some improvement in information provision had appeared without differentiating whether this concerned fund-holders' or non fund-holders' patients (Jones et al, 1994).

There is no published study dealing directly or indirectly with information aspects in relation to the market-oriented reforms of the Stockholm Model or any similar set of reforms for Sweden in general. However, there are some indirect indications that health care personnel experienced some form of stronger consumer orientation, which are provided in reports by Anell and Svarvar, but without any further reference to its consequences in terms of information aspects (Anell and Svarvar, 1993). Also the most recent evidence while in essence being critical towards reforms' impact on professional autonomy supports the former claim (Forsberg, 1998; Forsberg et al, 1999).

4.4 Quality

The improvements in the quality of care that should accrue from the introduction of market incentives were one of the proclaimed objectives of policy makers in the UK. Nonetheless, studies examining improvements in quality did not provide decisive evidence that any major improvements occurred in reality. The reasons for this are multiple and relate both to difficulties in defining relevant and measurable quality indicators, and to the fact that some of the available indicators, such as waiting times, were made unreliable through being used as targets by the government for assessing providers' performance (Mulligan, 1998) while and some authors claimed that the rigid and mechanistic nature of the

standards set around professional divisions played an important role too (Ovretveit, 1994b).

It may also be the case, however, that there were only very small or indiscernible improvements which quantitative indicators could not detect. On the other hand, even when qualitative changes could be ascertained, their direct link with a particular set of reforms could not be easily established, not least because of simultaneously occurring changes, which confounded the results.

In Sweden, the situation was similar, where several slightly divergent dimensions of quality existed. For example, Anell referred to the use of the accessibility to care perceived by patients and purchasers as a quality indicator (Anell, 1995). In addition, he pointed out elsewhere that reforms aimed at planned markets have themselves created new quality strategies (Anell, 1996). The most recently published research from Sweden infers that pro-market reforms had a negative impact on quality because they introduced disruptions in working environment and seriously eroded professional autonomy (Forsberg, 1998; Forsberg et al, 1999).

Also, the methods used for evaluation - too often relying on surveys of the opinions of health professionals - are difficult in terms of extracting conclusive evidence, as the views and opinions may not always coincide with what originally took place. While, for example, the majority of health professionals seem to perceive changes happening, they frequently refer to their own impressions and consequences for themselves, which is not unimportant but can supply quite unclear and often contradictory view on the impact of the reforms on the quality of care.

The evidence on aspects considered as explicit quality indicators in this study, from both the UK and Sweden, is presented below. These are concerned with the waiting times, attitude of providers to patients and quality of information.

4.4.1 Waiting times for a specialist service, including waiting time at the outpatients' clinics

Most UK studies which were aimed at measuring quantitative aspects of quality, such as, for example, changes in waiting times, found that both collective purchasers and GP fund-holders used the leverage of their newly acquired power to decrease the length of waiting times for elective procedures. This was, however, more marked in the case of the latter, and fund-holders were seen as more capable purchasers in obtaining improvements in quality of care for their patients, expressed, amongst other things, as a decrease in waiting times (Bain, 1991; Bain, 1992; Glennerster et al, 1994a; Dowling, 1997; Goodwin, 1998).

They also proved to have a greater ability to attract on-site services from specialists (Macrae Todd, 1993; Consumer's Association, 1995a; Gillam et al, 1995). Other researchers expressed doubts as to whether the latter development necessarily furthered the quality of care, as it was unproven and little evaluated (Maynard and Bloor, 1995; Kerrison and Corney, 1998; Harris, 1997).

In addition, the review of the literature on fund-holding examined by Coulter in 1995, concluded that that the improvements in efficiency, responsiveness and quality that were claimed to have been achieved by fund-holders, could not be substantiated by hard evidence (Coulter, 1995a). Most recent findings seem to disprove these early conclusions and provide evidence that fund-holders were proven at least to be better and more flexible purchasers (Goodwin, 1998).

Very few studies examined the impact of the reforms on changes in the attitude of providers and/or purchasers, and their adoption of more user-friendly approach towards patients, although some studies acknowledged that the communication between fund-holders and providers improved substantially (Wisley, 1993; Cornell, 1996; National Audit Office, 1994). It was uncertain, however, that apart from shorter waiting times any other tangible gains occurred, and it was even less certain that these occurred for patients or how patients regarded them. For example, Howie et al demonstrated that patients of six fund-

holding practices in Scotland were found to be slightly less satisfied with the scheme than before (Howie et al, 1994).

Another study, which examined the views of patients on the importance of the minimum waiting times at the outpatients' clinic in one of Oxford's hospitals, found that patients attached less value to the 30 minutes standard set in "The Patient's Charter", if this implied insufficient time for consultation with the doctor (Ulahannan, 1997). Some other authors have also criticised this exclusive focus on waiting time as being centrally originated and for ignoring less quantitative aspects, which may be of greater importance to patients (Lorentzon et al, 1996; Hart, 1996).

Charpentier and Samuelson in Sweden found a significant reduction in waiting times during the first two years of the Stockholm Model's implementation (Charpentier and Samuelson, 1999). But this was probably influenced by a variety of other factors, such as economic retrenchment, the introduction of the reforms, which had similar incentives for reducing the length of stay in hospitals, and the impact of medical technology (Anell, 1996; Brommels, 1995).

4.4.2 Changes in the attitude of providers – adoption of a user-friendly approach

Another perspective on changes in quality was inferred through satisfaction surveys which, while known not to be an easy subject for interpretation, nor for the drawing of straightforward conclusions, nonetheless provided some indications about perceptions of improvements in quality by patients and some other respondent groups. Thus, for example, the evaluation of the Integrated Purchasing Project in Berkshire seemed to produce more satisfaction than the control group of traditional schemes from neighbouring practices (Walsh et al, 1997). Nonetheless, the familiar problem of bias introduced by the criteria on the basis of which the pilot itself was selected, applies to this study, just as it applied to the evaluation of the results from fund-holding practices during the early stages of their implementation.

A more recent review of the evidence of the market's impact, conducted by one of the King's Fund teams, attempted to interpret the results on satisfaction with the NHS, conducted by the British Social Attitudes Survey for over a decade. Their cautious conclusion was that people's satisfaction is less correlated with any results produced by the internal market reforms and more with the public's perception of how sufficiently the NHS is funded and by the difference that this increased funding makes in reality (Le Grand et al, 1998). This hypothesis seems to be confirmed by another study referred to by other authors who were part of the same working group (Mulligan and Judge, 1997).

In Sweden, opinions about the effects of the purchaser-provider split on the quality of care reveal on the whole that there is no proof of quality being decisively impaired, but they are not unanimous in this assertion. This is strongly related to the anxieties preceding the introduction of the reforms, when fears that productivity or efficiency gains could be achieved only at the expense of the quality of care were loudly articulated.

Nonetheless, the internal organisation of the health care institutions has been more affected by the purchaser-provider split. Many hospitals and health authorities have been reorganised in a more "business-like" fashion (Axelsson, 1998b). They have to continue their high quality professional work, but they also have to take the economic aspects of their decisions into consideration. The role of the health care professionals, as providers of care, has meant that they cannot take their patients for granted, since there is a market where every participant is measured and judged.

One of the expected effects resulting from economic incentives being put to work was the reduction of the length of stay in hospital, which is what happened in reality. This, on the one hand, allowed for increases in productivity, but at the same time many physicians were doubtful about its effects on the quality of care. One study concluded that there was no clear indication that quality had deteriorated as a consequence of the implementation of the Stockholm model (Dahlström & Ramström, 1994), without, however, defining what was included in the concept of quality referred to. More recently Forsberg et al measured the

impact of decreases in length of stay and earlier discharges on quality of care and concluded that strong positive correlation between the two existed. However, again a convincing and unambiguous quality definition was absent (Forsberg et al, 1999).

At the same time, researchers cautioned against the uncritical acceptance of the results evaluated in quality studies, pointing out the multiple concepts and indicators that are used for this purpose (Anell, 1996). There were few evaluations that looked into more specific aspects of care, however. A repeated cross-sectional study, for example, reported that physicians in Stockholm felt that economic incentives affected their work in such a way that the quality of the encounter between them and the patients had decreased (Forsberg, 1998). Also, the problem of early discharge and its concomitant impact on the quality of care was reported in at least two studies, in which respondents linked it to the efficiency pressures introduced by the Stockholm Model (Forsberg et al, 1994).

4.4.3 Quality in terms of information provided in contracts

Contrary to evidence coming from Sweden, numerous studies in the UK found that the contracting processes made explicit the need for a definition of quality standards and also indicated that they had become more widely used by purchasers. Carruthers et al studied three Health Authorities and found that they had introduced quality standards into their contracts, which derived from the Effective Health Care Bulletins (Carruthers et al, 1995).

Frater and Dixon evaluated the use of effectiveness criteria in quality specifications as they were defined by the same publications, produced by the UK Clearing House on Health Outcomes. They found that approximately 60% of Health Authorities used some form of quality standards in their contracts, which were not necessarily effectiveness-based, and that less than 20% linked them to financial incentives (Frater and Dixon, 1994).

Coulter, on the other hand, demonstrated that both collective purchasers and fund-holders adopted quality specifications in their contracts as routine practice

(Coulter 1995b). However, the Audit Commission's study looking at the purchase of specialist activities found that, while Health Authorities were still the best purchasers of those services, their information on quality nonetheless remained poor (Audit Commission, 1997). Gill argued that the quality standards used in the contracts were not really meaningful, as they were predominantly aimed at capturing relatively unimportant and measurable indicators (Gill, 1993).

Some claimed that fund-holding has been instrumental in producing a shift in the quality of care delivery by influencing the organisational process of contracting and improving the information flow, which, according to them, also had a positive spill-over effect on non fund-holders (Corney, 1994; McAvoy 1993; Abel-Smith, et al 1995). However, there is no study comparing, in any systematic manner, fund-holder and non-fund-holder contracts as to the effectiveness and appropriateness of the quality specifications.

There is no proper evaluation of the impact of the purchaser-provider split on the quality of information received by patients conducted in either of the two countries. Some anecdotal evidence and indications that shifts in patients' orientation and the demand for more information had been positively influenced by market-orientated reforms, exists in Sweden (Hakansson et al, 1997; Axelsson, 1998b). A study aimed at assessing the written information given to patients, which was conducted by the Kings' Fund Institute in the UK, while not directly related to the reforms, confirmed the view that patients' needs were not being met with respect to the provision of information (Coulter et al, 1998).

4.5 Responsiveness

The reduction of waiting times, whether expressed as waiting times for elective procedures or for a first specialist appointment or as extremely long waiting times, were the highest priority on the UK's government's agenda at the beginning of the 1990s and found expression in "The Patients' Charter" and several Waiting List Initiatives. After a certain point in time, it was seen as the ultimate test of the reforms' success, or, more plausibly, "the government's

success", which also manifested itself in the annual publication of national league tables that evaluated the performance of providers across the country on the basis of a combination of different waiting times. The government had been eager, from the early days of the implementation of the reforms, to demonstrate its success in this respect, which occasionally even resulted in the misrepresentation of data (Radical Statistics Health Group, 1992; Radical Statistics Health Group, 1995).

In addition, even when decreases in waiting times really did occur, according to many they could be hardly ascribed to the "Working for Patients" reforms introduced in 1991. As Hamblin has pointed out, the waiting list initiatives and increased funding that was made available for this purpose had already started in 1987 and continued in parallel with the reforms until 1995 (Hamblin, 1998). Hamblin et al also found that there were reductions in average waiting times and especially in very long waiting times, notably during the first years of reforms.

The end result, however, was that average waiting times in the 1990s were, on the whole, similar to those of the 1960s and 1970s (Hamblin et al, 1998). Le Grand et al explained the real reduction in waiting times occurred for 100,000 patients between 1991-1995; these, however, were compensated for by the additional referral of 1 million patients in the same period, which kept the average waiting times constant (Le Grand, 1998).

The heated debate in the UK over whether fund-holders would fulfil the expectations placed on them and become more responsive providers of services to their patients, which meant that they would also need to become effective purchasers, was also reflected in researchers' interest. Many of them focused on evaluations of fund-holders' success in performing these functions with respect to reducing waiting times, amongst others. This was demonstrated in a few studies, most of which found that fund-holders' patients, in fact, had shorter waiting times when they were compared with non fund-holders patients. Dowling demonstrated this, using West Sussex Health Authority as an example (Dowling, 1997).

A study by Kimmerling and Kinnear conducted in one Health Authority on a sample of eleven fund-holding practices and 22 non fund-holding practices acting as a control group, found that the patients of the former were referred much more quickly than those of the latter (Kimmerling and Kinnear, 1996). However, Peeke's conclusion from examining fund-holding practices in Oxford area did not support this view, as, according to his/her findings, there was no evidence of shorter waiting times for hospital treatment as far as fund-holder patients were concerned (Peeke, 1993).

As in the UK, a simultaneous initiative in Sweden, aimed at reducing waiting times for some elective procedures and known as care guarantee, was introduced together with additional funds that were made available for this purpose (Federation of County Councils, 1993). This, while producing evident results, confounded the effects of the organisational changes and incentives introduced by means of the reforms, which were dependent upon extra funds flowing. It resulted in a sharp decrease in the waiting lists for specialised care at the beginning of the 1990s, most of all in the area covered by Stockholm County Council, but it was difficult to know how much of that was explained by the purchaser-provider split.

Some researchers claimed that most of the decrease in the waiting lists took place before the Stockholm model was introduced and it was mostly due to actions undertaken by the national government (Axelsson, 1999). In 1991, extra funds from national sources had already been allocated to the county councils in order to shorten the waiting lists for elective surgery, and, in 1992, the government introduced a guarantee of a three months' maximum waiting time for twelve elective procedures.

Moreover, in 1992, the responsibility for the care of the elderly was transferred to the municipalities, which meant that hospital beds became free. The importance of these actions is also shown by the fact that waiting lists and long waiting times have reappeared since the waiting time guarantee was taken away (Bergman, 1998). Yet, studies by Jonsson and Bruce and Jonsson suggest that there were some forms of market mechanisms operating along the way which were clearly

responsible for increases in efficiency that, amongst other things, manifested itself in a decrease in waiting times (Jonsson, 1994; Bruce and Jonsson, 1996). This evidence is discussed at length below (Chapter Ten, Efficiency).

However, when analysing the dynamics of the changes in waiting times, it has to be noted that the incentives introduced by the market-orientated reforms to under-report, or misreport, the actual length of waiting times might also be put in operation. Providers in both the UK and Sweden wished to be seen as effective and competent in order to maintain their position in the market, which might have led to an undesirable effect on how reporting of the decreases happened in reality. For example, Appleby suggested that providers, in their attempt to meet the waiting time targets established by the government, might lengthen the waiting periods before putting patients on the waiting list in the first place (Appleby, 1994).

4.6. Efficiency

The drive for increased efficiency was one of the main reasons for resorting to market mechanisms by the governments, which believed in the superior capacity of the market to deliver this objective. The evidence, as revealed in the literature, indicates that an overall increase in efficiency is apparent, even after deducting higher administrative and management costs, both in the UK (Le Grand et al, 1998) and in Sweden (Anell, 1996; Hakansson et al; 1997). In the latter case, this is even more strongly supported by the reversal of the gains in productivity and the lengthening of waiting times to the pre-existing situation, when the market mechanisms became blunted (Charpentier and Samuelson, 1999).

In the UK, similar changes in policy and a shift from “competition” to “co-operation”, which mirrored the political convictions of the incoming government, occurred two years later than it did in Sweden. It is, therefore, still too early to obtain evidence on the effects of these movements on efficiency and other indicators of service effectiveness.

Nonetheless, it has to be stated that the problem of the attributability of changes only to the quasi-market reforms *per se* is a question that can hardly be answered in positive and unequivocal terms, as it would be impossible to design a study that would control for all the factors that might have impacted upon the already changing environment.

However, what some studies attempted to assert, by presenting relevant evidence, was that the reforms applied the needed and decisive leverage that was represented by the shift in paradigm under which care could be effectively delivered in integrated systems. This also facilitated and enabled the eventual integration of all the similar effects originating from different sources where changes were simultaneously occurring, to produce auspicious outcomes whenever they took place (Anell 1996).

For example, this type of evidence was supplied by two Swedish studies which found that the overall volume of services provided had increased significantly in the county councils that decided to use market mechanisms to improve their care. Thus, in these county councils, the volume of care went up by 75% in the first two years of reforms, in contrast to a 25% increase in Kronoberg county council, which was more traditionally managed (Jonsson, 1994; Jonsson, 1994 cited in Anell 1996; Bruce & Jonsson, 1996; Hakansson et al, 1997).

4.6.1 Throughput and cost of services – productive efficiency

This increase in the UK was visible both when measured by the so called Cost Weighted Efficiency Index (CWEI), which referred to the specialist providers' performance, and when other separate indicators such as, for example, the prescribing patterns of fund-holders were concerned. The increases in efficiency, however, expressed as CWEI, have to be taken with a degree of caution.

Appleby and Little have warned against its failure to include any other activity than that measured by Korner data, which impeded innovation but also included non-recurrent costs, thus distorting financial calculations. They also questioned the accuracy of data used in all these calculations (Appleby and Little, 1992).

Raftery et al reported after surveying the Health Authorities' contracts that the latter's claimed efficiency index skewed the service provision towards acute services because these could be better reflected in activity rates (Raftery et al, 1994).

In a study of the effects of NHS reforms on hospital efficiency, Soderlund et al found real productivity gains during the period 1991-94 for trusts when they were compared with directly managed units in England. However, the same study also demonstrated, that some hospitals became intentionally less productive shortly before obtaining trust status, so as to be able to look more efficient under the new arrangements by comparison (Soderlund et al, 1997).

In reports by the NHS Executive analysing the activity data increases in the number of patients treated were claimed (NHS Executive, 1994; NHS Executive 1995). However doubts were raised whether patients or Finished Consultant Episodes had been counted, since the former tended to inflate the activity data (Clarke and McKee, 1992; Radical Statistics Health Group, 1992; Seng et al, 1993).

An overwhelming impression of many researchers was the degree to which the trusts' freedom to use even these modest market mechanisms to achieve higher efficiency was curtailed. Thus, although conditions for competition to take off existed already in 1991/92, according to Appleby (Appleby, 1994). Propper found that in reality it did not take place, as bilateral monopolies between purchasers and providers replaced it (Propper, 1995).

Other researchers pointed at restrictive financial regimes, which punished efficient providers (Adams, 1995), skewing the provision towards incentives for performing activities instead of "watchful waiting" which could be more appropriate but was not rewarded by reimbursement methods (Sheldon & Borowitz, 1993). Also, the negative impact of charges for capital on choice, quality and equity was discussed (Shaoul, 1996), as was the curtailment of the proposed trusts' freedom, which impacted upon the effectiveness of their operations (Caines, 1994).

The evidence for likely efficiency gains achieved by General Practitioner fund-holders is mixed, as there were studies which claimed that such gains were achieved with respect to the prescribing patterns, for example (Glennerster et al, 1994a; Robinson, 1996; Bain et al 1993; Bradlow & Coulter, 1993;), and some other efficiency gains (Bain et al, 1992;). Fund-holders' more efficient prescribing patterns and their increased ability to halt the pace of the rise in prescribing costs was further established by several studies (National Audit Office, 1994; Rafferty et al, 1997; Gosden and Torgerson, 1997). The explanations proffered were different.

Fund-holders, according to some, were keener to prescribe generics (National Audit Office, 1994; Gosden and Torgerson, 1997; Wilson et al, 1995) and to reduce the volume of prescriptions (Howie et al, 1995) or were more cautious in adopting new and expensive drugs (Audit Commission, 1995). A few, somewhat over-enthusiastically, claimed this to be the proof of the market's success (Le Grand et al, 1998).

There is also evidence to the contrary. Thus Coulter reviewing the literature on fund-holding, concluded two years later that claims that fund-holding had improved efficiency, amongst other things, could not be substantiated (Coulter, 1995a); this was also supported by the early findings of Petchy (Petchy, 1993). Another staunch supporter of the scheme, in his co-authored work, agreed that any efficiency in prescribing which had been achieved, was perhaps due to more generous funding of fund-holders' practices (Dixon & Glennerster, 1995).

It may also be explained by the fact that initial enthusiasm about fund-holding's potential to bring about significant efficiency gains withered as the reforms progressed. However, it is hard to use the same argument to defend Petchy's views on the same subject, especially since, in his later review of literature, it is stated that very few reliable conclusions can be drawn from the existing literature on fund-holding (Petchy, 1995).

According to others, the gains, even where they appeared, were not maintained for a long time (Robinson, 1996; Stewart-Brown et al, 1995). Keeley asserted

that overall fundholding did not succeed in containing the rise in prescription costs over time in general practice, nor did it succeed in reducing the use of expensive specialist services (Keeley, 1997). If anything, the cost of ophthalmology services provided on site at fund-holders' premises were found to be three times higher than when they were provided at a hospital' s eye unit (Gillam et al, 1995).

Several authors who looked into the issue of efficiency at any stage of the reforms, conceded that, overall, tangible changes (except for, possibly, prescribing costs) have either not happened at all (Healey & Reid, 1994; Howie et al, 1993), have been very small, or have been more apparent in the early stages of the reforms (Harris & Scrivener, 1996). However, the most recent and strongest evidence seems to support GPs' ability to achieve sustainable gains expressed in terms of lower prescribing costs demonstrated by fund-holders (Goodwin, 1998).

In Sweden, one of the main reasons for introducing the purchaser-provider split in health care was to increase the productivity of the health care system and to contain its rising costs. For this purpose, the purchasers were to carry all the costs and the hospitals would be paid according to fixed contracts. When the Stockholm County Council started to pay hospitals using the DRG performance based system in 1992, as reported by Hakansson et al, there was a quite dramatic rise in productivity, manifested in increases for some elective procedures ranging from 50-70%. Thus, for example, the number of hip replacement and coronary heart operations both increased by 50%, while the number of cataract operations increased by as much as 70%. Meanwhile, the number of people appearing on waiting lists for elective procedures, for which a care guarantee was provided, decreased by 30% (Hakansson et al, 1997).

Bruce and Jonsson discussed the evidence of higher efficiency that was present in 14 counties, at least at the initial stages of their experimentation with different forms of pro-market reforms, as compared to those counties who decided against experimentation. They found increases in productivity, attributed to increased

output, in three quarters and to decreases in costs in one quarter (Bruce & Jonsson, 1996).

Yet, the impression from the subsequent stages of the reforms, expressed in several evaluation studies that have assessed the reform models and compared 'reform' counties with 'traditional' ones, surprisingly revealed no differences in terms of cost-effectiveness and increased productivity. One plausible explanation, proposed by Brommels, was that the economic recession that coincided with the reforms forced all counties to take drastic managerial action, regardless of their governance systems (Brommels, 1995). There were also views that the reforms introduced by means of the Stockholm Model were anyway very much "*a game within the family*", as no real separation ever took place (Axelsson, 1998a; personal communication).

Some other later studies confirmed, however, that increases in productivity and efficiency appeared to be the main achievement of the Stockholm model. This happened because of the elimination of the fixed budget, which created clear economic incentives and an increased awareness of costs across all the structures in the health care organisation. It seemed, also, that the performance-based reimbursement system put pressure on health service providers to deliver efficient care.

In Stockholm County Council, one study has shown that the productivity of the hospital services increased by 20% between 1990 and 1993 (Diderichsen, 1995). Another study reported that physicians had learnt that every single decision affects the financial situation of their clinical departments. They had abandoned certain tests and certain types of treatment because the possible benefits did not warrant the costs (Forsberg, 1998). Another result was a reduction in the length of stay in most hospitals (Anell, 1996).

However, the increased productivity coupled with the freedom of choice that was introduced by the national government cancelled out the cost containment objectives. Patients could choose service providers independently of what contracts their local purchasers had made on their behalf, which left the

purchasers without any strong instrument of cost control. At the same time, as the productivity of the hospitals increased, while the DRG-based prices did not decrease, there were strong upward pressures, which led to an overall increase in costs (Diderichsen, 1995).

As predicted by economic theory (Le Grand and Bartlett, 1993), administrative costs also increased as a result of the contracting procedures (Axelsson, 1998b). In Stockholm, these increasing costs forced the county council to impose quantity-related ceilings on payment levels and to lower the DRG prices. These changes in the rules and prices diminished the cost increases, but it did not save the county councils from running into serious deficits (Hakansson, 1999); at the same time, according to many they had also *“drastically diminished the trust in the system”* (Whitehead et al, 1997; Forsberg et al, 1999).

4.6.2 Structural changes – efficiency implications

There is no doubt, however, that the incentives which stimulated the efficient provision of care have also led to numerous changes in the structure and organisation of care. In the UK, this has been manifested as a speedy and more widespread introduction of cost-saving technologies, not confined to trusts alone (Smee, 1995), and in the shift of some forms of care provision into primary care settings (Redmayne et al, 1995). The latter has been especially marked in fund-holding practices (Bailey et al, 1993; Macrae Todd, 1993; Gillam et al, 1995).

Similarly, in Stockholm County Council, two hospitals were closed down and one of the remaining hospitals was privatised. One study reported that, after the introduction of the purchaser-provider split, the number of hospital beds in Sweden fell by more than one third (Essinger, 1997). There is some additional evidence of important structural changes that have led to a reduction in the numbers of health service personnel by as much as 40% of the original number (Hakansson, 1999). Many hospitals had to close down or merge as a result of the reduction in the number of beds and these developments were not unique for the county councils with purchaser-provider splits. Similar changes also took place in

other county councils as a result of increasing problems in the Swedish economy.

Some authors argue that the important lesson, learned particularly by the metropolitan areas in Sweden, was that the quasi-market forces created by the purchaser-provider split could not correct for all structural imbalances in the service provision system (Brommels, 1995). Anell provides an explanation for this as being the result of the realisation of excess capacity in terms of facilities, which could not be sustained during a prolonged economic recession, and which was manifested in the policies of early retirement and dismissals (Anell, 1995; Anell 1996).

This predictably had an impact on staff morale and on the increase in stress at the workplace, which was acknowledged in a few studies, which examined this issue (Charpentier and Samuleson, 1996; Forsberg, 1998). But whether this would happen as quickly and effectively and whether it would have such a dramatic impact on the dynamics of health care provision in Sweden without the competitive incentives introduced remains an open question.

The role of the politicians as purchasers of care on the other hand, has meant that they can concentrate on policy issues and represent the interests of their citizens, but with an increase in responsibility and cost consciousness. Studies from Sweden have shown that the politicians assess their new roles as positive and stimulating, while the health professionals and the administrators see their new roles as stressful and problematic (Petersson, 1994; Petersson, 1995).

In addition, stronger management capacities were built into the system. For example managers in the UK according to one study felt they had more freedom in taking decisions (Traynor, 1995). Also, the roles of the administrators in the UK have changed greatly, since they have been divided between working either on the purchaser or on the provider side of the organisation. A National Survey of Directors of Public Health conducted by Marks found them being convinced that the trusts' status brings improvements in health and in a repeated survey the

majority also thought it meets the needs of the population (Marks, 1995a; Marks, 1995b).

Although, in Sweden there were no empirical studies to confirm a similar view, there were claims of a strong development of service management in the Swedish health care system since the 1980's and the purchaser-provider split strengthened this development yet further (Axelsson, 1998b). The change of the provider role on the other hand, is best illustrated by the most recent development where a previously county council owned hospital became privatised. After it quickly responded to the set of incentives introduced by the Stockholm Model by obtaining the status of a limited company and appointing professional managers it managed to turn the benefits accruing from the pilot status granted to it by the county council to its advantage.

4.6.3 Clinical Outcomes

In the UK, there seemed to be no published research, which attempted to use the outcomes of care as quality indicators and to measure them in relation to changes produced by the reforms. This reflected their rare use as quality specifications and their almost total absence from contracts.

A few evaluations conducted in Sweden, while not aimed directly at measuring outcomes, were more specific. Thus, in a study from Stockholm, 17% of physicians reported that they felt a pressure to reduce the length of stay in post-operative and intensive care units due to economic reasons and thought that this change in the discharge pattern had led to the deterioration of the quality of care (Forsberg & Calltorp, 1994). Forsberg and Calltorp stated that these specialists thought that patients were often discharged too soon as a result of the Stockholm model (Forsberg et al, 1994; Anell, 1996).

This view was also supported by a study conducted with general practitioners and nurses who conceded that the elderly, aged over 70, were discharged too early after the Adel Reform (Socialstyrelsen, 1995) and more so after the introduction of the purchaser-provider split (Norrbon, 1994 cited in Anell, 1996).

However, when the readmissions at seven and 30 days were examined, no confirmation of their increase could be ascertained, at least at the aggregate level (Stockholm County Councils, 1993). Despite this, however, it is possible that specific problems may have been recognised at the single hospital level, which might also have affected the perception of the users (Anell, 1996).

Another study, which seems to support this hypothesis, argued that the development of a number of injuries in health care, and the assessment of the general public, warrants the opinion of a real deterioration in the quality of care as a consequence of the Stockholm model (Bäck & Göijer, 1994). However, what became evident beyond any doubt through these evaluation studies was the lack of a system for describing qualitative changes. This, according to some, encouraged the work on the development of quality standards (Hakansson et al, 1997).

4.6.4 The impact of reforms on introduction of cost saving technologies

The forces that encourage or impede technological development and its adoption are multiple and interact with each other on many levels (Geijlins et al, 1994). It is widely recognised, however, that positive or negative payment incentives have a significant impact on the adoption of new technologies (Steinberg et al, 1993); this may even result in the phasing out of procedures of proven clinical value, when their cost is not reimbursed by a third party payer (Kane et al, 1989). However, the planned health care systems of the UK and Sweden, with their production of services regulated often at sub-optimal levels, had been facing the reverse problem, that of under-provision of services, manifested in long waiting lists (Frankel and West, 1993).

This was especially visible in the UK's case, where adverse incentives incorporated in the funding system (with budgets being allocated to providers on the basis of the previous year's spending patterns and not related to productivity) had led to impediments in diffusion and insufficient adoption of effective technologies (Beech et al, 1992). It was, therefore, expected that, with changes

in the reimbursement system introduced by internal market reforms, technologies contributing to meeting contract specifications and/or enhancing providers' competitive position in the market, would be more widely adopted (Beech et al, 1992).

There is little research on these aspects of the impact of the reforms, except for evidence provided by Smee that there was no difference in the rates of day cases, for example, between trusts and Directly Managed Units in 1994 (Smee, 1995). Another view presented in an unpublished MD thesis, which examined the diffusion of innovation using the example of three procedures, was that purchasers used very little of their leverage to affect these developments, which were in most cases, in the hands of the providers (Rosen, 1996). No equivalent published work is known to exist for Sweden.

4.7. Conclusions

The conclusions from this review of available evidence are summarised in Table 4.1. The overall impression is that, despite the many evaluations examining the impact of the market-oriented reforms in both the UK and Sweden, important questions remained unanswered. This is possibly because the complexity and intangible nature of some of the reforms' objectives rendering them a difficult subject for evaluation; but it may also arise from difficulties resulting from the politicised atmosphere surrounding the reforms, which, in turn, produced assessments that were not altogether unbiased and not always rigorously performed. This seemed to be the picture at least at the initial stage after their implementation, in both the UK and Sweden, although today many better quality evaluations exist.

In what follows, this study makes a contribution to this evaluation picture, using the case study of a particular service to examine the impact of the reforms in the framework of an international comparison, which is rather scarce in the literature on the subject. Using a combination of qualitative and quantitative methods, it also aims to examine the views and perceptions of most of the actors involved, on a set of indicators considered to be the reforms' key objectives, such as choice, responsiveness, quality and efficiency.

Table 4.1 Effects of the pro-market reforms in Sweden and the UK as revealed in the literature

Indicator	United Kingdom	Sweden
<i>Freedom of choice – Patient's influence</i>	<ul style="list-style-type: none"> • No increases in choice for patients and purchasers in some cases even less • Fund-holders do not seem to offer significantly more choices to their patients 	<ul style="list-style-type: none"> • Patients' opportunity to choose medical provider has increased • There is a conflict between freedom of choice and the possibility of cost control
<i>Information</i>	<ul style="list-style-type: none"> • No research directed at this evaluation. • Indirect evidence suggests that the changes are minute 	<ul style="list-style-type: none"> • No evidence apart from anecdotal indications about patients demanding more information
<i>Quality- Patients' orientation</i>	<ul style="list-style-type: none"> • No evidence of quality being significantly reduced or increased • New developments for fund-holders' patients which may imply higher quality but as yet unproven (outreach clinics) • Satisfaction with service higher in first years of reforms but maybe related to increased funding 	<ul style="list-style-type: none"> • There is no overwhelming evidence of quality being decisively impaired • Indications about too early discharges with possibly negative impact on quality • The lack of a system for describing qualitative changes have been exposed • The development of quality work has been encouraged
<i>Responsiveness to need – waiting times</i>	<ul style="list-style-type: none"> • Average waiting times and very long waits have decreased but waiting times on the whole have remained unchanged • Incentives for misreporting the actual waiting times 	<ul style="list-style-type: none"> • Waiting times have impressively decreased during the first two years of reforms which may also be related to other factors • Waiting times reappeared after blunting market incentives and reducing money
<i>Productivity, Efficiency and the Impact of Technology</i>	<ul style="list-style-type: none"> • Clear efficiency gains for trusts even if higher management and administrative costs are deducted • Freedom of trusts to achieve the potential efficiency gains is curtailed • Evidence on GPFH efficiency gains is mixed and even when it happens it may be due to more generous funding 	<ul style="list-style-type: none"> • The structural changes leading to efficiency are mostly an effect of spending cuts and new medical technology • A certain reallocation of resources from hospital care to primary care

Source: Various referred to in the preceding chapter and compiled by the author

II METHODS

CHAPTER 5

METHODOLOGY

This chapter outlines the research methodology. It explains how the methodological framework was used to address the research question on the one hand and to isolate the effects and factors that may confound with it on the other. The first part justifies the use of cataract surgery as a tracer condition by discussing the criteria used for its selection. The second and third parts are devoted to the discussion of general and service specific methodological considerations respectively and conclude by outlining methodological constraints. The fourth part provides a detailed description of the sample characteristics, time frame and tools used for investigating the main aspects of the selected indicators.

5.1 Selection of cataract surgery as a tracer condition

An evaluation of the impact of reforms on the range of concepts often regarded as elusive implied trade-offs between the depth of evaluation and its comprehensiveness, which is reflected in the set of indicators used (for details see Annex I, Table 1). The other decision was to use one single service combining the criteria of clinical effectiveness with features suitable for tracing the organisational changes attributable to reforms. It had to be a common procedure, easy to perform and measure, experiencing high levels of demand and be representative of a case study for reform. The criteria on the basis of which the particular intervention was chosen and used for examining the impact of reforms are analysed below.

5.1.1 Criteria used for service selection

Several parameters were taken into account when selecting cataract surgery as a tracer condition for the purposes of this study. The foremost concern was that reforms must have produced readily apparent recommendations for this particular service. Indeed, many of the initial changes were focused on elective

care and cataract surgery was one of the examples of procedures commonly referred to for illustrating the potential advantages of the internal market (Mahon et al, 1994).

The other two criteria were considered on purely methodological grounds. The compliance with the recommendations of reforms that could be proved by reviewing hospital's clinical records was one of them. This in the case of cataract surgery was relatively easy to fulfill. The aggregate data on throughput such as the number of operations performed both as day care and inpatient cases and their prices could be obtained from departmental records. It was also assumed that data intended for process indicators such as the number of waiting patients for the operation and the first appointment would exist and will be made available by most of the hospitals. However, this was rarely the case. In order to obtain some information on clinical outcomes audit data of an indicative sample of patients of the pilot site were analysed.

Also the procedure needed to affect enough patients to permit the development of a feasible sampling frame. This criterion could be easily fulfilled with respect to the cataract surgery because of the high prevalence of lens opacification (blurring) in the general population, which is commonly known as cataract. This led to the increased demand for surgery that restores vision by replacing the obscured lens with an intra-ocular lens implant (Williams et al, 1992; Batterbury et al, 1991). The widespread use of the treatment procedure was seen as the facilitating factor in the process of data collection, which was also confirmed in reality.

5.1.2 Cataract surgery and its suitability for measuring the impact of the reforms

Cataracts are the leading cause of blindness, and especially avoidable blindness, both in the developed and even more so in the developing world. This makes cataract surgery one of the most commonly performed surgical procedures worldwide (Bernth-Petersen, 1986; Steinberg et al, 1991; WHO, 1989). Age-related cataract extraction constitutes the main workload of ophthalmic services

(Courtney, 1992; Salive et al, 1990) and formed the bulk of ophthalmic waiting lists in the UK (Davidge et al, 1987; Goldacre et al, 1987) and Sweden (Glennerster et al, 1992; Federation of Swedish County Councils, 1993) during the pre-reform period. It is predicted that the growing numbers of elderly patients will increase the demand for this intervention significantly, which will have clear implications for resources. It may also become the 'case-in-point,' illustrating the priorities for health services that will be increasingly set by purchasers and decision makers (Williams et al, 1994; Mason et al, 1993).

Cataract surgery is also an intervention of proven and high rehabilitative effectiveness, which has been established through measurement of clinical outcomes such as visual functioning index combined with improvement in visual acuity, quantitative assessment of rehabilitation and analysis of outcome predictions (Bernth-Petersen, 1982; Bernth-Petersen, 1986). The clinical effectiveness also corresponds to high utility values that patients derive from the impact on their health status accruing from this procedure (Drummond, 1988; Torrance et al, 1982). Consequently, pertinent and valid outcomes, expressed both in clinical terms and functional health status, can be relatively easily identified (Torrance et al, 1982).

When a proper cost-benefit analysis was conducted it proved, moreover, that monetary benefits exceeded costs by a sufficiently wide margin, making the procedure worthwhile, even without taking into account the intangible benefits of increased sight (Drummond, 1988; Drummond et al, 1991). A few attempts to apply cost-effectiveness types of economic evaluation and to consider the cost of competing alternatives were also performed. They were aimed at measuring and comparing the costs and effects of alternatives such as surgery and non-surgical options, the costs and outcomes of day care versus inpatient care (Davies et al, 1987; Perceival et al, 1992), and the costs of private and public hospital treatment based on the length of stay variations (Clayton et al, 1989). Cataract surgery proved to be a relatively cost-effective procedure throughout all these measurements.

A large cross-national project initiated by the American PORT (Patient Outcome Research Team) aiming, among other targets, at measuring the costs associated with alternative strategies for the treatment of cataracts and defining the appropriate level of care for different categories of patients has recently been concluded (Salive et al, 1990). The results of the study on the range of outcomes of cataract surgery serve as a useful tool, highlighting the extent of coincidence of clinical outcomes with functional ones.

Cataract surgery is also a good subject for measuring patients' satisfaction and the self-assessed outcomes of care. This can be inferred from the interesting results yielded by studies that applied questionnaire methods in order to elicit patients' views on various aspects of cataract surgery (Davies et al, 1992; Lowe et al, 1991). They demonstrated high levels of satisfaction with the outcomes of surgery and the care given at all stages, especially when it was combined with the continuity aspect (Lowe et al, 1991; Lowe et al, 1992). The results of surveys looking into patients' preferences, regarding day care versus inpatient care, showed an overwhelming preference in favor of day surgery. This choice was significant even when some inconvenience involving traveling had to be incurred (Davies et al, 1992; Perceival et al, 1992; Strong et al, 1991).

There are also a few general points of concern, which have to be discussed.

First, there was little evidence on the relative benefit, when it was not simply compared with other elective procedures, but when it was applied to different case mix-groups of patients that underwent cataract surgery. There was also uncertainty about the appropriate level of treatment and there was little information as to when and for whom the maximum benefit would be achieved when applying this otherwise cost-beneficial procedure (Drummond, 1988; Drummond et al, 1991).

Second, the clinical outcomes depend on a range of factors. They relate to the surgical-indicators, complications, the type of correction that is required, as well as the individual patients' characteristics that involved the pre-existing co-pathology of the eye, the medication taken and, more generally, the social

circumstances. In addition, the clinical outcomes are measured as post-operative improvements in visual acuity in relation to the rates of post-operative complications. In order to apply the functional status measurements, there is a need to reorient them towards examining the extent of congruency between those two types of outcomes (Williams et al, 1992; Williams et al, 1994).

Third, the problem of a high level of variations that may be unjustified on clinical, epidemiological or any other evidence-based grounds is also apparent in this case. This not only refers to differences in surgical rates among metropolitan areas but also extends to the management approaches that are chosen by respective ophthalmic clinics and surgeons throughout all the various phases (preoperative, intra-operative and post-operative) of care (Williams et al, 1992; Williams et al, 1994). This may be regarded as reflecting the global problem of tremendous uncertainty that is inherent in medical practice (Eddy, 1984). However, uncertainty at the collective level does not necessarily indicate that an individual physician will be uncertain about the appropriate practice they use as pointed out by Giraud (Giraud, 1992).

The implications for the service selected start at the very first stage when a variability of indications for surgery, accruing from the lack of universally accepted standards, occurs. This in consequence determines the number of cases that are primarily categorised as qualified to benefit from the surgery, which is too often based on variable and arbitrary criteria. Furthermore, progress in surgical techniques and improved outcomes of surgery have undoubtedly influenced the threshold at which surgery is offered, which might exacerbate the variations in practice even further.

Finally, significant changes in surgical methods for cataract extraction, which have occurred since the introduction of microsurgical techniques and intra-ocular lens implants, have most certainly influenced the indications for surgery themselves. Consequently the adopted techniques, which by no means follow a universal pattern, determine the number of cases that undergo cataract surgery (Courtney, 1992; Williams, 1992). More recent developments, such as the shift to day care surgery (Perceival et al, 1992; Thomas et al, 1992; Watts et al, 1988)

and more advanced surgical techniques (including phacoemulsification and post-operative visual correction) mean that the total number of cataract operations performed must have increased yet further.

5.2 Methodological considerations

The next sections discuss the set of methodological considerations dealing with the service selected and also discusses the general methodological constraints related to the problems encountered in the process of outcome measurement. It also raises the issues concerned with the counterfactual evidence, where it explains how the changes that occurred simultaneously were disentangled from the effects of the reforms *per se*. In its final part, it discusses the methodological constraints accruing from the sample characteristics, the problems with generalisability of the case study and the limitations that are involved in the international comparisons.

5.2.1 General considerations

There are some methodological issues that raise important general considerations regardless of the type of service and/or outcomes that are evaluated. The initial problem encountered in evaluating any type of health outcome resulting from health care intervention is a conceptual one. There are several components of the definition of health outcomes, but the degree of attributability of each causal factor that is part of the process is still incomplete (Long et al, 1993a; Long et al, 1993b; Shanks et al, 1993). Therefore, the health care effects of any type of process, both within and outside of the health service, on health *per se* have to be recognised at the beginning of the evaluation. In an attempt to formulate a research question the first step is to specify them and then to establish in which way each of them has contributed to the final result.

The first issue was to decide between outcomes and process indicators that should become subject of our measurement. For the purpose of this study process indicators were chosen over outcomes because they were still very

rudimentary and incomplete when this study was designed. Although in the past few years the emphasis has been on building outcome measurement into the routine clinical management of departments and hospitals in the UK, this was attempted through the identification of outcome measures based mainly on the existing data.

Both before the introduction of the reforms and at their early stages of implementation, British purchasers had been using activity outcomes for assessing the quality of the services they demanded, supplemented by specific audit activities (Fitzpatrick et al, 1992; Shanks et al, 1993). They were usually conducted under the banner of evaluating the targets of the "Health of the Nation," but later on also tried to follow the recommendations of the "The Patient's Charter" (DoH, 1991b; DoH 1991a; DoH, 1995a), which dealt with process and not outcome indicators though.

Those measurements in the UK were basically derived from performance indicators that were promulgated by the Department of Health. They were predominantly focused on resource input and cost/volume (throughput), as well as process indicators such as waiting time for referral and waiting time on admission, length of stay and waiting time for the elective procedure itself.

There were also attempts to link the processes to the outcomes by using indicators such as 'Consultant Completed Episodes', which included the concept of continuity of care and the necessity for readmission after the procedure was completed. In Sweden there were no routine procedures for measuring outcomes as such during the pre-reform period and even after the reforms the performance indicators that were increasingly used at the initial stage of the Stockholm Model were expressed in terms of productivity measures (Jonsson et al, 1994).

Outcome measurement is an important objective in its own right. When clarification of the causes and effects is not feasible, recognising and measuring an outcome that serves as a meaningful indicator of the change should always be attempted even if the underlying causes remain only partially identified as is quite often the case in health care, (Shanks et al, 1993).

For measuring outcomes in terms of quality of life, functional indicators dealing with aspects such as utility derived from the use of particular service are often used. Those measures were not applied in this study, as it was not deemed feasible to examine them in a 'before and after' period. The methodological complexity of the task is related to the lack of specific questionnaires, limited applicability of the existing generic ones and problems associated with devising special ones for this purpose as it has been stressed in the relevant literature (Schumacher et al, 1991).

A number of life-oriented indicators, such as *mortality rates* and *avoidable premature mortality*, are not regarded as sensitive measures of quality of care, given the variety of factors that these types of outcome may be correlated with. In particular, they cannot be used for cataract surgery at all, as this condition does not result in death, neither does it fall into the category of avoidable mortality. Moreover, even when considering morbidity indicators such as prevalence rates, their usefulness becomes increasingly limited because of changing patterns of diseases, diffusion of new medical technologies and the increased range of treatment options (Morris et al, 1993). Consequently, in this study the focus was not on these types of indicators.

It is generally argued that the clinical, functional and patient satisfaction outcomes used as indicators in the evaluation studies should be critically appraised with regards to a number of aspects (Bardsley et al, 1992; Fitzpatrick et al, 1992). These are primarily concerned with their internal validity, reliability, variability and comprehensibility. They also refer to the definitions of variables and outcomes, their measurement and eventual quality of data, the treatment of confounders and the sample selection, and the statistical power of instruments used.

Furthermore, the clear specification of the hypothesis and methods of the data analysis before inspections of the results is crucial. In addition, external validity or, in another words, the generalisability of results is equally important and needs to be tested, as it is also important to perform an analysis of its sensitivity and responsiveness to change. The latter can be defined as the ability to detect

relatively small but significant clinical changes in the condition over time. Finally, the instruments' capacity to produce the same results if reapplied to the same situation needs to be assured.

5.2.2 Service specific methodological considerations

Apart from the general methodological considerations, there are also a number of serious practical difficulties that arise for any healthcare service chosen for outcome measurement, which were identified by the UK Clearing House on Health Outcomes (Long et al, 1993a; Long et al 1993b). An explanation of how the requirements were fulfilled for the selected service used in this study follows:

Clear definition of the treatment episode

A cataract is a focal or diffuse opacification (blurring) of the transparent lens or its enclosing membrane, which interferes with the transmission and refraction of light rays within the eye. This results in diminution of vision, which is due to the scattering of the light within the lens, which leads to the impairment of the focusing of images in the retina (Hart, 1992) (see Fig. 5.1). Moreover, the cataract can predispose the patient to other conditions of ocular co-pathology or delay the diagnosis of other potentially treatable conditions (i.e. diabetic retinopathy).

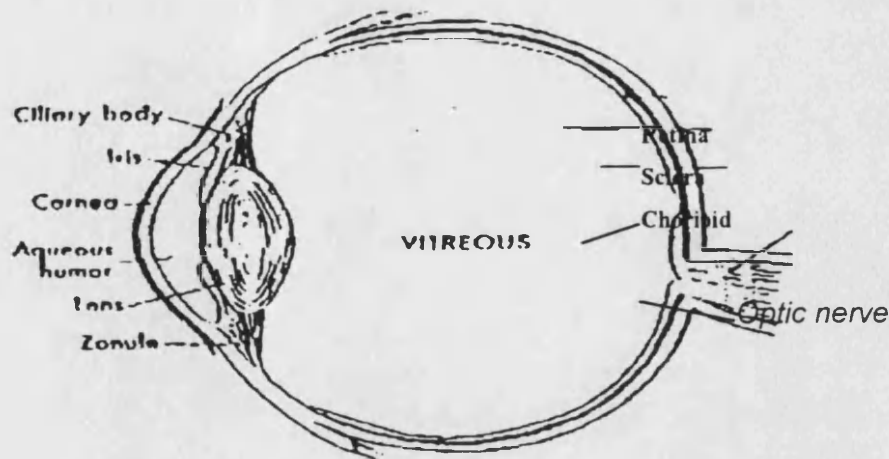


Figure 5.1 Diagrammatic section of the human eye

(Adapted after Hart, 1992 "Adler's physiology of the eye")

Surgery is currently the only method of treatment for a cataract with non-invasive treatment being a subject of research investigation, though no conclusive results have so far been achieved (Cheng, 1987; Kador, 1983). The therapy available for restoring blurred vision involves extraction of the opacified (hazy) lens, and is usually followed by Intraocular Lens Implantation (IOL). The development of IOL has been of considerable assistance in increasing both the acceptability and ease of the procedure and the quality of outcome. The most recently applied techniques, such as phacoemulsification and post-operative visual correction, will probably improve this process even more (Williams et al, 1994).

The period of data collection must be long enough

This is to ensure that all relevant effects will appear or that a sufficiently large sample can be studied. The cataract surgery is performed on 1.2 bln beneficiaries of the Medicare in the United States annually (Steinberg et al, 1993). The surgery rates performed each year in the UK vary from 100 to 250 per 100.000 of the resident population in different areas of the country (Williams et al, 1993) and are also relatively high. These are at even higher rate for Sweden (between 250 to 400 per 100.000 of residents) (Swedish Association of

Ophthalmologists 1993-95; Federation of County Councils; 1993; Eckerlund et al, 1992) making it an easy subject for data collection for the purpose of this study.

5.2.3 Problems of counterfactual evidence

In designing the methodology, it was necessary to establish which of the changes simultaneously occurring outside the reforms' framework contributed to their aims. Two aspects were considered.

First, the increase in resources that may have smoothed the way for the reforms, giving a false impression of the perceived efficiency gains, (as different sources suggested) was the case in Britain (Radical Statistical Health Group, 1992; Butler, 1994). In Sweden a similar situation occurred. For instance, it was quite difficult to ascertain whether many observed increases in efficiency and reduction in waiting lists for elective surgery could be attributed to the organisational changes brought by public competition alone or whether this was the result of a significant increase in the resources that were deployed (Federation of County Councils, 1993). This was one of the limitations that had to be accounted for.

Second, for any positive or negative conclusion as to quality and efficiency of production resulting from reforms, the counterfactual evidence of what could otherwise have happened, had reforms not interfered with the course of action, also had to be tackled. Such was the impact, for example, of organisational changes stimulated by the market reforms, and the advances in adoption of technological innovation for example day care surgery and/or phacoemulsification techniques. Day care cataract surgery, a highly cost-effective procedure, (Davies et al, 1987; Perceival et al, 1992) and of probably even higher quality than conventional method, if patient satisfaction is taken into account, (Loewe et al, 1991; Loewe et al, 1992) was well suited to meet these requirements.

It was known that changes in medical technology (including a shift to day care surgery) had an impact on the increase in the number of operations performed. One of the hypotheses of this study dealt with the role of the reforms in the

process of speeding up the adoption of cost-effective procedures. If this was the case, it meant that the effects of diffusion of medical technology on quality or efficiency of care delivery could not be easily dissociated from the impact of the reforms, because they were introduced concurrently. In order to detect the extent to which these arrangements were a result of the reforms and how much were they due to other independent factors the following questions were rigorously examined:

Did the reforms stimulate change where nothing else would have otherwise happened?

This probably was the most difficult question to answer as it was largely confined to the sphere of pure speculation. The only way of attempting it would be to employ theoretical predictions and analyse the trends that existed previously. Even then any confidence about the validity of conclusions would be limited. This problem was addressed by probing the views and perception of all groups of respondents who were asked to comment on the dynamics of different aspects of the service in the periods before and after the reforms.

Did the reforms accelerate changes that were already under way?

Some of the results stimulated by means of reforms, which are of particular relevance to this service such as the expansion of day care surgery, might have been happening simultaneously. However, as can be inferred from the literature, at the same time the rates of cataract day surgery for Britain were significantly lower than those of other industrialised countries (Davies et al, 1987; Perceival et al, 1992; Thomas et al, 1992; Williams et al, 1992). What this study argues, is that reforms introduced incentives criteria for efficient producers thereby stimulating them to find new ways of less costly delivery of care of acceptable or higher quality such as day care surgery for example.

The argument that reforms prompted a more widespread use of day case surgery, while being plausible for the UK, was not equally relevant for Sweden as its rate was comparable to the trends in other industrialised countries (Davies et

al, 1987; Effective Care Bulletin, 1996). It was certainly less relevant for the Stockholm area where 80% of cataract cases were already performed as day cases at the beginning of the 1980s and were widely applied throughout the 1990s, a fact that placed Sweden in a very high position in comparisons with other OECD countries when rates of day care surgery performed were measured (see Table 5.1). For this reason, the evaluation of the effect of the reforms on the adoption of day care, was mainly restricted to the UK.

Table 5.1 Day care surgery in selected OECD countries in years 1994-96

<i>Country</i>	<i>Year of measurement</i>	<i>Percentage of operations performed as day care procedures</i>
USA	1994	93%
Sweden	1996	88%
Canada	1995/96	76%
New Zealand	1995	58%
The Netherlands	1995	58%
United Kingdom	1995	46%
Denmark	1995	41%
Belgium	1995	39%
Ireland	1994	38%
Australia	1996	35%
Finland	1995	32%
Luxembourg	1995	19%
OCED		49%

Source: OECD Health Data (1997)

Did the research question address an area with a great need for change, and which was likely to be influenced by reforms or was it an area in which quality of service and level of satisfaction were already high?

It is difficult to ascertain whether quality of service provision in case of cataract surgery was universal or whether satisfaction was equally high except for the proven benefits and utility that patients could derive from the procedure. However, it is also known that long waiting lists for some elective procedures including cataract were one of the

commonly quoted examples in the debates concerning unmet need and the usefulness of market incentives in tackling this issue (Maynard, 1993b; Hutton, 1993).

In 1991 people awaiting cataract surgery in the UK and Sweden were over 50.000 in each country respectively, although the threshold for cataract operations in Sweden is much lower. It is set explicitly and not left to the discretion of the clinicians as it is in the UK. It was in this context that cataract surgery was considered to be an area where the likely implications on quality of care could be demonstrated. It was also expected that the reforms were likely to have a positive influence on enhancing the responsiveness of health care system that would manifest in higher throughput and decreases in waiting times.

5.2.4 Methodological constraints

Constraints related to the service and the sample's characteristics

The generalisability of the results may to some degree be constrained by the type of service selected, which, although justified both on the grounds of its relevance to reforms and also its representativeness for health services, may still pose some problems. These relate to the age of users, the high specialism involved in the service modalities and the size of the sample.

The most significant limitation relates to the age factor of patients, which is one of the important respondent groups. The national audit on clinical outcomes for cataract surgery, conducted on behalf of the Royal College of Ophthalmologists, has shown that the mean age for men undergoing cataract surgery is 75.9 years and for women 76.8 years (Courtney, 1992). Although these figures were not exactly confirmed in the sample of this study, the overall age related limitations apply here too.

In the case of choice this may for example be reflected in patient priorities when choosing the location of the hospital for their operation. Moreover, their expectations of service may be quite different from those of other age groups, brought up outside the framework that created a universal healthcare service

such as the NHS example, which may in turn introduce bias into their responses on quality evaluation. Finally, age related frailty and dependency on public services could constrain them from expressing views that may sound critical.

On the other hand, the importance of this age group, which is already significant, is likely to grow even more so in the near future (Jones et al, 1994; Hakansson, 1998). This is primarily because of the sheer size of the elderly population, which, by the year 2020, may be as high as 25% of the total population (for details see Fig. 5.2) for countries like Japan. But also in the case of both the UK and Sweden this rise during the same period is quite significant although more stable. It is projected that for Sweden it will increase more than two and a half times reaching something less than 20% while for the UK it will be below 15%, again reaching almost the double value in 2020 of what it were in the 1950s (for details see Fig.5.2).

Another limitation relates to the use of a highly specialised service for measuring patients' choice for example where the technical complexity involved may intimidate them and impede their choices from being fully expressed. High specialism of the service may also create additional difficulties in proper understanding and relating to the information provided.

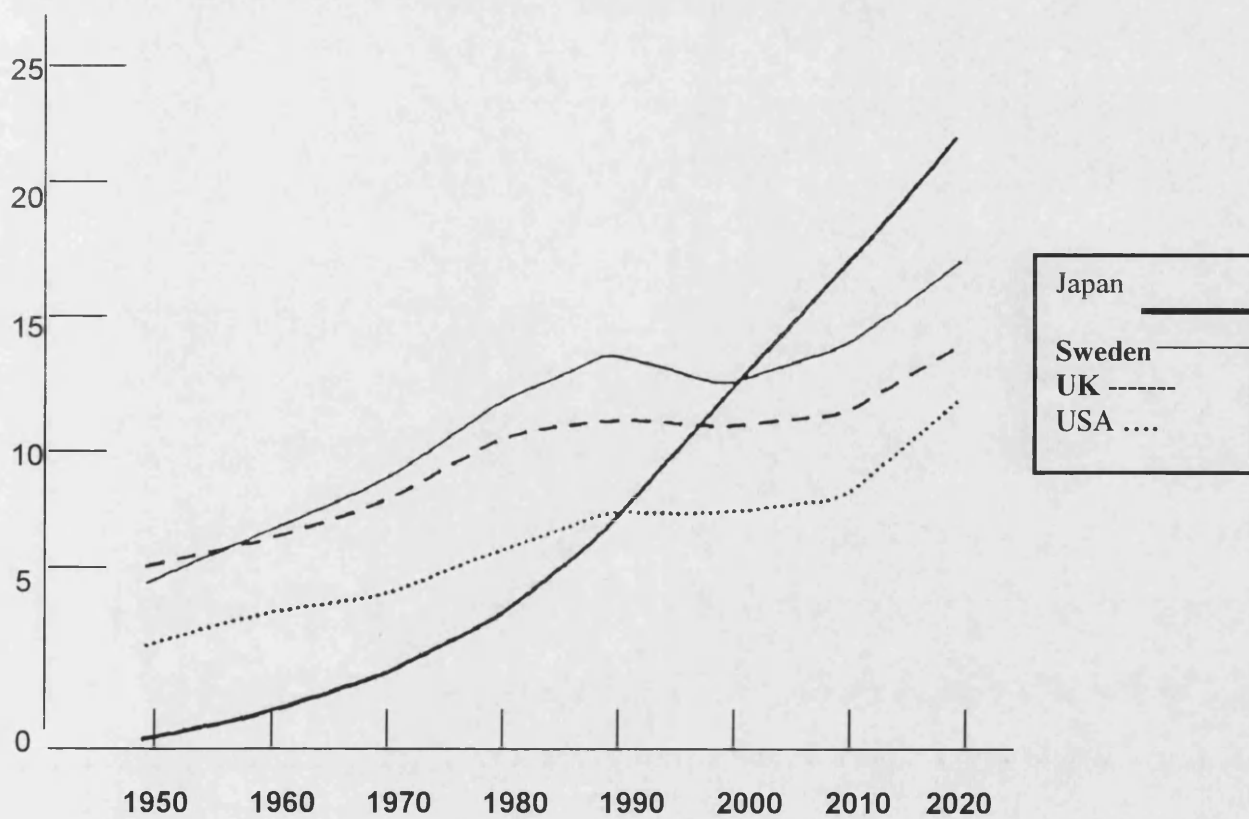
The third constraint relates to the problems of limitations in the generalisability of results encountered when researching a case study. Additional difficulties are unearthed when the methodology used relates strongly on qualitative techniques because it limits the size of sample significantly thus increasing the errors of bias. This held for all samples but was especially relevant when an attempt was made to compare the reactions of General Practitioners fund-holders with non fund-holders, which was restricted by the total number of GPs and fund-holding respondents in particular that were interviewed in study sites of this research.

On the other hand, the purpose of a case study, investigated by means of qualitative methods is to provide a deeper understanding into the causes and highlight the underlying layers and factors that determine the final outcomes of specific policies and which can research by means of qualitative interviews (Britten 1995; Baum, 1995).

Purpose for conducting international comparisons and their limitations

International comparisons provide an important source of information against which the performance of the specific health system can be measured. They can also provide insight into the different solutions for common and/or similar problems, which acquire an additional weight in the age of rapid change and globalisation with less space for separate policies (Ranade, 1998). However, these so far are also fraught with many problems that mainly relate to the absence of common standards and variable quality of data. As a result different things are measured or the same things are measured differently and compared against each other (Schieber et al, 1991; Schieber et al, 1993). This leads quite often to significant inaccuracies that are involved in these comparisons.

Figure 5.2 Actual and projected proportion of the elderly to the total population.



Source: Hakansson (1998) Health Economics of Dementia. John Wiley & Sons Ltd

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On the whole however, if these limitations are taken into account it can be a rewarding and worthwhile exercise because it provides unique information on the different approaches and solutions to similar problems. It can reduce uncertainty and by dissemination of good practice it can serve as an input to policy making. Also different countries with similar conditions, such as for instance, income, can compare their performance with their peer group.

5.3 Detailed methodology

In this section the details of the methodological framework are outlined. It was designed to tackle successfully the problems of measurement of the impact of pro-market's policies on the set of selected indicators, while isolating effects that were unrelated to reforms. The instruments applied for this purpose are presented below. The next section expounds on the criteria used for choosing the study sites, the time scale and characteristics of the samples and the ways used for constructing the questionnaires.

5.3.1 Methodological framework used

This section presents a review of available outcome and process measurements for cataract surgery with the characteristics that may serve as proxies for outcomes. These concern the choice of processes versus outcomes, which is based on the availability of the former and discussion of the reasons that led to the preference of qualitative methodology. In addition the rationale for using the perspective of the different actors is outlined in the section presenting the detailed methodology.

Processes and outcomes for cataract surgery

Clinical outcomes for cataract surgery are measured as the change in pre and post-operative visual acuity expressed in the Snellen scale with the improvement in vision of 6/12 being considered as a satisfactory outcome. However, as has been suggested, the indications for surgery increasingly follow the trend of

operating at an earlier stage, which may also change the notion of improvement of visual acuity (Batterbury et al 1991; Williams et al, 1992; Williams et al, 1994). Pre and post-operative visual acuity is also correlated to risk factors such as coexisting ocular pathology (i.e. diabetic retinopathy, glaucoma, and iritis).

On the other hand, *process based outcome measures* such as relapses, readmission rates and complications are of limited relevance to cataract surgery, because if the operation is not successful, for whatever reason, it cannot be performed again, thus making a relapse a non-applicable process-based outcome indicator. Also, readmissions for complications after cataract surgery are quite often found to be in reality related to other conditions common in the elderly (Cox et al, 1998). Thus readmission rates for conditions related to operative or post-operative complications (that may be immediate or distant, manifesting after three months period), while being more meaningful, are rarely considered as sensitive outcome indicators.

The type of complications and their frequency is closely related to the surgical technique (Acheson et al, 1988; Cheng, 1987; OCTET I, 1986), as well as anaesthesia (Davies et al, 1997), and it is obviously correlated with co-existing ocular pathology (Perceival et al, 1992; Davies et al; 1987; Desai, 1993). Complication rates may occur in all the stages of the surgical procedure, such the intra-operative stage, which may result in vitreous loss and tears of the posterior capsula. During the immediate post-operative period, (next day) iris prolapse and high intraocular pressure are most likely to happen and in the first post-operative period (one week) retina detachment and central macular oedema are the most common complications (Courtney, 1992; Desai, 1993).

If these complications are used for the purpose of measurement they would also have to be correlated with factors outlined above and would also need to be adjusted for surgical techniques such as phacoemulsification and extracapsular extraction with intraocular lens implantation.

For the purpose of this study, a small audit was conducted at the pilot site where the case notes of 53 patients, operated on during a two month period in 1996,

were examined with reference to clinical outcomes and complication rates. These were then examined as regards their correlation with the surgeon's grade and surgical technique used. This small study was aimed at testing the links (if any) between the technique used (the conventional extra-capsular extraction or the newest phacoemulsification small incision technique) and the operating surgeon's grade (consultant, service grade or trainee) with clinical outcomes and complication rates (for details see Annex I).

The assumption was that the organisational changes and incentives to perform efficiently, introduced by market-oriented reforms would stimulate innovation, contributing to the attainment of these objectives. In other words, they would be responsible for the adoption of technologies and the other inputs including the skill mix of the team.

Qualitative versus quantitative methods

It was decided that for the purpose of this study a combination of qualitative and quantitative methodologies should be used to capture the range of phenomena occurring for different indicators employed in this study. It has been recognized that such a mix best reflects the complexity involved in evaluating public health issues despite the tendency to follow the artificial dichotomy approach in considering quantitative-qualitative methods and the limited application of the combined approach which in health service research is still much too common (Baum, 1995).

This on the one hand, happens because the quantitative methodology with its too strong reliance on statistical methods that imply straightforward causality, deeply rooted in the positivist tradition of medical science, appears to be hopelessly reductionist in the view it provides of health issues (Holman, 1993; Silverman, 1993). On the other hand, qualitative techniques were until recently regarded as being too "soft," and thus not capable of providing real evidence, which might have been largely influenced by the quality of their design that was not always high (Mays et al, 1996b).

While this contradiction is essentially a discourse between positivism and interactionism that belongs to the realm of epistemology, the tendency to combine these two different approaches and to acquire deeper and more comprehensive understanding of issues involved in healthcare is increasingly common in the health policy arena (Mays et al, 1996b; McKinlay, 1993; Baum, 1995). This is because while quantitative tools can be best used for drawing the broad picture of facts and problems contained in a given subject, qualitative methods can highlight the underlying causes and reasons providing an answer why these occur in the first place (Silverman, 1993; Mays et al, 1996b; Britten, 1995). In addition, this plurality of methods, which is reflected in their combination, helps to delineate the boundaries of the general approach and bring the importance of individual factors into context (Baum, 1995).

In this study qualitative research methods were primarily relied upon in conducting the interviews with all respondent groups. Some respondent groups, such as patients, were randomly selected, but for some other groups purposive sampling techniques were used. Interviews with patients' samples were conducted using the structured and semi-structured questionnaire and less and no in-depth interviews were applied to a lesser degree. This was determined by the nature and the scope of questions asked of patients, which were relatively limited when compared to the multiple aspects of the same issues that were raised with other respondents. The size of sample in the former case also acted as a limiting factor in performing the full scale in depth interviews with all concerned.

On the contrary, a combination of semi-structured and in depth interviews was chiefly relied upon when quizzing consultant eye surgeons, General Practitioners, managers and purchasers (for details see Appendix II). The method used was that issues that were investigated for patients as the first respondent group were examined in the form of open-ended questions, but the key concepts, identified in an *aide memoire* were then probed in depth (see below section 5.4). In order to assure uniformity of style and comparability of results, the same person conducted all interviews.

Qualitative methods were used for content analysis of the transcribed interviews and textual analysis for examining the quality specifications and arrangements devised to monitor it. These were contained in the contracts that collective purchasers (District Health Authorities in the UK and County Councils in Sweden) had concluded with specialist providers. Quantitative methodology was used for identifying the correlations between outcomes and complication rates on the one hand, and surgical techniques and surgeons grades on the other.

Statistical analysis was performed to identify whether the changes in the numbers of day care procedures performed in the earlier period had any significance. In addition, changes in the dynamics of the length of waiting lists (for surgery and the first specialist appointment), using both departmental data and those recorded in the national league tables, were analysed, partly using statistical methods.

The use of the computer programme NUD*IST version 4 as an aid for analyzing the interview data was also explored but it was decided that the analysis of data manually was the preferred option. I found that the programme was good at producing rudimentary links; but it missed important fragments from the interview excerpts that were relevant but not directly linked to the identified categories. Surprisingly, the large amount of data proved to be easier and more flexibly managed using manual processing rather when they were input into software programme.

Analysis of the data on waiting times and changes in the rates of day care surgery was performed using the statistical tools of the Excel programme ToolPak.

The context of the UK national policy documents ("Working for Patients", 1989; "Promoting Better Health", 1989; "Health of the Nation", 1989; "The Patient's Charter, 1991; "The Patient's Charter and You", 1995) and the NHS Management Executive documents were analysed with the view to consider how institutional framework pertaining at the time impacted upon the individuals' behaviour and the indicators that this study considered.

Examining the perspectives of different actors

The general condition that should be fulfilled by a measurement of activity is its relevance and its potential ability to be used by the different levels of health services. It was decided to use the same set of indicators and to examine their effects on the service from different levels and viewpoints. A modified welfare model developed and tested in the Stockholm area by Charpentier and Samuelson was used (Charpentier and Samuelson, 1994) to evaluate the effects of reforms on different aspects of care in the selected service. This implied that the variables of care such as quality, efficiency, choice, information and others were the inputs coming from the patients' perspective as well as from health care professionals, managers and purchasers.

For this purpose interviews with ophthalmic consultants, general practitioners, managers and patients were conducted in order to elicit their views with respect to the impact of reforms on chosen aspects of healthcare in both countries. In addition, the views of contracting directors of purchasing agencies on the quality were sought. The attempt was to replicate the same set of questions especially the ones that dealt with key aspects of care under investigation, which was reflected in the respective questionnaires (see Appendix II). Not all the examined aspects could be repeated in the same way for all the groups of respondents nor was the ratio between the structured and open-ended questions the same. An outline of the similarities and differences in the ways the same concepts were used for different groups of respondents is presented in Table 2 of the Appendix I.

Interviews with patients, for example, were oriented towards exploring their attitudes to changes, but also towards revealing their level of satisfaction with the services that were offered to them by the selected provider units before and after the reforms. Structured and semi-structured questionnaires were consequently used. Interviews with patients were focused on investigating the process of choice (type and extent), satisfaction with given information, changes in some aspects of waiting times, the perceived effectiveness of the operation, the attitude of the staff and overall satisfaction with the service.

Consultant eye surgeons and General Practitioners were also questioned on the dynamics and effects of change, in addition to addressing the same issues as in the case of patients. These were related to issues such as the changes in the ethos of providers and the working environment, the impact on equity and the ability of providers to participate and influence the service. The effectiveness of the reforms in promoting their proclaimed aims and their interrelation with other simultaneously happening events were also researched. For example, the diffusion of technology and how this contributed to quality and efficiency outcomes, in addition to the increased funding, were investigated.

Semi-structured interviews and in-depth interviews were used for probing their views and recording their interpretation. Managers were asked about their perception of the changes and their contribution in shaping provider's new role in the internal market environment. Purchasers were quizzed with respect to their perspective on changes, including aspects of choice and information, but more importantly on the way providers responded to their needs (and their patients' needs by extension). They were also questioned about the standards and specifications of services they used.

5.3.2 Development of the structured and semi-structured questionnaire

This study focused on a few aspects of perceptions of changes in the service and their evaluation of those changes. Only the ones that were most relevant to the selected service were investigated in full awareness of all the limitations and implications for the comprehensiveness of evaluation that this approach might preclude. However, it was not deemed feasible, nor was it the aim of the study, to simply record patient satisfaction oriented outcomes that could be performed by means of a survey.

The reasons for this concern are, on the one hand, conceptual, but also relate to the limitations of the survey itself. The former is connected to the notion of satisfaction, which is a multidimensional issue and there is so far no widely accepted unitary concept to underpin it (Carr-Hill, 1992). There have been some

notable attempts in this field such as the development of a standardised questionnaire for evaluating patient satisfaction with day care surgery (Black et al, 1993a; Black et al, 1993b).

The major difficulty encountered when conducting surveys of satisfaction (and one that is not solely confined to these circumstances however) is the reluctance of patients to express dissatisfaction. In British studies, for example, this leads to a typical level of satisfaction response rates of up to 80-90% (Baker et al, 1992; Boufford et al, 1992; Carr-Hill, 1992). This can be overcome, to some extent, through the development of questionnaires where questions are modified to encourage a wide range of replies, as well as through differentiating categories that express moderate levels of satisfaction, or even more radically by actively seeking dissatisfaction (Carr-Hill, 1992).

This problem was not entirely eliminated, though, even with the fully confidential face to face interviews that this study used, but the impression is that it was significantly improved despite (or maybe because of) the foreign origin of the interviewer. In terms of the sample of respondents questioned in this study, this problem may be partly explained by the age-related dependency on the service that many patients perceive, which makes them fearful of expressing negative opinions. Another explanation was connected to the respondents' educational and socio-economic status that may or may not be conducive to articulation of criticism.

There were also several other conditions that had to be fulfilled in the questionnaire's design. The questionnaire had to be assessed with regard to its ability to secure findings that were meaningful. Content validity and face/criterion validity were tested through pilot work with patients. Construct validity was difficult to gauge because it is known to be the least easy to establish due to the lack of universal standards for satisfaction (Boufford, 1992). The questionnaire that was designed and used in addition to being valid and reliable had also to include questions about specific aspects of care, as they are considered to be less ambiguous and more sensitive than general questions (Black et al, 1993a;

Black et al, 1993b). Open-ended questions were included to aid the interpretation of the responses of the preceding questions.

A low rate of response and bias in the overall results had to be anticipated and counteracted. In order to prevent this phenomenon, the co-operation of the consultant involved in the treatment was sought, and it is likely it had a positive influence on response rates from patients as only 15% of respondents declined to participate in the study. Maintaining the register of all patients that were invited to participate in the interviews was seen as an important part of the procedure to allow for assessing any non-responder bias in relation to the study site.

The questionnaire developed for the purpose of this study took its inspiration from a similar one applied for examining the impact of the Stockholm Model by Charpentier and Samuleson, (Charpentier and Samuleson, 1993) elements of which were used as a matrix for further work, with adjustments made to reflect the objectives of this research. It was divided into sections corresponding to the set of selected indicators. Each of the sections consisted of sub-divisions, which comprised several questions dealing with different aspects of each concept being investigated.

The strategy was to start the interview on each subject with a structured question (with types of possible answers listed), to continue with open-ended questions and to conclude with in-depth probing of some of the key aspects that were considered crucial to the research hypothesis. The attempt was to replicate the questionnaire as much as possible across the board of respondent groups, however, the specific insight that each group possessed had also to be accounted for in the questionnaires (for details see Appendix II). The analysis of the pilot project's results was used for a slight redrafting of the questionnaires and modifications to the *aide memoire* (for details see below section 5.4).

5.3.3 Description of the study sites

A limited number of sites from the area of outer London that fulfilled the criteria of both diversity and representativeness, and the specialist eye hospital from the

County Council of Stockholm were selected for the study. In the UK, four hospital sites were chosen (including the pilot site) from the area of outer London. One was a typical teaching hospital (coded as T) from inner city London, which covered areas of diversity and difference in the level of affluence. The other was an associated teaching hospital NHS Trust in the South London area, which, on the whole, covered an area of deprivation, but also had pockets of relative wealth (coded as S).

The third was a district NHS Trust hospital in the North London area, whose eye services at least could not successfully respond to new organizational environment and had in effect been negatively impacted by its trust status (coded as U). Its ophthalmic services had been closed down and moved to other sites and it was decided that the hospital should become a community hospital. It was situated in a middle-class and traditionally wealthy area.

The pilot study was conducted in a hospital in West London (coded as P). Although reforms were adopted by the hospital, there were no changes in the eye unit until 1995/96. Only then was it decided that the new eye unit would be re-established on the site of the old one, which was not unrelated, however, to changes happening in the other study site U, as the team of consultants who left it were hired by the hospital P.

This choice was based on the consideration of the fact that a diverse range of hospitals needed to be selected to represent the differences in hospital status (teaching, district and associated teaching), and to cover a wide range of populations served, including inner city and suburban areas with different socio-economic statuses. The difference in the level of specialisation in terms of performing cataract surgery was also considered (including aspects such as use of day care surgery and the likely difference in the number of cases performed in the pre-reform period).

The diversity in the study sites selected was seen as important for examining and comparing the responses of different units to the same set of policies, and only hospitals that opted for a trust status were included in this study.

Hospital T is a typical teaching hospital with old traditions and priorities, oriented towards postgraduate education, and, for this reason, might not be expected to react in the same manner as a typical district hospital to the competitive pressures accruing from the reforms it decided to follow. It was assumed that it could not be compared in terms of throughput, for example, with a district hospital such as unit U or S. Yet, the effects of reforms on the teaching hospital could not be disregarded because of the role it had to play in the health care system and the scheme of continuous postgraduate education.

Another assumption was that it could also be slower in adopting the newest techniques such as day care surgery because this would, in its case, require more rigorous trials before it being fully introduced. On the other hand, these constraints were less likely to hold for hospital S, which, while having an associated teaching hospital status, was at the same time an enthusiastic follower of innovation and of the reforms. Its experiments with day care surgery, for example, had already started at the very beginning of the 1990s.

In addition, it was relevant to investigate the reasons for the closure of the eye department in hospital U, which had occurred in the context of the reforms, though it had a seemingly high throughput and had followed a similar course of action in adopting reforms as the other units of the study. The investigation could lead to the identification of those factors introduced by the new arrangements that were conducive for this development and precipitated its final outcome.

Finally, hospitals' willingness to participate in the study was not an unimportant factor influencing this choice as it was appreciated it would ensure access to information and co-operation during the data collection stages of the project. The last was enabled either through the researcher's personal or family contacts.

In the case of Sweden it was decided that two or three hospitals from the area of Stockholm County Council would ideally serve the purpose of this research, both because of its size and its relatively early adoption of experiments with a purchaser-provider split and performance based payment systems. Stockholm

County Council is the largest and probably the most diverse county in the country, though it is not strictly comparable with the area of Outer London.

Following, and according to some influenced by the UK reforms (Whitehead et al, 1997), Stockholm has also separated the functions of buyers of services from those who deliver them, replaced its traditional control over the budget with payment for services made on the basis of the DRG system and simultaneously gave more freedom of choice of provider to the patients (Charpentier and Samuelson, 1994).

However the eye units of three major hospitals merged into one specialist eye hospital (hereafter referred to as K) in 1992, which, while not being directly related to the reforms, was a manifestation of the pending changes. The influential players captured the gist of the time expressed as need for change in the field of health, which made this merger possible. This specialist eye hospital has since that point dominated the market, only leaving a niche for small private clinics to divide among themselves. It was decided that the study site in Stockholm County Council could, by definition, only be located in this hospital.

The participation of all hospitals was agreed with consultants, managers and purchasers and all were very keen to co-operate. Approval for conducting the research in the teaching hospital (T), which was an essential precondition, was obtained after the examination of a detailed research proposal by the ethical committee, comprising of 17 members of the trust.

5.3.4 Time scale, size and the characteristics of the sample

It is not a proper before and after study although two periods chosen for comparison refer to pre and post reform intervals in time. The first period used for measurement was the immediate one before the reforms' introduction beginning in 1991 in the UK and 1992 in Sweden, which coincided with the respective time that reforms were adopted in both countries. The second one is the period of four to five years after the reforms and it refers to the years 1995 and 1996. This was considered to be a sufficient time for a follow up evaluation as some stability

within the system would have been achieved after the first phase of enthusiasm or rejection had subsided.

The selection of patients was random, in an average week during three different periods of time (February/March 1995, June/July 1995, and January/February 1996) representative of regular levels of productive activity. Two periods were avoided – the immediate one before the end of the financial year due to a possible lack of resources and the possible bias reflected in respondents' spirits. The period immediately following the beginning of the new financial year was also avoided because the relative abundance of money may have introduced a positive "optimistic" bias.

A three-week period was a sufficient time for extracting the sample of approximately 15 to 20 patients from each hospital. If the number of operations performed in the UK varies between providers from 100-250/per 100,000 residents/year, as was known to be the case at the time when the study was initiated in autumn 1993, (Williams et al, 1992; Williams et al, 1993) then the number of patients operated on should average 30-35 per provider/per period. A figure of 20 should be reached after the percentage of patients "missed" for whatever reason is calculated (usually around 15-20%). In Sweden's case the throughput of the specialist eye hospital was much higher and a period of one and half weeks in November 1995 was used for conducting all interviews with patients.

All patients who were present for post-operative assessment were asked about their willingness to participate in the study under conditions of full anonymity. The aggregate number of all patients interviewed was $n=81$ of which 52 were from the UK (including the pilot sample) and 29 were from Sweden.

In addition, General Practitioners from the three study areas in the UK ($n=16$), of which approximately 25% were fund-holders (4 out of 16), were also asked to participate in the study. In Sweden, our sample of primary care providers ($n=5$) was composed of three family doctors from two health centres, one private general practitioner and one non-surgical grade ophthalmologist. The

representatives of purchasers (contracting managers, quality managers, and public health doctors n=9) from the respective Health Authorities in Outer London and the Western District of the County Council of Stockholm (n=6) were asked their views on the relevant issues, as were the managers and/or the executives of the respective provider units in both the UK (n= 5) and Sweden (n=3).

For identifying General Practitioners in the UK, complete registers provided by the Family Health Service Authorities of the respective areas (named H, I, N) were used, and all GPs listed were contacted in alphabetical order. In Stockholm, the County Council representatives were asked for assistance in providing a list of respective primary care providers (for details see Appendix III).

All consultant eye surgeons from the UK hospitals and senior eye surgeons from the Swedish hospital were asked, and agreed to be included in the study. Consultant eye surgeons and senior grades of ophthalmic surgeons working in the above units (n=13 in the UK and n=5 in Sweden) were interviewed (for details see Appendix III).

The response rate of patients was quite high in both countries (82% in the UK and 88% in Sweden). However, a significant number of General Practitioners (especially in the UK) seemed quite unwilling to devote any of their time to this research project. It was particularly high in the inner city area where those willing to participate represented a very modest 12% of all GPs registered. In two other suburban areas the respective figures ranged between 35-40%. This could possibly be explained by the low priority they attached to this research project, in the context of the time pressure they continuously face. Moreover, the specificity of working conditions in particular areas with transient a population may also have played a role.

In order to assure uniformity of style, all interviews were taken by the same person throughout 1995 and at the beginning of 1996. The pilot study was conducted in November 1994 and its results were used as input in the final draft of the questionnaire, while some of the new elements were also included in the *aide memoire* (for details see the section below).

5.4 Measuring the market's impact using selected indicators

The essential question from a methodological point of view was how to identify the best way of measuring the impact of internal market reforms and how to define the indicators that would best capture this impact. What were the most important functions of this impact and from which perspective are they seen as important?

A combination of process and outcome (including some clinical) indicators that were relevant to the selected service (cataract surgery) was used for testing the research hypothesis of this study. These dealt with greater efficiency, responsiveness to needs and more choice. In addition, some other aspects that economic analysis predicted would be affected by reforms such as information and quality of healthcare delivery were included as indicators of market impact. In short, the concepts incorporated into the set of selected indicators were linked to respective governments' statements about the expected outcomes of the reforms. These were applied to the tracer condition to examine whether the expected changes in healthcare delivery were happening in reality (for details see Table 1, Annex I).

5.4.1 Choice

Different aspects of the choices given to the users of services were measured through the structured and semi-structured patient questionnaires, where the gist of questions asked was (for more details see Appendix II):

- ❖ *Whether they were given a choice with regard to the preferred provider unit (i.e. with shorter waiting times or using different procedures) by the GPs, and if this choice was expressed, was it respected by the GPs?*
- ❖ *Were patients encouraged to choose the preferred form of procedure (i.e. local or general anaesthesia, day care or inpatient stay if there was felt to be a lack of adequate support at home)?*

General Practitioners, fund-holders and purchasers from the District Health Authorities of the respective areas were also interviewed. Interviewing techniques that were regarded as being more meaningful for an understanding of the perception of interviewees, thus open ended and in-depth interviews were employed. In addition to the questions asked of patients, they aimed to find out:

- ❖ *The change in the degree of choice in contracting provider available to them*
- ❖ *Changes in the criteria on which they based their choices*
- ❖ *GP fund-holders were asked as to whether they gave preferences to treatment of cataract surgery in comparison with what they did before the reforms*

When concerning the other actors such as consultant eye surgeons their views on choices given to them by purchasers were explored and as in the case of General Practitioners the presence or absence of the elements of choice in their relationships with providers was investigated. Managers were asked to provide the organisational viewpoint on changes in choices offered from the providers' perspective and the purchasers were quizzed on their impressions of changes in choices available to users.

5.4.2 Information

Again patients were asked a series of questions which were replicated for all the respondent groups using the respective methods for each group. These were the following:

- ❖ *Were the patients given sufficient information by the specialist provider units regarding the procedure itself and the availability of its different options and the likelihood of side effects?*
- ❖ *Who gave the information (senior/junior doctors or nurses)?*
- ❖ *Was the information given in oral and/or written form and how was it rated by patients?*
- ❖ *Were patients informed about the date of the operation sufficiently in advance to make arrangements?*

5.4.3 Quality - processes and outcomes

The concept of quality concentrated on selected clinical outcomes and processes that mostly served as proxies for quality indicators. For this purpose, quality indicators were designed along the following aspects of care:

- ❖ *Promptness of service received measured as waiting times at the outpatient's department*
- ❖ *Changes in the attitude of health providers (primary and specialist)*
- ❖ *Changes in the orientation of information (type and form) provided to the users*

5.4.4 Responsiveness –waiting times

A measurement of waiting times was used for establishing the changes in responsiveness to unmet need expressed as demand. Changes in waiting times for surgery and the first specialist appointment were measured through extracting data from hospital records on both waiting times for elective surgery and the specialist appointment, and relating them to national figures (for indication and comparative purposes only). Also the interviews with all groups of respondents including patients, assisted in understanding the dynamic of change. Waiting times for the first specialist appointment and the surgery itself were also measured.

5.4.5 Efficiency

Hospital activity data and hospital operation registers were used to extract the number of operations in selected periods. These were also used for comparing the changes in prices throughout the period of reforms. In some cases, the prices of cataract surgery were not available and in this case an attempt was made to calculate them in order to draw conclusions on efficiency gains observed. Clinical outcomes were measured by means of a small study conducted on the site of our pilot hospital in order to relate them to the potential efficiency gains acquired at the same unit. The aspects investigated were the following:

- ❖ *Has the number of operations performed increased in relation to prices for services over the years of reforms' implementation?*
- ❖ *Could the efficiency gains be influenced by the changes in the skill-mix or other means of input substitution?*
- ❖ *What was the role of cost-effective technologies in this process?*

All these factors had to be specified for their associations with the organisational changes and incentives introduced by internal market reforms. As outlined previously potential gains in efficiency may have had an adverse impact on quality both in technical terms and as a broader concept incorporating satisfaction, choice and responsiveness.

It was also assumed that advances in surgical techniques and organisational changes brought about the efficiency outcomes in case of cataract surgery. However, the adoption of more cost-effective procedures such as the shift to day care that was deemed to be more efficient and acceptable than inpatient care (Strong et al 1991; Perceival et al, 1992) could be attributed to the reforms' introduction or to be a result of other changes that were occurring simultaneously.

5.5 Conclusions

This chapter has attempted to provide the justification for selection of cataract surgery to serve as a tracer condition of the impact of the market reforms on selected indicators. Theses dealt with choice, information, quality, responsiveness and efficiency. They were chosen on the grounds of their relevance, appropriateness, and representativeness of the changes that reforms were to bring about. Cataract surgery fulfilled well the criteria of being a representative case study, illustrating the effects of reforms, because it is both frequently performed and an important procedure in terms of the benefits yielded.

This study was designed as an assessment of the changes occurring after reforms with respect to these indicators. However, in most of the cases it was not

possible to examine the changes in before and after the reform period as the data on a number of aspects that this study examined did not exist for the period before the reforms. In this case the perception of changes by main participants was recorded.

The methodology selected was principally based on qualitative techniques, which included interviews with all groups of participants: patients, primary care providers, eye surgeons, hospital managers and purchasers. It also involved an international comparison between two countries whose pre-reform health care systems and the changes introduced after the reforms were similar.

There were methodological limitations that mainly related to the age of the one group of participants, the patients, the use of process instead of outcome indicators and the need for providing counterfactual evidence for changes that were simultaneously occurring and distinguishing of them from the effects of the reforms. Despite these constraints the methodology chosen was expected to yield promising results and contribute to the knowledge on the consequences of market incentives for health care delivery in publicly provided and financed health care systems.

III. RESULTS:

DATA PRESENTATION AND ANALYSIS

Foreword to Part III

Part III of this thesis is concerned with data analysis and the presentation of results with regard to all indicators (where their different aspects are highlighted) and the perspectives of all involved actors. The result is that analysis is densely interspersed with large amount of quotations and consists of a fairly detailed reference to the material from transcribed interviews. This while providing substance and evidence to the results of analysis also contributes to the substantial length of most chapters. In order to make manageable their length and enhance the accessibility of data presented, each paragraph is summarized with key findings where many of them are illustrated by tables and graphs. For a quick review of the principal results the reader should refer to the end of each chapter.

CHAPTER 6

CHOICE

In this chapter, the analysis of changes in different aspects of choice as perceived by the different actors - patients, doctors (primary care and eye surgeons), managers and purchasers - is presented. Respondent groups were asked about the availability of choice over the modalities of treatment (local versus general anaesthesia and day care versus inpatient care); about the possibility of registering with a GP of their choice in the UK and a family doctor of their choice in Sweden; and about their power to obtain referral to a particular hospital in which to have an operation.

Furthermore, patients' willingness to participate in choices and their view of the limitations (if any) of professional involvement in decision-making was traced by means of additional questions. This was decided after a pilot study had been conducted and it was aimed at acquiring greater understanding of patients' attitudes towards involvement in choices regarding their treatment.

In addition, in cases where only a few GP fund-holders were represented, the original question used was modified to include the possibility of choice in a hypothetical form. When more than one factor was mentioned, patients were asked to specify which was the single most important factor, although all parts of the answer were taken into account.

6.1. Interviews with all groups of respondents

PATIENTS' VIEWS

6.1.1 Was choice over the procedure given?

ENGLAND

The answers received were diametrically different in four study sites, which seemed to reflect the differences in policy adopted by the eye departments examined. Thus, at pilot site P (n=7), only one patient reported the absence of any form of choice. Three patients said they had choice concerning day care and the form of anaesthesia, one patient reported that choice only existed in respect to the former and yet another two patients claimed it applied to the latter.

By contrast, in S (n=18), all the patients' replies pointed in one direction. While detailed information about the ease of the procedure (day care surgery under local anaesthesia) was given, they were, at the same time, strongly encouraged to follow the only available form of treatment. All patients in this group, representing the majority of respondents, expressed views that they were strongly encouraged to opt for a day care procedure performed under local anaesthesia, and persuasion was achieved through making this option as attractive as possible. It turned out, in reality, that they were not asked about their preferences, as there was no information about alternative options, which was succinctly outlined by one of the patients as:

"They will ask a few questions, but they already know what is to be done and it was usually they who said what they thought you should have."

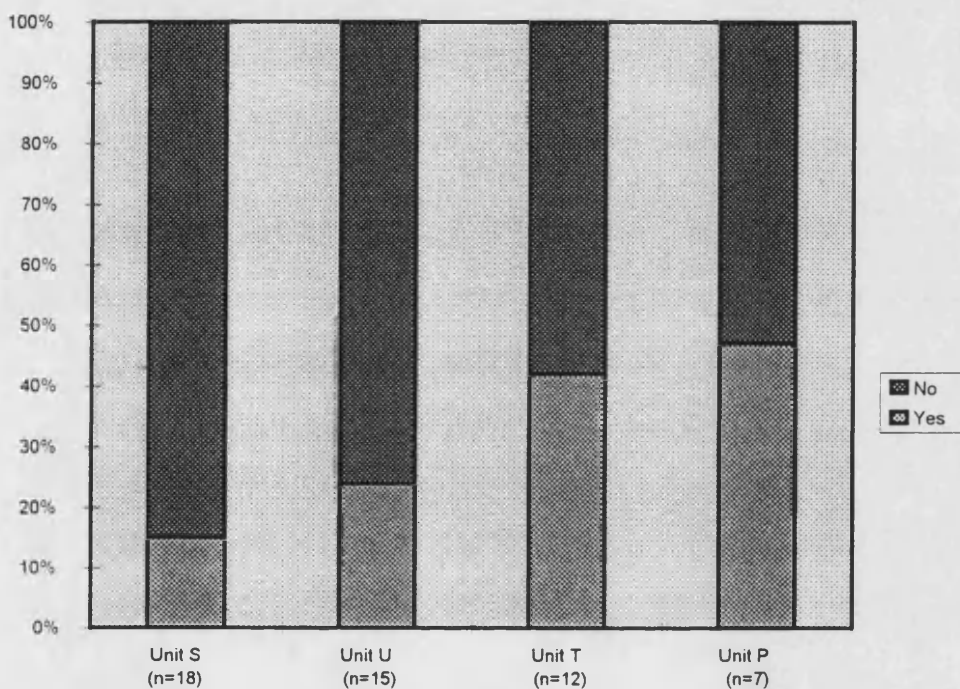
Only three patients felt they were given some choice (see Figure 6.1). One of them said s/he had full choice, pointing out at the significant difference s/he was experiencing currently in comparison to her/his treatment in the past. Eventually, though, the overwhelming majority of respondents seemed to be satisfied with the outcome. A few of them added that when they had felt anxious, they had been able to ask further questions until their worries had been resolved, which was seen as a positive feature.

In U, only four patients of the total sample (n=15) regarded positively the aspects of choice they were offered in terms of day care versus inpatient stay, and local anaesthesia versus general anaesthesia (hereafter referred to as L.A. and G.A.

respectively) (see Figure 6.1). A few patients considered that they had been given some choice. However, their answers suggest, rather, that they were strongly encouraged to accept what the doctor thought was best for them. For example:

"It was suggested that I should have L.A. because I would get a check-up earlier in the morning (8 a.m.)."

Figure 6.1. Availability of choice regarding the modalities of treatment among different eye units in the UK (patients' views)



Quite few opinions from U confirmed the health professionals' attitude and their attempts to convince patients to follow certain modes of therapy, which were also reported by the overwhelming majority of patients in sample S. One third of the total sample (five out of fifteen) claimed to have been persuaded that they had better have L.A. on the grounds of medical indications (the reasons referred to were mainly circulatory and respiratory problems). Interestingly, all the patients of this group were convinced that the question of choice was not relevant to their cases.

In unit T (n=12) the first group of patients (five) felt that choice had been given to them in all, or in the most important, aspects of care. They were mildly positive about it, without demonstrating any strong feelings for or against the choices that had been offered to them (see Figure 6.2). In any case the conclusion to be drawn, it is that they were rather reluctant to make use of them. The following comments sums up their attitude:

"I left the decision to the doctor and it eventually came out as a mutual agreement".

The second group represented patients (six) who were not given enough choice and felt stronger about the lack of it. Patients also referred to the persuasive efforts made by the health professionals to get things done their way.

SWEDEN

In unit K, a definite majority of patients (sixteen out of 29) denied that choice was ever given to them. They justified and explained its lack in various ways such as, *"I already knew the procedure"*, or, *"I did not ask for it as it was a specialist hospital"*, and also *"I could not influence it because I didn't know what would happen so I had to trust my doctor."*

Only eight patients out of the total sample (n=29) were positive about the choices that had been offered to them. Their strongly affirmative comments ranged from those of a more general nature, such as, *"the choice over the procedure was fantastic, a very good service"*, to more specific examples of how this choice was perceived:

"Yes, I felt that I was trusted with respect to my ability to choose."

Interestingly, the possibility of opting out of the treatment altogether was also referred to as one of the aspects of choice by some patients. There were also views that referred to choice which, in reality, pointed rather more towards information aspects and the joint decision making process, than towards choice *per se*, such as, *"I could ask questions but decisions were taken together"*.

A second group of patients (six out of 29) expressed their uncertainty about the choices offered and either did not answer the question at all (three) or expressed their belief that they had only been moderately involved in choices over the modalities of treatment. However, there were also comments which did not simply imply a lack of choice but indicated that the whole concept was missing, such as, for example:

"I do not know how to answer this question"; "I did not think it was a matter of choice".

6.1.2 Would you like to have had more choice over your treatment?

ENGLAND

In unit S, there were only three patients who claimed to be satisfied with the amount of choice they were given. Thus, two-thirds of patients (thirteen out of eighteen) expressed the desire to be involved in choices over all the aspects of treatment, which in their view should be based on information given by medical staff. The involvement in decision making of the latter was still seen as very important, though.

Only two patients opted out altogether from the possibility of being involved in choice over the forms of treatment because, *"what the doctor says is law"*. This was *a matter of upbringing that did not allow for asking questions and suggesting to the doctor what to do*" as one of the respondents explained while adding *"the younger generation is more demanding in this respect."*

Another patient, on the other hand, expressed a totally opposite view, pointing out the inherent inconsistencies between the NHS structure and patient choice, for which, in his/her view, there was no place in the system:

"The reforms could not have had any impact on this issue since it is the hospitals of the area that choose the patients, who, in fact, have no other option but to rely on what they are offered by the hospitals."

A bigger group of patients from unit U (eight out of fifteen) was also interested in having more choice. After closer examination, however, their responses often pointed more towards information aspects rather than to choice itself.

Even when patients asked for more involvement in the different aspects of treatment, this was very often expressed in very general and vague terms. Characteristically, one of patients said, *"I would like to have had more choice but I am not sure I understand what it means."* There were also a few more specific statements referring to *"more convenient time for the operation"* and *"not having a junior performing the operation for the first time under L.A."*

In T, a larger group representing over half the number of patients (seven) did not think they would like an increase in the amount of choice in reference to any aspect of care. The main reason proffered was that they either did not feel competent or secure enough to make choices, or that they were already satisfied with what was offered. Four patients explicitly declared that they would have liked more choice, though not all of them specified what should be involved in this. There were also few specific examples such as *"more choice over going home"* as well as *"more choice and more explanation as it lessens the fear and gives reassurance that everything will go well."*

SWEDEN

By contrast, the overwhelming majority of patients (21 out of 29) felt that their needs had been satisfied as far as choice was concerned and they therefore did not have any additional requirements for it (see Table 6.2). The explanation given by them was that the choice provided had been sufficient. Other respondents stated that there was no point in them seeking more choice because it was perceived as being the health professionals' exclusive domain. Despite the fact that, by general acclaim, not too much choice existed, the impression given was that only a few patients would welcome changes in this area (five).

There were patients (four) who thought that there was no room for choice as far as this specific procedure was concerned as, *"the choices and decisions belong to the professionals"*. Some patients seem even annoyed or surprised:

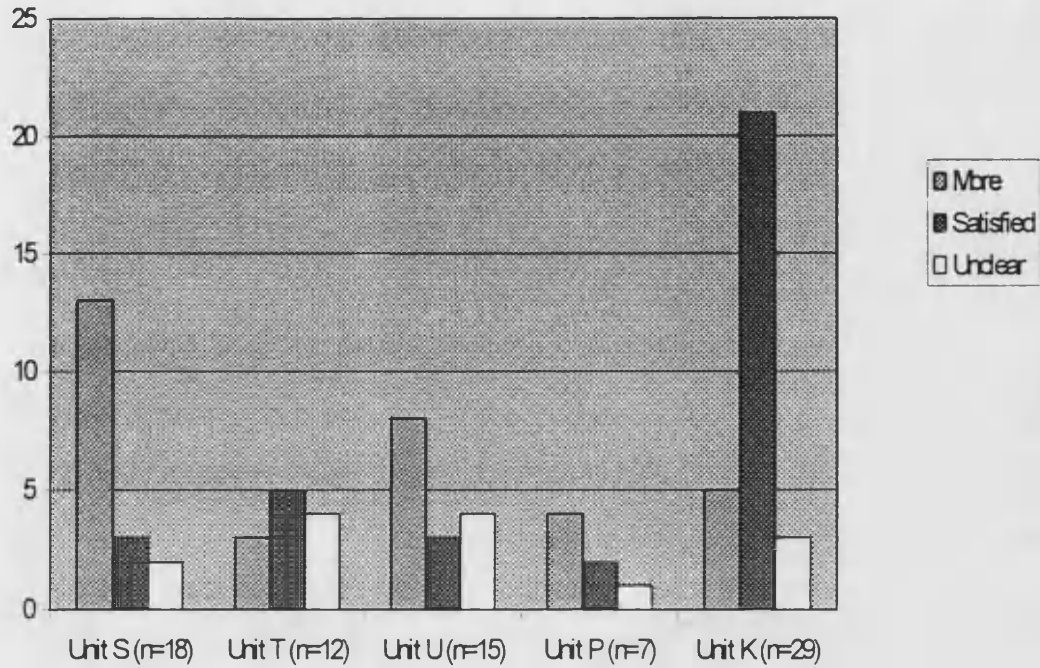
"I did not ask for choice but for help with my sight."

"I am surprised by the question; the patient should trust the doctor."

A significantly smaller group (five out of 29) spoke out in favour of choice (see Table 6.2). but even in these cases, it was not always very clear what patients meant by it. Only one patient was explicit in what s/he wanted which was more discussion about the choice of lens to replace the original blurred one. Two other patients said that they were for choice in principle, but they were happy with what had happened to them. Another liked the idea of choice as a virtue in itself, which reflected her/his general attitude of being a person who liked to take decisions. It seemed that at least two thirds of all those opting for choice had rather referred to the unfulfilled need for better information.

One patient demanded to be paid for participation in the different research programmes carried out by the hospital after s/he had consented to them. S/he felt did not have enough choice, which s/he explained as being a result of belonging to a generation *"which is not used to asking for too much"*, adding, *"even when I dared to ask questions, they were not answered."*

Figure 6. 2 Patients' satisfaction with choice over the modalities of treatment of cataracts in Outer London and Stockholm



6.1.3 How far should health professionals be involved in the decisions about your treatment?

ENGLAND

The majority of patients in sample S (twelve out of eighteen) thought that it was primarily the doctors' responsibility to make decisions about the treatment, but the degree of the desirable involvement varied. Most patients said that doctors knew best and everything regarding treatment should be left to them. Others understood that it was not easy for doctors to give full choice to patients and yet others said that they would not mind the eventual decision being taken by doctors, but that information about the treatment was essential. Three patients clearly stated their wishes for deeper involvement in choices, but without providing further details.

Similarly, the majority of patients in T (eight out of twelve) were perfectly happy for choices and decisions about their treatment to be taken by the professionals, by which they usually meant doctors. Respondents felt that doctors were best placed to perform this task. This is confirmed by comments like:

"I am happy for the doctors to make the choices, as it is their field of expertise."

"For me, it is up to doctors to decide; doctors are in a position to know better."

Even when respondents did not clearly assert the superiority of the profession's view over their own judgment, they still did not object to their primary role in decision-making:

"I have nothing against the doctors taking the decisions, as they are qualified to do so."

Only two patients expressed the view that it might not be sufficient if only professionals made all the decisions on behalf of the patients but, again, this was generally and vaguely expressed as, *"more choice for the patient."*

By contrast, six patients from unit U also expressed their explicit views on the preferred degree of involvement in decision making by both patients and doctors and nurses. The professionals should, in their view, be confined to dealing *"only with purely medical issues."* In the same time, they thought that health professionals should be more focused on their advisory role and on the provision of information (i.e. more details about what, when and why something was going to happen).

SWEDEN

Fourteen patients in K thought that choices and decision-making over the modalities of treatment definitely belonged to the health professionals' domain. The justification provided referred to patients' limited specialist knowledge and, consequently, their inability to understand the issues involved. Further elaboration pointed towards patients' lack of capacity (real or perceived) and, possibly, also to an unwillingness to break through the barrier of specialism. This is reflected in the following comments:

"Elderly patients may not be in a mental condition to understand."

"The doctor should definitely decide. This is not an area for amateurs."

"I do not feel how I could be part of it, not in the case of a specialist disease."

For most patients represented in this group (nine), choices and decisions were seen as an exclusive part of the health professionals' job description, which gave them the exclusive ability to deal with each and every aspect of treatment. In short, the most common and prevalent views could be summarised as, *"leave it to the specialists"*. It is tempting to speculate that the latter may either be caused by difficulties involved in obtaining information, or by the increased responsibility this would entail, or by a combination of both.

The second groups of patients (five out of 29) were those who liked to have some involvement but rarely referred to details and who did not wish to take the decisions themselves. Their views pointed towards a desire to have more options and illustrated patients' cautious and ambivalent view on involvement in choices, which occasionally resulted in contradictions such as the following, *"I want to decide myself, to have choice, but not to be involved too much"*.

The third group consisted of those who clearly stated their will to make choices and to be part of the decision making process. However, they represented less than one-third of all respondents (eight out of 29). Furthermore, few of patients in this group (three) already felt that this condition had been fulfilled in their case and only one patient was openly dissatisfied with the existing possibilities for exercising choice.

On the other hand, there were a very few respondents who were prepared to take the risks that their decisions might carry. One of them said, *"I want to be part of it, even if it implies some risks for me"*, and another felt, *"I trust the doctors, but I want to be a part of it"*. Another wanted his/her right to consent to the treatment reserved, and, for another, choice was an indispensable dimension of the patient's function:

"If I had not been part of it, I could not have been a patient".

6.1.4 Can you exercise choice more now because of the NHS reforms and “The Patients Charter” in the UK, the Stockholm Model and the introduction of the ‘house doctor’ in Sweden than you could before?

ENGLAND

The answer to this question varied significantly among different eye departments. There were diverse views expressed as to the impact of changes in the NHS and the introduction of “The Patient’s Charter” on patients’ feeling of empowerment and ability to act upon the choices offered.

In the case of P, patients’ responses ranged between a marginal impact (three) and no change at all (four). In S, more than one third of patients interviewed (seven) had never heard about “The Patient’s Charter” and nothing, or almost nothing, about the reforms, so the question didn’t seem relevant to them. Of the remaining two thirds, none could see a big difference, except for one patient. S/he said:

“I could see a real difference, because if nowadays I do not want something to be done to me, I have the right to oppose it, whereas, before, I would not even have had a chance to ask why things happened.”

Also in unit S, three people had heard about “The Patient’s Charter”, but had a very imprecise or vague idea of its content, because they had not read it. The largest group of patients (eight out of eighteen) voiced uncertainty over whether this document had made any significant difference and whether it had contributed to their capacity to exercise choices. One of them elaborated further, pointing out that:

“It is a useful document for some people to know they could use, if need be, and that the hospital’s management will take notice of it.”

Three other respondents also agreed that it was good to have such a document outlining the rights of the patient, especially for those who have a limited experience of the NHS as it: *“was useful to have written clearly what a patient might expect from the service.”*

Another patient was doubtful as to whether a person using the service would get any feedback, while someone else, referring to the age factor, commented on how this limited the patient's voice.

A third group of patients, representing less than one fourth of the total sample (four out of eighteen), saw significant changes resulting from the reforms and the introduction of "The Patient's Charter". Those mainly referred to were the decrease in waiting times and a kinder and more caring attitude on the part of the personnel. One patient pointed out the ability to express a view and the significant difference that this represented with the past. Still, s/he was not able to identify this as being a definite result of the reforms or of "The Patient's Charter", as it could also be ascribed to the different team, hospital and other factors. One patient pointed out that

"Before, information had been kept secret and patients had been given no access to his/her own notes, while, today, this attitude had changed".

In U, the situation was similar, as approximately half the number of patients (seven out of fifteen) had never heard about "The Patient's Charter" or about changes in the NHS, or had very vague idea of what they were all about. Consequently, they were not in a position to comment on the likely impact of changes on the level of choice that may have resulted from the reforms. One patient said s/he would not know where to get "The Patient's Charter" from, while another, who had heard about it, found it too confusing.

Another group of patients in unit U, which consisted of six patients, was more aware of the reforms and of "The Patient's Charter", but held a negative opinion about the latter's impact on choice and, more generally, on the quality of care. There were also much more critical voices, referring to it as "*a lot of rubbish*" and "*good, but meaningless propaganda, not acting upon the substance*". Another respondent thought:

"It is all a gimmick, because a lot of resources are required to provide what is in the Charter."

Only two patients thought that the reforms and "The Patient's Charter", in particular, gave them more rights.

Similarly, in T two thirds of the respondents (eight) had not seen any discernible difference resulting from the introduction of "The Patient's Charter" and the reforms, and most of them claimed there had been no any changes at all. The clarifications provided were either that there was already high satisfaction with the existing service or that, where empowerment had occurred, it could have been due to other reasons, such as, for example, patient's familiarity with the environment. Some patients were not sure about the Charter's impact and could not comment on its usefulness.

There were others who thought "The Charter" an entirely inappropriate device for the purpose it was meant to serve because the *"relationship between doctor and patient is all about trust"*, acknowledging, meanwhile, that *"this was good, though, for the pressure groups"*. Someone else commented on the discrepancy between the reforms that were proclaimed and the resource constraints that limited their effective implementation and even the adverse *"boomerang effect"* this could have on patients who, in theory, were to be empowered:

"They do not have the money to do 75% of what is there, and if the patient takes too literally what is written in it, s/he is labelled as a trouble maker."

However, someone pointed at the importance of its existence, which s/he could assert without even reading it: *"I know it is in black and white and, if something happens, people can use it."* The person who, in fact, made use of it recounted her/his evidence of its usefulness:

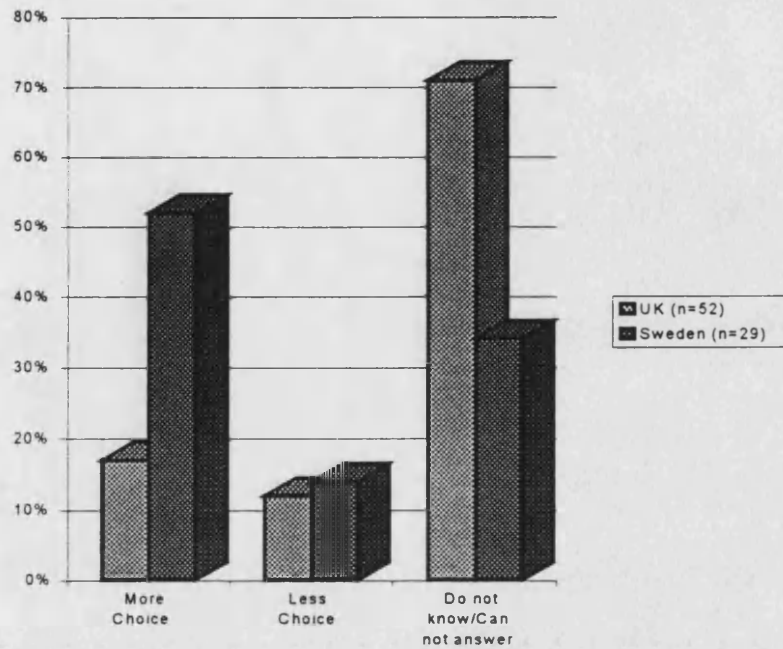
"I feel definitely more in a position to exercise my choice, nowadays. I myself used the "Charter" to complain about an impossible nurse. The correspondence was very slow, and I had to go back to the same ward many times, which horrified me, but the nurse apologised, for she had received a letter."

SWEDEN

A slight majority of patients (seventeen out of 29) felt that they were definitively more in a position to exercise choice (see Table 6.3). In addition, a few others felt that, while no major change had taken place, there was a positive difference (three). Almost all of them (with the exception of one who, while admitting significant changes in his/her empowerment level, did not relate it to the reforms) ascribed them to the introduction of the Stockholm Model, of which many of them were aware.

Figure 6. 3. The impact of the reforms on the choice of hospital or primary care provider

in the UK and Sweden (patients' views)



The single factor mentioned by most of the respondents in this group (twelve) was the ability to choose a family doctor - or 'house doctor' as s/he is called in Sweden. This was a new scheme for a generalist primary care provider, introduced concurrently with the provider-purchaser split in Sweden.

A few patients reported changing from a private doctor to a house doctor as soon as the choice of doctor became available through this scheme. Almost all of them experienced a higher level of satisfaction with the new situation, mainly because they had formerly had no other option of having a personal relationship with a doctor of their choice, except by going private. Changing to a house doctor was not necessarily related to dissatisfaction with the previous scheme or to satisfaction with the present. In some cases, patients plainly made use of increased opportunities, which was generally acknowledged. For example, one reported that, although s/he had had difficulties getting the doctor she wanted:

"I was given an option to change the doctor I did not really like and I feel a bit more in a position to exercise choice now."

In short, patients in this group were happy because, in their view, their ability to exercise choice served as a guarantee of a high quality of care, which enhanced their confidence in the primary care provider.

A second group of patients (seven out of 29) held an opposite view, as they could not see how changes in health care organisation could have influenced their ability to choose a provider or any other aspect of their care. Most respondents in this group thought their level of choice in the pre-existing system had already been high, so there was really no change needed. One patient mentioned that the availability of choice depended, in his case, on the district of Stockholm and, more generally, on the part of the country a patient lived in, as the level of choice was not the same everywhere. Of all the respondents in the sample, two patients found the present arrangements more complicated than the previous ones. Another patient found the present system *"more difficult for the elderly"*, without elaborating any further on this matter.

6.1.5 Is your choice over hospital influenced by the fact that your GP is a fundholder/non fundholder (in the UK) or by the fact that you are registered with a house doctor (in Sweden)?

ENGLAND

In P, two patients out of seven did not know whether their GP was a fund-holder or not. The other five patients gave various answers. Three of them did not think that the reforms and/or, in particular, the GPFH scheme had had any impact on their increased ability to choose a preferred hospital site for referral. Only two of them said that the changes, and/or their GP fund-holders, had made a difference and increased their degree of choice.

Virtually no patient in S knew anything about the status of their GPs and most of them had never heard about the fund-holding scheme (the term itself, when explained, did not sound any more familiar, although afterwards a few assumed that their doctor was not a fund-holder). The majority could not answer whether the introduction of the reforms and, in particular, the GPFH scheme had given

patients more ability to choose the preferred hospital site for their operation. This ignorance probably reflected the number of GP fund-holding practices in the area, which is relatively small and constituted only 16% of the total number of General Practitioners (in the second half of 1995) and was different from P, where quite a number of GP fund-holders was represented.

Only one patient in S said that it would not matter for him whether his/her GP was a fund-holder, as even without the scheme s/he was in a position to speak up for her/his rights. However, s/he was also one of the very few patients who chose to be registered with a fund-holder. Of the few patients in unit S who knew about the reforms, fewer thought the introduction of the reforms and/or the GP fund holding scheme could have enhanced their ability to choose preferred hospital sites.

Of those two patients, only one was positive about the relation that the increased availability of choice bore to the NHS reforms and the introduction of the GPFH scheme. The other patient, who had come from outside the hospital's catchment area, did not think that s/he had more choice available to him/her. S/he admitted that it was her/his GP fund-holder who had convinced her/him to have the operation in this particular unit, because the quality of care provided was known to be very high and the waiting time low.

Also in unit U, more than one third of patients (six out of fifteen) were not in a position to comment on the issue of increased choice in relation to their GP status as they could not see any difference at all for them as a result of reforms. Another group were patients who did think they currently had more options regarding which hospital to have their operation in. Three patients expressed the hope, in a very hesitant manner that the reforms would result in more choice for them. One gave the example of being offered two alternative hospital sites and another referred to her/his expressed preference of hospital being met.

To sum up, of all the patients interviewed in unit U, one-third had never heard about the fund-holding scheme and the remaining two thirds either were not sure about their GP's status or could not link it to an increased availability of choice.

The percentage of GPFHs in this sample was the highest of all. This is probably due to the fact that *"the GPs were very busy, anyway"*, as one patient put it. One person thought that it was a patient's right to choose a hospital, regardless of the GP's status (fund-holders or non fund-holders). Another two said that the status of their GPs (who probably were fund-holders) would not make any difference to their availability of choice with regard to the preferred hospital.

The majority of patients in unit T (eight) were convinced that GP status did not matter at all. Seven of them replied that they could not see any difference. The remaining one-third of patients, who knew that they were registered with a fund-holder, were still not at all sure whether this could give them any distinct advantage in the choice of hospital. One patient, for example, felt:

"The GPs would be too hesitant to refer me, as they are trying to save money and do not fully investigate. They could deal with me by prescribing a medicine instead."

SWEDEN

Almost half the number of patients (fourteen out of 29) felt that, since the introduction of reforms, they had been given increased choice over which hospital site to have their operation performed in (See Figure 6.3). The reasons cited were diverse. A few patients referred to their increased ability to ask for this from their house doctors. One patient stressed the importance of the combination of choice and continuous support and advice coming from the house doctor. Other patients also stressed the importance of availability of choice across catchment areas:

"There are alternatives and the patient has the full possibility to choose for the first time."

Other respondents regarded the possibility of self-referral, through walking into the Accident and Emergency department, as a manifestation of choice of hospital. Walk-ins to the A&E for planning an elective operation, although not very common, were not unusual.

In two other groups, which consisted of six patients each, the responses given were either negative or could not be answered. Three patients did not answer the question and yet another three felt that there had been no major change. The arguments indicating less choice dealt mainly with the issue of the merging of three eye departments and the closure of other hospitals and the resulting decrease of options available. Also, a few patients indicated over and over again that choice was not a matter within their own competence and should be dealt with by referring it to doctors (private eye and house doctors or, sometimes, opticians).

6.1.6 Which are the main factors that influence/would influence your choice of hospital?

ENGLAND

The majority of patients in sample S opted for travelling distance (ten out of eighteen). Four of them thought that waiting time was the most important factor in deciding where to have an operation. An equal number of two respondents referred to the doctor's opinion and the quality of care as the most important factors. It is likely that they may, in some cases, have interchangeable use and the doctor's opinion may serve as a proxy for quality. However, after the interviewer had asked for further explanations concerning quality, the answers given pointed towards the direction of professional expertise (which seemed to be gained through the fame of the hospital as *"being the best in its speciality"*).

Three out of seven patients who opted for travelling distance also referred also to the quality of care. Only one person named waiting time as the most important factor. Patients who favoured travelling gave more specific comments on this issue, such as:

"It is especially important when outpatient visits are taken into account."

"I still have difficulties to see the number of buses (to get to the clinic)."

In T half, the number of patients (six) also opted for travelling distance. The reasons given were convenience and, as one patient explained, *"most of the*

London hospitals are the same anyway and it is easier for people to visit". Second came quality of care and quality of surgeon. Two patients expressed their views more explicitly, stating:

"The quality of the doctors matters, travelling doesn't matter and waiting time is not important."

For two patients only, waiting time was the most important.

In U, travelling distance was again referred to as the most important factor by an overwhelming majority of patients (eleven out of fifteen) while waiting time and the GP's opinion was each mentioned by two people respectively. One of the patients, who pointed out waiting time as the most important factor, added that it was also a combination of travelling distance and the GP's advice.

Responses at P were more heterogeneous with waiting time and quality of care (without providing any further explanation as to what was meant by this) in addition to traveling, which was seen as being more important. Although more patients were registered with the fund-holders in this area, it seemed that the majority of patients did not realise that they could ask to be referred to a preferred provider unit.

SWEDEN

For the overwhelming majority of patients (22 out of 29) the most important factor for "*choosing*" the hospital was the view of the referring doctor. In eleven cases, it was the view of the private eye specialist (usually an ophthalmologist of a non-surgical grade). In yet another six cases, the recommendation where to have surgery came from hospital eye doctors (usually a surgeon), who, in half of the cases, saw their patients in their private practices. Two patients referred to their house doctor's opinion, another two to their referring doctor's opinion, and only one patient said that the view of the optician had played the most important role.

Three patients said that this was the only option available and yet another three self-referred themselves to the hospital by phoning or walking in. There was only

one patient who spoke about travelling distance as the single most important factor for choosing the hospital.

PRIMARY CARE PROVIDERS' VIEWS

6.2.1 Choice over the modalities of treatment given to patients which could be attributed to the reforms

ENGLAND

On the whole, there were only a few answers from the primary care doctors that suggested a positive attitude toward the effect of the reforms on the amount of choice available to patients or themselves. Several of them felt that the level of choice had indeed improved, but not all were satisfied that the reforms were at the root of this change. Views expressed by quite a few GPs indicated that the level of choice was already in place before the introduction of the reforms. The largest number of GPs, however, found it difficult to judge or said simply that there had been no appreciable change.

There were a variety of answers across the samples, most of which were fairly vague. Of those GPs who felt that choices available to patients had decreased, they suggested that this had happened because patients were having day care surgery, when this might not be what they really wanted. UN, in sample T, went as far as say that patients were *"forced to be treated as day care patients"*, and CA, although less extreme, also thought that patients were *"pushed into having more day care"*.

The comparison of responses between the three samples of respondents showed that sample T seemed least knowledgeable about whether the reforms had affected any aspects of choice at all. More specifically, General Practitioners in this sample (except for one who was openly negative about the reforms' results) were not very much in a position to comment on the changes in the choice of forms of treatment available to their patients.

The practitioners from sample S referred to the aspects of high quality they believed their patients received at the provider's site, but at the same, they paid little attention to choice over the modalities of treatment given to patients. The belief in - and impression of - a high quality of care was the strongest in this sample. The only fund-holder in the area vigorously opposed the notion of the reforms' positive influence on patient choice, saying, *"they had already choice of day care as more people could be treated this way"*.

In sample U, the responses were no different despite the fact that fund-holders constituted half the number of respondents. Again, surprising as it may seem, fund-holders were no more aware of the choices given to patients with respect to different treatment options than GPs from other samples. In U, the views were divided and most GPs again either demonstrated limited knowledge of this aspect of patient care or pleaded ignorance altogether.

For example, HW, a non fund-holder, was unsure and thought *"these things are more discussed with patients now"*. One of the fund-holders, GG, voiced some criticism:

"There has not been more choice; it hasn't changed, and there is no feedback on this." Again, GPs felt that patients were being influenced in the direction of having day care under local anaesthesia but *"the push towards day care"* was not necessarily seen as a bad outcome by most GPs, despite it being achieved at the expense of choice.

SWEDEN

Respondents in Sweden were on the whole more positive about the impact that reforms had on the choice for patients. Three out of five primary care providers interviewed in Sweden (including one non-surgeon private ophthalmologist and a specialist nurse) thought that choice had been low before and was not too high under the new arrangements either. This view was expressed by JS (an ophthalmologist), who thought that:

"Choice did not matter at all as patients went where they were directed, which has always been the case."

The ophthalmic nurse thought: *"there was not much choice as the patients came to K for highly specialised treatment."* The other two doctors reckoned that choice or at least patients' attitude, to it had changed because there *"was more freedom of choice given to patients, as they could now choose the doctor with whom they wanted to register"*. PG reiterated this message, explaining:

"Before, patients would be happy to see the doctors at all; now they want more choice".

MK stressed the increases in aspects of information provided and the change of attitude towards patients:

"They are listened to more; also, doctors and nurses respond more to their questions."

6.2.2 The impact of the reforms on empowering patients to exercise choices (including "The Patient's Charter")

ENGLAND

Nearly all GPs had noticed a change in the level of empowerment of their patients. Only AR and GR in sample T (inner city), and CA from sample U (North London) said that there had been no change. CA was of the belief that patients had always been *"able to speak for themselves"*. OL, in sample S (South London), said that s/he was not sure about developments in this area but was actively opposed to the philosophy of "The Patient's Charter", arguing that *"doctors' intentions to do the best for their patients should be taken for granted, and not seen as the part of the bureaucratic procedure"*.

The changes that had been noticed by other doctors were in the amount of questions that patients asked, and in the demands they made. For example KS and PW in sample T commented:

"There is a visible difference in the choice that is exercised by patients as they are more inclined to ask for a second opinion and also to ask for a referral to a particular hospital."

PW agreed that *"patients in general have become more assertive and demanding and they express their need to obtain more information"*. But in contrast to some other doctors s/he felt it was not the reforms but the idea of patients' rights put clearly in "The Patient's Charter" which may have played some role and may also have helped to set a "GP Charter of Practice". Another GP thought that there had been no change because *"choice was difficult to measure"*.

On the whole, GPs from samples S and T (both of mixed population from deprived and middle class areas) did not generally relate the changes that they had seen to the reforms. The one who did from sample T (PW) only went so far as to say that "The Patient's Charter" *"may have played some role"*. Someone else reiterated the view of increased patients' awareness, which according to him/her was mainly due to the *"changes in society and the impact of information provided by the media"* while acknowledging the contribution of the reforms and "The Patient's Charter" in this process.

The GPs from sample T gave the impression that patients were much more interested in making choices nowadays, regardless of the reforms, whereas those from sample U either attributed the change specifically to the reforms or claimed that patients were already demanding quality care before the reforms were introduced. GPs from S were the least convinced that reforms were at the root of changes that had taken place.

In sample U (a relatively affluent suburban area), three of the six GPs, two fund-holders and one non fund-holder, directly linked the reforms to manifest changes in patient empowerment. HW, for example, thought: *"They asked more to be referred to the best hospital and choice has been improved by the implementation of contracts."* PE agreed this was very much the case, but qualified it by saying that cataract surgery was not a good case to demonstrate it, *"as the elderly like doctors to decide for them; but overall, people are more in power now"*.

SWEDEN

Most primary care providers, with the exception of one (a medical ophthalmologist), had seen changes in patients' empowerment and they invariably linked them to the reforms; but they also referred to parallel changes that might have contributed to this outcome. MK, for example, agreed that there had been a visible difference in choice exercised by patients, which in her view, *"was due to the reforms but also to the new health laws of 1982/3, compelling doctors to inform patients more"*.

NB commented that patients had become more demanding and asked more questions, which was *"due to the new system of freedom of choice of doctors"*. It had also had some side effects; for example, doctors were now called on to resolve all problems at any time *"in order to fulfil expectations which were unrealistically high and which had been created for purely political reasons"*. PG and CH both thought that choice and empowerment had increased, but while the latter felt that this had resulted from the reforms, the former ascribed it to changes going on in society outside the health sector.

6.2.3 Patients' choices of hospital site, the factors influencing their choice, and the factors influencing GPs' choice of hospital for referral

ENGLAND

When asked whether patients' choice of preferred hospital site for surgery had increased, the overall opinion was that this was very much less than before. Eight of the doctors said that there was less choice, in one way or another. Only AU in sample S thought that there was more choice, although s/he made it clear that this choice was only for fund-holders and that patients' choice was no greater, because, *"they will, anyway, go where they are told to go"*.

It turned out that all General Practitioners were convinced that contracts had had a limiting effect on freedom of choice for referrals. It also was clear that any

increase in choice accrued only for GP fund-holders and not necessarily for their patients. Overall, the fund-holding GPs were in agreement with the non fund-holders on this point.

NO, in sample T, implied that less choice was linked to the fact that Health Authorities had a list of preferred providers, whereas before they could refer wherever they liked, agreeing, though that *"not too many patients were involved in that"*. GR, in the same sample, also saw a divide between fund-holders and non-fund-holders in this respect: *"There is definitely less choice for non-fund-holders nowadays, because of the contracts."*

This was echoed by another doctor in sample S who also thought that for a non fund-holder it had got worse; before, s/he could refer patients anywhere, *"but now that was gone, because referrals are bound by Health Authority contracts and a giant bureaucratic system"*. Surprisingly, the only fund-holder in sample S reiterated this point by saying *"I could refer patients more freely before, if they wanted"*.

In U, fundholders and non fundholders alike acknowledged the limiting nature of contracts and elaborated on how they always tried to refer patients according to their preferences. CA said, for example, *"when clinics in hospital U were in upheaval, I did not refer patients there but to unit T, although the waiting time there was longer"*. HW also encouraged patients to go to places they knew, *"so it would make things easier for them"*.

The exceptions were two respondents in this group whose views were discordant with the majority. One thought that it did not matter too much that contracts limited freedom of choice because, *"more than anything, patients do not want to have many choices"*; another, who was generally frustrated with patients' expectations from the new scheme, said:

"Middle-class patients misinterpret fund-holding and ask for more things nowadays because of the reforms."

A broad spectrum of replies was received when doctors were quizzed as to what they felt most influenced patients' choices in terms of the hospital to which they

were to be referred. Topping the list were length of waiting times and distance from the hospital, closely followed by the opinion of the referring doctor. Strangely, if the GPs are to be believed, the quality of care available at the different sites plays a smaller part in patients' choices than convenience. The replies have also provided some insight into General Practitioners' understanding of patients' priorities, which were analysed concurrently and compared with the GPs' responses (See Figure 6.4).

This diversity of responses reported by the General Practitioners contrasted with the almost unanimous message coming from patients, where the majority referred to travelling distance as the single most important factor. Waiting times were ranked first by the GPs but came only third in the patients' valuation. Convenience and habit or attachment to the local hospital, were the determining factors expressed in patients' preferences. Close behind came quality of care, a definition influenced by opinions of the immediate environment and by the view of the primary care doctors.

The only difference in perception was observed in sample U, where General Practitioners' views came closer to what the patients thought important for them in choosing a hospital. This convergence in responses could be linked to the characteristics of the population living in the area of sample U - homogenous and predominantly middle class patients, who could possibly communicate their needs better - or it could be because the GPs were more in touch with their patients' needs and perceptions.

When in turn doctors were asked which factors influenced their own decision on where to refer patients, the leading factor was the quality of service and their previous experiences with each hospital. In sample T (consisting of non-fund-holders only), it was clear, that they were still interested in cultivating personal relationships with providers as, in their experience, it was a proven method for obtaining results. For two other GPs from sample T, waiting time was also of importance because, as expressed in the words of the latter: *"The reforms have fuelled the drive to provide the service quicker."*

In sample S, quite a few GPs referred to aspects such as waiting time and the quality of care and they seemed to be satisfied with what the local hospital offered in this respect. There was an element of loyalty in an attempt to support the local hospital, as referred to by one GP who pointed towards previous patterns of co-operation:

"There is only one hospital, close to my practice and the travelling distance is normally most important unless the service is very bad or patient prefers it otherwise."

Except for the sole fund-holder in sample S, all other fund-holders (from the sample U) made surprisingly little reference to the variance in cost between the different hospitals although, interestingly enough, non-fund-holders felt that this would be the primary factor, were they to become fund-holders themselves. Cost implications were referred to in a general manner and the price of service was not mentioned explicitly. This glossing over of the cost aspects of service could be linked to the so called "halo effect", where the respondent presents an idealised vision of his/her behaviour with the aim of preserving a good self-image.

One fund-holder in sample U admitted that patients were solely referred to the hospital of the consultant who did the out-reach clinic regardless of the travelling time involved. The justification provided turned out to be a combination of factors with quality being the most important. Only one General Practitioner mentioned the distance as his/her main consideration but even for her/him the patient's wish was supreme. Patient preference was often quoted as a deciding factor, and was of overriding importance to two of the GPs in the sample U.

SWEDEN

While patient choice was a new feature promoted by the reforms in the Stockholm Model, there was uncertainty expressed as to whether patients had increased choice in reality, mainly because the County Councils had tried to influence them to use their own hospitals. At least, this was the view of the majority of respondents, whose views pointed out the change in policy over time regarding choice of hospital given to patients. BN and MK commented respectively:

"Patients are still free to express their preferences, but the County Council tends to influence GPs to send patients to their own establishments."

"One or two years ago, a house doctor had to offer choices to patients and even had to tell the patient that s/he needed choice. Now we have to sell by recommending a particular hospital within the County Council boundaries."

Two other two primary care providers saw the choice of hospitals decreasing as a result of the reforms, either because of mergers or because of new payment methods. PG did not necessarily see this as a negative effect - *"it is convenient to have all the services in one site"* - but JS thought this was achieved at the expense of the choice of hospital:

"After the prices between private and public hospitals were equalised, the waiting lists disappeared, but only two hospitals have survived. Now the County Council has a monopoly on service provision and consequently there is less choice for patients."

Only one respondent thought that choice had increased without, however, qualifying it.

When asked which were the factors that mostly influenced patients in their choice of hospital, most of them thought that it was their opinion or the opinion of relatives and also, as MK put, it *"the lack of bad publicity about the hospital"*. In quoting the factors they primarily took into account, previous patterns of co-operation came out as the most important factor, along with waiting time. One doctor mentioned waiting time to be the most important factor and another explained how *"a private clinic which is very good does the cataract operation within one week"*.

CONSULTANT EYE SURGEONS' VIEWS

6.3.1 Choices over the modalities of treatment resulting from the reforms

ENGLAND

There was general agreement among the consultants in sample S that there had been a certain degree of change in the levels of choice available to patients and their GPs. But it seemed that the shift towards day care surgery and local anaesthesia had reduced the amount of choice available in this area. DA said, *"patients were 'guided' by the medical staff rather than given complete freedom"*, and AL elaborated:

"There was very little choice at all, unless there were strong contra-indications for using day care, but most patients were happy with the suggested arrangements, once the implications had been explained to them."

There was some doubt expressed as to whether this reduction in the level of choice could be directly attributed to the reforms. AL linked choice and the introduction of technology in the following way and expressed his/her conviction in lack of interest that patients had about choice:

"There was no day care ten years ago and when it started to come in, patients had choice; but now they all have local anaesthesia and day care. It's not an issue, as patients don't want to have choices anyway."

The clinical director, a strong supporter of the reforms, put it even more strongly:

"There is less choice now. I firmly believe in not giving any choice."

The pressure from management to use certain methods (day care, local anaesthesia) was also ascertained, and so, even when patients expressed a preference, they were pushed towards making a decision that was suitable to the hospital, which was called by one consultant a *"guided choice"*. JO elaborated: *"Patients do as they are told, because it is how we see the service developing."*

All four consultants felt that the choice available to patients was very limited. None of those questioned saw this as a direct consequence of the reforms, and none of them mentioned that they thought this lack of choice was in any way detrimental to the quality of treatment received by the patients.

In sample T, there was a mixed response to this question. All the consultants, except BL, felt that there had been changes in the amount of choice over procedures. There was a general feeling that the greatest change was in the form of anaesthesia, although the clinical director expressed some doubt as to whether this change was directly accountable to the reforms, believing this

development had been well under way before 1991. MH, of unit U, who was also doubtful about the reforms' impact in this respect, explained that in terms of modalities of treatment:

"Patients still have the same amount of choice; there has always been a choice between local and general anaesthesia, but the choice over day care has changed."

Most consultants in P also agreed that there had been no significant change in the choice available to patients that could be related to the reforms. One of them explained:

"Patients' choice has been always a priority for me, and I have maintained it even in today's environment where there is pressure from management to promote day case surgery."

TF pointed out that: *"Choice for some patients (those registered with GP fund-holders) may have increased, while for others (those who are not) choice has got worse"*.

However s/he did not think that there was any difference among patients as to what was offered in terms of procedure; it was rather the possibility of having the operation sooner.

SWEDEN

Swedish surgeons did not think that any changes in the choice of treatment for patients could have resulted from the reforms, although each of them proposed a slightly different explanation for this. MH thought that some impetus for choice had been provided by the reforms introduced through the Stockholm Model:

"It created some incentives in this direction, but I think that we would have had it in any case."

But, like everyone else, s/he admitted that patients had very little choice because for the past 10-12 years all patients had been treated using local anaesthesia and day care, adding that:

"If they wanted to have another form of anaesthesia, they would be sent to a regular hostel or home".

"If the patient insisted on having a particular doctor, s/he would be referred to a private establishment."

Another surgeon thought that, in the latter case, a patient had simply to face a longer waiting time. Two other surgeons, SW and BC, elaborated that:

"The question of choice is only put to some patients, to whom it may be of importance (e.g. for psycho-social reasons) but this is a small fraction of the patients. It has not changed, no options are given and we try to convince them that whatever is to be done is due to medical reasons."

BP provided an explanation for this situation by stating that the general public was not very well informed about what medical care could offer and there were fewer eye units in the hospitals nowadays (in Stockholm County Council).

On the other hand hospital eye doctors felt strong about this aspect of care possibly because they perceived it as an area they had some leverage in influencing their choices. MH had a view that patients were not that much interested in choice but, instead, followed the advice of the doctor who was operating.

6.3.2 The impact of the reforms on empowering patients to exercise choices (including "The Patient's Charter")

ENGLAND

With respect to the empowerment of patients since the reforms, there is a certain level of contradiction. From the answers that the consultants gave, there is an opinion that patients are now more aware of their rights and better informed about medical conditions and procedures. In the same time, doctors agreed that it was them or purchasers who maintained control, one of them commenting:

"The patients haven't had more choice; they are sent to the same hospital, or to the hospital where the GPs get cheaper deals. Only the purchasers' choice has increased."

However, there was a wide difference of opinion between consultants, even from the same units, over the nature of the changes, when they had occurred, or whether the changes were necessarily due to the reforms. For example, in S neither AL nor DA had seen a change. The clinical director thought there had been a slight change in "middle class people knowing more about their rights", which in her/his view was related to "The Patient's Charter' creating higher

expectations". JO thought there had definitely been a change, but did not state whether s/he thought it was directly attributable to the reforms.

In unit T, consultants could identify some impact on patients' empowerment resulting from the reforms and "The Patient's Charter". As the clinical director of the unit put it:

"Doctors are encouraged to think more about "The Patient's Charter" and things in writing that should always be adhered to."

In U, one consultant thought similarly that contracts empowered the purchasers but not the users:

"When the Secretary of State said how marvellously patients' choice would increase, knowing it couldn't be true, but the government now argues that patients are not aware of their rights, and that is why they do not make the decisions."

At the same time, s/he admitted, though, that there was a general trend towards patients' empowerment as they became more knowledgeable about what the surgery involved:

"Ten years ago, patients were more ignorant. But there is still a long way to go in the field of patient education".

In P, one consultant (JJ) thought that patients now had more options in the way that the cataract operation was performed; referring to small incision surgery (phacoemulsification), s/he said it had resulted in less follow up and better quality of sutures, but this *"was due to the developments in surgery itself and not related to the reforms"*. S/he acknowledged, though, that day case surgery and its wider use had resulted from the reforms and made available more forms of treatment. TF while supporting the view of the increase in day case surgery was partly as a result of the reforms, claimed that this was not in the same reflected in patients' choice over the procedure.

As for the factors influencing choice of the hospital, this was a question intended for those who were responsible for referrals (general practitioners/family doctors) and those who were referred by them and was therefore not asked of hospital doctors. However, some of the consultants referred to this issue while answering earlier questions but only AL in sample S made an explicit comment. S/he

thought that the choice of hospital was not available to patients as this choice was made by the GPs - as were the choices regarding day surgery or overnight stays, which were very much guided by the supervising medical staff. This view seemed to be confirmed by BL in unit T who also thought that patients never showed a preference.

SWEDEN

Surgeons almost unanimously thought that choice for cataract surgery had not increased, either because patients were not used to asking for choices or because it was not very suitable for this procedure. MH summed it up by saying: *"It will take time before they get interested in choice, and in ophthalmology there is not too much to choose from anyway."*

BC was uncertain as to whether patients exercised choice or not, as only very few moved from their own area even though they could, concluding, *"it was important for politicians but turned out not to be very important for patients"*. Only one surgeon thought there was a visible difference in choice exercised by patients but, again, it was *"rather a slower, continuous change in society and not due to the market"*.

WS thought it was primarily the fame of the hospital, the hospital's resources and equipment, general information about the quality of care in the hospital, and the opinion of relatives; s/he also believed that referring doctors might direct patients to private clinics because they knew the doctors performing there, which was simpler with small private clinics.

Surprisingly, surgeons did not particularly comment upon merging of the eye units into one specialist eye hospital in the County Council of Stockholm and its impact on choice.

MANAGERS' AND PURCHASERS' VIEWS

Managers and purchasers from each hospital and/or catchment area were interviewed in both countries. However, in some units the clinical director had assumed the management duties (S in the UK and K in Sweden) and the management of the hospital usually had broader responsibilities of the surgical sector and often could not reply to specific questions asked with regard to the eye services. Similarly, issues such as for example choice or peculiarities of cataract surgery were either too detailed or outside the interest of the purchasers and they could not provide relevant answers. For these reasons, they were not treated as core respondent groups and their replies are reported only when they contribute significantly to the understanding of the specific issues.

ENGLAND

The deputy director of the acute service from unit S acknowledged that at the end patients were given choice if they insisted on staying in hospital for treatment but that a lot of emphasis was placed on the positive aspects and benefits of day care surgery. Despite the many changes which had occurred as a result of the reforms with regard to patients' choice:

"There was no choice as to the change of consultant, nor could the patient ask for a second opinion."

By contrast, the director of the acute services in unit U thought that the opposite was true:

"The reforms have brought a positive pressure for change and there is a visible difference in choice exercised by patients, which is better seen in some services such as maternity care. I am not sure that this always coincides with the interest of clinicians and the management."

S/he also thought that patients' attitude had changed as they had become less tolerant of the status of public service and attitudes such as, "we don't have much money". While the public's trust had been eroded by the higher expectations created by "The Patient's Charter" the elderly, though, were still "over-tolerant" according to him/her.

The public health doctor from T, who was involved in providing input to the top management of the hospital, elaborated that because of the fact that all negotiations were made between purchasers and providers, the choice issue really depended on the purchasers. S/he reflected:

"A lot of people complain that choice has been reduced because of the contracts and the providers trying to become a monopoly. The money, however, is still not following the patient, largely due to the surplus of providers within the Health Authorities."

The responses coming from purchasers were diverse and reflected the peculiarities of each situation. The purchasers from T for example felt that they were in a very special position as a Health Authority, having the choice of three hospitals and one tertiary specialist eye hospital, because of which they have always enjoyed good service and choice. There was the possibility of buying cataract services from all these provider units, and this they did. The director of acute commissioning admitted, nevertheless, that the reforms had made providers think about how to deliver a better service. S/he thought that they had realised that they could not compete in such a small market and were obliged to co-operate:

"For example, in shifting day care services to one site and in-patient care to another, both situated close to each other. The reforms made these types of decision much more visible and transparent, because they had to be taken publicly."

By contrast, the commissioning director in sample S, who was also responsible for quality issues, thought that the reforms relating to Extra-Contractual Referrals had been restrictive as they diminished choice. S/he elaborated further:

"We try to get the best deals for the population as a whole within the given budget but ECRs do not contribute to that."

The Public Health director in S and the chief of the research department in U did not comment on this issue, as they both felt that their responsibility was concerned with issues of needs assessment and the appropriateness of services provided, and less with choice. The impression was that they did not consider it important, in comparison with the former aspects of care.

SWEDEN

Four purchasers were interviewed in Sweden, consisting of the director of commissioning department from one of the nine district areas of the County Council of Stockholm, and two executives and the quality director of Stockholm County Council. Here again, their replies dealt more with concepts of choice and information, among other things, rather than with specific questions, as was the case with other respondents.

There was unanimous agreement that the reforms had improved choice, which was in accordance with what had been proclaimed to be one of the main priorities of the reforms and reasons for their introduction. However, they also acknowledged that this might not have been so much the case for eye services in the Stockholm County Council.

Other respondents also acknowledged that hospitals had become public firms under the reforms (with County Councils owning most of the shares) and the fact that they were also allowed to make a profit had energised their managing boards and led to many positive developments. It gave most of the hospitals the opportunity to meet the same - or even additional - needs of the population, which were previously delivered by larger number of hospitals. This has also resulted in the merging of the functions of the hospitals and in a decrease in the number of beds, which might have impaired the choice of facilities for some specialist treatments, such as eye services.

In the view of executives from Stockholm County Council, there were shifts in the pattern of service provision which were labelled as choices, but which could hardly be considered as such. Thus, for example patients were more often referred to local hospitals rather than tertiary teaching hospitals, which used to be favoured before the reforms. The purchaser from Z district in Stockholm added that:

"The local hospital is supported so that it can achieve better results in co-operation with primary health care and secondary care centres (health centres) in the area."

One of the executives from the County Council agreed that the empowerment of patients in exercising their choices was an increasing trend. This, in his/her view, was especially manifested in changes of house doctor, although s/he thought that, in choosing the specialist provider, people still asked their family doctors to refer them to the hospitals. S/he thought that choice had been stimulated by:

"The introduction of the concept of the consumer which was a very important development and gave patients the freedom to chose among competing providers".

The purchasers representing a district in western Stockholm referred to this shift in culture in following words:

"Until then, the idea of choice for the County Council administration was a bureaucratic concept, based on people's place of residence; the notion of patients being treated more like customers was not a priority."

KEY FINDINGS

- The majority of patients in the UK felt their choice had not increased while in contrast in Stockholm patients acknowledged this development and approved of it (See Figure 6.4). However, in both countries there seemed to be a moderate or weak desire for involvement in choices and in decision-making about treatment (See Figure 6.5).

Figure 6. 4. Patients' views on increased choices of forms of treatment after the reforms in London and Stockholm (n=81)

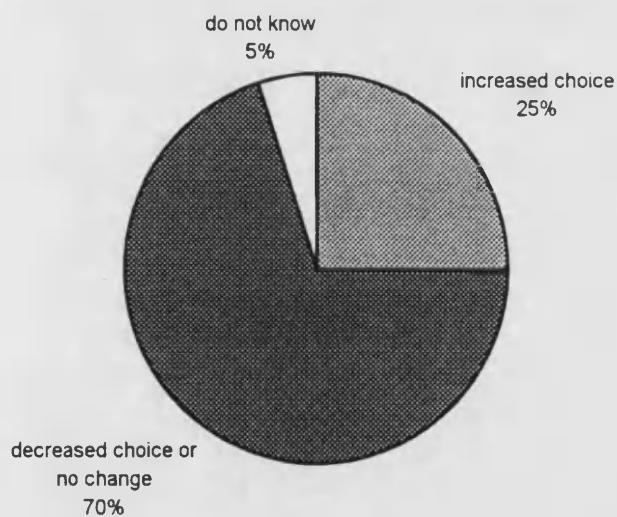
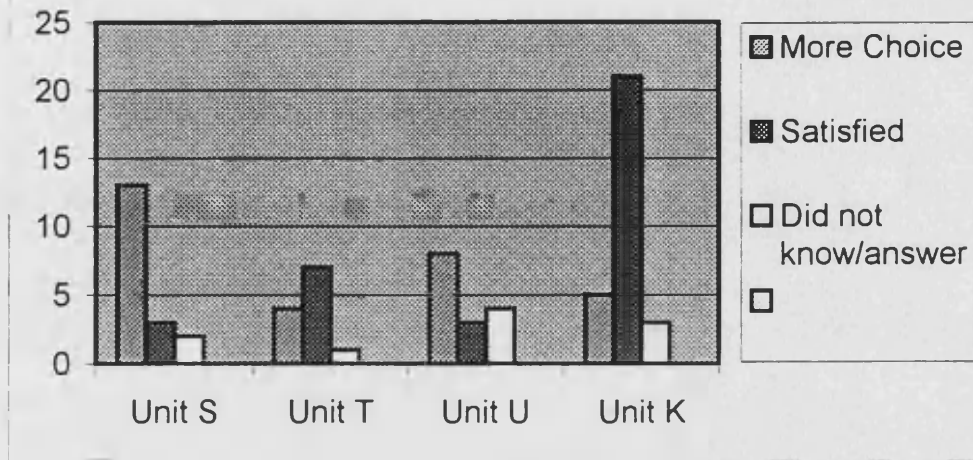
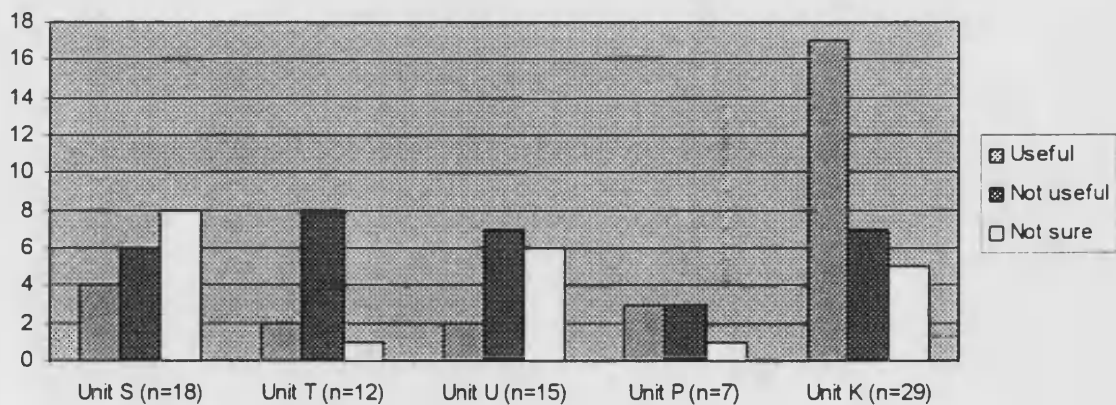


Figure 6.5 Patients' satisfaction and wish for more choice in different eye units in the UK and Sweden

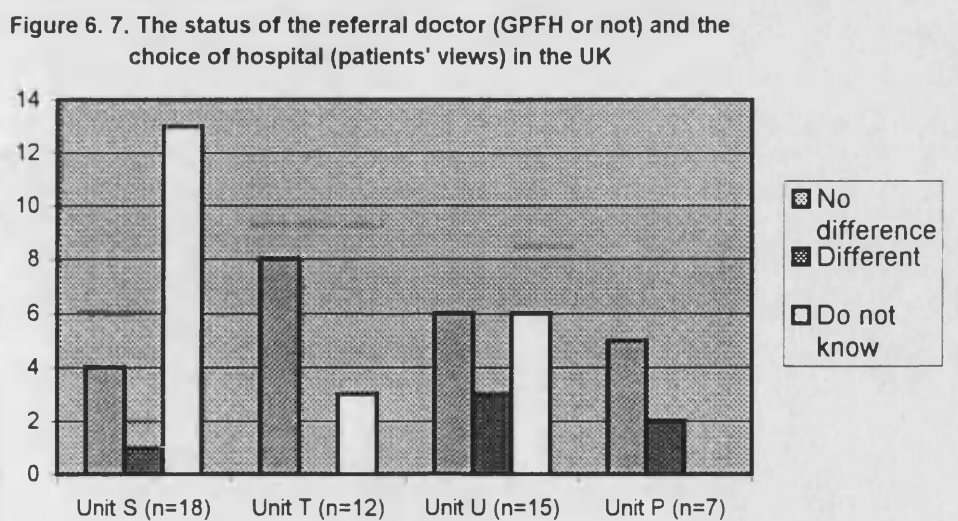


□ The overwhelming majority of patients in the UK were unaware of the reforms and of "The Patient's Charter" in particular. Those who knew of it were uncertain of its usefulness or were downright negative about it. By comparison, patients in Sweden knew more about the reforms and approved of their content (see Figure 6.6).

Figure 6.6 Patients' views on the reforms and on the usefulness of "The Patient's Charter" in promoting choice in London and Stockholm (n=81)



- Not all UK General Practitioners were convinced that the reforms had had any impact on patients' empowerment, with the notable exception of fund-holders. Primary care doctors in Stockholm held exactly the opposite view.
- The most important factors for patients' choice of hospital in the UK was travelling; waiting time comes a distant second, with the doctor's opinion and quality of care coming afterwards. However, GPs thought waiting time was the most important factor for patients and eye surgeons thought patients were not all interested in making choices. In Sweden, patients overwhelmingly opted to follow the doctor's view when choosing a hospital, but primary care providers did not always seem to be aware of this.
- There was unanimity among PHC doctors in both London and Stockholm that the reforms had decreased the choice of hospitals available to patients, mainly because of the limits imposed by contracts and merging several eye units into one specialist eye hospital in Sweden. In the UK, the divide between more choice being available for fund-holders and less choice being available for non fund-holders has been criticised by both fund and non fund-holders alike.
- The status of the referring doctor in the UK (GPFH or not) and its relation to the choice of hospital available to patients seemed not to be unimportant, according to the views of most GPs, but patients were not at all aware of this role or of its influence (see Figure 6.7).



- Consultants in both countries admitted they actively influenced patients' choices over the procedures and reported an overall decrease in choice in this respect, which they ascribed more to the advent of technology and the way services were developing and less to the reforms.

- Consultants in the UK and Sweden felt patients were now more aware of their rights, and were better informed about medical conditions and procedures. But there was a wide difference in opinion between consultants, even from the same units, over the nature of the changes that had occurred, and whether the changes were necessarily due to the reforms.

- Purchasers in Sweden unanimously agreed that the reforms had improved choice, which was in accordance with the proclaimed priorities, and that empowerment of patients was an increasing trend, although changes in the society contributed to the outcome, which according to them primarily resulted from the reforms. Purchasers in the UK provided more mixed reviews and were both less certain about the reforms influence on choice and less preoccupied with this aspect of care.

CHAPTER 7

INFORMATION

This chapter looks into the changes in the type and amount of information given to patients at the specialist providers' units. It looks at the aspects of clarity and accessibility of the information provided, whether the presentation of different options and modes of treatment existed and also whether patients could understand and anticipate the likelihood of the post-operative complications. The first section examines the provision of verbal information from the perspective of all the actors involved; in the second part, the content and quality of the written information is considered.

7.1. Interviews with all groups of respondents

PATIENTS' VIEWS

The introduction of market elements into the system of health care delivery was expected to bring about some aspects of patient empowerment, either because it was seen as one of the explicit aims of the reforms - as in Sweden - or because it would be its inevitable concomitant, as it was argued in the case of Britain. Relevant and usable information is an important precondition for this process to occur because only informed users can make rational choices and participate in the shaping of the provision of their health care systems.

7.1.1 Verbal information regarding health problems and the way of dealing with it (cataract operation)

ENGLAND

The responses from the hospitals varied diametrically, which should probably be interpreted as reflecting the policy differences of each department.

In S, every patient said they had received very satisfactory and useful explanations regarding their health problems. This referred mainly to the mode of treatment in detailed and simple form and was both given orally and was often demonstrated on a special maquette (three out of eighteen patients mentioned the latter). It seemed that every single patient treated at hospital S was left with an impression of being in some way informed about the treatment procedure.

The overwhelming majority of respondents (twelve out of eighteen) evaluated the quality of information received as very good and sufficient. The attitude of the group of respondents who were very satisfied was summarised in the words of one them:

"Details of how the operation was to be carried out were given at length and the inclusion of technical aspects made me feel amazed at the efforts put in the preoperative information session, which lasted about one hour. I could ask all my questions there."

Another group of patients, representing a third of all respondents, expressed more moderate comments about the quality of information received. Thus, one patient characteristically said that the information provided was *"more or less on how the operation would be done"*. Another had the impression that *"the information on the condition and the procedure of treatment was vague"* and someone else stated that s/he was not sure what the operation was to be about, especially since in his/her case co-pathology (glaucoma) was involved. Another patient noted that it was given to him/her on the way to the operating theatre and clearly stated that relevant written information given beforehand would have been the optimal solution.

There were patients who complained that the most common and prevailing attitude was still of the kind *"we will let you know when the time comes, which does not meet the patient's need for knowing what is going to happen"*. However, the same person also admitted that doctors were reassuring when providing information and giving out details about the application of the local anaesthesia.

In P, by contrast, three patients stated that they had received no information prior to the operation. Another four respondents affirmed that they had received some information in form of a printed leaflet without providing any further elaborations.

In sample T, the overall satisfaction with the information given ranged from good to moderate, which was expressed by approximately 80% of respondents. Only 20% of patients in this sample said they did not receive any information at all. Most patients thought that the information provided was good or satisfactory and that *"much more information was given, compared to what they did before"*.

Another patient commented:

"All my questions were answered, the staff was very helpful and I felt optimistic afterwards."

There were other patients who acknowledged that information had been given to them although there was a feeling of insufficiency that pertained to all their responses: *"I didn't know what would be done and knew even less what was going on when complications after the operation occurred"*, as one patient put it.

Two other comments highlight some of these aspects further:

"Maybe I was told but I still don't know what the problem in my eye was".

"The only thing I was told about the treatment was that an operation had to be done".

Three other patients, who also felt that the information provided was insufficient, considered this an important omission and, more importantly, thought this was a missed aspect of care they were entitled to. *"This is a more general issue of not being in control of what is done to you"* as one patient put it and another one reiterated this message by saying:

"I don't like the idea of being told that this is nothing important, especially when someone is doing things in my eye."

The importance of information in the context of the situation of the elderly was stressed:

"Doctors should consider this aspect of patient care more, in particular in a situation when the patient is living alone".

In U patients were the least satisfied with this aspect of care. Almost half the number of respondent (seven out of fifteen), complained about the amount and quality of information received. Of the remaining half, only a few patients seemed to be moderately satisfied with what was offered to them. Few of them claimed

they did not need it as they had obtained it somewhere else. One person already knew about cataract operation through her/his family, another was informed about it because of her/his profession (staff nurse).

Those who were fairly content with the information received commented generally on this issue. Three patients admitted that the information provided helped them to dispel their fear, expressed by one of them as: *"I was afraid about the operation, but then, after the information was given to me, I became convinced"*. One of patient described his/her positive experience as:

"I had information from the optician but then I received it again in the hospital where I was encouraged to ask any question I wanted."

Respondents representing one third of the total number of patients were the most visibly dissatisfied either with the quality of information (*"only very basic things were given out"*), the timing of its provision (*"at a very late stage on the day of the operation"*) or its amount. In most cases, the complaints were multiple:

"The information given was fragmented, and I needed to know how to put the drops in afterwards".

Some patients were deeply disturbed about the elementary lack of concern they experienced:

"I was not even told that I should not eat before the operation as I was going to have local anaesthesia."

Complaints about the attitude of health professionals were also voiced in this group and one patient characteristically pointed out that the reforms were to blame for their attitude:

"I was feeling that the consultant was interested in me as a number and not as a patient. The reforms are to be blamed for a lot of this, as the emphasis is put on piece-work and on sending the patient home quickly."

Only two patients were not in a position to comment on this subject because they either could not remember or were uncertain about what had happened. Given the age of respondents and the likely deterioration of their memory and/or other mental functions, which are typical concomitants of senility, this was an expected outcome.

SWEDEN

Slightly less than half the number of patients (fourteen out of 29) treated in hospital K in Stockholm expressed their full satisfaction with the quality and amount of information provided, although this did not necessarily imply that it came from the hospital. Four patients named other sources such as the referring doctor, previous experience and friends, which is reflected in the following statements:

"The information was good and I already knew from other patients what would happen."

"I had a cataract operation 15 years ago, so I knew everything about the side-effects and the fact that this was the only treatment."

A quite unexpected source of information was also reported (offering surgery to people who had self-referred themselves or had come in because of another eye problem), which might indicate new marketing strategies adopted by the hospital to attract patients:

"As I was self-referred through the A&E department, I was told everything beforehand and I am very happy about what was explained to me."

Patients who were satisfied with the information provided referred to the aspect of its continuous provision something that was stressed by at least two respondents. The confidence acquired through the process of provision of appropriate information was also referred to. One patient, who compared the quality of information given out by different units, came to the conclusion that the unit included in this study (K) was much better than the previous settings s/he had experience of:

"Where none talked too much and I had to ask a lot of questions. This should be done by the hospital, especially when the patient is stressed."

There were other patients who expressed their ambivalence about the desirability of provision of thorough information, which was expressed by one of them as, *"I don't want to know too much because I'm afraid"*.). The evidence for the latter opinion is provided through statements such as:

"Patients should be informed very carefully and only as much as they understand should be said to them".

Others thought that information on what would happen to them was quite important. Despite rather widespread satisfaction with the information provided, only one patient linked this to the features introduced by the reforms: *"I got everything very clearly explained. I think competition did a lot of good."*

The other quite large group of patients (twelve out of 29) consisted of those who felt that the information received was not sufficient, both in terms of quality and amount. As far as quality was concerned, the prevailing feeling seemed to be that it was either too general or that essential pieces were missed out (i.e. information about after care and about the treatment procedure itself). Other respondents also referred to the gaps in information and the lack of continuity. One of them commented: *"I would appreciate having more continuous information."*

Quite often patients found it confusing and at least two patients stated clearly that the information received was also not sufficient. In at least one case, doctors at the specialist hospital assumed that the specialist who had referred the patient would have already provided it. Also, the importance of informing individual patients about the outcomes that could be expected, was stressed:

"I would like to have been told that I would still not be able to see clearly, due to the co-pathology involved, so I would have had more realistic expectations from the operation."

7.1.2. Provision of printed leaflets with detailed explanations of the health problem, the treatment and the available options, as well as the likely post-operative complications

ENGLAND

In P, only one patient remembered receiving printed information in the form of a leaflet, which included information on cataract and its treatment, aspects of anaesthesia and the options for day care. For three others, it had contained information only on the former and for two others, only on the latter. There was, however, a unanimous agreement about the lack of information concerning post-operative complications. This relative divergence can be explained in two ways.

Either the leaflets distributed were not the same one, which is a rather unlikely option, or the patients paid particular attention to the parts that were of most interest to them.

In sample S, the responses to this question varied. The first group of patients, which represented almost half the number of respondents (eight out of eighteen), agreed that information on the health problem, on the procedure of the treatment and on the likely post-operative complications, had been included in the leaflets. But more detailed comments revealed that the degree of discomfort was understated. As one patient put it:

"The possibility of post-operative discomfort was only mildly put in the leaflet, but a warning was given orally."

Quite a few patients (four) also stressed the lack of information concerning after care and the fact that the verbal explanation of how to use the drops after the operation was not sufficient. Another four patients stated that, in their view, only information on the type of problem and ways of treating it had been included. One of the patients concluded that even this was not specific enough.

There was also another group of patients, comparable in size with the first group (six out of eighteen respondents), who could not remember whether any of these details had been provided. Some patients, who could not remember specific details, would typically use the phrase *"very useful"* when describing the leaflet, and another two indicated clearly that they did not remember the fact of information being given away in printed form. Another stated that s/he was not in a position to read the received leaflet.

Another respondent group referred to the importance of diagrams and the user-friendly layout of the leaflet. In general, this group of patients stressed the overall usefulness of the leaflet because it had enabled them to know *"what to expect from the whole procedure"*, as phrased by one of them; but they could also point at the improvements needed, which were significant. Some respondents commented that what mattered for them in terms of information were rather different issues. For example, two patients mentioned aspects such as clear instructions on the date and place of the operation and two others referred to

details concerning after care. Also, the availability of a contact number for further clarifications was important, and even things such as the size of print, which was expected to be bigger and thus more adequate.

The respondents in T can be divided into two broad groups. In the first group, representing half the number of respondents (six out of twelve), the receipt of booklets and other forms of written information was acknowledged but the level of satisfaction varied. In this sample, as much as in the others, the impression given was that the written information provided was not seen as sufficient or specific or even the way that booklet was given out was not very helpful. For example one of the commentators said:

"I received a general booklet from the hospital without any particular information about the eye problem".

Only one patient asserted that all the information s/he needed had been included. All patients unanimously pointed out that no information was given about the likely complications or the availability of options. Sadly, the second group of patients, representing the other half of respondents, who stated that no written information had been provided at all, voiced their complaints at the quality of the oral information given, which did not differ greatly from the replies given by the former group. For example someone remembered, *"only some rudimentary information was provided afterwards on what should be done and what avoided"*.

The situation did not seem to differ much in sample U, as the replies coming from the largest group of respondents (six out of fifteen) stated that they had not received any printed information. The other group consisted of seven patients who shared the opinion that printed information had been given, but they disagreed as to its type. Only two patients of the whole sample of fifteen respondents could specify what was in the printed material. One of them mentioned the information regarding after care and the other remembered information on what a cataract was and how it could be treated.

Another five people had a very general and vague impression of what was in the leaflet. For example, they commented *"yes, a leaflet with everything in there but I am not sure what it was as it happened on the ward"* or even as general as *"some leaflet"*. Two patients could not remember anything about it, which, as explained by them, was a result of their weak memory, raising the question about the usefulness of such material when it is only distributed and not followed up by oral explanation, as it seemed to be the case in U.

SWEDEN

Slightly less than half the number of patients (fourteen out of 29) confirmed that they had received some sort of printed information. However only two of them suggested that all the above mentioned aspects were included in it. A few patients were quite critical of the quality of information included in the pamphlets. On occasions, they had not found it very helpful either because it did not contain information on the options available or because it gave no guidance on after care. Some patients compared it unfavourably with the quality of information provided by other sources:

"I got the usual information that a patient gets, which was not very helpful. I read books at home and listened to the radio programs instead."

As far as the content of the leaflet was concerned, it seemed that the information on which most patients agreed had been contained in the leaflet, referred to preparation and after care, although even here there was the exception of one patient who thought differently: *"No information on the condition, treatment or its options and after care was contained in the pamphlet."* Others thought that the leaflet contained information on the problem and the procedure of treatment. Finally, two other respondents concluded that the procedure itself was seen as a learning experience, which is reflected in their opinions:

"The information contained in the printed leaflet referred to what to do before the operation and not to the operation itself. I also learned a lot during the operation."
"I have to say though, that I learned more on the operating table".

In the second largest group, where eleven out of 29 patients were represented, the respondents claimed they had not received any printed information. Half of the answers were constrained to a monosyllabic "no". However, there were also

patients who elaborated further, referring, for example, to the unavailability of brochures *"because they were out of stock"*. Also, patients in this group expressed their wish to receive information and stressed its importance:

"I found information in the newspaper which referred in particular to K hospital but I would have liked to receive it from the hospital itself".

"No, which would be quite useful, especially with a reference to the likely complications as it turned out to be relevant in my case".

There was only one patient who thought that the lack of written information did not matter too much, but only again because s/he *"got the information about the condition from other sources"*. There were also a few patients (five) who provided unclear answers, either because they did not remember or because of other reasons, such as *"receiving the leaflet from the private clinic"*.

PRIMARY CARE PROVIDERS' VIEWS

7.2.1 Changes in the amount and type of information provided resulting from the reforms

ENGLAND

In sample S, the majority of respondents either thought that there had been no major changes or were not sure about them. Two doctors acknowledged the increase in demand for information on the users' side, which at least some of them received with mixed feelings. At least one primary care provider openly expressed his/her concern whether this could be satisfied within the constraints of general practice. The other respondent who admitted that improvements in patients' level of information had happened, also related this change to the introduction of explicit entitlements stated in "The Patient's Charter". Another GP agreed that the need for information has increased, but s/he thought that, *"this reflected the general trend in medicine and people wishes to be more informed"*.

Although the answers in sample T were by no means unanimous, there was, however, a common thread, which can be summarised as disbelief in the ability

of the reforms to promote genuine changes in the patient/doctor relationship. Even where changes did occur, they seemed to be resented by at least some of the doctors and were seen as aimed at reducing their status and clinical freedom. It was also felt that they pressurised them to devote more time to issues that were not most highly valued by the GPs. In addition, they tended to see any changes in patients' requests for more information as being a direct result of changes other than the reforms, of which the most commonly mentioned were a consumerist approach and the media's impact. Thus, for example, one of the doctors thought:

"Patients were more demanding in terms of wanting things sorted out quickly, because of the changes in communication culture and also because patients were now more often perceiving health care as a service".

KS, while expressing her views more cautiously, still thought that changes such as more information being made available in areas like counselling occurred, but she thought that these had been due to, *"increased pressure from the management of the Health Authorities for this to be provided"*. S/he concluded, *"it always depended on the doctors, and this was still the same"*. UN said that there were probably some changes, which could be summarised as doctors having less time for the patient, but, on the other hand, they were giving out more leaflets.

General Practitioners seemed not to be really aware of the extent to which patients desired more information, which is evident when the responses of the latter are compared. This difference in perception is mirrored in RA's view that the concept of patients wanting information was distanced from reality:

"It was rather my problem to find out whether patients wanted to know more about issues surrounding the treatment. Maybe patients from affluent areas would be much more interested in asking for - and obtaining - information on their health problems."

By contrast, most doctors in sample U seemed to be more knowledgeable; and they agreed that patients did get better information, either because the reforms created an environment for better communication and they, GPs, were given an increased role; or because they had greater need for it; or both. Some doctors

pointed out their own efforts at providing information, which according to them, had always existed.

One respondent expressed the view that, as this procedure was a clear-cut one, there was possibly no need to give out further information to the patients. HW thought, *"people generally wanted to know more as they read more about these things"*, but CA did not think this was specifically relevant to the case of cataracts, as, in her words, *"it is a fairly confined and dry field"*. Two doctors pointed out the aspects of communication, which, in their view, the reforms had improved. For example, DC, a fund-holder, thought: *"it was better communication in both directions - providers and patients"*; and PE, a non fund-holder concluded:

"These days patients know why they put the drops into their eyes, which is a result of reforms and all the talk about the increased role of the patient. There is a lot more respect for what the patient can understand".

Two other doctors, in addition to the impact of the reforms, also stressed their attempts to educate patients, which were summed up in the words of GG, a fund-holder, as:

"In the case of a cataract, I always try to explain things to patients, because I do not know what happens when they are with the provider".

SWEDEN

Most respondents were uncertain about improvements, which might have occurred with regard to the quality and amount of information provided. They expressed cautious views on this subject, which NB summed up as:

"There were probably slight improvements, compared to what it was like before, due to competition and the fact that doctors were more conscious and more respectful".

JS thought:

"It is possible that patients get more information at present; this is probably happening more widely and can be seen as a result of competition."

CH, on the contrary, held a clear view that the information provided was better on the whole, because staff were aware of these requirements and the content of what was needed. As she characteristically put it:

"We also realise that it pays off to take time with a patient, otherwise s/he will come back to demand even more information."

PG, who also stated that this was the case, reiterated the last comment:

"We have to provide information, otherwise patients will ask for a second opinion if they are not happy".

MK, on the other hand, explained that there was a current focus on co-operation with the family, so, even if patients did not ask, the doctor would put the question to find out whether they wanted information and what type of information they required. S/he qualified further, referring to the changes in patients' attitude:

"Nowadays we meet more people who want to know about their condition and their care but the elderly do not usually dare to ask questions as they are afraid, or still regard the doctor as a semi-God."

Also, the health centres ran training courses for young doctors in order to improve their communication skills with patients. S/he suggested that there was a difference between older doctors and young doctors who were more trained, as well as women doctors *"who give more time to patients and listen more to them"*.

7.2.3 Provision of printed information with detailed explanations on the health problem, treatment, the available options, and the likely post-operative complications

ENGLAND

Of all the GPs questioned, only one expressed an opinion as to whether leaflets for patients were used more widely since the reforms. All the other GPs replied either that there had been no discernible change, or that they did not know. The answers show the GPs to be very poorly informed in this respect, which is really rather disturbing.

All respondents from sample S either did not know or guessed that it had not changed significantly. Findings from the other study sites also confirmed the inability of primary care providers to reply to these questions. This is even more worrisome in the context of the very limited time that patients spend in the GPs' surgery and during the specialist consultation; in the former, it does not exceed 10 - 15 minutes

and is usually less. The distribution of printed information, presented in a user-friendly form, could at least partly ameliorate the insufficiency of information that was felt by the patients.

Typical responses from doctors in sample T provide an example of their attitude, which is quite similar in all the samples examined, although ignorance seems to be more prevalent among primary care doctors in inner city areas. Thus, the majority of them (four out of five) were not in a position to answer the question at all. Some comments provided, such as the ones of PW and GR, pointed in the direction of guesses rather than informed judgment:

"No astounding change. There is certainly more talk than real change".

"This hasn't happened, but even if information is provided in the form of leaflets, it has nothing to do with increasing patients' choice as they are not at all in a position to judge."

No respondent was aware of how much (if any) information patients got from the hospitals; they could not answer this question in sample U either, where half of the GPs were fund-holders. For example, one of them commented in the following manner:

"The trend was definitely for giving out more information to the patient and they received it from the hospitals in the form of a copy of the discharge letter".

This means that, despite the belief that fund-holding incentives would motivate primary care providers to become *"the patients' best advocate"*, this has not happened to the extent expected at least when information aspects were concerned.

SWEDEN

Only one primary care provider (the ophthalmic nurse) was able to provide some information on this subject, and she thought that more leaflets were being given out, following the reforms' introduction. All doctors pleaded ignorance.

CONSULTANT EYE SURGEONS' VIEWS

7.3.1 Changes in the amount and type of information provided resulting from the reforms

ENGLAND

On the whole, in sample S, all the consultants agreed that there had been developments in the information given to both patients and purchasers. Once again, according to the surgeons' views there was little evidence to suggest that the change in patient education had come about as a result of the reforms, according to the views of most consultants interviewed. AL in sample S epitomised the attitude of the consultants' in the statement, *"this has always been there"* at the same time pointing out that the way in which information was conveyed had changed.

JO in sample S agreed that the type of written information provided in the form of leaflets had increased, while s/he stated at the same time, *"it is not a result of the reforms, we had them before, and they are increasing all the time"*. The clinical director clearly related the changes s/he had seen to reforms, while another younger consultant actively rejected the idea that the reforms had had an effect in this area.

However, even doctors, who were critical of the reforms' impact, agreed that nowadays patients had more material available to inform them of ophthalmic conditions and procedures. On the other hand, the clinical director in sample S, who was most likely to acknowledge the reforms' impact, believed it rather to be a consequence of attempts to satisfy patients' and purchasers' desires for more information. This indicates that in the aftermath of the reforms, the need to keep GPs 'happy' in all respects has become very important:

"There has been an enormous change since the reforms. We had to become business-minded in order to compete with other providers and to make sure that patients and purchasers were satisfied."

In unit P, the clinical director, similarly to some of the previous respondents, thought that the amount of available information had not changed and that there had always been good information due to internal initiatives, which had nothing to do with the reforms. However, s/he agreed that there had been some change in the form that information was now given out. All other respondents in this sample were inclined to accept that the reforms were at least partly at the root of the changes introduced. Thus, for example, the consultant with the longest working experience, while explaining that s/he always used to give oral explanations about the procedure, agreed that:

"Written information has been routinely used only after 1991, although I believe that it would also have come about anyway, even without the reforms."

TF, a staunch critic of reforms also thought that: *"patients are now given more information, due to the introduction of {The Patient Charter} "*.

In sample T, one of the newly appointed consultants did not know the answer to this question, as s/he had not been in the post for too long. The clinical director of unit T elaborated that, in her/his view, there was more written information about the operation itself nowadays, which s/he found very helpful:

"Use of the written information is a useful weapon and there is added enthusiasm for doing things that should be done."

MH, of unit U, thought there had been a sort of continuous improvement, an effort to increase the quality of service they provided, not as a result of the market but rather because of patients' increased expectations and their higher level of education. S/he elaborated somewhat contradictory:

"We often operate on elderly patients who are very poorly educated and being a doctor entails an obligation to give some essential information. With day care, we can inform and explain things to a group of patients".

SWEDEN

The views of surgeons were rather divided, although the overall impression was of some improvements positively influenced by the reforms; however, these were not very significant and possibly not sufficient either. Predictably, changes were

also attributed to influences outside the sphere of health care or the reorganisation introduced by the reforms. Thus, one surgeon thought:

"The changes are linked more to the level of knowledge of patients, who are more informed; they know more about methods and options and demand more."

One of the leading consultant eye surgeons in hospital K expressed genuine interest in the results of this study with regard to patients' responses on the information that had been provided to them and explained the changes occurring:

"I think we have improved the information we give out, but there are still problems and a need to improve on this aspect of care."

CZ compared the standards of information provided in hospital K to the highest in the world, without being able to provide any specific comments other than: "We do inform them, and this is exactly like in the USA." BC, a holder of the vice-director's position, was, on the contrary, not convinced about the reforms' impact on the information aspects.

7.3.2 Distribution of printed information with detailed explanations referring to one or more of the health problems, the procedure and options of treatment, as well as the likely post-operative complications

ENGLAND

The content of these leaflets was reported as being very similar by almost all consultants from the four units studied. Medical conditions and the different treatments available were covered, with information on the relative benefits of the type of anaesthesia, and day care, as opposed to overnight stays, were also outlined. None of the consultants said that the leaflets given to their patients contained information about the possible complications from surgery. This was most probably a conscious decision on the part of the leaflet's designers, rather than an oversight.

For example, in sample S, the clinical director said of health problems and procedures that *"the leaflets describe the procedure, and patients can expect to know how it is done"*. For leaflets dealing with post-operative complications, s/he felt that there was not sufficient detail, stating: *"we have to put in more"*, and of leaflets relating to the options of surgery and anaesthesia, *"no, we don't give a choice because it is not relevant."*

DA explained that leaflets were currently more in use and mostly included aspects of health problems and the procedures of their treatment, but *"did not really expand on options for surgery"*, adding that *"leaflets about possible complications did very poorly."* JO agreed that the leaflets contained information on health problems, treatment procedures and options for surgery. In his view, post-operative complications were not covered in the written form but s/he explained that this depended very much on various booklets *"which were being currently updated."*

Only one consultant (AL) had not seen any change as opposed to all those who thought that this difference was reflected in the leaflets made available, which covered the aspects of health problems and medical procedures.

The clinical director of unit P clarified that only the health problem and procedures of treatment were included in the leaflets, while her colleague, CH, thought that the available options of surgery and anaesthesia were also contained. The latter added that, since 1991 patients had been given printed leaflets, which, at the time of interview, were not available however, as the clinic had run out of them. S/he also somewhat improbably claimed that very serious and rare complications were very briefly mentioned.

By contrast, other surgeons who had been more recently appointed to the unit, elaborated more on the leaflets that were to be used. JJ thought that they would include a description of the problem in lay terms, the likely side effects and expectations of how the patient might feel thereafter. TF briefly concluded that the leaflets were going to be introduced and that they would include all the

information on the health condition, the options of treatment and the likely post-operative complications.

Surprisingly, in sample T, only a few of the consultants were in a position to answer this question. BL, for example, who was relatively newly appointed, did not know what was happening. MJ, who had worked for quite a long time in the same unit, was not sure either pointing:

"You should ask the nurses. Leaflets are more widely used in this hospital than in some others, I believe."

The clinical director was more knowledgeable and s/he said that leaflets referring to what a cataract was, what should be expected from the operation and advice on patients' self-care afterwards, were distributed but, as s/he conceded:

"No complications were mentioned but information on local and general anaesthesia was included."

MH explained that, in unit U, the policy adopted was to give out written information in the form of a leaflet, but not to all incoming patients:

"Only those who ask about it are given a printed leaflet. Not everybody wants them and some probably know about it already. We are considering producing a video with information on the operation."

SWEDEN

The overall impression of Swedish surgeons was similar to that of their British counterparts as they could all trace some changes but did not consider them very significant and, in any case, not a result of organizational reforms.

WS, for example, conceded that there was standardised information given out, agreeing that it might have increased but for reasons other than to facilitate patient choice or to increase their empowerment:

"We give a little bit more information but not in great quantity, as it is aimed more at helping us to handle the patients and not to give them options. There is not too much information about aftercare or the side effects".

BP reported that there was a booklet given out which contained some basic information about cataracts, including information about the health problem, the procedure of treatment and the likely post-operative complications. S/he explained, however:

"We always had it but we put more emphasis on it now. We have also created some videos to be shown in the waiting room, which have not been used yet."

CZ acknowledged that booklets, which contained information on the health problem, the procedure of treatment and the likely post-operative complications, were now given away adding, *"We didn't have this book before."* BC thought that, while more written information of better quality is given out now, which had already been initiated in the past:

"It started ten years ago and lectures for patients started even before. But now it has grown and it is more focused on specific conditions and there is now a special reception for patients with certain diseases - for example, melanoma".

MANAGERS' AND PURCHASERS' VIEWS

ENGLAND

The views on information provision coming from the trust executive of unit S were fairly general. S/he stated that it had become more language-sensitive and age-sensitive, with numerous translations being made available. Attempts had also been made to reflect and to be consistent with the composition of the population in the area. S/he commented:

"Answers are given in a reassuring manner and also more attention is paid to the detail."

The senior nurse from the eye unit of hospital S, who had also quite extensive management responsibilities, ascribed the changes in the provision of information primarily to the existence of "The Patient's Charter". In her view, this had encouraged giving more information to patients on the one hand, and had led to them becoming more demanding on the other. She noticed that those patients who were more informed were also the most co-operative. She commented characteristically:

"The attitude of health professionals in the past was dictatorial as compared to the more democratic attitude at present, which is attributable to the reforms. We more often use the phrase, "It is up to you". We are guided more, and led more, by the patients".

She provided further explanation on the role of the written information contained in the leaflet:

"Yes, the leaflet is given out at the time when the date of operation is defined and the possibility of risk is explained orally. We tend to play down the major aspect of the surgery in order to make them less nervous. We also try to make them feel comfortable in the waiting room and to provide any additional explanations needed."

The views of a manager from unit T were represented by the Public Health Doctor, whose views were that information was mainly provided in order to respond to purchasers' requirements and was, in addition, more often than not provided in quite a bureaucratic form in response to the purchasers' demands. Although s/he could identify *"a lot of rhetoric about information for the patients, which was a part of the bigger rhetoric of responsiveness to patients needs"*, s/he could also see patients themselves acting to put forward their demands for information that *"reflected the wider movement in a consumerist society and not just the reforms in health care."*

At the same time, s/he analysed the incentives that the purchaser-provider split reforms created for trusts: *"It has clear interests in promoting its image of being user-friendly in order to attract more referrals"* remaining deeply suspicious, however, as to whether these changes could definitely alter the behaviour of doctors and nurses.

"The real agent of change is consultants' attitude to information. Nonetheless, in practice, it is translated into the production of booklets and posters, with information on issues considered to be strictly professional".

The purchasers were asked whether they had observed changes in the quality of information provided to them as, on the whole, they were in no position to comment on what had happened to the patients in this respect. The view of the director of commissioning services from the area of unit T was that the information was much better now. In his/her own words, *"one may say that it is light years ahead of what it used to be"*. However, s/he quickly added:

"I am not sure that we make the best use of it. As purchasers, we are very good at accounting but less so at interpreting the data and turning it into meaningful information".

S/he complained that the information provided was quite often superficial and of poor quality but at the same time acknowledged that the purchasers lacked the time to ask for precise information. An example of difficulty in using the database provided and in extracting the relevant information was provided:

"Even obtaining something as basic as the number of people in attendance may not always be possible, because the data base provided is not always relevant".

His/her proposals for improving the quality of information were numerous and quite innovative:

"Possibly we should think of establishing an information service on the providers' side and we need to be able to ask more for things like case/mix, but so far we don't get it or the information we get is not good. The future trend of commissioning could be to ask for a particular type, and not just an indiscriminate amount, of information".

Another purchaser in area T spoke of the lack of preparation time needed to fulfil the tasks that purchasing involved, which was dependent on the provision of reliable information - a situation which in his/her view Health Authorities faced continuously.

The director of commissioning from S expressed similar worries:

"We have very little information about price, as each hospital has a different case/mix. The NHS performance indicators referring to different health services, which are published, can provide some help but are not sufficient."

She also pointed out the need to upgrade the quality of information received:

"We quite often receive information that is still bloody awful. Before, there was an integrated quality approach and assurance was based on inspection by District Health Authorities".

SWEDEN

There were no comments on these issues other than those already expressed by senior eye surgeons who were responsible for their management.

The purchaser of district Z of Stockholm County Council asserted that there was more flexibility about appointment times and that there were also attempts to provide patients with more information about the procedures of treatment. Providers to keep their staff on their toes also manifested this in an increased

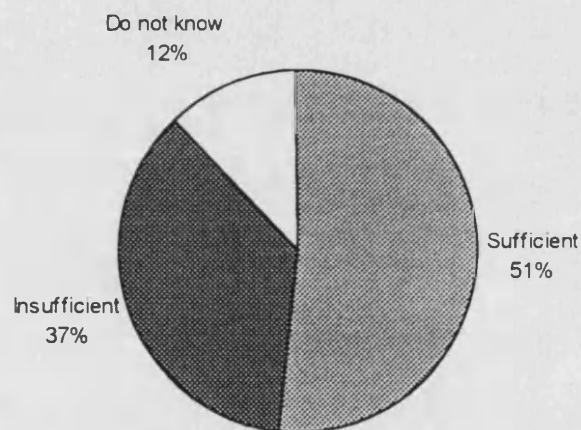
use of patients' questionnaires and in more attempts. S/he was aware, however, that the area that had not been much affected by reforms and where one could still not see much difference was the information about medical outcomes, which was not provided to the patient. S/he articulated the fears related to making public this type of information:

"There is a lot of discussion whether organising an information centre in the hospital for users, is an appropriate development. Heads of departments are very conscious about this because it could be misused in a competitive market, which has somehow created incentives to suppress information that could be used for improving performance. But on the other hand it had a positive impact on monitoring activities by the GPs and Councils".

KEY FINDINGS

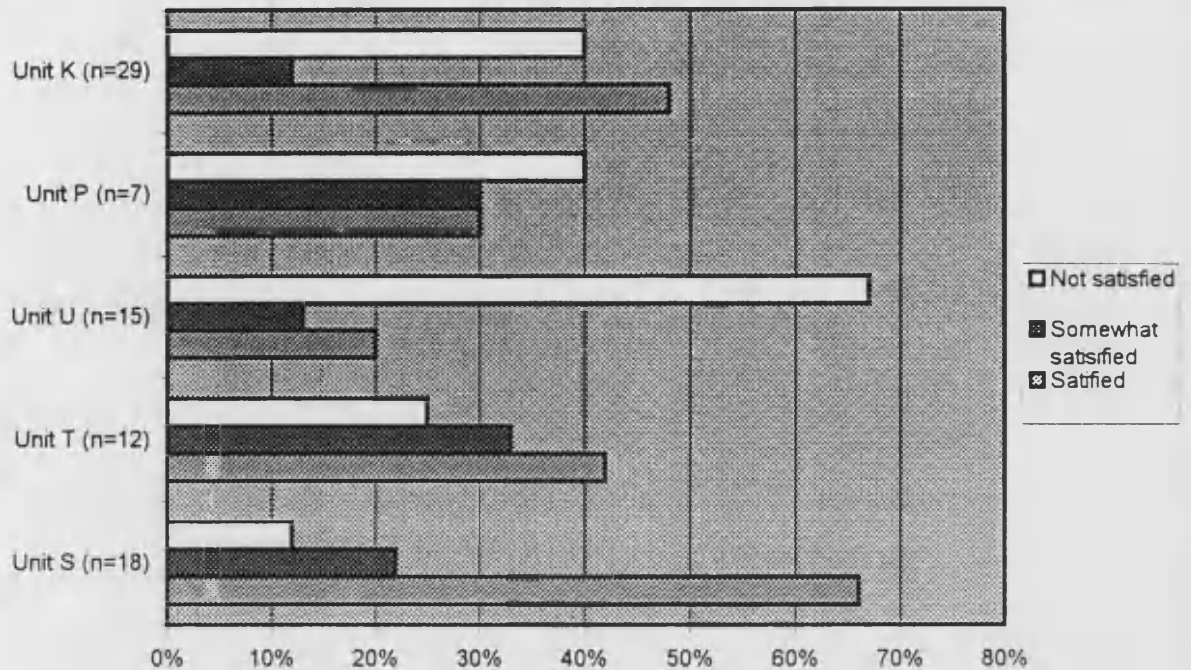
□ Only half of the patients were satisfied with the type and amount of information received (see Figure 7.1) and these are the patients who came from units that were performing well under the reforms, such as S in the UK and K in Sweden (see Figure 7.2); lower satisfaction with the information provided was reported by patients from an under-performing unit, U. Patients in Sweden who reported that they possessed sufficient information, qualified it by saying it had not necessarily come from providers' units but rather from the media or other users.

Figure 7. 1. Patients' satisfaction with the type and amount of information received in London and Stockholm (n=81)



□ The reasons for low satisfaction was linked to both content (too general, out-of date and not responsive to patients' needs) and also to the timing of its provision at too late a stage of the operation. Patients who complained felt that appropriate information could facilitate them to get through the operation and care for themselves better after the operation.

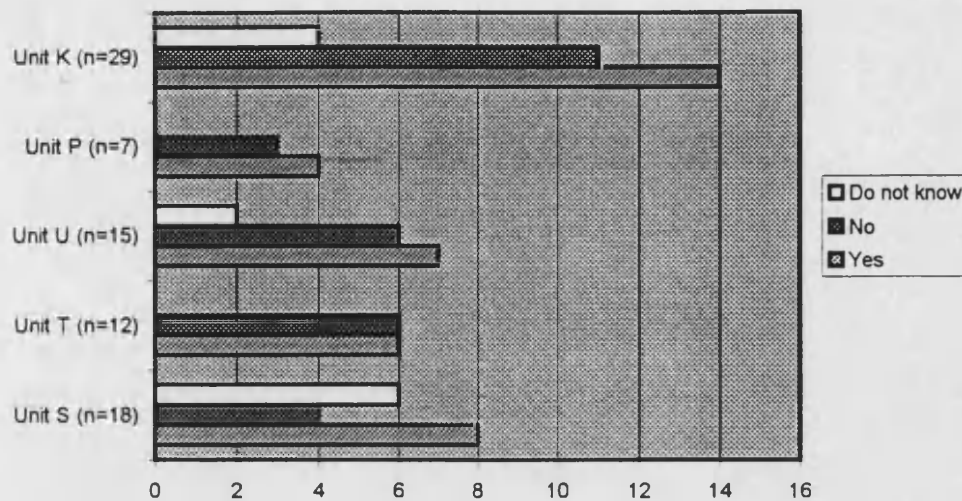
Figure 7. 2. Satisfaction with information received in different eye units in London and Stockholm (patients' views)



□ The information contained in the leaflets was not highly thought of by patients in both the UK and Sweden. There was no unit in which the written information contained details on all the aspects investigated, such as the health problem, the treatment alternatives, the post-operative complications, and after care. The last was especially highly valued by patients, but very few found information about it in the leaflets and those who reported receiving any type of written information represented less than half of patients both in the UK and Sweden.

□ Perplexing as it may sound patients across all the units studied in the UK were rather uncertain as to whether they received written information or not. Less than half of them could confirm receipt of information in written form (usually a leaflet). The situation in Sweden is different as the majority of patients got written information in form of a leaflet (see Fig.7.3).

Figure 7.3. Patients' views on written information provided in different units in London and Stockholm



□ GPs in the UK and Sweden tended to see any changes in patients' requests for more information as being a direct result of changes other than reforms, of which the most commonly mentioned were a consumerist approach and the impact of the media. Nonetheless, "The Patient's Charter" was also referred to as a source of the increased expectations it nurtured in some patients.

□ What was surprising, though, was that General Practitioners seemed not to be really aware of the extent to which patients desired to receive more information. The answers show the GPs to be very poorly informed in this respect and they were equally uninformed as to whether the provision of written information had changed in any significant way after the reforms. On the whole, there was no big difference between fund-holders and non fund-holders with respect to how well they were informed about these issues.

□ Consultant eye surgeons agreed that there had been developments in the information given to both patients and purchasers, but they only reluctantly ascribed them to the reforms' impact. While agreeing that the systematic provision of written information is a recent phenomenon, they thought these changes had already been under way. Some of them accepted, however, that they had to become yet more responsive to purchasers' requests in this respect.

□ Managers in the UK felt that purchaser pressure was the real agent of change transforming their attitude, but some of them openly stated that they were

not sure about the benefits accruing to patients. The purchasers, on the other hand, were uncertain about the usefulness of all the data that providers gave them and were in the process of establishing mechanisms for gauging really meaningful information.

CHAPTER 8

QUALITY

The aspects of quality investigated in this chapter include the type of health specialist who provides patients with information, the length of notice patients are given of their operation, and waiting time at the outpatients' clinics. Changes in the attitude of the health professionals are also examined. All these aspects of quality trace changes that are concerned with process indicators.

The importance of patients being seen and being given information about their condition and proposed treatment/s by a fully specialised doctor, and not a trainee - at least on the first visit - is considered to be a quality safeguard. Its importance has been reasserted and is implicitly stated in "The Patient's Charter"; it is also requested by a number of purchasers.

Informing patients well in advance about their operation time on the other hand is important for the elderly, who can then make arrangements to be taken into and out of hospital. It is valued by patients and is thus seen as an important quality indicator. The notice given to patients of their operation date relates to the fact that elderly patients, who often live alone, need to make appropriate preparations for after-care in their own homes and it also relates to the waiting times for the first specialist appointment and the operation. In the case of day care surgery, they also have to attend a follow-up session, which is quite often on the next day. Patients usually need assistance to travel to and from the hospital with their vision as of yet poorly restored that is why allowing sufficient time for necessary arrangements is essential.

This study also takes the view that waiting time at the outpatients is an indicator that reflects the success of the provider in securing quality of service beyond the level of technical competence. Another quality indicator considered here deals with changes in the relationship between patients and doctors and the attitudes of the

latter, its respective success or failure in user-friendliness and responsive to patients' perception of quality.

8.1 Quality - Information Aspects: interviews with all respondents groups

PATIENTS' VIEWS

8.1.1 Who provided information about the treatment: senior doctor, junior doctor or nurse?

ENGLAND

There is, again, a significant difference between the hospitals (see Table 8.1). In S, the consultants saw most patients on their first visit (which was not a very long one, however) and then further explanations were given by the nurse allocated to each patient throughout the duration of care. Quite a few patients found this later arrangement useful. Rarer were the cases where patients made their first contact with either a junior doctor or the staff nurses. Three patients could not remember or were not sure of the status of the person who saw them, one of whom commented on the poor continuity of care: *"each time I was seen by someone else."*

In P, patients were seen in equal numbers either by consultants, junior doctors or staff nurses. One patient could not remember any details.

In T, the majority of patients (eight out of twelve) thought that a consultant eye surgeon or another senior doctor had seen them. Two patients thought they had been seen by a junior doctor, another two were not sure and another two did not reply.

In U, a senior doctor saw more than one third of patients (six). Another third (five people) could not remember who first saw them. Four patients were certain that it was a junior doctor who received them on their first specialist appointment.

SWEDEN

Over half the number of patients (sixteen out of 29) received an explanation of the treatment procedure, which came either from a nurse (six) or from the nurse and junior doctor (six), or from a nurse and senior doctor (four). The few comments provided by this group were, on the whole, very positive, which is reflected in the following statements:

"I saw many nurses. All were very kind."

"I was surprised by the clarity of information given by the young and intelligent doctor".

Two patients claimed to have been seen by the consultants only, two by the consultant and junior doctor and another two by a team of senior and junior doctors. Nurses saw four other patients. Some insight on how patients felt about this aspect of care is provided by the following comments:

"I was seen by the same doctor, who made me feel reassured."

"Doctor spoke to me throughout the operation, which was very different from the time when I had the same operation on my first eye, when I was not told anything - even when I asked questions."

Three patients did not reply and one was not sure.

On the whole, it turned out that senior doctors saw patients quite often in approximately half of the cases in the UK and one third of the cases in Sweden. The responsibility for diagnosing was quite often devolved to junior doctors who were supported by nurses and, increasingly, to teams in which all grades of seniority were represented, which was especially prevalent in Sweden (for details see Table 8.1).

Table 8.1: Patients' views on the seniority grade of the doctors/nurses who saw them on their first visit in the eye units in Outer London and Stockholm

<i>Name of the unit</i>	<i>Senior doctor</i>	<i>Junior doctor</i>	<i>Junior doctor and nurse</i>	<i>Could not remember/did not know</i>
Unit S (n=18)	12	2	2	2
Unit T (n=12)	8	2	0	2
Unit U (n=15)	6	4	0	5
Unit P (n=7)	2	2	2	1
Unit K (n=29)	8	6	10	4

8.1.2 The ease of arranging appointments and the timing of information provision concerning the date of the operation (> 2 months before or > 2 weeks or < 2 weeks)

In S, thirteen patients stated that they were informed *two months* in advance about their date of operation (though, in practice, it varied between *two and three months*), one patient was informed *five months* beforehand and two others were called prior to the given date, following someone else's cancellation). Four people were given between *four and six weeks'* notice and another two could not recall any details. An overall conclusion can be drawn that the majority of patients were informed of their operation date sufficiently in advance to make the necessary arrangements and preparations, with the median being approximately *twelve weeks*.

In P, the eye unit recreated in November 1994 with a team of four new consultants hired, the waiting time for surgery or for the first appointment was expected to be unusually low, at least when the pilot study was conducted (in the autumn of 1994 and the winter of 1995). More specifically, in five out of seven cases, it was more than *two weeks* but less than *two months* and in two cases it was less than *two weeks*, and this was very short by London standards and was exclusively due to the special situation of this unit.

Thus, when comparing the very short notice given to patients in unit P with the notice of surgery appointments given by the more established units (which was also reflected in the difference in their other waiting times), this peculiarity has to be accounted for (see Table 8.2).

Table 8.2: Advance information about the operation date given to patients in eye units in the UK and Sweden (median values)

Eye Unit Examined	Length of waiting times
Unit T (n=12)	8-10 weeks (median)
Unit U (n=15)	20-25 weeks (median)
Unit P (n=7)	2-3 weeks (median)
Unit S (n=18)	10-12 weeks (median)
Unit K (n=29)	3-4 weeks (median)

In U, patients also seemed to be informed well in advance about the date of their operation, which was, on average, somewhere between *two to four months* (the median being 23 weeks). However, there were some cases where patients were informed only *two to six weeks* beforehand.

In T, the largest group, consisting of six respondents, was informed relatively late about the operation date, the notice ranging from three to five weeks. Second came a group of four, who were informed more than two months in advance, with the maximum period being six months. One patient was informed of his/her operation only a few days beforehand; another stated s/he could not remember.

Two patients provided further information, pointing out the fluidity of waiting times and the unpredictability of dates, which were quite often subject to changes for a number of reasons. These, in the patients' view, brought about some degree of uncertainty as they were not sure whether it was created to give flexibility to patients or whether it was simply a manifestation of poor management of the appointments system in this particular clinic:

"I was given notice of less than two months but, in reality, I had to wait double that time".

"First, I was given a date one month beforehand. Then the operation got postponed and I went back on to the waiting list, but eventually I got it".

These differences in waiting times among the units could be interpreted in several ways. First, it seems that the date reflects the length of the waiting list when the patient is given a date nine months beforehand and, in fact, has the operation on that date. Second, it is based on the assumption that the patient will probably not make use of the availability of an earlier date which could, for example, result from a cancellation likely to occur during such a long period. In this case, the patient could be waiting one year for the operation and be given notice of the date of the operation just two months in advance.

Third, in some units there seems to be some flexibility built into the waiting time system. This can be inferred from cases where patients have been able to change the initial date, given five months in advance, for example, to a later date because of travel or other reasons. A similar situation occurred when a GP obtained an earlier date of two to three months ahead as opposed to the one-year originally planned, after acting on a patient's complaint.

SWEDEN

The majority of patients (thirteen out of 29) were informed *three to four weeks* beforehand about their operation date. This effectively represented the waiting time for the operation itself, calculated from the moment when patients were given a specialist appointment. In order to estimate the duration of waiting time for the operation, an additional two to three months had to be added on average. The latter represented the whole period, from diagnosis and referral to the date of securing the first specialist appointment.

The next largest groups of patients (five and two out of 29) were informed *one to two weeks* beforehand and *less than one week* respectively. One of the respondents in this group provided an interesting comment, which illustrated the patients' widespread perception of day care: *"Initially, I thought that they would operate on me the same day."*

In the third group, patients had their operation date set *three months* (three), *two months* (two) and *six weeks* (two) in advance.

There were also comments on the general nature of waiting times and on the appointments system for the operation, but apart from stating that "*there was a big difference*", respondents did not usually quote any specific figures. Two patients referred to the difficulties they had experienced in arranging an appointment, having had to re-confirm the appointment date or rearrange the appointment:

"I had to call twice to get the operation date. They had somehow forgotten me, and I don't understand why I had to go twice".

"I had to reconfirm my appointment by calling more than once".

PRIMARY CARE PROVIDERS' VIEWS

8.2.1 Who provides information about the treatment: senior doctor, junior doctor or nurse?

ENGLAND

Primary care doctors did not seem to be very well informed about who gave information to patients at the eye clinics in the hospitals. Almost everyone in samples T and S felt either that the situation was the same as it had always been (without actually stating precisely what this entailed), or said that they did not know. Of those who did express an opinion, there were contradictory beliefs. UN, in sample T, thought that a consultant had seen less than half the patients, and AR of the same area came up with the somewhat improbable figure of "*more than 90% of patients seeing the consultant without any change occurring in this respect*". The situation in sample S as to the level of General Practitioners' knowledge seemed to be only marginally better. One of the doctors expressed a view that:

"Most patients are seen by consultants nowadays, though there are various models, for example, the assessment can be done by a junior doctor first, followed by a consultant."

Most General Practitioners said there had been no change, without being able to give more specific information about whom patients, in fact, saw. One GP in sample S came up with an explanation for the presumed absence of change:

"If there had been a great change, they would sell it. Certainly, there are fewer complaints about this issue now."

The primary care doctors in sample U were better informed about this aspect of patient care when compared to the doctors in the two other groups. There was the impression of a good deal of variation from hospital to hospital; nevertheless, this was not mentioned as being a problem area by any of those interviewed. However, there was no great difference between fund-holders and non fund-holders, except in the case of an outreach clinic where the treatment of patients could easily be considered as being preferential, as was confirmed by one of the fund-holders:

"Now that there is the outreach clinic, we are mostly sending patients to P and they are invariably seen by the clinical director or someone very senior."

Possibly this ability to make use of the outreach clinics and refer patients accordingly created differentiation in quality of care aspects that were available to some patients; it also gave fund-holders a feeling of higher empowerment in comparison with the majority of their non-fund-holding peers. One non-fund holder found this an opportunity to remark on the inequity of access, stating: *"elderly who don't get information and care, do not benefit from that."* CA, also a fund-holder, thought that nursing input had become more significant. Another GP (soon to become a fund-holder) conceded that, in all the units s/he worked with, it depended on the hospital whether or not senior doctors saw patients on their own or had delegated this task to the junior doctors or nurses.

SWEDEN

Swedish primary care providers seemed somewhat better informed about this aspect of patient care, which was not least due to the fact that, in the hospital where this study took place, there was a clear policy on who should see the patient first. Thus MK, the female GP, thought that, *"most of the time it is the consultant eye surgeon"*; and NB expressed his view that, *"referrals are dealt with by the senior doctors"*. PG, the only private GP in the sample, thought, on the contrary, that, *"it*

was the junior doctors on call who usually dealt with the patient first", which was somewhat curious as the service in question was a strictly elective procedure. CH, an ophthalmic specialist nurse, agreed that:

"It was important for the patients to be seen by the doctors and, for this reason, hospital policy was that all patients were seen by both the doctors and nurse".

8.2.2 The ease of arranging appointments and the timing of information provision concerning the date of the operation (> 2 months before or > 2 weeks or < 2 weeks)

ENGLAND

When asked how far in advance patients were informed about impending surgical appointments, only one doctor from unit T gave a specific answer (UN), suggesting that *more than two months'* notice was given for the operation. Nobody else could say for certain, although HW of unit U said that patients were being given more notice these days; but s/he could not name the average length of time.

PE, of unit U, said that s/he was not sure, simply because patients had not complained to him/her about the lack of notice, so there was no need to know the precise times. This was partly echoed by CA, of the same area, and it is even more interesting that both of the respondents were fund-holders. Another fund-holder in the same sample characteristically commented: *"It is difficult to say because we have an outreach clinic, so everything was very quick."*

This result is a little unsettling. It seems that once a patient's care is passed from the GP's surgery to the hospital eye unit, the GP very much loses touch with the treatment process.

SWEDEN

No primary care provider in Sweden could comment on this issue; instead they referred the interviewer to hospital data, saying that it should provide all the information requested. Although there is no real justification for this ignorance,

the existence of the three months care guarantee (which was still operating at the time when the interviews took place) can be regarded as a factor which somewhat mitigates in favour of the respondents. In addition, the fame of hospital K, which, as a virtual monopoly provider was known in the market to deliver high quality services quickly, may be another factor contributing to the primary care providers' perceived lack of responsibility in monitoring this aspect of care.

However, the most important reason in this case is the almost *de facto* separation of the two tiers of service and the very poor communication between the primary and secondary care sectors that is still characteristic of the Swedish health care system.

CONSULTANTS' EYE SURGEONS VIEWS

8.3.1 Who provides information about the treatment: senior doctor, junior doctor or nurse?

ENGLAND

In unit S, all the senior doctors interviewed agreed that information provision was not confined to one particular staff group. HS (the clinical director) and AL, the newly appointed consultant, pointed out that senior medical staff usually gave the initial information, and then others joined in later. The other consultants gave broad answers, saying that all groups were involved in providing information. More specifically, the clinical director expressed a view that, "*it varied*", explaining, "*booklets were given by the nurses pre-operatively and senior doctors saw the new patients*".

DA, another new consultant, agreed that there was a variation, asserting that all three tiers of health professionals, including senior and junior doctors, dealt with patients on their first appointment: "*The doctor who saw the patient gave some information and the nurse did the rest.*" AL shared this view and spoke of a tendency towards keeping down the length of appointment time, due to pressure

caused by "The Patient's Charter", which had led to a lack of time being spent on complicated cases:

"There is a tendency to cut the time for consulting. I think that patients are aware of what's happening and they are willing to wait for a while for good treatment and for good information".

JO confirmed that information was given by each of the three groups.

In sample T, the consultants explained the way the process of information provision to patients was carried out. The overall impression was that they were quite modest about their role in this process. Also, they did not seem to explore patients' needs in this respect. For example, BL, a newly appointed consultant, replied that, while s/he saw patients in the clinic, *"more detailed information was given to them on the pre-operative ward by junior staff and the nurses"*. MJ, who had worked for a long time as a consultant in the unit, thought that information about the disease and its treatment was given out and added, somewhat vaguely, *"patients now get more information from everyone"*.

The clinical director of unit T was more specific, explaining that Senior House Officers gave out information during the pre-clerking clinic, where they went through the details of the operation. The nurses also did this upon patients' arrival for the operation, and patients were also seen post-operatively by both of them.

MH, of unit U, said that patients received information from a senior doctor as a rule, and it was usually a consultant who saw them on their first visit explaining:

"There is an attempt to provide continuity of care as we try to have patients kept under the same consultant, but not necessarily to be seen by him/her. The consultant tries to look at all the notes and checks whether what s/he asks for is done."

SWEDEN

In Sweden, the care of patients and provision of relevant information during the first specialist appointment is designated to a team of professionals. It seems, however, that the input from senior surgeons was rather limited and nurses and junior doctors carried out most of the procedures that were necessary at this stage. The director of the hospital provided some details on how this system operated:

"The information is usually given by nurses, as it is more efficient in terms of the use of doctors. Surgeons provide information before the operation and also on the first visit."

BP, an experienced surgeon, explained in greater detail the procedure that was followed:

"Patients are sent an answering sheet prior to their first visit. Then they meet a nurse who does the measurements for the lenses to be fitted. Some of the junior doctors take over after this procedure is completed."

CZ thought that, most of the surgeons meet the patients on their first visit, during which time the patients also meet the nurse, who takes measurements of their visual acuity.

8.3.2 The ease of arranging appointments and the timing of information provision concerning the date of the operation (> 2 months before or > 2 weeks or < 2 weeks)

ENGLAND

There were a variety of opinions expressed on the average amount of notice that patients were given before their date for surgery. It was generally thought to be a matter of weeks rather than months.

For the clinical director of unit S, the main factor here seemed to be that patients were told of their operation date on the day on which they were placed on the waiting list. S/he pointed out that the aim was to improve the percentage of patients who were given more notice, as a response to the competitive nature of the market that the reforms had introduced:

"We try to give the date of the operation at the time of the appointment to a higher percentage of patients, because it is a quality issue for the patients to know the date of the operation beforehand. Approximately 20% to 30 % of them know this two to three weeks in advance, and we intend to provide this for all, because that is what patients and GPs prefer."

All other consultants came up with quite contradictory views, both as to the length of notice patients were given and as to how this procedure was carried

out. For example, AL, a new consultant in the unit, said that the date was given on booking, which was six to eight weeks in advance, and that *"all patients were operated on within six weeks"*. DA, another newly appointed consultant, was less certain and said that this practice was a new development: *"We often give the operation date at the time when patients are listed, which was not done before."* Also, according to JO, patients were told about their surgery date on *"the day they came to the clinic."*

In unit T, most consultants did not know the answer. MJ compared the periods before and after the reforms by stating:

"Before, they would get a letter informing them when the operation would be performed, which could be done at relatively short notice; now, when they come to pre-clinics, they are informed two weeks in advance."

MH, of unit U, replied that this period was generally three weeks in advance, adding:

"Sometimes we bring the patient in at short notice, asking them whether they would agree to come in for the operation as there is a slot free on the operating list."

SWEDEN

In Sweden, the situation was broadly similar to the UK in terms of giving patients information about the date of the operation, although the period of notice was much shorter. The latter was related to the much shorter waiting time characteristic of the Swedish health system as a whole, and of cataract surgery in the Stockholm County Council area in particular. Replies from respondents within this unit seemed to be more consistent than those of their British counterparts. The hospital director referred to the data available within the department and commented:

"One aspect of its high quality of care is that patients can go home as soon as possible. We also provide a human approach by planning our procedures well, in order to give patients time to plan their operation."

WS explained that patients usually came in with a diagnosis. Once the specialists at hospital K had confirmed this, the patients would be listed for the operation on a specific date: *"Usually two to four weeks ahead."* S/he explained that in fact, all

planning was done well in advance, *"primarily due to administrative requirements to organise surgical resources in advance"*. CZ similarly said that it was two to three weeks, adding:

"They can choose a surgeon and the preferred length of waiting time, which some do, and I think this is going to be more and more common."

MANAGERS' AND PURCHASERS' VIEWS

8.4.1 Who provides information about the treatment: senior doctor, junior doctor or nurse?

8.4.2 The ease of arranging appointments and the timing of information provision concerning the date of the operation (> 2 months before or > 2 weeks or < 2 weeks)

ENGLAND

A senior nurse with extensive managerial responsibilities in unit S explained that all nurses had to take care of their own client group and each did this according to the task s/he was assigned. For example, the theatre nurse and the assessment nurse each had to provide care during the relevant stages of treatment. She elaborated further on attempts made to provide continuity of care in terms of nursing care and explained the role of the consultant in this process:

"The intention was that the same nurse should see the same patient. The consultant gives the initial explanation, but does not spend too much time on this. One week before surgery, the patient is called in and the personally assigned nurse gives him or her all the information."

The deputy chief executive of the same unit explained, with regard to question one, that the operation date was given to the patient during his/her visit to the outpatients' department. S/he added that patients were informed of the hospital's policy of allowing flexibility in fixing the date of the operation so as to accord with what the patient's family wanted, rather than simply following the strict order of the list. S/he summed up by pointing out *"the greater emphasis on what people wanted"*, adding that satisfaction surveys on how patients had been dealt with were now carried out more often.

The professionals involved in the management of other respective units (T and U) could not answer these questions and considered them to be too specific for them.

Purchasers in both countries seemed to have no view on this subject. On the whole, they considered that this was beyond their area of responsibility. Some of them also justified their ignorance by stating that this information could be inferred from the quality specifications used in the contracts. This situation was similar in both the UK and Sweden.

SWEDEN

The leading doctors in the hospital deal with all the management issues, other than finance, and the hospital's director and deputy director, whose views are outlined above, managed most of the aspects of care.

A typical comment, articulated by one of the Swedish purchasers in the Stockholm County Council area, provides an insight into how purchasers perceived this issue:

"I am not sure whether this has happened, but it should apply for highly specialised services. In the future, where they will be dealing with customers, this aspect is likely to acquire a new importance."

A purchaser from Z district in Stockholm County, demonstrated some knowledge of this subject and asserted:

"Patients are now seen as people, who can turn round and go somewhere else for the service. There is more flexibility about the appointment times."

8.2. Quality - Waiting Times at the Outpatients'

Department: Interviews with all respondent groups

PATIENTS' VIEWS

8.2.1 Changes in time spent waiting to be seen at the outpatients' department resulting from the reforms

ENGLAND

Most replies indicated a waiting time of approximately thirty minutes for both hospitals (unit S and unit P) and occasionally less than this. Only one patient in P said that s/he had had to wait for more than one hour. Two patients (with previous experience of S) could not help remarking on how different things were from a few years back, as expressed in the words of one of them:

"Before, one could wait for two or three hours in a room full of people, and no one seemed to take any notice of it or even bother to apologize for the situation."

In T, the majority of patients (seven out of twelve) had waited either thirty minutes or less. The second group were patients (four) who had waited for between thirty minutes and one hour. Only one patient had had to wait for more than an hour. However, only a few patients could comment on the difference from the pre-reform period and, even then, no impression of a major change came across from their responses.

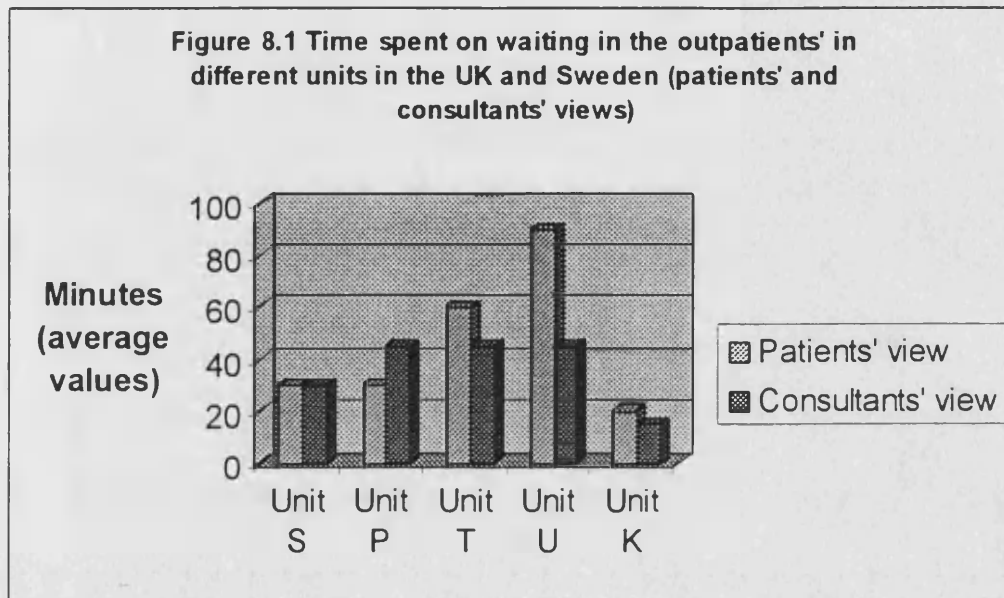
In U, the figures were quite different as no patient had waited for less than thirty minutes and slightly less than half (six patients out of twelve) had waited for between thirty minutes and an hour. But most of them (nine out of fifteen) had had to wait for more than an hour, with the median being two to three hours on average, and patients were visibly dissatisfied with it (See Figure 8.1).

SWEDEN

The overwhelming majority of patients (27 out of 29) confirmed that waiting time in the outpatients' department had been less than half an hour and, in most cases, it had actually been much less. Thus, ten patients had waited for less than five minutes or not at all, another ten patients had waited for 10 to 15 minutes, on average, and seven patients had waited for a period of < 20 minutes. Only one patient taking part in the study had waited for more than an hour and one other

patient for between half an hour and an hour. Typical comments from patients were very positive, as could be expected:

"All the waiting times are very short" and "did not have to wait at all."



PRIMARY CARE PROVIDERS' VIEWS

8.2.2 Changes in time spent waiting to be seen at the outpatients' department resulting from the reforms

ENGLAND

In unit T, the importance of the long waiting times at the clinic were certainly more of an issue for some doctors, but by no means for all of them. Most GPs in the area had no idea about this subject. UN, for example, thought that it was between half an hour and an hour:

"Since the service is overloaded and patients have to wait a very long time, and it gets especially bad towards the end."

KS also thought that it was between thirty minutes and an hour, expressing a hope that, *"it must be less than an hour"*, and adding quickly:

"Nowadays, one would not want to have people waiting for hours as it is more of an issue than it used to be and, even if this happened, explanations would have to be given".

In S, most GPs, again, could not say for certain what the situation was but, as one of them estimated, using rather a crude method, *"there were no complaints and after one hour patients would complain"*. AU reinforced this by saying, *"I had no feedback as there were no complaints about eye services."* TR thought that it had been slowly improving over the last ten years, *"as the hospitals increased the effectiveness of service provision"*.

The other practitioners did not know, and did not even attempt to answer the question.

Responses to this question in U gave the impression of a more accurate picture of the situation as far as waiting times at the outpatients' department were concerned. DC, a fund-holder in U, thought it was less than thirty minutes, justifying this by saying, *"they also see a lot of extras"*, which is actually incorrect, since emergencies were, in most cases, separated from the routine appointments. CA, also a fund-holder, was not certain but also thought it was less than thirty minutes, guessing that there *"may have been a slight improvement"*, and qualified that it also depended on how the counting was done, *"whether it included the other staff or just the senior doctor"*. The other fund-holder also thought it was less than thirty minutes, but had no evidence for it.

LB, a non fund-holder, held a contrary belief, thinking that it was more than an hour: *"People still waited two hours, although fund-holders' patients were marked in a different way"*. S/he also confirmed: *"This has not changed, because people's complaints are the same."*

Two other doctors, one of them a fund-holder and one a non fund-holder, did not know.

SWEDEN

On the whole, primary care providers were not in a position to comment on what the situation of the specialist provider was and referred the interviewer to the hospital data. The data confirmed the information given by patients, and firmly endorsed the belief that communication between specialist and primary care settings in this matter was not the strongest point of their co-operation, even casting doubt on whether it existed at all.

CONSULTANT EYE SURGEONS' VIEWS

8.2.3 Changes in the time spent waiting to be seen at the outpatients' department as a result of the reforms

ENGLAND

All the consultants thought that waiting times in the outpatients' departments had declined since the reforms, AL saying that consultants were now more aware of the problem and that *"this was a good thing brought about by the reforms"*.

According to the majority view, the average wait seemed to be in the region of thirty minutes. It was also generally thought that patients with earlier appointments at the clinic were more likely to have a shorter wait. This was certainly a problem area, MJ of unit T pointing out that the administration system was ill-equipped to reduce waiting times significantly because of unexpected emergencies, over-booking, and inflexibility over the order in which patients were seen. MH, of unit U (the one with the most abysmal record), also cited limited resources as a reason for the long waiting times.

All the consultants in P were in agreement that there were no major changes to be reported. The clinical director gave an explanation relating this to the number of doctors available and the number of appropriately trained nurses able to do the first assessment. Moreover, according to him/her, *"the referral patterns also*

seemed to have played a role as numbers doubled following the increases in throughput". Another surgeon clarified that although waiting time may not have changed, there is an increased consciousness that the patient is waiting adding: "Before, if the patient was waiting, even for two hours, it wouldn't have mattered to the doctor, but now s/he tries to avoid this."

Another surgeon explained that it also varied according the time of the appointment: if it was 9am, patients had a good chance of being seen without delay, but waiting time worsened as the clinic progressed.

In unit S, the clinical director proudly replied, *"92% of patients were seen within approximately thirty minutes."* All the consultants confirmed this figure and took the opportunity to stress that this was a unique achievement when compared with other eye units, where the average was at least double that figure.

In T, all the consultants agreed that waiting time was not less than half an hour and usually about one hour. The clinical director explained that there was a difference between hospitals, mentioning the example of one hospital, where according to him, *"65% of patients were seen within an hour, and only 1% in more than an hour"*, which she apparently considered a satisfactory outcome. MJ (the consultant with the worst record) held a view that not much has changed in this area *"because patients either did not arrive when they were asked to, or eventually decided to seek private care."*

S/he went further, dwelling on numerous factors responsible for the situation, such as an administrative system that over-booked patients and inefficient transport, concluding with a quite pessimistic remark: *"There are too many factors in the NHS in which you can't intervene. This will never be possible."*

MH, of unit U, openly admitted that no significant changes have happened despite the new arrangements made for measurements of the visual acuity to be taken by nurses; patients still had to wait for a long time to see the doctor in spite of or because:

"A lot of requests to see patients more urgently, there were limits imposed by scarce resources."

S/he could not comment on the number of on-time appointments, guessing, *"maybe the early ones are on time, maybe 60% are on time, but the later appointments run late."*

SWEDEN

All the eye surgeons in Sweden were positive about the impact of the reforms in decreasing waiting times for patients, especially the wait to see a specialist at the outpatient's department in the hospital. WS, for example, thought that waiting time had been reduced, adding: *"Doctors cannot be negligent any more about waiting time."* An older surgeon, BP, also shared this view and explained how disincentives had operated in the former system, conceding that:

"While waiting time was never extreme, we used to be a little more negligent, so nurses could put more patients on the lists."

S/he also added that patients in particular were asked about their perception of the quality of care - whether doctors were nice to them or how long they had to wait while before only clinical outcomes were important clarifying: *"In the past, we used to get rid of patients, because the money for their care was fixed"*.

CZ also thought that waiting time had been reduced, *"though maybe it was only sometimes a bit longer than it is now"*. BC, the deputy director heavily involved in clinical management issues, explained that patients have been given an individual booking time for the last two years, to reduce or rather, in this case, to virtually eliminate waiting time upon patients' arrival at the hospital because:

"If they were not seen within a half an hour the hospital loses money - the fee paid for seeing a specialist is refunded to the patient."

S/he also commented on the dynamics of waiting time and its tendency to build up as the clinic progressed and was especially high around the lunch break as the survey conducted at the department has demonstrated (see Figure 8.2). Her/his information confirmed that certain actions needed to be taken for these improvements to materialise, even if waiting time before the reforms had not been extreme. The length of waiting time at the outpatient's department quoted by the eye surgeons confirmed the information provided by the patients.

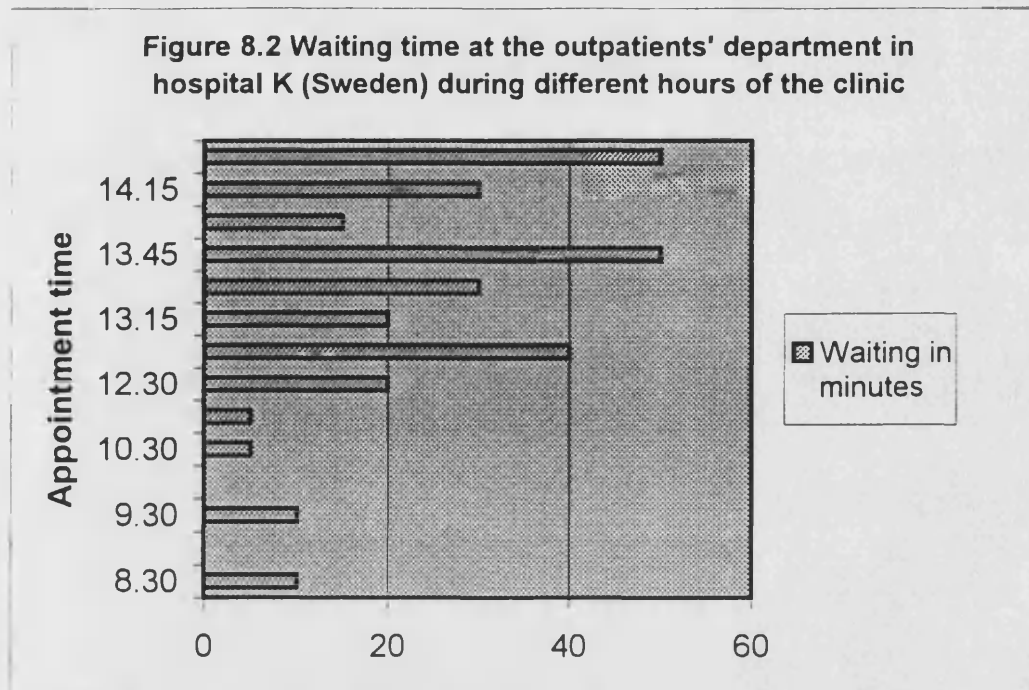


Figure 8.2 Waiting time at the outpatients' department in hospital K (Sweden) during different hours of the clinic

MANAGERS' AND PURCHASERS' VIEWS

8.2.4 Changes in the time spent waiting to be seen at the outpatients' department as a result of the reforms

ENGLAND

The deputy director of surgery at hospital S acknowledged significant changes in a number of areas and mentioned waiting times at the outpatients' department as an example:

"Before, all the outpatient appointments were made for 9 o'clock. Now, everybody gets an individual appointment time, and compliance with it is monitored."

The senior nurse in S was another representative of management in unit S able to comment on this subject. She was the best-qualified person to provide

answers to this question, as it was her direct responsibility to manage waiting times. Her reply was:

“The quarterly audits we conduct have shown that it is between thirty minutes and one hour, but the majority of patients have to wait for less than thirty minutes.”

The quality department of hospital T presented its reports on the monitoring of compliance with targets set within the hospital for each of the main specialties. The table below provides some insight into the gradual progress achieved over a period of three years after the implementation of the reforms. Thus in 1994/95 less patients are seen within thirty minutes (82.2%) than in 1996/97 (92.4%) and the total number of patients seen is also lower by at least a quarter (see Table 8.3).

Table 8.3: Changes in waiting times at the outpatients' department (all ophthalmology services) in unit T

<i>Agreed position: 80% of patients to be seen within 30 minutes and 95% to be seen within 60 minutes</i>						
<i>Agreed position: 75% of patients to be seen within 30 minutes and 95% to be seen within 60 minutes (in 1994/95)</i>						
<i>Year of measurement</i>	<i>Patients Surveyed</i>	<i>0-30 minutes</i>	<i>>30-60 minutes</i>	<i>>60 minutes</i>	<i>Cumulative % of patients seen between 30 - 60 minutes</i>	
1994/95	185	82.2%	15.7%	2.2%	82.2%	97.8%
1995/96	197	88.3%	8.6%	3.0%	88.3%	97.0%
1996/97	237	92.4%	7.2%	0.4%	92.4%	99.6%

Source: Data from Quality Department unit T

It did not seem to be an area of specific interest to the purchasers interviewed. On average, they had a broad or vague idea that the waiting time must have changed but it was not usually an indicator on which providers were asked to report. It had been included in “The Patient’s Charter”, however. On the whole, it seemed that purchasers were more interested in the waiting time for the first appointment and for elective operations than in how long patients had to wait in the hospital after securing an appointment.

SWEDEN

This question is answered under the heading where the eye surgeons involved in management outline their views (for details see Figure 8.2). The unanimous

opinion was that the introduction of the Stockholm Model had given incentives to work in a different way and that these incentives were very strong in promoting productivity, thus decreasing most types of waiting time. The purchaser in Z district was aware that appointment times had been individualised and the representatives of Stockholm County Council themselves expressed a view and a hope that waiting time at the outpatients' department must have improved, along with the decrease in other waiting times.

8.3 Quality: The Attitude of Health Professionals: Interviews with all respondent groups

PATIENTS' VIEWS

8.3.1 What are the improvements resulting from the reforms (if any) in the way you are treated by the health professionals?

ENGLAND

In S, the general impression was of patients being truly impressed by the quality of care provided, the kindness of the personnel and their helpfulness, as well as the speed with which everything was executed. Therefore, most of them found it quite difficult to add anything more on this issue. Comments like *"sympathetic care"* and *"professional but not cold staff, efficient but caring"*, *"perfect"*, *"everything marvellous"* and *"could not criticize"* were commonplace.

There were a few comments on improvements needed, such as, *"the need to be seen by the same doctor on the first post-operative visit"*. Only a few patients, though, were able to compare this attitude with the one that existed in the former system because of their limited experience of hospital care.

In U, by contrast, almost half the number of patients (six out of fifteen) thought that the previous system had served their needs better. This was justified on several grounds, such as more time being devoted to the patients in the past,

and higher staff morale and a better overall attitude were frequently referred to.

For example:

"A change is for the worse. Twenty years ago, things were more efficient and care was more personalized."

"Much better before. Patients were treated properly. Nowadays the waiting is longer and treatment is very rough."

Grievances were voiced as to staff's attitude, which was perceived as inappropriate:

"Before, patients were not kicked out of the hospital, as happened in my case."

Of this group, a few patients (four) admitted that there had also been some positive changes (such as less waste, better premises, occasionally nurses being kinder), but eventually even for them the losses outweighed the benefits, as was succinctly described by one patient:

"Their job insecurity and problems of staffing are now much felt by the patient."

Another, less numerous, group of patients from unit U (four) saw no difference in the professionals' attitude and for them this question seemed not to matter. One of them explained: *"I am a very demanding and kind of pushy patient and that is why I always get what I want."* Someone else said s/he would not know for sure and could not see any difference, also adding: *"I am quite scared to give answers, especially when they deal with judgments."*

Finally, a third group of patients, consisting of three people, was not in a position to comment, as they had had no previous experience of the NHS - surprising as it may sound! One of them said that s/he had enjoyed excellent treatment on this sole occasion.

In T, the prevalent view seemed to be positioned between the responses received from the two previous units. Two big groups of respondents, both composed of five patients, either thought that, *"people are more considerate now; questions are answered and information about the treatment is given before and during the procedures"*, or saw more modest changes. Those who didn't see major differences or no difference at all came up with the following statements:

"No, I haven't experienced any change, except for the fact that, before, there were a lot more people around. The wards are, however, still overcrowded and people sit for hours in the waiting room."

"I haven't noticed any difference, except for the doctors doing everything more automatically and more efficiently, so patients don't have to wait. But the treatment remains the same."

There was also a third, much smaller group of two patients who did not feel they could comment on this issue, as explained by one of them: *"I cannot tell, anyway. It is the doctors who will tell me what to do"*.

SWEDEN

Almost half the patients (thirteen out of 29) held the view that the present system was better in terms of an improved attitude on the part of the health professionals, which was supported by four patients, and better information provided to patients, stressed by three patients. The following comments provide some insight into their opinions:

"Everything has improved, and it is better both as a patient and as a human being."

"There is a big difference. It's better now, as there is more respect for each other than there used to be and the communication between nurse and patient is much better."

While patients acknowledged positive changes, they could also ascertain their limitations: *"Most of the changes are positive, but these are not big changes"*. Interestingly, there were also views, which linked new achievements, such as the increase in information and choice and improvements in the attitude of the professionals, to the competitive ethos introduced through the reforms:

"Competition with the private sector has been very good for Sweden, especially on the information side. It has also created a less nonchalant attitude among the staff".

"The matter of choice in today's society is the slogan of the day and I am very strong about that."

The possibility of voicing complaints and articulating demands was also seen as a new development: *"In the past, one would not have thought of complaining"*

about things." The strengths of the system most often referred to were the change in attitude of the doctors and nurses and the decrease in waiting times. On the negative side, patients reported a lack of continuity of care and occasionally a lack of quality in inpatient care. The following comment illustrates these points:

"Before, when I had to stay in hospital, the personnel had more time for me. Nowadays, I feel that patients are not too much cared for. Sometimes I even feel neglected."

One respondent pointed out an important factor, centred on the patient's ability to articulate demands:

"I cannot say about the difference, because the quality of treatment the patient gets depends a lot on how much self-confidence s/he has to ask for it, and a lot of old people don't dare to ask."

PRIMARY CARE PROVIDERS' VIEWS

8.3.2 In what way has the introduction of the reforms influenced your relationship with patients?

ENGLAND

There was no unanimous view as to how the reforms' impacted on doctors' relationships with their patients. This might possibly reflect the doctors' perceptions of the opportunities given by the reforms and the way each of them made use of them. Thus, the views were divided.

In sample T, GR, a younger single-handed GP, and an elderly retired GP, thought they could devote more time to their patients. However, the latter explained that this was due more to *"my move to the health centre and sharing work with my colleagues"*. PW, the GP linked to academia, and UN thought, on the contrary, that *"it is now more difficult to find time for patients compared with before"* and that *"it was probably true that doctors have less time for their patients nowadays."*

Primary care doctors in sample S echoed these views, and were again divided along the same lines. There was, however, a majority of doctors who could not see

that any changes had occurred. Even when the changes were acknowledged, they did not relate them to the reforms. For example, TR explained:

"I can devote more time to my patients, but this is not because of the reforms. It was already a trend before the reforms."

Someone else pointed out that the time devoted to patients had not changed, but s/he admitted: *"The reforms have, to some degree, helped me to understand patients' needs."* Another GP said that s/he could not devote the time to his patients s/he used to because of pressure on his/her time introduced by the reforms.

In sample U, there was unanimity among doctors about patients' increased demands and the resulting pressures on doctors. The overall impression was that, even when the doctors devoted more time to patients, the patients did not feel that their needs had been always entirely satisfied. Respective statements coming from a fund-holder and a non fund-holder who intended to join the scheme illustrate this point:

"Patients are more insistent and place more demands on my time. There are also more complaints about waiting time and an increase in grass-roots empowerment."

"I feel more pressurised. Patients expectations are much higher, and patients like to discuss the options more."

Two out of three fund-holders felt that they could not devote the same time to patients either *"because of the workload"*, as one of them explained, or *"because it sounded like a discrepancy to me: the more the patients demanded, the less I caught up"*, as another one had put it. PE, a non fund-holder, also stated that s/he devoted more time to patients because they demanded it, but s/he also thought this was possible because:

"Doctors saw fewer patients than before and some of their work was now done more frequently by other health professionals, such as counsellors, nurses and dieticians."

LB, a non fund-holder involved in commissioning initiatives, explained that while:

"Patients are becoming more and more demanding, I am trying to meet their needs."

SWEDEN

The Swedish doctors and a nurse were asked about certain aspects of care, such as the time they devoted to their patients. The responses from primary care providers were mixed. While some of them, such as the female primary care doctor and the private ophthalmologist admitted, *"this has not changed very much"*, the other primary care providers, both the private doctor and the ophthalmic nurse, thought their working style had changed, as the former summed up:

"I cannot devote the time I used to before, because of the pressure for higher productivity."

However, MK who felt she had not changed her attitude to patients, reported at the same time that most of her colleagues were complaining about not having enough time for research and other activities or for family life. On the other hand, NB thought that:

"There were probably slight improvements due to the competition and to the fact that doctors are now more conscious and more respectful, in order to avoid the mistakes of the past."

CONSULTANT EYE SURGEONS' VIEWS

8.3.4 In what way has the introduction of the reforms influenced your relationship with patients?

ENGLAND

The overall impression from the consultant eye surgeons' responses was that their pattern of clinical work seemed not to have been greatly affected. Thus, the majority of them did not feel that their time for patients had, in any significant way, decreased, either because they had withstood the reforms' pressures or because their time was already quite limited.

The clinical director of unit P, who stated that this *"has not changed, because pressure on performance was always that way for me"*, confirmed the latter view. Two other consultants from the same unit felt they understood that provision of

good care might not be achieved if it were inefficient, but only one of them indicated that the reforms had affected his/her attitude to patients:

"I now think more about providing better information for patients without wasting their time, and about giving them a pleasant and personal service. I regard this as being a direct benefit of the reforms."

This attitude was also reiterated by the clinical director of unit S, a pro-reform, business-minded person who saw the patients "as customers with rights", admitting that, before the reforms, s/he had considered the same issue quite differently:

"I thought I was doing them a favour. This has changed completely, and all for the better."

DA, a newly appointed consultant to the S, thought that time pressure had negatively affected his rapport with patients and the time s/he should spend with them from medical point of view, elaborating:

"I cannot do enough, because of these nonsensical standards, which are often artificial - for example, those that concern waiting time at the outpatients' department."

S/he was also the one who explicitly asserted that the reforms had helped him to understand the difference between his and his patients' perception of quality care:

"This is one of the biggest impacts of the reforms, as far as I am concerned, but possibly few doctors would agree with me."

Another newly appointed surgeon in the same unit agreed, with this comment, explaining:

"The time I devote to my patients has slightly decreased, but my attitude to patients has now changed."

As in the former unit, there was also one consultant who thought that things had remained unchanged for him/her.

In T, two of the consultants admitted that they had less time to devote to patients, one saying that waiting time standards had forced him/her to cut the amount of time spent with patients. One consultant was not sure, but, in his/her view, "patients behaved as customers and demanded more", without providing any hint as to whether this change had been for the better. The other consultant believed

that there had been very little change in this area: *“but a certain decrease was noticeable because of productivity pressures.”*

The clinical director also supported the latter colleague's view, pointing out the marginal character of the changes that had taken place:

“It is about the same, although timing is better and therefore more things are done within the primary health care clinic.”

MH, of unit U, did not provide a comment on this subject.

SWEDEN

The director of hospital K painted an optimistic post-reform picture stating the importance of the human approach to patients that has been much enhanced because of savings made in time-management: *“Time once wasted can now be used for talking to patients on the day after the operation.”* However, no other eye surgeon could confirm this statement. The two other senior surgeons felt that, on the contrary, they could not devote the time given previously to their patients because of higher productivity pressures. As of them explained:

“On the one hand, I have to do a lot of surgery and, on the other hand, the investigation is standardised. As a result, the time devoted to the patients has suffered in the system.”

The other doctor elaborated that s/he had to do a lot of cataracts it paid for his/her other interests – such as research while conceding *“I do not know how other doctors can deal with this issue of lack of time spent with patients.”*

MANAGERS' AND PURCHASERS' VIEWS

8.3.5. Do you think that after the reforms were introduced, health service provision acquired a more user-friendly approach?

ENGLAND

The Public Health doctor involved in the management of hospital T thought that more comprehensive changes were needed to bring about a different attitude

among health professionals. These would involve more interest on the purchasers side in all sorts of communication groups and learning from patients' activities. S/he concluded:

"In reality, however, a lot of this information is ignored because there is no money to respond to it and act on it."

The deputy chief executive of the hospital in unit S saw the patient-provider relationship as having changed quite significantly. S/he commented on patients' willingness to exercise their rights:

"Yes, patients will now complain about a five-minute delay, which is a definite sign of their empowerment. They also question consent and seek a second opinion. But we can see positive effects as a result of their complaints over processes."

S/he also added that changes of attitude were occurring and were influenced by the increase in the number of consultants, junior doctors and nurses, who *"tried to make the service more customer-orientated."*

The nurse managing the eye services in S had a few comments to make on the changes in the attitude of providers and patients in the aftermath of the reforms:

"In every change we introduced, we asked patients first, as patients have to be satisfied with the change. We even tried to obtain feedback from the patients in our attempts to perfect the surgeon's technique."

In U, the director of the acute department provided an insightful comment on the reasons why the attitude of the providers had changed, which, in his view, was more a response to the purchasers' needs, both GP fund-holders and non fund-holders:

"The efforts of the providers are directed at meeting specific targets set by them for their patients. But, in fact, the patients don't decide. Even GPs can be persuaded that, for example, small incision surgery is less invasive and thus has positive implications for the quality of outcome."

A manager from the quality department of hospital T gave information about a survey conducted every half a year and which investigated patients' general impression of care, but s/he thought there was still a long way to go in terms of incorporating patients' concepts of care.

Of the purchasers in the UK, the director of acute commissioning for the Health Authority covering unit S provided information on changes introduced by the reforms. Most of the doctors in S Health Authority were non fund-holders at the time the survey was conducted (summer 1995). Only 16% were fund holders, which meant that there were six fund-holding practices out of 60; another six planned to join in 1996. S/he explained the Health Authority's interaction with them and commented on changes brought about by the reforms in the providers' behaviour:

"We try to work very hard with the fund-holders, but it is very difficult as they are very individually-minded and act independently. It is easy to get their views, but more difficult to influence their patterns of behaviour. The power of individual consultants has been eroded and there are attempts to reach the middle ground in power between managers and doctors."

SWEDEN

The management of hospital K in Sweden is in the hands of the leading eye surgeons, the male director (MH) and his female deputy (BC). They are supported in their duties by a small team of accountants who have strict responsibility for financial matters and are headed by a financial manager. Their answers regarding this aspect of have already been outlined in respective section.

The purchaser in district Z of Stockholm County thought that there had been, so far, no negative signs as far as quality was concerned. However, there was an increased interest in recording quality *"as this had not been done before"*. According to him:

"It was very difficult to say whether there was an improvement or a worsening in the quality of care. The only thing one could mention was the increased awareness of its importance."

Another member of the County Council, who was directing the quality evaluation unit, thought that the steering system itself could not change the behaviour of the actors involved:

"Some changes will occur, but they will not be big, because the performance of doctors is not related to financial incentives, which are the real changes."

S/he added that, even within the reformed system, *"the money still flowed internally in the system"*. Thus, the real gains of competition had not been brought forward.

The other purchasers refrained from commenting on this issue.

KEY FINDINGS

- A wide range of people supplied verbal information. It appears that the general rule is that the consultant is the first to give information, during the patient's initial visit. After this point, both junior doctors and nurses provide further information at different stages in the patient's treatment, both pre- and post-operatively. Senior doctors in the UK more often saw patients (54%) than in Sweden (only 28%) on their first diagnostic appointment, but not as often as the specialist doctors in the hospitals claimed to be the case (see Table 8.3).
- There is a wide difference in the timing of information about the operation date given to patients in different units, with the most notable difference occurring in an under-performing unit U (double the average value), which attracted the most complaints from patients. This seems not to be recognised by clinicians or the management of the respective provider.
- The primary care doctors from the most of the samples in question do not know anything about how long in advance patients are informed of their operation date. It seems that, once a patient's care passes from the GP's surgery to the hospital's eye unit, the GP very much loses touch with the treatment process, although the doctors in sample U (where more fund-holders were represented) were better informed about this aspect of patient care than the primary care doctors in the two other groups where no fund-holders were represented.
- Waiting time at the outpatients' department in unit S was on average about 30 minutes or less according to consultants, which was also confirmed by the majority of patients. It was for about one hour in T and it was significantly above this hour limit in U. It was much more according to patients and some consultants. There were no major changes in unit P and in unit K. In both cases all respondent groups unanimously agreed that waiting times were on average less than 30 minutes and quite often it was just 5-10 minutes (see Figure 8.1).
- Waiting time at the outpatient units has been improving on the whole although the differences among units were significant. It seemed that those units, which

embraced reforms and were in favour of the business – like mentality were more successful (S in the UK and K in Sweden). Conversely, the unit U that was torn by internal tensions between the management and clinicians and was eventually closed down had by far the worse record.

- Similarly, the positive shift in the attitude of health professionals was also markedly different in the units (S in the UK and K in Sweden), which had better performance on the number of indicators; a finding that was further confirmed by higher levels of patients' satisfaction and dissatisfaction (unit U) respectively. However, even in the few cases that patients could see the positive changes this was accompanied by a marked awareness of the limitations involved. On the other hand, poor attentiveness and lack of friendliness in unit U was perceived as a result of changes created and it gave rise to open dissatisfaction on the patients' side.

CHAPTER 9

RESPONSIVENESS: WAITING TIMES

This chapter deals with responsiveness to need, which is measured as changes in waiting times for the first specialist appointment (from the moment of referral) and the waiting time for the operation itself. Both waiting times are treated as crude measures of demand for surgery, and in the absence of more accurate indicators also as a proxy for need for cataract treatment. Bearing in mind all limitations that this approach entails, the views on sensitivity of this method are sought after from General Practitioners, eye surgeons, managers and purchasers.

Figures on the length of waiting times quoted by patients, GPs, eye surgeons, managers and purchasers are compared with national figures when these are available. Unfortunately, there is very little service-specific information on the waiting times for the period before reforms, which is non-existent for the first specialist appointment.

9.1. Waiting Times for the First Specialist Appointment: Interviews with all respondent groups

PATIENTS' VIEWS

9.1.1 How long did you have to wait for your first specialist appointment?

ENGLAND

In S, quite a few patients did not remember what had happened to them and the answer to this question posed significant problems. Six out of eighteen patients thought the waiting time was less than six weeks, and it ranged from one week

(in the case of a private patient) to six weeks - the average being four weeks. One patient thought it was around three months and the remaining ten respondents could not recall this information at all.

In P, five out of seven patients replied that the wait was less than six weeks; the other two patients waited for ten and twelve weeks respectively.

In T, five patients waited from three to six weeks. Another five patients had to wait for several months and the most often quoted figure was two months. One patient had to wait for only a few days and another could not remember the exact figure.

In U, four patients waited for less than six weeks, while the remaining eight patients waited for more than ten weeks. Two patients said it was not very long but they could not be more specific about the length. There seems to be a sharp division between the waiting times faced by patients in U. While the minority had to wait a reasonable time for the first specialist appointment, the majority had to wait for between four and five months (two patients), six months (three patients), and a year (three patients). One patient said that she was given a date one year ahead for a specialist appointment but, following her/his complaint, s/he received one after two or three months.

The differences between different units are presented in Figure 9.1.

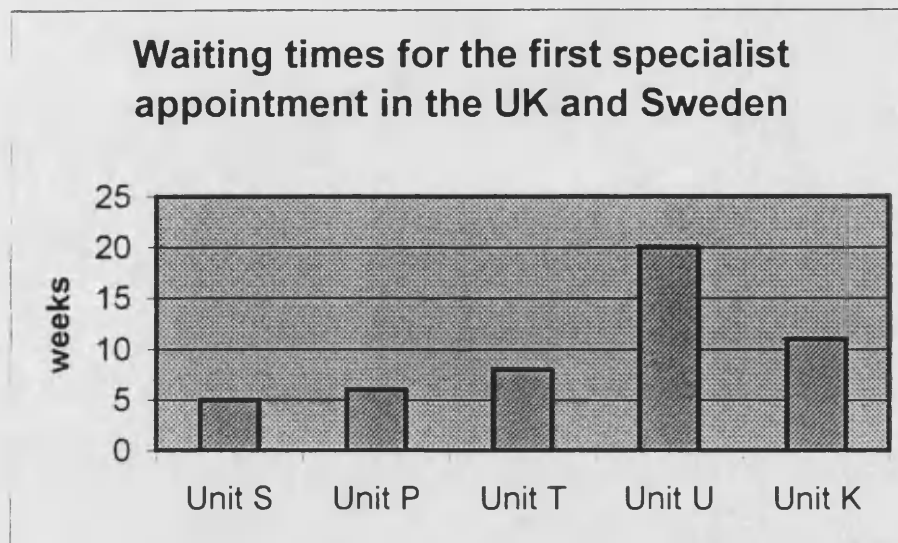


Figure 9.1: Patients' views on the length of waiting time for the first specialist appointment in different eye units in the UK and Sweden (unit K) in 1995/96

SWEDEN

The average waiting time for the first specialist appointment was eleven weeks, which was almost double that of the best performing eye units in the UK (see Figure 9.1). The largest group of patients (nine and eight) waited for two and three months respectively. A few patients had to inquire whether the referral had arrived.

The next largest group included patients who had waited either for one month (four) or for a period between one and two months (three). Finally, one patient reported waiting for less than three months, another referred to a waiting time of one year, and someone else could not reply.

PRIMARY CARE PROVIDERS' VIEWS

ENGLAND

The general feeling among GPs was that of a decreasing length of waiting time for the first specialist appointment in the eye units they worked with. Sample T in the inner city was certainly the most positive, with all believing that there had been improvements, although some doctors admitted that these were only slight. Only one doctor was of the opinion that the closing of hospitals had increased waiting times. The doctors were better informed of developments in this field as this was something that was included in GP information packs dispatched regularly by providers. One of the GPs explained how this new system enabled him/her to contact a particular consultant:

"GPs are sent a list of doctors with personalised information on waiting times for an appointment by doctor, which gives the GP an amount of choice to refer the patient to a particular surgeon instead of writing 'Dear Doctor' as it used to be before."

When asked to expound further on their knowledge of the wait for the first appointment by giving an actual estimate of the time, there were some telling responses. Doctors in sample T were largely in agreement, with three out of five suggesting waiting times in the region of three months. One doctor was not sure, and another gave the somewhat alarming figure of thirty months. This was, in fact, far beyond the absolute maximum at the hospital to which this doctor referred most of his/her patients, at least during the time that this study took place in 1995/96 but it was a reality during the pre-reform period.

GPs in sample S gave a range of answers, but all were in terms of weeks rather than months, and it was a fairly accurate portrayal of the situation. RE summed it up by stating:

"It is four weeks. It used to be eight weeks. It is continuously decreasing, but varies from month to month."

Sample U showed an interesting divide between fund-holders and non-fund-holders. The two fund-holders estimated the waiting time as being less than six weeks, and no more than four weeks respectively. The non-fund-holders from the same area were clearly less well off, or at least perceived this to be the case,

most settling for figures in the region of ten weeks, and one guessing at six months. LB, a non fund-holder involved in commissioning initiatives, said it was more than ten weeks, explaining that, *"the leaflets would say within a few weeks. But it was even longer before - about six months"*. HW, a non fund-holder who intended to join the scheme, also agreed that it was between six and ten weeks, adding that, *"it was sometimes less but it could also be three to six months"*.

Fund-holders of the area CA and DC said that the waiting time respectively *"was between seven and ten weeks and sometimes less"* and *"one month in the outreach clinic"*. Another fund-holder also agreed that waiting time had been reduced, which s/he also related to the outreach clinic, but argued:

"It was hard to say whether outreach clinics happened only because of the reforms as, even before becoming a fund-holder, outreach clinics were organised by FHSA."

The variation in figures quoted could be partly justified by the variation in waiting times in the hospitals to which different primary care doctors referred their patients; but it could also be due to their different status. This could happen either because they had special arrangements in the form of outreach clinics at other hospitals outside their area or because they could be offered shorter times in the same hospitals. On the whole, fund-holders as opposed to non fund-holders waited less, which is reflected in Figure 9.2, that compares waiting times among two types of GPs in sample U.

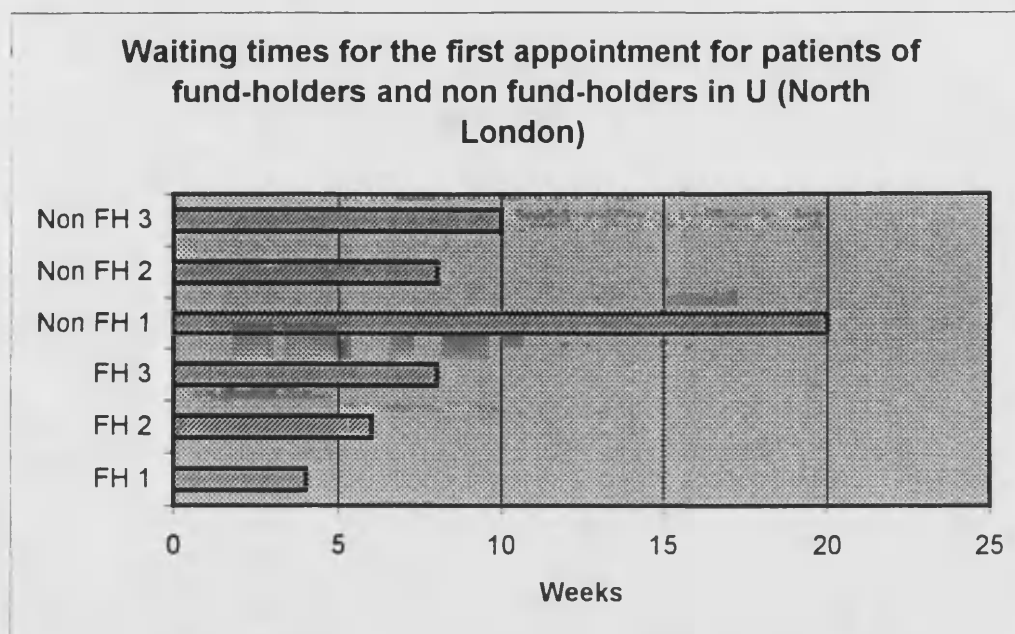


Figure 9.2: Waiting times for the first specialist appointment at eye units in area U for patients of fund-holders and non fund-holders in the UK in 1995/96

SWEDEN

MK, the only female GP in the Swedish sample, thought waiting times had been reduced which, according to her, could be attributed to the reforms. NB also supported this view, explaining that waiting time has been reduced to a period of between two and six months for cataract surgery *"while before, it used to be from one to one and a half years."*

PG, the private GP, reiterated that *"waiting time has been reduced due to the reforms"*, adding that when s/he had wanted to secure access to an eye doctor within one week, s/he had referred the patient to a private clinic.

When asked to indicate more specifically the approximate average waiting time for the first appointment, only MK and BN could provide an answer and they respectively thought *"it was between six and ten weeks"* and *"two to six months"*. The reason for this relative lack of knowledge about the specific length of waiting times can be sought in the information provided by PG, who explained that:

"A lot of patients can go to the Accident and Emergency department of K hospital directly even for planning elective care, because they are less prepared to wait."

CONSULTANT EYE SURGEONS' VIEWS

ENGLAND

According to the views of most consultant eye surgeons, the new stricter attitude towards waiting times - with specific targets being set by the government - seems to have forced them down. The decrease has not been a passive result of the reforms, but rather an area that has been targeted by the government. It was suggested that the main factor in reducing waiting times was extra staffing and the additional resources that were made available for this purpose.

Interestingly, consultants in sample T expressed their doubts most strongly as to whether the reforms were at the root of the decrease in waiting times for the first specialist appointment for cataract surgery. MJ, the consultant with the longest waiting times, thought:

"Waiting time has improved, but this was not due to the reforms. It was due to the number of consultants hired."

S/he also ascribed it to the clinical director's initiative to start primary health care, where patients could come in for specialist consultation, which had made a temporary difference because doctors' limited time was used more efficiently. S/he complained, though, about the inefficiency in ophthalmology services in the UK, which had not followed the USA example:

"Where technicians look at the patient first and it takes only five minutes of the consultant's time to examine the patient."

The clinical director of unit T also supported the view that any changes that were happening were not related to the reforms, as they depended on the number of staff and on the popularity of the hospital because of its teaching status. She referred to new consultants being hired and to the waiting list initiative being launched, which were both responsible *"for the decrease in the waiting time from thirty weeks to nineteen"* (see Table 9.1).

Table 9.1: Changes in waiting times for the first appointment (by consultant) in unit T (inner city) by weeks in comparison with the agreed standard for the speciality

Name of consultant	Waiting time in 1994/95		Waiting time in 1995/96		Waiting time in 1996/97	
	December	March	December	March	December	March
<i>CD</i>	16 weeks	18 weeks	3 weeks	3 weeks	16 weeks	26 weeks
<i>MJ</i>	29 weeks	40 weeks	12 weeks	14 weeks	25 weeks	23 weeks
<i>BL</i>	14 weeks	12 weeks	4 weeks	5 weeks	15 weeks	15 weeks
Target agreed	10 weeks standard		12 weeks standard		6 weeks standard	

Source: Quality department data of the hospital T

It can be seen that the targets for waiting times were only achieved in unit T for 1995/96, with most consultants reaching the standard agreed for that period. However, the preceding average lengths of waiting times and the ensuing ones in 1996/97 were only remotely related to what management aimed to achieve. The observed discrepancy between performance and the set targets in year 1994/95, the overall compliance for the subsequent year 1995/96 (with the exception of one consultant), and the rebound to the previous state of divergence in 1996/97, is rather difficult to interpret. Possibly the effects of the reforms were short-lived and just when the results were starting to show, the reforms were quite hastily abandoned.

The overall average waiting time for a specialist appointment in sample S was about six weeks, with an upper limit of ten weeks. There was general agreement over this question. JO thought that this was partly due to the reforms, mainly the targets, which were set, and the strict control over them. The waiting times for specialist appointments did not differ among consultants; therefore, it was probably not relevant to provide this information to the purchasers. However, the changes in the number of patients waiting for more than three month for the first specialist appointment, although not calculated specifically for the cataract surgery, present a telling picture - especially when they are compared with the number of operations performed (See Table 9.2).

Table 9.2: Number of patients waiting over three months (total for day cases and ordinary admissions - all ophthalmology services) in unit S (Southern London)

<i>Period measured</i>	<i>June 1992</i>	<i>Sept. 1992</i>	<i>Dec. 1992</i>	<i>March 1993</i>	<i>June 1993</i>	<i>Sept. 1993</i>	<i>Dec. 1993</i>	<i>March 1994</i>	<i>June 1994</i>	<i>Sept. 1994</i>	<i>Dec. 1994</i>	<i>Mar. 95</i>
<i>Number of patients waiting</i>	68	49	13	24	115	131	76	82	147	134	62	9
<i>Number of patients operated</i>	98	76	62	102	79	104	68	107	108	131	69	141

Source: departmental data from Eye Unit S Hospital

Table 9.3: Waiting times for cataract surgery in all eye hospitals in the County Council of Stockholm (expressed as numbers of patients and waiting times) in the years 1992-1995

<i>Name of the hospital</i>	1992 (December) Number of operations	1992 (December) Waiting time (in weeks)	1993 (December) Number of operations	1993 (December) Waiting time (in weeks)	1994 (December) Number of operations	1994 (December) Waiting time in weeks
<i>Hospital K</i>	1455	10** weeks	2172	7*** weeks	1161	4-12 weeks
<i>CC hospital X*</i>	95	10 weeks	-----	-----	-----	-----
<i>CC hospital Y</i>	260	6** weeks	249	6-8 weeks	134	4-8 weeks
<i>CC hospital Z</i>	-----	-----	165	2-8 weeks	60	9-24 weeks
<i>Private W</i>	n.a.	-----	n.a.	-----	n.a.	3-4 weeks
<i>Private X</i>	n.a.	-----	n.a.	-----	100	3-4 weeks
<i>Private Y</i>	-----	-----	-----	-----	117	10 weeks
Total	1810	-----	2586	-----	1615	-----

Source: hospital K data and County Council data

*Clinic closed in May 1993, ** patients without the care guarantee wait 16 weeks,

*** Patients with the care guarantee waited 15 weeks and those without the care guarantee waited 19 weeks.

As the data illustrate, in S, there is a rise in the number of patients' waiting in June and September, which is significant in all the years examined. It can also be noticed that the absolute numbers of patients waiting for more than three months increased over time, which may also be due to the total increase in patients seen (see Table 10.1 in Chapter 10). The department recognised that quarterly targets for waiting lists had to be set and ways of reducing waiting lists in the summer months devised without adversely affecting the revenues of the department.

Uniquely, in P, the prevalent view was that of an increase in waiting time for the first appointment because of the increase in referrals, which according to the clinical director had doubled as a result of the unit's performance and the increase in the number of patients operated on. They added that waiting times depended greatly on the hospital and in particular on the management, on departmental policy and on set quality standards.

This was supported by one of the leading surgeons in the unit, who thought, *"the reforms were responsible for increases in the waiting time for the first appointment"*. Their views as to the length of waiting times were divided, which seemed to reflect the individual waiting times per consultant. Thus, the more established clinical director and another senior consultant had a waiting time of more than ten weeks (twelve to fourteen weeks) and six to ten weeks respectively, while the newer surgeons had waiting times of less than six weeks.

MH, the leading consultant in unit U, claimed that the waiting time was much shorter than the times quoted by patients in the same sample. S/he quoted a figure of twelve to thirteen weeks, while patients referred to 20 weeks on average. MH acknowledged that s/he did not know for certain what the length of waiting time was, but explained that the recent increase in waiting times *"was caused by the specific policies pursued by the trust, which in order to become a community hospital reduced services and moved them to a nearby hospital."*

Unfortunately, data for the period before the introduction of the reforms, which could have provided some comparison, were not available because they were not at all monitored, either by the hospitals or by the eye departments. This lack

of data refers to the waiting time for cataract surgery, the waiting time for the first specialist appointment, and the waiting time at the outpatients' departments across all the units examined.

SWEDEN

The hospital director was not aware of the exact figure for waiting times and referred the interviewer to the data from the specific departments. The surgeons in the departments confirmed that the period was around three months. WS explained that this included between six and ten weeks waiting for the pre-operative examination and another three to four weeks waiting for the operation itself, adding that the hospital made a serious attempt to stick to that.

BC said that where patients were found to have waited longer than the care guarantee maximum of three months' waiting time, they could ask for the refund of 180 SEK paid for each attendance. S/he confirmed:

"Some patients were making big deal about this and, as the hospital was losing money, it acted as a deterrent."

S/he elaborated further that had it not been for the substantial amount of extra money given specifically for this purpose, waiting times would have stayed equally as long as in the past. In his/her view:

"This was rather a political decision. It can also be said that the reduction in waiting times was a joint contribution of higher efficiency and more resources being made available."

BP explained how the hospital dealt with referrals that came from primary care providers:

"They were then given the exact date of arrival, which was one month later, but most patients had to wait for about three months."

CZ said waiting times were less than two and a half or three months, adding that:

"The waiting time has been reduced and there is a proof for that in the form of feedback in writing from the doctors who refer patients to the hospital."

MANAGERS' AND PURCHASERS' VIEWS

ENGLAND

The management in unit S thought that the waiting time for the first specialist appointment was less than six weeks and was closer to five weeks. Figures quoted by the management in unit T are presented in Table 9.1. In U, according to the director of acute services, this was more than ten weeks (thirteen weeks). In P, this was said to be around two months, although a wide variety in waiting times between consultants was also confirmed by the manager of the respective unit.

From purchasers, only the acute commissioning officer of the Health Authority to which hospital T belonged administratively provided a specific comment on waiting times for the post-referral period. S/he asserted that:

"While waiting times for operations have certainly gone down, the waiting time for specialist appointments has not necessarily followed the same trend."

In his/her view, the latter was probably due to the choice available through the different units in the inner city area, and also due to more activity being carried out and more patients being operated on. These patients were picked up more easily, because of greater development of the outpatients' facilities. The average waiting time for first specialist appointment, when compared across the different hospitals in the area, was currently three to four months.

Purchasers from other units decided to comment on waiting times in general or not at all and did not make specific references to waiting times for the first appointment.

SWEDEN

The data presented by the clinicians were confirmed by the figures quoted by the deputy director responsible for the management of waiting times and other quality related issues. When purchasers were concerned the situation is similar to that of the UK, with purchasers not being preoccupied with distinctions between waiting times for the first appointment and the surgery itself; this could

be a result of relatively insignificant difference between those two at least in case of Sweden.

9.2 Waiting Times for Cataract Surgery: Interviews with some respondent groups

PRIMARY CARE PROVIDERS' VIEWS

ENGLAND

The GPs showed a relatively poor knowledge of the changes, which had taken place when questions about the length of the waiting lists for cataract surgery at the local hospitals were asked. In most cases, they also could not say whether there had been any significant change in their length since the introduction of the reforms.

Samples T (inner city) and S (South London) seemed to be the least informed, with doctors in the former answering that they did not know, or that there had been no significant change. Those in the latter did feel that waiting lists had decreased, but often said that their patients had not made any complaints. There were responses that indicated unwillingness by the doctors to acknowledge the reforms as being at the root of the changes occurring, which was well summarized by the only fund-holder in the S area:

"Hospital S was always world famous and its performance has nothing to do with contracts. The contracts coincided with what was already happening."

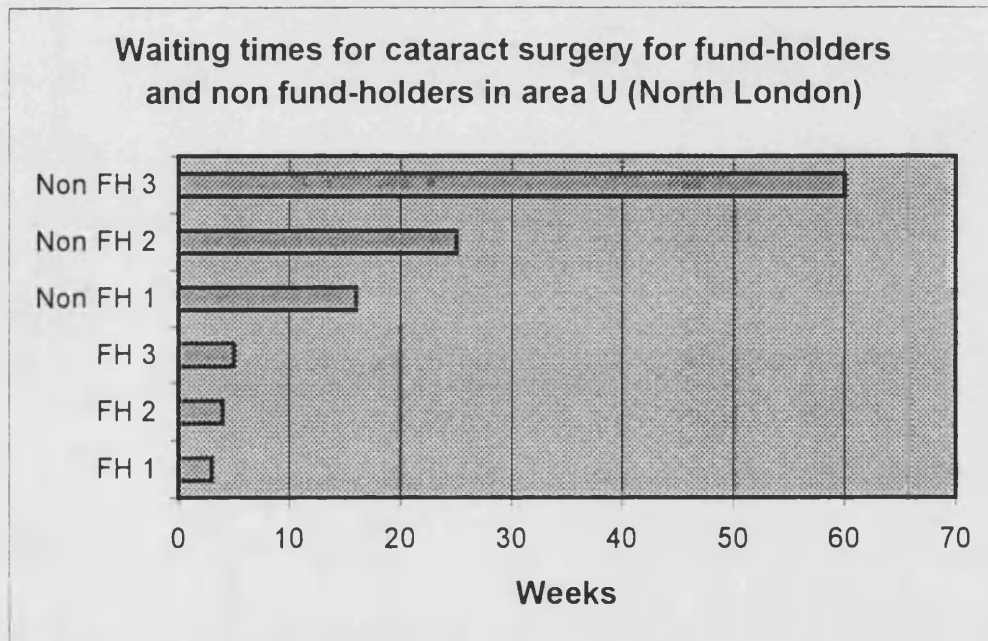
Most interesting are the replies from area U where differences between the reports of fund-holders and non fund-holders are even more evident. The two fund-holders from sample U (North London) said that waiting times had decreased "*enormously*", according to one of them, and they were respectively quoted as being less than three weeks. The non fund-holders were divided between thinking that there had been no real change or that waiting lists had grown slightly smaller.

One non fund-holder summed up the current attitude of providers, and also patients' compliance with whatever was offered, as follows:

"It [the waiting time] is less than it was. They [the hospitals] are slightly more sympathetic and if people complain they immediately get a place after a phone call from the GP. Although patients are often told to get a General Practitioner to write a letter, which is a total waste of time, people do not complain."

The figures quoted by the non fund-holders were respectively four months, three to six months, and one year to eighteen months (for details see Fig. 9.3).

Figure 9.3: Waiting times for cataract surgery in hospitals in area U for fund-holders and non fund-holders in the UK in 1995/1996



The doctors were then all asked if they thought that the waiting list was unacceptably long and, if so, what actions they had taken to tackle the problem. None of the GPs in sample S chose to answer this question. Those in sample T offered a range of solutions, and all agreed that waiting lists were too long, which was odd when their ignorance of the state of waiting lists at the time is taken into account (as demonstrated above in their responses to the previous question).

Sample U offered solutions along the lines of increased communication between GPs and consultants (two of them) which was not in any way a novel solution, and another two pointed to the transfer to fund-holder status. The GP in U who had decided on the latter move commented:

"Now consultants are more interested in contracts coming from fund-holding practices. Fund-holders have made a difference. That's why we are aiming at becoming fund-holders."

The doctors were asked whether they felt that the size of the waiting list could be used as a sensitive measure of the demand for cataract surgery. There was very little agreement over whether or not this was the case, and a number of different points were mentioned in the answers. One GP from area T expressed a view that s/he did not think it was a sensitive measure, adding that in order to get a clearer picture, *"the number of people being operated on has to be compared with the number of people being referred for cataract surgery"*. Another answer summed up the complexity of the issues involved:

"It was a difficult question to answer as, on the one hand, it does not give you a guide to the throughput of the unit and, on the other hand, a long waiting list does not have to mean low productivity."

One doctor from the inner city area T presented an alternative hypothesis and explained that people who were kept on the waiting list to be seen in one year's time were now being sent back to be cared for by the GPs. S/he added:

"There would also be other pressures for referring or stopping the referral of someone who had been on the waiting list too long."

A non fund-holder in sample U thought, *"it was not a sensitive measure of demand but a measure of agreed supply"*. S/he referred to the example of his/her practice, which was situated in quite an affluent area, where half the patients did not wait at all as 50% of them would go privately, and s/he characteristically commented:

"They are not on the waiting list at all. It is, rather, people who are poor and inarticulate who agree to the second-tier service."

Another interesting point, which may or may not necessarily be relevant, is that the two fund-holders were both of the opinion that the length of the waiting list was a sensitive measure of demand for cataract surgery. Someone else guessed:

"It must be some reflection of demand but it also comes down to beds, change of consultants and how many of them were employed."

SWEDEN

The responses of the Swedish primary care providers to this question were rather short and concise. Most of the primary care doctors agreed there had been a decrease of waiting time, with BN, the other GP, explaining that it usually took one to two months more after the specialist appointment. When asked about the resolution of the waiting lists problem, MK thought different budgeting systems could possibly be an option in resolving this problem. NB said:

"A lot of cuts that are made nowadays could lead to a decrease in the quality of care - in the form of long waiting lists for operations and other elective procedures."

CONSULTANT EYE SURGEONS' VIEWS

ENGLAND

On the whole, consultant eye surgeons from all units agreed that waiting times for cataract surgery had decreased. Notable exceptions were some consultants in P who felt that their productivity achievements had resulted in them being "penalized" in the form of more referrals, which, in combination with scarce money from purchasers, had eventually led to the rise in waiting times.

In P, the reason that was specifically mentioned as being responsible for increases in waiting times was "ex-listing", where patients were taken out of the list to be replaced by fund-holders' patients, as explained by one consultant:

"This was due to pressure from management before the end of each financial year, when there was no more money to operate on patients from the list."

S/he noted that the fund-holders' patients waited for only two to three weeks in this period but this meant an increase in waiting time for the patients who were already on the list. In support of this view, another consultant described the results of the lack of funding typical of the end of each financial year and resulting in surgeons being unable to operate at all. S/he gave specific examples:

"After the hospital became a trust, we did not operate for four months in the first year, for two months in the second year and for six weeks in the third year, which had an obvious impact on the waiting list."

S/he continued to explain that it happened because of the "vicious" financing system employed by purchasers. The system they used was to discount the amount of money for the number of operations that had been performed in the previous year by 5% each year, which obviously had to have a cumulative effect over the years. Hospitals were pressed by the management to perform fewer operations in order to preserve their financial stability. Thus, an "iniquitous system", as expressed by TF, was created.

The clinical director and another surgeon took a different view and focused on the positive side of the reforms, which, for them, meant the new £5 bln. eye unit, which had been created on the site of hospital P in order to meet the needs of the local population. This, it was hoped, would solve the problems of waiting times in the longer term and, as expressed by JJ:

"This would never have been possible without the reforms enabling hospitals to act under Trust status, which gave them more flexibility and freedom of movement."

In S, the unanimous belief among the consultants was that the waiting time for cataract surgery had decreased since the reforms. The reasons for this drop were many and varied. There had been an introduction of extra operating lists, leading to an increased patient throughput. The shift to day care treatment was mentioned, as was an increase in the number of patients having surgery on each operating list, and a general rise in efficiency. However, here again the clinical director complained of the perverse incentives that "over-performers" faced in the form of more work for the same amount of money:

"We get more referrals which are not funded, but we don't necessarily increase the number of operations. Money does not yet follow the patient because only the GP fund-holders have money."

This view was also echoed by another consultant from the same unit, who on the one hand criticised the artificial incentives to reduce waiting lists that had existed before, but also disapproved of the mechanistic nature of the standards for waiting times set in the contracts:

"In principle, it's enough to complete all the cases within six months but they have to be spread throughout the whole year and, in order to solve this problem, we try to attract a number of referrals from GP fund-holders."

All consultants in T also felt a decrease of waiting time had occurred. CD thought that it was about one to two months after the first specialist appointment and the other newly appointed surgeon, BL, thought it was two to three months. MJ commented:

"It may have come down due to the reforms. Waiting lists have come down a lot, from six - twelve months to four months due to the introduction of the re-clerking clinic where eye sight was measured"

MH in unit U quoted a figure of ten months for routine cataract surgery, adding *"but it has still decreased from what it used to be"*. S/he commented:

"We were forced to bring waiting times down because otherwise we would have been penalised. This was extremely difficult though. We achieved it only with extra lists. I am now more aware of waiting time for patients who want to see me."

There was a good deal of doubt among consultants about the sensitivity of the length of waiting lists as a measure of the demand for cataract surgery. It was pointed out that a longer waiting list did not necessarily imply a greater demand for surgery, but perhaps an inefficient or over-stretched provider.

The many suggestions for a more sensitive measure included: patient throughput per doctor; the ratio of people with the diagnosis to the number of people operated upon; and needs assessment based on the prevalence of patients with cataracts per 100,000 of population. The age structure of the population in different areas was also referred to; and the creation of a central computerised service, with all GPs referrals estimated and linked to the diagnoses made by consultants, which could provide a more accurate estimate of real demand, was also proposed. Finally, someone said, half jokingly, that the only resolution would probably be:

"To assassinate the recent government, but this would also be an impermanent solution, as they would come back on the wave of popular support they enjoy."

AL, a newly appointed male consultant in S, said that waiting time perversely increased with increased efficiency:

"Given the set referral patterns, the waiting list should decrease with increased efficiency but that's not the case. If we outperform the operating list in order to cut it down, the waiting list will go up as more patients will get referred."

BL, the newly appointed surgeon in unit T, also thought waiting time was an insensitive measure, suggesting that the use of the number of facilities divided by the cataract's prevalence would be more useful, as *"this would avoid an artificial sense of need and the sense of an artificial lack of provision"*, as s/he put it. MJ, of the same unit, considered that waiting time was related to the number of doctors and amount of money available, stressing *"this has changed as the GPs look more at the cost and not so much at the waiting time, which has become less important now"*. The clinical director of the same unit stated:

"It was difficult to know what the real demand was when patients could go to several places with different prices; also, some could have died or moved and yet still appear on the list."

MH of U thought that the actual waiting time was not a very reliable measure of demand as it depended on a lot of other factors that interfered with waiting:

"For example, it depends on throughput and turnover, and if a waiting list was short, this could mean problems with the staff."

The clinical director of P thought that the waiting list reflected only 50% of the real demand and particularly that of the lower income groups in the population as, in her/his opinion, half of all cataract operations were done privately. S/he suggested that the age threshold for cataract had dropped. The other consultant in the unit thought that it was a good measure, provided that the system worked efficiently *"with no running out of funds and cutting of the list"*. TF saw it as only a very crude measure of demand because different surgeons use different criteria for operating and there also be a backlog in referrals from the GP or the opposite - long waiting lists may discourage GPs from referring patients.

SWEDEN

All consultants agreed that there was a real decrease in waiting time as a result of the reforms, which amounted to about three months for the first eye surgery; but as one of the surgeons acknowledged:

"The people who come now may have better vision than those who would have qualified for the operation in the past, because the standards have changed. The waiting time for eye surgery has also changed in this respect."

S/he continued by explaining the political nature of the problem involving the cataract queues, which the establishment needed to solve because of the increasing pressure from patients' groups who *"were not prepared to accept these waiting times any longer and which was especially strong in big cities"*. In Stockholm, they had been more successful than elsewhere because they had obtained a three months guarantee for cataract surgery in both eyes and not in one eye, as was the case for the rest of the country. The vice-director elaborated on the aspect of changes of criteria for the operation: *"about 50% of waiting time has changed in this respect"*.

CZ compared the situation with the past and explained the changes in waiting times: *"less than two months and down from six months"* stating somewhat curiously *"some waiting time between the diagnosis and the operation is reasonable for patients to adjust to the idea."*

When asked about their views on whether waiting lists for cataract surgery constituted a sensitive measure of demand for the service, most of the other respondents either did not know or were not prepared to answer in any different way from the way they had already answered.

MANAGERS' AND PURCHASERS' VIEWS

ENGLAND

The deputy director of acute services in the hospital in unit S claimed that 50% of patients were operated on within three months and that everybody was operated on within twelve months. When asked about the waiting lists' suitability for measuring demand, s/he doubted the validity of this indicator if interpreted out of context, because long waiting lists could mean that no one wanted the service at all or that it did not exist:

"If a service exists, the demand for it will exist too".

S/he conceded that it could be used as a pressure tool by consultants to extract additional resources from an unresponsive management but it might also mean that not enough work is done in the clinic. Accordingly waiting times would have some validity only when all the other quality indicators were being satisfactorily met but *“the numbers of referrals by GPs to consultants should also be taken into account”*.

The senior nurse managing quality aspects and waiting times at unit S stated that, while the waiting time for an operation from the moment that patients were sent by their GPs was approximately nine months for other hospitals, the wait for a first appointment in S was about five weeks. According to her, the average waiting time for cataract surgery was about two years elsewhere but in S it was less than three months (approximately twelve weeks).

The manager of the quality department of unit T stated that patients waited for about twelve months to have the cataract operation while, before, it used to be eighteen months, clarifying *“there was some differentiation, however, and some of them waited less”*.

The public health doctor responsible for management in hospital T saw waiting lists as:

“A big political football, and when the issue became sensitive the strategy was to throw more money at it, e.g. by launching the waiting list initiative.”

In his/her view, the real problem was the lack of money. Attempts to squeeze things as much as possible had led to the reforms and not the inappropriate structure of the system. S/he doubted whether the reforms could tackle this successfully as waiting lists were not necessarily an issue to be resolved in the market place:

“But with the existing excess capacity on the providers’ side, extra work could now be done because of more money being made available to Health Authorities.”

The public health doctor from area S, who acted on behalf of purchasing authority, thought that waiting lists were a poor and counter-productive indicator of quality as they were too often politically driven:

“They were probably there because there are a lot of incentives for maintaining long waiting lists on the surgeons’ side - for example, to feed their private

practice. They [the waiting lists] are very confusing and there are all kinds of incentives to put people on them."

S/he thought that the real answer to the problem of waiting lists were protocols of care and standardisation of clinical procedures as well as clinical competence. S/he also suggested that the GPs should have more knowledge of the former in order to refer their patients properly, mentioning an initiative by the clinical director of the eye unit in hospital S who wrote guidelines for GPs outlining the criteria for referrals.

The director of acute commissioning in the same unit was also adamant in negating the use of waiting lists for this purpose, stating, *"The opposite held true"*. S/he pointed out that they were dependent on the volume of care and if the volume was low, the waiting time would go up. S/he also felt that purchasers had to take more responsibility:

"If we continue to say we cannot afford to buy enough cataract operations, there will always be a waiting list. One of the worst problems, though, is the inability to plan in the event of excess capacity that quite often exists on the providers' side."

S/he complained about the providers' attempts to deliver or extract work from Health Authorities that was not initially included in the contracts, despite their efforts *"to plan according to the suggestions provided to us early enough by the clinicians"*.

For the purchaser from T, who was also responsible for acute commissioning, things had markedly changed, which, in his/her view, boiled down to the attitude of the providers: *"Before the reforms, the consultants used waiting lists as an internal bargaining tool."*

S/he went on to explain that the reforms' contribution was to make the process of putting patients on the list more explicit. Consultants were required to justify the number of people on the waiting lists, which made them reluctant to list people who should not have been there in the first place. According to his/her information, the average waiting time for secondary elective procedures was twelve months and the next target was to reduce this to nine months but 70% of patients were operated on within three months.

S/he reckoned that cutting the waiting lists should be a priority, with purchasers having to decide *“where to draw the line on the level of waiting time that was acceptable”*. S/he also pointed out that, even nowadays, clinical judgement impinged excessively on waiting lists, which in turn *“pushed towards the direction of evaluating the effectiveness of procedures”*.

SWEDEN

In specialist eye hospital K, there was no separation of management functions, which in most cases were assumed by the senior clinicians (the heads of departments). Therefore, almost all questions concerning the organisational aspects of care have already been explained through the views of clinicians also responsible for management.

According to one of the purchasers, the executive from Stockholm County Council, the waiting list of the past could be used as a way to obtain resources for the clinic, but the introduction of the Stockholm Model gave incentives to work in a different way, which were very strong in promoting productivity. As s/he explained further, the problem was that purchasers were supposed to meet the needs of their population for a given budget, but the providers had not agreed to provide the same level of care for much less money.

The issue of rationing had therefore come into the arena. This was manifested in the reappearance and building up of waiting lists. Also, criticism was raised against the care guarantees, which could no longer be adhered to, because it was believed they had been subsequently expanded too much and had ended up including conditions, which were too narrow. Also the example of patients in Stockholm exceptionally obtaining a care guarantee for surgery in both eyes was introducing some new and explicit inequity. An executive of the Stockholm County Council was quick to point out that the decrease in waiting time for second eye cataract surgery:

“Was a purely political decision for Stockholm and not the result of the work of the market”.

The purchaser in district Z of Stockholm County Council explained that the care guarantee introduced in 1992 for several elective procedures, including cataract

surgery, had resulted in an overall decrease in all waiting times; in particular, the waiting time for the operation itself had been dramatically reduced from about one year in the Stockholm area to approximately three months (which was the requirement outlined in the care guarantee).

However, when the figures for waiting times provided by the same purchaser in Z district were analysed, a quite different picture emerged, despite the limitation caused by the absence of data for the period before the introduction of the Stockholm Model (see Table 9.3). As the comparison of the waiting times for surgery in hospital K and other eye units in the Stockholm area in years 1992-94 indicates, there seem to be fluctuations in the lengths of waiting times rather than a linear decrease. This is observable not only in hospital K but even more so across all other hospitals.

Table 9.4: Percentage of appointments fulfilled according to “The Patients’ Charter” standards - all ophthalmology services

Name of Hospital/ NHS Trust	% seen within 3 months 1993/1994	% seen within 12 months 1993/1994	% seen within 3 months 1994/1995	% seen within 13 weeks 1994/1995	% seen within 26 weeks 1994/1995	% seen within 12months 1994/1995	% seen within 3 months 1995/1996	% seen within 13 weeks 1995/1996	% seen within 26 weeks 1995/1996	% seen within 12 months 1995/1996
<i>Unit S</i>	44% *	100% *****	45% *	91% ****	99% ****	100% *****	74% ****↑	99% ***** ↑	100% *****	100% *****
<i>Unit T</i>	63% no star	99% no star	63% ***	54% *	87% *	99% *****	38% *	84% *** ↑	97% ***↑	99% *****
<i>Unit U</i>	56% **	96% ****	56% **	83% ***	97% ***	95% ****	53% **	96% *****	96% ***	78% *↓
<i>Unit P</i>	15% *	56% *	55% **	95% *****	100% *****	91% *** ↑	96% ***** ↑	99% *****	100% *****	99% ***** ↑
National average	not avail- able	Not avail- able	51%	73%	94%	91%	52%	76%	96%	95%

*Star ratings according to the Performance Tables in ascending order. Where no star ranking appears, it indicates that the Audit Commission was not satisfied with the quality of data presented and results were published without ranking.

Thus, waiting times in K were just below the care guarantee at the end of 1992, decreased significantly during the same period in 1993, and doubled again by the end of 1994, which could have coincided with misgivings about the Stockholm Model reforms and their sustainability, already expressed in 1995. Another interesting point is that the private clinics competing with the virtual monopoly provider K halved their waiting times. This could have been done in order to attract referrals from the very few primary care providers (such as the private GP represented in this study's sample) but could also have been related to their much lower throughput.

9.3 Comparison of the study's findings with the national data on waiting times

ENGLAND

Before 1991/92 there was no routine collection of data on the numbers of patients waiting for specialist referral either on a national scale or at Health Authority level. As there was no incentive to measure them on a regular basis, no systematic records were kept before 1991/92 with the exception of some departmental data collected as a result of individual consultants' initiative. Some specific targets were set explicitly for the first time in "The Patient's Charter" and in 1993, measurement of the performance of all providers on a national scale against related indicators was initiated in what became known as League or Performance Tables.

Data used in the League Tables collected during the period 1993/94 - 1995/96 and extracted for the purpose of this study, refer to all ophthalmology services. However, as cataract operations and related outpatient visits make up the bulk of eye services (approx. 75% of all of them, Davidge et al, 1987), they were analysed and used as a proxy for the cataract procedure itself (see Table 9.4).

Analysis of the data presented in Table 9.4 highlights some interesting changes that took place during the first three years of the reforms' implementation. These mostly refer to increases in admissions within three-month and twelve-month periods, observed at the same hospitals. More specifically, the change in the former is most visible in S, where admissions within a three-month period rose

from 44% in 1993/94 and 45% in 1994/95 to 74% in 1995/96. This is even more remarkable in the case of unit P, where in 1993/94 only 15% of admissions were within three months; in 1994/95, they increased more than threefold to reach 55% and were about six times higher during the following year, reaching an impressive 96% in 1995/96.

The proportion of admissions within twelve months is constant for S and T, at 100% and 99% respectively. However, changes occurred in unit P: in 1993/94 the percentage of admissions within twelve months was 56%; in 1994/95 it was 91%, reaching an even higher 99% in 1995/96. Interestingly, in the case of U there was a significant fall from 96% in 1993/94 and 95% in 1994/95 to 78% in 1995/96, with a further tendency for decline projected.

As far as longer periods of admission - within thirteen and 26 weeks - were concerned, the data are only available for two years, but there is a visible trend towards an increase in the former. Thus, in S they rose from 91% in 1994/95 to 99% in 1995/96; in T they rose from 54% in 1994/95 to 84% in 1995/96; in U they rose from 83% to 96% respectively; and, finally, in P they rose from 95% to 99%. These last figures have remained constant since then as there was very little room for further increase.

Although the general trend seems to be a decrease in the number of patients waiting for longer periods, there was one surprising finding in the figures for unit U. Standards for admission within 26 weeks were met for 96% of cases, while standards for admission within twelve months were fulfilled in only 78% of cases, and there was a notable trend towards further deterioration in 1995/96. A year earlier, the respective figures had been 96% and 95%, which again confirms the dramatic impact of changes resulting from the conflict between the management and the clinicians, leading to the resignation of the latter.

When the national data were compared with the study's findings, some of the latter seemed to be confirmed, whereas others were disproved. As can be inferred from the Figure 9.4, the waiting time for the first appointment in S was approximately six weeks, while the national figures for the years 1993/94 and

1995/96 suggest that only 44% and 46% of patients were seen within a three-month period in these respective years. This, however, rises to 74% in year 1995/96 when the interviews for this study were taken, which could also mean that the references made by the interviewees were mostly made on the basis of this last period.

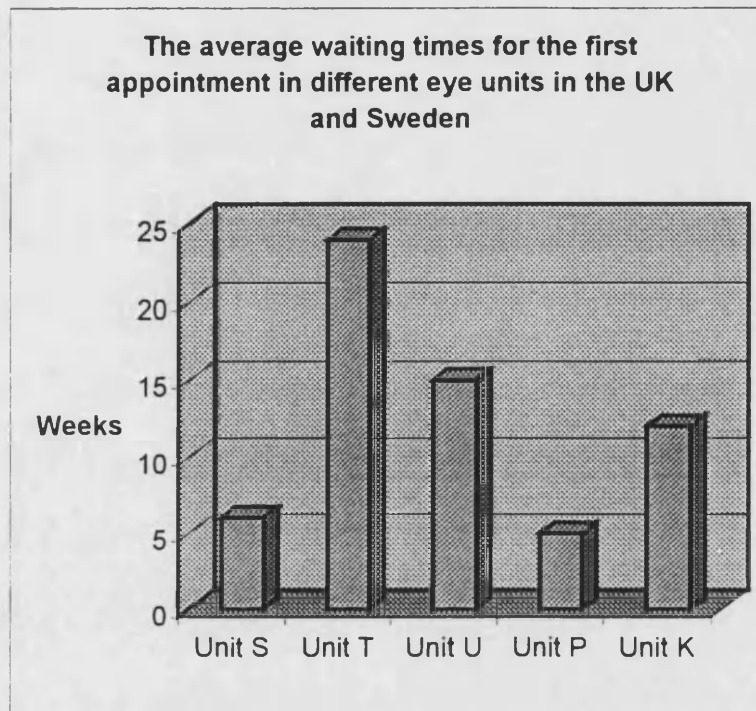


Figure 9.4: The average waiting time for the first specialist appointment in different eye units in the UK and Sweden in the views of different actors in years 1993/94-1995/96

In unit T, there seems to be higher consistency between the study's findings and the data reported for the purpose of the Performance Tables (usually by the hospital itself, but also subsequently scrutinised by the Audit Commission). These figures indicated that in 1993/94 and 1994/95, only 63% of patients were seen within a three-month period, which decreased even further to 38% in 1995/96. In the same year, 84% of patients were seen within 13 weeks, but there were also few waiting longer than 26 weeks. Data provided by our respondents

confirm unusually long waiting times that ranged from 19 to 26 weeks, with the average being 20 weeks (for details see Fig. 9.4).

By contrast, in U the average waiting time reported by the study's respondents was approximately fifteen weeks but waiting times reported to the Audit Commission indicated that 56% of patients were seen within three months in 1993/94 and 1994/95 and 53% in 1995/96. However, 83% of them were seen within thirteen weeks in 1994/95 and 96% of them were seen within the same period in 1995/96.

The example of P is also interesting as reports from the study site present a picture of a very efficient unit. But this picture was not reflected in the data of the Performance Tables for the year 1993/94, and the effects of the overhaul of the eye department, which occurred simultaneously, were not even apparent during the subsequent year 1994/95. Thus, according to the present study, the number of patients seen within a three-month period represented only 15% in 1993/94 and 54% in 1994/95 but rose to an impressive 96% during the next year. In this very same year, the average waiting time for the first appointment was less than six weeks (for details see Fig. 9.4).

This pattern was confirmed by the changes in waiting times for patients seen within thirteen weeks. In 1993/94, only 56% of patients were seen within twelve months with the remaining 44% having to wait longer than that. However, in 1994/95 and 1995/96 almost all patients were being seen within thirteen weeks, with the respective figures being 95% and 96%. In the same years, no patient had to wait longer than 26 weeks to be seen by the specialist.

SWEDEN

Waiting times for elective surgery in unit K, in the other eye units in the Stockholm County Council area, and in the hospitals in south east Sweden were compared, and this led to several conclusions. First, hospital K was ranked between the two other public hospitals (R and Y) in the Stockholm County

Council area, with its waiting time for an operation being eight weeks for patients with the care guarantee and twelve weeks for those without, as opposed to four weeks and six to eight weeks for hospital R, and a ten- week waiting period for hospital Y.

Hospital K's performance was worse when compared with private eye clinics in the same area - the best performers being W and X, where the waiting times were only three to four weeks and four weeks respectively for those with the care guarantee. But K was much better than Y, where waiting times were up to ten weeks for those with the care guarantee and 12-24 weeks for those without. However, when these waits were compared with the numbers of patients waiting for the operation and with the numbers of operations performed, the picture becomes clearer. Thus, in unit K in 1994/95, 1,611 patients waited for an operation, which represented 18% of the total number of 6,855 operations performed during the year. The same rough percentages of patients waiting were found in the two other public hospitals (in R and Z) while the percentage of patients waiting in private eye clinic was respectively 6% for W 4% for X and even for Y it was only 12%.

When waiting times for patients with the care guarantee in counties outside Stockholm (Southern Sweden) are compared, a fairly constant picture emerges. Most figures range between eight and twelve weeks in most cases, with an occasional sixteen and seventeen weeks' wait. As most places outside Stockholm County Council have no private eye facilities, there is no room for this type of comparison. However, there are big differences between K and other areas in waiting times for patients without the care guarantee. They start from twelve to thirteen weeks and go as high as 50 weeks, which was not unusual. The most common figure is between 20 to 26 weeks (see Table 9.5).

This difference can be explained by the fact that the care guarantee in Stockholm applies to two eyes and in the rest of the country to only one. The number of patients waiting without the care guarantee (expressed as percentage of all operations performed) usually ranges between 8% and 12% in more than half of the cases with 18%-20% being quite common, but occasionally even a figure of

50% appears. What is positive is that, in the vast majority of county hospitals, patients without the care guarantee having to wait for quite a long time represent less than 5% of the total cataract operations performed (see Table 9.5).

Table 9.5: Waiting times for cataract surgery in eye hospitals in Stockholm and selected County Councils in South East Sweden (expressed as numbers of patients waiting and weeks of waiting time) in year 1994/95

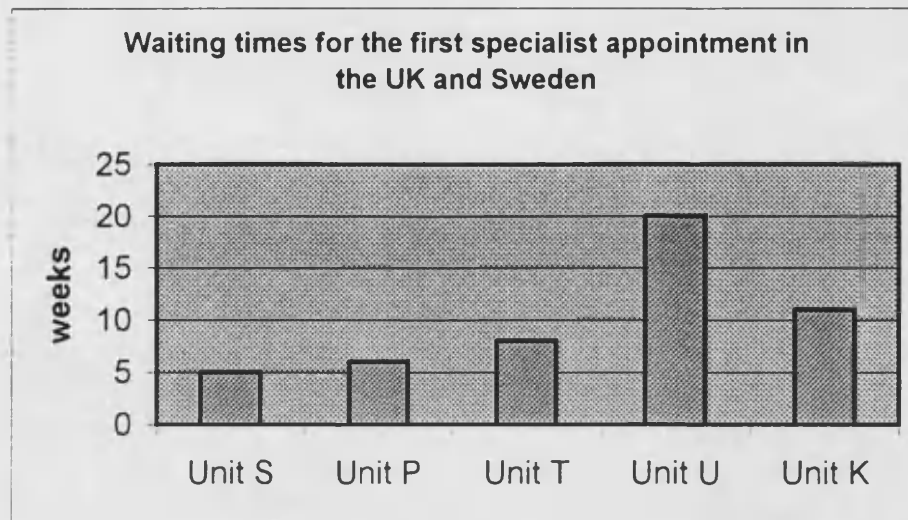
<i>Hospital</i>	<i>Patients with care guarantee</i>	<i>Patients without care guarantee</i>	<i>Weeks with care guarantee</i>	<i>Weeks without care guarantee</i>	<i>Operations performed</i>
Stockholm C.C.		<i>Not applicable</i>			
Hospital K	1611		8	12	6855
CC hospital R	134	<i>n.a.</i>	4	6-8	671
CC hospital Z	117	<i>n.a.</i>	10	---	674
Private W	100	<i>n.a.</i>	3-4	---	1392
Private X	43	<i>n.a.</i>	4	---	1105
Private Y	60	<i>n.a.</i>	9-10	12-24-	427
Uppsala C.C.					
University Hospital	146	232	8	33	786
Sormland C.C.					
Malar Hospital	95	317	10	26	895
Nykoping	27	117	11	25	417
Kulbergska	---	---	---	---	..57
Ostergotland C.C.					
Linkoping	157	287	9	48	854
Norrkoping	87	165	12	20	657
Jonkoping C.C.					
Ryhov	202	163	10	50	942
Hogland hospital	41	182	11	52	333
Kronoberg C.C.					
Vaxjo	110	157	10	20	597
Gotlands Commun					
Visby	24	65	8-10	23-30	222
Blekinge C.C.					
Karlskrona	62	119	8	12	703
Kristiansand C.C.					
Kristianstad	500	----	16	----	114
Malmo city					
City hospital	159	480	12	..28	1165
Malmo area C.C.					
Lund	157	231	...9	16-24	1450
Landskrona	8	18	...4	4	469
Helsingborg	53	73	10	13	834
Ystad	17	120	17	24	272

Source: data from hospital K and various County Councils

KEY FINDINGS

- According to the extracts of data reported by the actors interviewed waiting time for the surgery varied. For example in S it was around six weeks according to the consultants and four months according to the patients and GPs. In T it has changed from 30 to 19 weeks according to the consultants but it was still nine to twelve months according to the purchasers. In U, it was only about ten weeks according to the consultants but again the management reported different period of four to ten months according to the defined priorities. In unit P it was about twelve to fourteen weeks according to one consultant and around ten weeks according to some others. Finally, in K unit in Sweden patients' reports (app. eleven weeks on average) coincided with reports of providers and purchasers (app. twelve weeks).
- Similarly, waiting times for first specialist appointment varied in accordance to the source of report. Thus in S it was less than six weeks according to the consultants but slightly higher in patients' estimation. In T the report of consultants coincided with figures quoted by patients, which were in the range of 26 weeks or even less according to the latter. In unit U patients waited for about 20 weeks, which for the consultants was between 5 -18 weeks and depended on emergency and the consultant. In P it was less than six weeks according to most reports but still the views were not unanimous. Again in K all actors seemed to agree on one approximate figure of about twelve weeks.
- The waiting times for the first specialist appointment seem to be the shortest in the units that have embraced the reforms and have benefited from them, such as unit S in South London in the UK and unit K in Sweden (for details see Fig. 9.5).

Figure 9.5 Patients' views on the length of waiting time for the first specialist appointment in different eye units in the UK and Sweden (unit K) in 1995/96



- Analysis of the data from the National League Tables in the UK (DoH, 1994; DoH, 1995a; DoH, 1996) highlighted the changes in waiting times for the first specialist appointment that took place during the first three years of reforms' implementation. They indicated that increases in admissions within three-month and twelve-month periods were mostly observed and reflected a general trend to decrease the very long waiting times that were beyond 26 weeks and more. Most of the national data confirmed the findings of this study and occasionally provided insight and better understanding of the specific results. In Sweden national data helped in positioning the results of the unit K, which turned out to be not the one with the shortest waiting times but it had the shortest waits in relation to its throughput.

CHAPTER 10

EFFICIENCY

Efficiency was measured in terms of increases in throughput, changes in prices and their impact on waiting times, and also on the basis of clinical outcomes (visual acuity and complications). At least two hypotheses were examined. The first was whether hospitals that increased their throughput might also be the ones that provided quicker services; the second was whether this had an adverse result for clinical indicators. Another hypothesis dealt with counterfactual evidence that changes other than the reforms, which occurred simultaneously, might have produced similar results. Such could, for example, be the influence of advances in medical technology, like day care or sutureless surgery.

Quantitative data on the number of operations and the price of cataract surgery are presented below, followed by the results of an audit on clinical outcomes and data on changes in the amount of day care surgery performed in the UK and Sweden. Subsequently, an analysis of the responses of doctors (GPs and surgeons), managers and purchasers and their perception of the results that the reforms had on providers is summarised.

10.1. Comparison of the cataract figures in eye units in the UK and Sweden

If changes in the number of cataract operations performed are compared for the years 1988-1996, it is evident that some increases (in quite few cases significant ones) took place (for details see Table 10.1). This is most visible in the case of unit S, which is shown to be "the super-performer" of all the locations studied as it achieved an almost six-fold increase in throughput between 1989 and 1996.

The second highest increase happened in unit T, where the 1989 figures had almost doubled by 1996. In the case of unit U, the situation is more complex as

there was a moderate increase from 1988, peaking in 1994, at which point it had improved by approximately two thirds, and then suddenly dropping to its 1988 levels in 1995 (for which the latest data existed). This irregularity can easily be explained by the clash at the end of 1994 between the management and the clinicians in the eye unit, which resulted in the voluntary resignation of the latter.

The situation in unit K in Sweden was also somewhat different from the first two units in the UK where an uninterrupted rise was observable. This, however, can be easily explained by the course of reforms in the Stockholm County Council area. After high productivity gains had been achieved in 1993 and 1994, the arrival of a new government in 1995 signalled a departure from competition. It was argued that the budget deficits that County Councils would have to incur, should they continue to reward the productivity gains of some of the providers, would be overwhelming. This was because reimbursement on a fee per case basis was inflationary, since many hospitals were in a position to provide services on demand, which did not necessarily coincide the needs of the populations concerned.

Table 10.1: Number of cataract operations performed in S, U, T, and K in years 1988-1997

	1988	1989	1990	1991	1992	1993	1994	1995	1996
Unit S	n.a.	270	294	887	1021	974	1132	1484	1366
Unit U	545	613	694	666	n.a.	n.a.	841	482	n.a.
Unit T	n.a.	489	558	703	837	744	605	777	879
Unit K	n.a.	n.a.	n.a.	n.a.	n.a.	7271	6855	6600*	6600*

Source: Departmental and hospital data from S, U, T and K

**Estimate*

10.2. Analysis of the data on prices for cataract surgery in London and Stockholm

The analysis of the available data on changes in prices resulted in clear-cut conclusions only in the case of unit S, where prices followed a constant decrease for both inpatient and day care procedures (see Table 10.2). This, when combined with big rises in throughput, clearly means that efficiency gains were most likely to have been achieved in this unit. However, this was less clear for

unit T, where prices for both inpatient and day care procedures fluctuated, dropping in 1993/94, rising in 1994/95 and 1995/96 and decreasing again in 1996/97 and 1997/98. The last decrease may partly be related to the different method of measurement that started to be used during these last two years (see Table 10.3).

The data for unit U are mostly missing and in P they are available only for three years starting from 1995/96. They are divided into prices given to fund-holders and Health Authorities, but, on the whole, there is a rise in prices for both inpatient and day care procedures over the years. Interestingly, the prices for fund-holders were constantly higher than those offered to the Health Authorities (see Table 10.4). For unit U, in the year 1995/96 the prices for cataract surgery were £878 for inpatient procedures and £751 for day care. Data were not available for previous years. Data on costs of the services in the UK could not be obtained and those that were available from Stockholm were not used for the purpose of the analysis.

Table 10.2: Ophthalmology prices in years 1991/92-1995/96 in Pounds Sterling – Unit S

<i>Year of measurement</i>	<i>1991/92</i>	<i>1992/93</i>	<i>1993/94</i>	<i>1994/95</i>	<i>1995/96</i>
Extra-contractual Referral Prices					
• Day case	n.a			73	61
• In-patient	.	49	72	2	9
	1,4	1	5	82	91
	04	1,1	1,1	4	0
		36	13		
GPFH Prices					
• Day case	31	33	n.a	68	59
• In-patient	3	2	.	1	1
	95	72	1,0	81	86
	4	0	09	9	2

Source of data: Departmental data from Hospital S

Table 10.3: Prices of cataract surgery OPCS4 according to the hospital data – unit T

<i>Year of measurement</i>	<i>Method of costing used</i>	<i>Inpatient procedure</i>	<i>Day care procedure</i>
1992/93	Procedure cost	723 GB Pounds	496 GB Pounds
1993/94	Procedure cost	666 GB Pounds	Not available
1994/95	Procedure cost	914 GB Pounds	615 GB Pounds
1995/96	Procedure cost	904 GB Pounds	686 GB Pounds
1996/97	HRG cost	796 GB Pounds	525 GB Pounds
1997/98	HRG cost	852 GB Pounds	377 GB Pounds

Source of data: Financial Department of Hospital T

Table 10.4: Prices of cataract surgery OPCS4 according to the hospital data – sample P

<i>Year of measurement</i>	<i>Inpatient procedure</i>		<i>Day care procedure</i>	
	<i>Fund-holders/Health Authority</i>		<i>Fund-holders/Health Authority</i>	
1992/93	n.a.	n.a.	n.a.	n.a.
1993/94	n.a.	n.a.	n.a.	n.a.
1994/95	n.a.	n.a.	n.a.	n.a.
1995/96	979	1359	979	790
1996/97	787	1359	787	790
1997/98	1741	1506	1741	960

Source of data: Financial Department of Hospital P

The prices for specific cataract operations performed as inpatient procedure (Table 10.5) and day care (Table 10.6) in Stockholm County Council including hospital K, with codes for the different surgical procedures, are presented below. These two tables clearly demonstrate the gradual drop in prices for most of the procedures. The prices were set artificially high in 1992 at 15,500 SEK for inpatient stay and 7,872 SEK for day care and were lowered to more realistic levels in 1993. There was, again, a significant rise across the board in 1994. The prices rose from 11,601 SEK from in 1993 to 15.252 SEK in 1994 for small incision surgery (inpatient) and from 6,961 SEK to 8,528 SEK when performed on a day care basis.

Table 10.5: Prices for cataract surgery as inpatient care procedures in the Stockholm County Council area in years 1992-1996 (median prices in SEK for each financial year are used)

<i>Type of cataract operation coded in KOKS system</i>	<i>1992 inpatient care</i>	<i>1993 inpatient care</i>	<i>1994 inpatient care</i>	<i>1995 inpatient care</i>	<i>1996 inpatient care</i>
039 Cataract (lens & corpus vitreum)	15500	8723	7708	8094	8435
039B Simple cataract	n.a.	7763	10168	8100	9517
039C Phacoemulsification (small incision surgery)	n.a.	11601	15252	14294	12981
039D Lens extraction	n.a.	17446	17876	18772	19560
039E Lensectomy	n.a.	20324	26568	21183	22072
039F Complicated lens extraction	n.a.	24250	24928	26177	27278

Source: Hospital data, Stockholm County Council data, SPRI information

Table 10.6 Prices for cataract surgery for day care procedures in Stockholm County Council in years 1992-1996 (median prices in SEK for each financial year are used)

<i>Type of cataract operation coded in KOKS system</i>	<i>1992 day care</i>	<i>1993 day care</i>	<i>1994 day care</i>	<i>1995 day care</i>	<i>1996 day care</i>
039 Cataract (lens & corpus vitreum)	7872	5234	5248	4650	4251
039B Simple cataract	n.a.	4658	6396	4572	4376
039C Phacoemulsification (small incision surgery)	n.a.	6961	8528	5838	5332
039D Lens extraction	n.a.	10467	5248	5315	4597
039E Lensectomy	n.a.	12195	5248	5065	4597
039F Complicated lens extraction	n.a.	14550	5248	5065	5248

Source: Hospital data, Stockholm County Council data, SPRI information

This trend is especially visible for day care surgery with the exception of year 1994 where, for example, the price for a simple cataract operation dropped to 5,234 SEK from 8,727 SEK in 1993. However, the lowering of prices in 1993 as compared to both the previous and the following year was not confirmed by the departmental data, which referred to only one procedure C39 (phacoemulsification) and which are presented in Tables 10.7 and 10.8. Thus, the hypothesis is that data for 1993 could possibly be an artefact because data

provided by the County Council quote different figures for day care at 6,961 SEK as opposed to the 9,087 SEK quoted by the hospital data. The situation is similar for inpatient care C39 (phacoemulsification), where the respective figures are 20,102 SEK and 11,601 SEK.

In Tables 10.7 and 10.8, changes in prices for small incision surgery (phacoemulsification) are presented. Unit K moved swiftly towards this procedure not only because adopting new technologies would keep it at the cutting edge, but also because it was more attractive in terms of DRG prices. Small incision surgery, which at the time of the study (Fall 1995) made up almost two thirds of all operations performed, was chosen as a typical case to illustrate the decrease in prices for services. A comparison of 1992 and 1996 shows a drop from 9,087 SEK to 5,332 SEK for day care and from 20,102 SEK to 12,981 SEK for the inpatient procedure (See Tables 10.7 & 10.8).

Table 10.7: Prices for cataract surgery operations performed as day cases using small incision surgery (phacoemulsification) 039C in hospital K (Sweden) including the cost of the visit

	<i>Day surgery procedures</i>		
	1993 1996	1994	1995
Cost of the operation	9087 SEK 5332 SEK	8528 SEK	5838 SEK
Cost of the out-patients' visits	1377 SEK 1129 SEK	946 SEK	1010 SEK
Total amount	10 464 SEK 6 461 SEK	9 474 SEK	6 848 SEK 6 642 SEK*

Source: Financial department of hospital K

** In 1995, a discount of 3% was applied to all patients in the Stockholm area*

Table 10.8: Prices for cataract surgery operations performed as an inpatient procedure using small incision surgery (phacoemulsification) 039C in hospital K (Sweden)

	<i>Inpatient procedures</i>		
	1993 1996	1994	1995
Cost of the operation	20102 SEK 12981 SEK	15252 SEK	14294 SEK
Cost of the out-patients' visits	1377 SEK 1129 SEK	946 SEK	1010 SEK
Total amount	21479 SEK 14110 SEK	16198 SEK	15304 SEK 14845 SEK*

Source: Financial department of hospital K

* In 1995 a discount of 3% was applied to all patients of the Stockholm area

10.3 Audit on clinical outcomes at the unit P in the UK

To ascertain how far the real improvements in clinical outcomes occurring in everyday clinical practice corresponded with the views of clinicians on this issue, a small audit was conducted at the pilot site, unit P. For a sample of n=46 randomly selected patients, improvements in vision (defined as pre and post-operative changes in visual acuity) were measured. Data on surgical technique and the surgeon's grade were also collected, as was the information on the time when the assessment was made upon discharge. Data on patients' age, gender and the experience of complications were also recorded (for details see Box 1, Annex I).

As to the improvements in visual acuity, this seems to have been achieved for the overwhelming majority of patients (41), which was significant for most of them measured in Snellen scale. Three of them experienced no improvement, and in one case the outcome was worse than before the operation. As far as complications were concerned, their number was negligible and they were only noticed in three cases. Finally, the patients' gender, the grade of the operating surgeon (service grade or consultant), the technique used (small incision or extracapsular extraction) and the period after which they were discharged, were insignificant both as to their severity and in absolute numbers (less than 1%) in relation to the clinical outcomes.

These findings suggest that clinical improvements achieved either by means of organisational innovation (i.e. reforms, day care) or the diffusion of medical technology (suture-less surgery) had insignificant impact in terms of side effects and complications. Although the sample used is very small with all limitations that this entails, it provides some indications on the relation between clinical outcomes and the input structure that could be impacted upon in the environment undergoing intense organisational change.

10.4. Changes in rates of day care surgery in outer London and Stockholm

The analysis of quantitative data from the hospitals in the UK shows that the number of operations performed as day care procedures significantly increased, especially after the years 1993 and 1994. This was very strongly manifested in the case of S, where the number of operations performed as day cases doubled, though it should be noted that the starting level in S was already relatively high at 18% in 1990 and so was very different from that of other units, such as unit U, where this figure was below 5% (See Fig. 10.1 and Fig. 10.2).

In S, the number of day care procedures rose to an impressive 92% already in 1994, while in unit U, this figure was only 14% higher than the previous year's. The figures for the other two units, T and P, were similar to those of unit U, where a steady increase (even two or three fold) from a very low starting point though, was observed. But this was not as significant as the almost total shift to day care that occurred in S (for details see Table 10.9).

Table 10.9: Cataract operations performed as day cases in the years 1989-1997 in S, U, T, P and K (expressed as a percentage of total number of operations)

	1989	1990	1991	1992	1993	1994	1995	1996	1997
Unit S	17%	36%	18%	31%	74%	94%	97%	96%	98%
Unit U	n.a.	12%	13%	20%	n.a.	15%	21%	n.a.	n.a.
Unit T	n.a.	0.2%	11%	14%	16%	19%	30%	34%	26%
Unit P	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.		
Unit K	n.a.	n.a.	n.a.	90%	95%	97%	98%	99%	n.a.

Source: Departmental and hospital data from S, U, T, P and K

Figure 1. Cataract operations performed as day cases in Unit S (%)

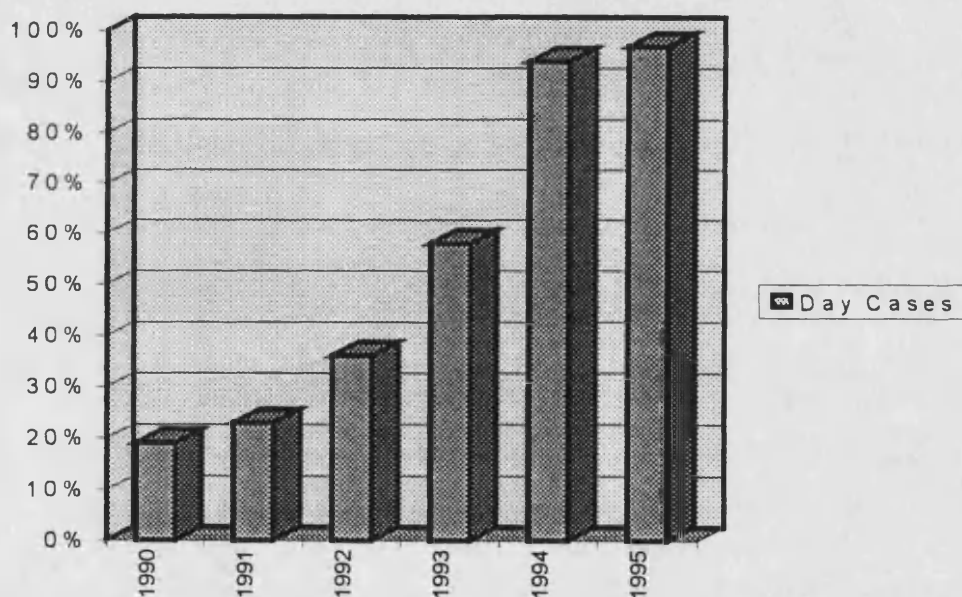


Figure 10.1 Cataract operations performed as day care procedures in unit S in 1990-1995

Figure 10. 2. Cataract operations performed as day day cases in Unit U

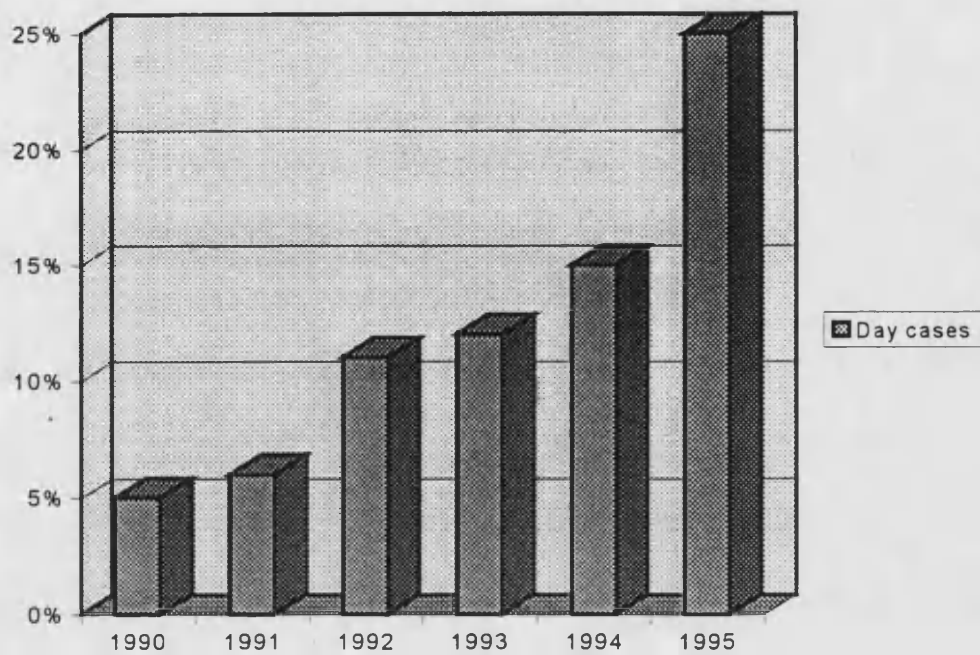


Figure 10.2 Cataract operations performed as day care procedures in unit U in 1991-1995

In the Stockholm County Council area, the situation was somewhat different as day care cataract surgery was already relatively widely used from the middle of the 1980s. Even before the introduction of the Stockholm Model, the rate of adoption of day case surgery in unit K was 96% (See Fig. 10.3), according to SPRI data (Ophthalmology Services in Sweden 1988-1991, SPRI 1992). When the aggregate data were analysed on a national level, however, there was a noticeable increase between 1991 and 1995 (See Fig. 10.4). This is an indirect evidence of market's work both in the counties that introduced different forms of competition and purchaser-provider split but also for those who did not it had some spill-over effects that manifested as a significant increase in the rate of day care surgery (see Fig. 10.4).

Figure 10.3. Cataract operations performed as day cases in Unit K (%)

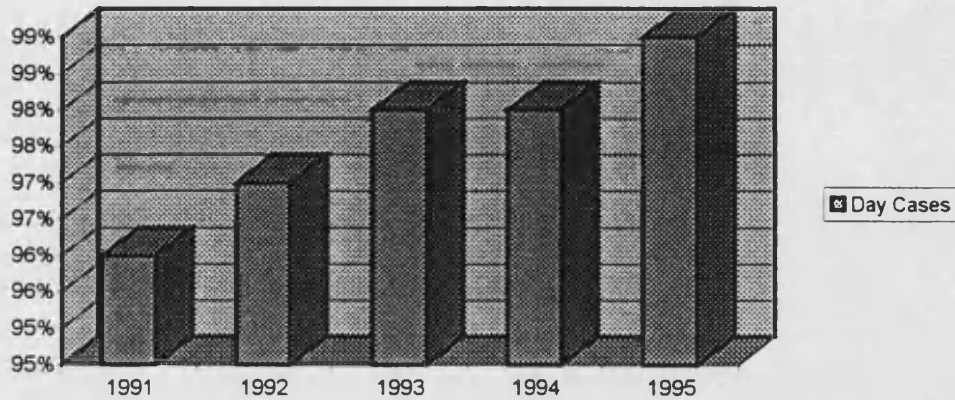


Figure 10.3: Cataract operations performed as day care procedures in unit K in 1991-1995

Figure 4. Day case cataract surgery performed on national level -Sweden (%)

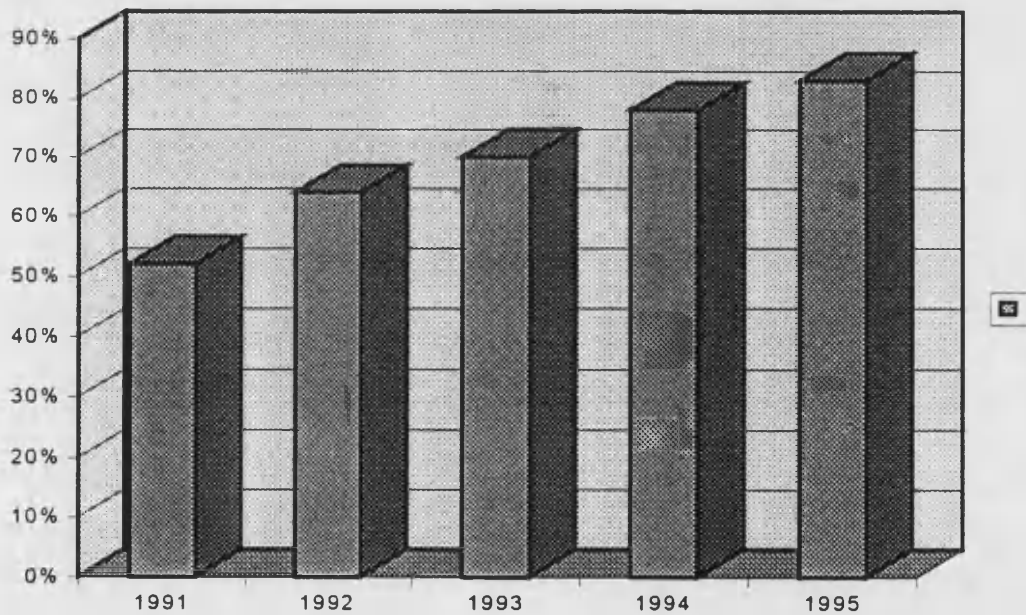


Figure 10.4: Cataract operations performed as day care procedures in all eye units in Sweden during 1991-1995 (SPRI, 1994, Association of Swedish Ophthalmologists, 1993-95)

10.5. Changes in the Numbers of Operations Performed: Interviews with some respondent groups

GENERAL PRACTITIONERS' VIEWS

ENGLAND

On the whole, GPs thought there had been no change in the number of operations performed in the units in which they worked. Responses from sample S were unanimous in this respect, but this belief was also partly held by the doctors in sample T, although there were notable differences in opinion. One of the doctors in the former pointed out that the incidence of eye complaints had not changed, and so, in his/her view, the amount of surgery had not changed. Two other doctors did see a change, with one of them explaining that *"it did not relate to the reforms"*, and the other putting the change s/he had seen *"down to medical technology, as more frail people can have it now"*. Yet another doctor commented on interrelations between GPs' work and the hospitals' throughput:

"Throughput has increased in response to the patients' demands, although a lot more of these things could be done in the GPs' surgeries. However, we are limited by time pressures and the amount of money we are paid for carrying out these tasks."

Sample U revealed a variety of opinions. All the fund-holders in the sample thought that numbers were bound to increase because of the operation's impact on quality of life and the higher demands by elderly patients. One GP stated:

"In absolute numbers, there has been a 10% increase for those over the age of 65 and this is going to become even higher."

Yet another said that this was because *"more patients come through the optician anyhow"*. A non fund-holder, in spite of the lack of major change, saw potential for higher throughput *"because the decrease in the length of stay and the set amount of money created more idle time"*. When exploring the reasons for this increase one of the GPs felt that changes in the number of operations were *"demand led"* and not a consequence of the reforms, but someone else thought that there had been some relation:

“As the service was quicker, more patients got operated on and more patients came through the care provision process.”

The doctors were asked to expand on these beliefs, and asked whether an increase in the number of operations could be attributed to the introduction (or wider use) of day care surgery and local anaesthesia. The replies were generally vague, and gave the impression that GPs had not had the time or the inclination to explore the effects of new methods of treatment on the number of operations performed.

Three of the doctors in sample S either didn't know the effects or could not answer the question; the other two suggested that there was no relation. Those in sample T thought that an increase in operations was partly attributable to an increase in the use of day care and local anaesthesia, but did not expand on their answers. Sample U gave a variety of answers, with one of them saying it was *“the main reason for the change”* and another thinking it was not related. A third GP said that it was not relevant, as the patients would have been referred anyway.

The responses again demonstrated a lack of awareness on the part of GPs, but this did not seem to be something that they were too concerned about, leaving the choice of method of treatment and its effects up to the provider unit, and not taking an active part in these processes.

SWEDEN

MK had an impression that the total number of referrals had increased *“because of the role of active marketing in this process”*. S/he recalled the differences with the past:

“Ten years ago, people with the same condition would have been referred, but not all of them would have had their problem solved, which is easier now because of the earlier operation date.”

NB also thought that the total number of operations had increased, *“but only slightly”*.

When questioned on the reasons that were at the root of the changes, or the lack of them, most practitioners could not come up with a response. CH thought the fact that patients from other districts, who were being referred outside their area and could also get treatment, played a role. JS thought:

"There was some impact of the reforms on medical technology, although there is no direct relation between these changes and medical procedures per se."

CONSULTANT EYE SURGEONS' VIEWS

ENGLAND

Six of the eight consultants questioned said that there had been an increase in the number of operations performed at their clinics since the introduction of the reforms. BL in unit T thought that it was hard to judge in which way things had changed, if at all, and AL in unit S was alone in thinking that the number of operations performed had actually decreased, unfortunately not elaborating on this answer.

On the whole, the consultants in unit S varied in their responses to this question. Three of them stated that the number had definitely increased, with JO suggesting that the increase had not been particularly marked, not because of lack of capacity but because of the limited demand by purchasers: "*we could do more if we were paid for this*". The clinical director of unit S, who also believed that the number of operations had increased, explained that this was because money had been attracted "*through extra business*" and the process had become more formal "*as there was more sense of the market*".

MJ, in unit T, who thought that the number of operations had increased on the whole, ascribed it "*to the younger staff*" and the clinical director of the same unit provided figures which reflected a slight increase, "*not a lot, about 950 to 1,050 a year*".

MH in unit U also opined that there was an increase in U.

Consultants in unit P were on the whole pessimistic about the reforms' ability to promote higher turnover as they felt their capacity was rather under-utilised as a result of cash limits on operations imposed by the purchasers, which was "*translated into pressure by the management*", as put by one consultant. Someone referred to organisational shortcomings, such as the waste of time engendered by patients walking from the ward to the operating theatre, poor preparation by the nurses, inefficient taking down of a patients' medical history, and others, adding:

"The potential for an increased number of operations on the surgeons' part and day care surgery alone cannot produce higher turnover."

They were then asked whether they agreed that the increase in the number of operations performed could be attributed to the introduction or the wider use of some forms of medical technology such as day care surgery and local anaesthesia.

More than half of the consultants felt that the increase in the number of operations was attributable to the use of day care and local anaesthesia, at least to some extent. Only DA of unit S was convinced that this was the main reason for this rise. BL and MJ of unit T thought that the use of local anaesthetics was the cause, rather than the switch to day care. Other reasons given were pressure from management and higher staffing levels. It was also said that the trend toward performing more operations was in place before the reforms, that general efficiency had increased, and that there was now more operating time available.

More specifically, the clinical director and one of the leading consultants of unit S (South London) were of the opinion that the increase in the number of operations carried out was related to the wider use of day care surgery and local anaesthesia, the clinical director adding, "*we did this before at our hospital, but it is relevant for most of the country*". AL thought that the increase was more closely related to the targets set by the management, and hence a product of the reforms, rather than advances in surgical treatment.

JO also did not believe that the rise had come about as a result of day care and local anaesthesia, pointing out that the number of operations had always been

increasing, and attributing the rise to greater numbers of staff and higher efficiency:

"We could increase the number of operations due to our increased capacity. For example, in 1987 the number of operations performed was 400 a year and in 1991, 1,000 a year."

One consultant explained that this rise was because of local anaesthesia, but not day care, because the number of anaesthetists needed had decreased:

"In the case of general anaesthesia, two anaesthetists were needed and it could quite often take 20-30 minutes for the second anaesthetist to come."

The clinical director of unit T felt that although more patients were operated on under local anaesthesia, the difference was not that big and the reforms' impact was even smaller.

MH, in U, gave no answer and consultants in unit P were almost unanimous in thinking that technological changes (such as local anaesthesia) were at the root of a more efficient performance but they could not link these to the advent of the reforms. The above replies could be seen as contradicting each other. In fact this was not the case because different respondents referred to their own experience.

SWEDEN

All surgeons agreed that in the aftermath of the reforms an increase in productivity was observed, which had nevertheless already stabilised by the end of 1995 (when the interviews took place). One of the leading surgeons provided figures:

"For the last three years it has been relatively stable at about 7,000 a year, in 1992 and 1993 around 5,000 a year, in 1991 3,000-4,000 a year and in 1990 much less."

Another surgeon asserted that during the last ten years productivity had doubled in the Stockholm area because no limits had been put on hospital production. At that time, anyone - even those who had a small private clinic - could raise the number of patients. S/he thought that clinical guidelines were needed in order to avoid this situation, but these were difficult to establish because:

"Vision was a complicated combination of factors and, as a consequence, there had been a tendency to cut down on the number of cataract operations in Stockholm County because otherwise it would be a freely growing tree."

By contrast, the director of hospital K, who thought that the number of operations might have increased and referred to the current figures as being 5/1000, was critical of the timing of the operation because it was usually done for those who already had visual impairment, while it would be important to have the operation prior to the handicap:

"This would save the municipality the money spent on providing home support and taxis for visually impaired who then gradually got used to it and were not prepared to give them away."

CZ claimed that the number of operations had increased as more people were currently working to provide for patients. The increase of operations performed was from seven or eight daily to ten or twelve per surgeon, which were consecutively performed in five theatres, and this had been a routine process for the last three years. S/he added, *"Reforms have influenced this process, as each operation is reimbursed using the DRG prices."*

Surgeons were divided between those who thought that organisational changes introduced by means of the reforms had been responsible for the wider introduction of day care and those who considered this rise was because of independent advances in technology. The clinical director and the two most senior surgeons in the hospital belonged to the first group. One of them explained that, after 1990, private clinics were allowed to offer day-care and that the care guarantee was introduced for each patient with vision of less than 0.5 in the best eye (and in Stockholm in either of them), which guaranteed an operation within a three-month period:

"Before the budget was fixed but with the care guarantee more money was made available for employment of new doctors and the purchase of more lenses was possible. Before it was not possible as money did not follow the patients."

The deputy director explained that in 1992/93 an additional 5 million SEK was provided to shorten the waiting list and for this reason:

"We operated on Saturdays and Sundays in order to meet this target. All these factors taken together have an impact on the increase in the operations performed."

The clinical director and the other leading surgeon had similar views and stressed other aspects contributing to this outcome such as the way the work was organised and certain routines for the standard procedures, which were

implemented to avoid long waiting times for patients. CZ also thought that changes in the organisation of work, such as planning nurses' time, sessions, and payment by DRGs, had an influence, but more important was the combination of medical technology (new lenses) and the higher demand that it had created and the higher life expectancy of patients. By contrast, WS believed that technology had to come first because *"the changes occurring in the system were aimed totally against the medical profession"*.

MANAGERS' AND PURCHASERS' VIEWS

ENGLAND

The deputy director of hospital S acknowledged that both the activity rates and the discharge policy in cataract surgery had been influenced by the reforms but in a more limited way than in other areas. S/he thought it was a combination of factors, such as technological development, pressure on the number of beds and enthusiastic young consultants keen to introduce changes.

A view from the management of hospital T held that *"pressure for efficiency helped us to become aware of excess capacity"*, which made them realise that there should not be too much activity performed for the money available, *which also made us feel dysfunctional"*.

According to the deputy general director at unit U, there seemed to have been no major change. S/he explained that the numbers were roughly the same, regardless of the fluctuations as contracts moved from one environment to another, commenting:

"The demand for elective surgery was made more visible in the market environment. In this sense, the reforms can lead to frequent increases or decreases in workload."

The view of the scientific consultant employed by the purchasers' agency in U reckoned these diseases were neglected in comparison with cataract operations, both because there were no effective treatments for the former and also because the latter was remunerated on per case basis *"with obvious incentives for providers."*

In S, the purchaser concentrated on *“the fact that the provider, who is contracted to a specific number of procedures, over-performs and asks for more money afterwards”*, which was strongly resented by the organisation.

SWEDEN

After conducting an interview with the financial manager of the hospital, it became clear how the hospital carried out its activities, not only in terms of obtaining contracts but also in terms of pricing the services. It had contracts with all nine districts in the Stockholm County Council area, which were made at the end of each financial year for the following year in advance. This was helpful in terms of estimating the number of operations to be performed the following year for the population of each respective area. If specific regions wanted to buy more operations without having a contract for the additional number, it was subject to negotiations.

The executive from Stockholm County Council reported that, in 1991, the cataract operations performed in all hospitals in the Stockholm County Council area amounted to 5,178. According to his/her view, there was pressure from providers to show competitors that they could perform:

“There was a threat to survival as beds were taken away and day care had to be introduced on a wider scale or else providers would not be able to meet the needs of the population.”

Another purchaser, in Z district, stated that during the 1980s the average number of cataract operations performed nationally was 7,000 and that, in 1992, this had increased to 37,000. This could have also happened because budget devoted to health care had increased by an average of 10% each year. Thus, for example, the budget for 1996 was 11.7% or 1.5 bln SEK higher than the budget of 1995. Prices in 1992 had been set at 10% less than before and, in 1993, by 7% less than in the previous year. S/he said:

“This resulted in DRGs being used as the indicators of performance although there was initially no intention to use them for this purpose.”

S/he was certain that all had been set in motion by the care guarantee and the differences in prices for phacoemulsification and that the standard procedure had caused the rapid shift to the former (see Tables 10.7&10.8).

10.6. Changes in the Price of the Service: Interviews with some respondent groups

GENERAL PRACTITIONERS' VIEWS

ENGLAND

The GPs were asked whether or not the reforms had influenced the cost of cataract operations at the hospitals with which they worked. Almost all doctors responded that they did not know, but again this question related to information, which was not necessarily directly relevant to them. It is not surprising that the non fund-holders did not know about the cost of the service, and two of the fund-holders (out of four) were among the few who offered an answer. Of the latter, one GP thought that there had probably been no effect, and another simply answered that the cost had come down.

SWEDEN

Only PG (a private GP) knew about the cost of care and the way it had changed after the reforms and, in his/her estimation, the overall cost in the case of his/her practice had decreased. JS commented:

"The County Council insists that the total cost of care has increased due to widespread private practice. However, in reality, only 3% of the population uses private services."

MK referred to the most important impact of the reforms on cost saving, which was related to restructuring and *hospitals looking more carefully at their bed capacity and how to improve the follow-up of patients within different departments of the same hospital."*

CONSULTANT EYE SURGEONS' VIEWS

ENGLAND

There was a fairly even split between the consultants who felt that the cost of operations had increased, and those who thought that they had decreased. Of those who thought that the price had increased, the reasons cited were inflation and raised staff salaries, a greater awareness of the actual cost of surgery, and an increase in the cost of theatre time. The clinical director of S thought that the price had increased but that the reforms had had no impact, admitting though:

"We certainly became better at pricing and costing because of the market and business mentality."

DA thought the price of operations had decreased but AL said:

"Formally, they became more expensive after the reforms - at least, we had better information on it."

It seems that following the reforms, the awareness of the financial outlays of the departments increased, and money saving measures were introduced. Departments attempted to get the best prices for their drugs, lenses and equipment, from different suppliers. Individual departments paid more attention to their budgets, and to areas in which savings could be made. In respect of the latter, the clinical director of unit S clarified:

"Purchasers demand a 5% improvement in prices each year but our different ways of saving include negotiating prices for lenses, stopping the use of sutures, analysing budgets and making them more realistic, and prescribing spectacles for children only."

One other consultant supported this view by stating that changes in cost-saving measures were a result of the reforms and related to *"managing our own budget and increased cost-consciousness, expressed in tendering for implants and drugs, whereas in the past there was no reason to do this"*. Yet for someone else, *"it has always been the practice to try to obtain the best prices for lenses and drugs"*.

In sample T, one of the new consultants replied that the cost hadn't changed for outpatients, but some money had been saved through more aggressive

negotiations with medical drug companies. Again, another senior consultant was more pessimistic:

"The problem is that everything is a part of a huge hospital drug bill and we don't have the incentive to save on helon, for example. We would have saved if we could have kept some of the money for new equipment."

The clinical director of T provided some other examples of savings made, such as the reorganisation in nursing that had resulted from cutting down on beds:

"When the outpatient sister left, we were not allowed to replace her, and instead we used the remaining nurses more efficiently."

MH, in U, said that s/he had always been cost-conscious anyway *"and had always tried to get the best deals, even through personal involvement."*

In unit P, the whole range of answers was presented. Some consultants thought prices had increased because of introduction of new and expensive technologies, which were *"inherently more expensive"* or because the cost of the reforms *"was ridiculously high"*, but someone else thought price had decreased. The clinical director stated that prices had not changed greatly but *"the awareness of the cost has changed significantly"*. This had also had an impact on cost-saving methods, expressed in giving equally efficacious but cheaper drugs, and in replacing theatre materials such as helon with cheaper ones (air bubble). There was also more of a cross-cover for consultants, which also extended to lower grades of surgeons.

SWEDEN

All eye surgeons agreed that the cost of the procedure had decreased, which, according to the clinical director, *"had to do with increased volume and better equipment"*. The deputy director explained that:

"DRG prices for cataract surgery have decreased by 20% from 1994, which was a result of competition with the private clinics."

When asked whether they had put in practice different ways of savings as a result of the reforms, MH was convinced that economic incentives created by means of the reforms had resulted in savings; in addition, there was now *"the possibility of negotiating deals, with approximately 5m to 8m SEK a year being saved this way"*. The deputy director who stressed another aspect created by the reforms supported this:

"Staff suddenly realised how much things cost and negotiations with companies were initiated."

The clinical director provided a detailed report on how the price for services had decreased by 17% from 1994 prices, which had been achieved by shortening certain routines, like establishing cashiers and introducing a high level IT network:

"This was an indication of good quality that, in turn, resulted in efficiency, but also improved patients' satisfaction."

Further examples given by the director referred to the organisation of work in order to minimise patients' waiting time at the outpatients' department and to motivate the personnel:

"It initially took time to establish a different working culture. Now the personnel are happy because they are working as a team - and the absenteeism rates are very low."

WS reiterated that the most important aspect of saving was linked to the fact that all the companies from whom goods were procured by the hospitals had been made cost-conscious and had consequently lowered their prices:

"This has been a very important result of the reforms, especially in the long term contracts and high volume contracts, as they are all now subject to negotiations."

BP also agreed this was happening:

"Possibly it was because of the way patients were handled (more efficiently, there was less waiting time); also transportation back home was quickly arranged."

MANAGERS' AND PURCHASERS' VIEWS

ENGLAND

The executive from unit U thought that the cost of performing cataract surgery had decreased significantly because *"of the reduction of time spent in hospital, which had an impact on the nurses, staff and beds that were needed"*.

The manager from unit S thought that, *"the cost has decreased slightly in total, as more patients are now operated on during a single theatre session"*. When reporting on cost saving measures, s/he referred to the clinical director who

managed the whole budget of his/her unit and explained, *"We, as the management, were very keen to let her/him do so."*

The representative of the purchasing agency in U explained that the cost of theatre time was higher than it used to be before the reforms, but this was offset by the cheaper bedtime due to the wide use of day care surgery.

The purchaser in area T expounded on the changes that the role of the Health Authorities had undergone. S/he reckoned that, under the previous system, they had dominated the system but had also had to run the hospitals so there was always a conflict between their double role of planner for the population and manager of the hospitals. Before the reforms, Health Authorities had been very preoccupied with running the hospital budgets and protecting the interests of the providers, which had dominated their activities. Now they had to think more about the population's needs the purchaser/provider split and not so much the competition, *"which is not real anyway"*, giving an example when the Secretary of State intervened to prevent the closure of hospitals, *"which would have been the outcome if the market had been allowed to work."*

SWEDEN

The financial director of the hospital explained that pricing at hospital K was undertaken once a year and was basically calculated by dividing the total amount of fixed costs by the number of operations. Doctors were very actively participating in pricing procedures and they estimated how labour intensive each of them was. According to him/her:

"The cost of each procedure has been gradually lowered over the years. This is also because the hospital's productivity has increased dramatically."

S/he provided examples that were supported with figures. Thus, in 1993, the total number of outpatients' visits was 60,000/year, increasing to 90,000 in 1994 and 120,000 in 1995. Prices in the years between 1992 and 1995 decreased by 34% and in 1996 the price was lowered by another 10%.

According to the purchaser in district Z, hospital K was a monopoly in the eye service market as it provided about three-quarters of the cataract operations. There were four other private providers and one eye unit in a general hospital situated on the southern outskirts of the Stockholm County Council area, which shared among themselves the remaining one quarter of the market for cataract services (for details see Table 10.10).

Hospital K was still a dominant player in the market at the end of 1995 but there had already been a marked decrease in its percentage of market share, down from 73.1% in 1992 to 57.7% in 1995. This was largely because of more vigorous competition from the private sector, where private clinic W increased its percentage of operations performed from 6.9% to 9.5%, while clinic Y raised its percentage from zero to 5.6%. The dominant position of hospital K was likely to become even more threatened as a new competitor, a teaching hospital in southern Stockholm, restarted its operations in 1995.

Table 10.10: Operations performed by different eye units in the County Council of Stockholm area in numbers and their percentage of market share

<i>Name of the hospital</i>	<i>1992</i>	<i>1993</i>	<i>1993</i>	<i>1994</i>	<i>1995</i>
Hospital K	7263 (73.1%)	7271 (69%)	6855 (61.6%)	6548 (60.6%)	5452 (57.7%)
CC hospital X*	276 (2.8%)	131 (1.2%)	-----	-----	-----
CC hospital Y	568 (5.8%)	794 (7.5%)	671 (6.0%)	669 (6.1%)	426 (4.5%)
CC hospital Z	n.a.	161 (1.5%)	427 (3.8%)	426 (3.9%)	78 (0.8%)
Private W	686 (6.9%)	770 (7.3%)	1105 (9.9%)	1100 (10.1%)	900 (9.5%)
Private X	1135 (11.4%)	1417 (13.4%)	1392 (12.5%)	1400 (12.9%)	1100 (11.6%)
Private Y	n.a.	n.a.	674 (6.1%)	649 (6.0%)	500 (5.3%)
Total	9938	10544	11124	10792	9434

Source: hospital K data and County Council data;

** Clinic closed in May 1993*

10.7. Changes in discharge policy, clinical outcomes and the use of cost saving technologies: interviews with some respondent groups

GENERAL PRACTITIONERS' VIEWS

ENGLAND

The GPs were asked if they had experienced any changes in the discharge policies at the units with which they worked, that they could attribute to the reforms. The replies almost exclusively pointed to a significant decrease in the length of stay, mainly due to an increasing use of day care. For example, all of the doctors in samples S and U said that there had been a significant change, referred to as *"the most tremendous impact"* by one fund-holder of the latter sample, and most pointed to day care surgery as the cause. GG, another fund-holder in the same sample, added that, once again, *"advances in technology were central to this change, rather than the reforms"*.

The doctors were questioned further on this point, and were asked exactly what they felt a decrease in the length of stay could be attributed to, for example changes in discharge policy, or the introduction of new technology. Almost all of them attributed them to both advances in technology and to changes in discharge policy brought about by the reforms. Only the doctors in sample T once more proved to be the least certain, with two of them not being sure of the reasons. The doctors in samples S and U expressed the opinion (either explicitly or implicitly) that while new technology had undoubtedly affected the length of stay, the new policies on discharge had also had a major effect. DC, from unit U, stated, *"They have gone hand in hand"*.

There was a lack of certainty among the GPs when they were asked whether a decrease in the length of stay had had an impact on the rate of readmission or complication rates. Six of the doctors either offered no comment or said that they

did not know. Among those who did reply, the overall feeling was that there had not been a significant effect. RE, of sample S said that while earlier discharge did not cause much of a problem in the field of eyes, it had had a greater impact elsewhere *“where patients were handled by community care, whereas they required intensive nursing.”*

In sample T, the majority of doctors thought there had been no changes in clinical outcomes, nor were they aware of any changes happening. AR and UN did not think that any significant changes had occurred, UN added:

“There are no significant differences, although improvements in technology have had an impact on efficiency and clinical outcomes.”

One doctor said that readmission and complication rates remained the same, adding *“Surgeons would not allow themselves to compromise in clinical matters”*.

In sample S, opinions were more diverse. For example, one GP stated s/he wouldn't know but they were definitely not worse. Someone else said that if this happened it should not be the case of cataract surgery. The most prevalent view was summed up in one of the statements: *“The reforms may have partly prompted the use of day care which has improved clinical outcomes.”*

In sample U, doctors not only saw improvements in clinical outcomes but came up regularly with their own clarifications as to what may have been the reason for this and it was almost invariably ascribed to changes in technology, rather than to anything else. DC, a fund-holder, said, for example: *“the whole cataract procedure has been a revolutionary thing and patients were thrilled by local anaesthesia.”* One non fund-holder thought that there had been no changes and another reckoned that: *“people were very satisfied because of technological and not so much political changes”*. When questioned about the complications, the majority of doctors dismissed the possibility of increases except for one or two doctors who thought:

“In terms of readmission there is no increase but there are more complications than before, such as fibrosis behind the lens, but this is treated quickly with a laser.”

“There is an increase in complications, such as scar tissue, because the cataract is more common; but there is no association at all [between this and the changes] as a lot of complications happen in private practice too.”

The GPs were asked whether they felt that the element of competition introduced among self-managed trusts had enabled providers to adopt or experiment with new forms of treatment and medical technology. The answers did show a limited knowledge among the GPs on this issue, but the subject was very much out of their field and was intended more for those working within provider units. The doctors were also asked for their impressions regarding the range of treatments available, compared to those available before the introduction of the reforms, specifically in terms of day care surgery, local anaesthesia, and the phacoemulsification technique (small incision surgery). They were asked to expand further, on whether they would attribute the wider use of new methods of treatment to the introduction of the reforms.

Sample T seemed to be the least certain, with only one doctor offering a vague answer *"increases in all of the procedures have happened, but it is difficult to know if it is only due to the reforms or also to technology"*. Overall, the doctors in sample T were divided between not answering and believing that these changes would have occurred anyway.

An elderly GP believed that the advance in technology was the main cause of the adoption of new treatments, and not the reforms. UN said that although day care surgery was on the increase, some patients had suffered, as there had been *"insufficient support from district nurses, and the patients themselves could not put drops into their eyes"*. Someone else (coincidentally a foreign GP from an English-speaking country) added that:

"The UK is always a bit behind, as, being more conservative, the UK's doctors pick up later on changes in technology."

The fund-holders in sample U were both of the opinion that the methods would have been adopted without the reforms, but that they had certainly acted as a catalyst in the process of their widespread uptake. Apart from the doctors who chose not to answer, the two fund-holders summarised the general opinion quite well that medical technology was the real cause of developments in this area, but the reforms had had an effect in that more cost-effective methods were adopted more readily. There was, therefore, a generally positive feeling, but the lack of

certainty again pointed to GPs not being well informed about developments at their provider units.

SWEDEN

MK expressed a view that problems related to the increased introduction of expensive technology may be related to these changes. NB thought that competition had speeded up the introduction of some forms of technology; for example, day care surgery had certainly been influenced by the reforms, but for other technologies the changes had had very little impact, as their diffusion had already been happening before the reforms. PG did not know/did not answer the question, while JS felt:

"It is rather a matter of scientific obligation for the departments to introduce new technologies and this cannot only be interpreted in terms of the impact of the reforms."

CH pointed out that the reforms had not greatly accelerated the evaluation of the technologies introduced. The continuing lack of audit was also widespread:

"Very little evaluation was done and it was very rudimentary and usually done at the initial stages of the introduction of the technology, but the approach was not systematic at all."

CONSULTANT EYE SURGEONS' VIEWS

ENGLAND

It was agreed that the average length of stay was decreasing, though this was not believed to be an effect of the reforms. Only AL in unit S thought that there might have been a very slight increase due to the inevitably less satisfactory work performed by junior staff while learning the technique. New technology (more specifically phacoemulsification) was again believed to be central to the lower discharge threshold. The trend towards using day care was also cited.

Earlier discharge, according to one surgeon, had caused problems of its own in terms of follow-up care for the patient. However, the common position from

almost all the consultants was that this reduced length of stay did not have any negative effect on complications following surgery or readmission rates. Only JO of unit S said that if there were a slight rise, it would not be due to the discharge policy, but because of the learning curve involved in the phacoemulsification technique.

Comments in unit P on changes in discharge policy again pointed towards advancements in technology, with better wound construction (small incision and suture technique) that made the earlier discharge safer and enabled the immediate post-operative period to be spent at home. There was one notable exception of a consultant who believed that *"the reforms have hastened the 'kicking out' of people"*.

In unit P also, the clinical director thought that local anaesthesia was related to more difficulties in performing surgery, which was due to the learning curve in the initial stages of the technology's diffusion. JJ for example thought that outcomes in visual acuity after day case surgery could be slightly worse, *"but it had yet to be definitely proven"*. S/he also claimed that, after local anaesthesia, some post-operative complications could be slightly more common. On the other hand, it was free of systemic complications that were common in the use of general anaesthesia on older people.

When asked whether the reforms had encouraged experimentation with new technology, the response was largely negative, and that the practical implications of adopting the new methods (patients' and purchasers' satisfaction and better clinical outcomes) were the primary reason for their acceptance. The three consultants who responded to this question all gave different answers. Points mentioned were that the increase in operations was a continuation of a trend already in place that more operating time was now available, and that people were now working more efficiently.

The clinical director of unit S, for example, thought, *"it was a natural propensity of something that we had already started"*. DA, from the same unit, explained that

this was because *“people were forced to do it to perform more efficiently and that was where the clear impact of the reforms was manifested”*.

In unit P, the responses of most consultants clearly stated that the widespread introduction of day care was a result of the reforms, although other reasons were also referred to, such as experience transferred from the USA (where the number of ophthalmologists was greater) and *“the feeling that there was a tide flowing”*. This was summed up by one of them:

“The increase in day case surgery is a result of the reforms; nevertheless, the trend was present before.”

Two doctors also unusually commented on reasons for the delay in adopting proven procedures by saying:

“The conservatism and backwardness of the British establishment, as well as a national mentality that prefers old-fashioned ways of doing things and is reluctant to take on new ideas, is to be held responsible for this delay.”

There were also, however, quite a number (four out of sixteen) who chose not to reply.

All in all, only three of the consultant eye surgeons regarded the set of incentives introduced by the reforms, such as freedom to organise their workload more efficiently and the ability to respond to clients' needs. This was seen as a strong positive force speeding up innovation on all levels of everyday clinical practice. This included the adoption of cost-saving technologies, as well as managerial procedures.

When asked if the range of treatments had increased, there was a very positive response. Again, phacoemulsification was put forward as an important development, as was the increasing use of day care. AL of unit S pointed out that there was now a more aggressive approach to treating eye conditions across the board, leading to a greater variety of treatment methods. It was not felt that the reforms had had a large influence here, and that the new methods of treatment were a consequence of advancing technology, which would have occurred anyway.

BL of unit T felt that the reforms were largely responsible for the introduction of new techniques being used on a widespread basis, though higher cost-consciousness had posed problems in purchasing the appropriate equipment. One of the consultants in the same unit elaborated on the difficulties in communicating with the administration:

"We had to say we needed phacoemulsification for more day cases, which was not true."

SWEDEN

MH was sure that the reduction in the length of stay was in some way related to day care surgery and the reforms and the decrease in number of beds. WS could not say definitively whether the reduction in the length of stay was related to productivity. It was explained that the extra money did not always follow the increases in productivity because, after certain level of operations had been performed, no more money was provided for extra production. S/he rather thought that this was related to the introduction of the new technologies:

"The intraocular lenses are the most important development in day-care surgery, as local anaesthesia has been used for at least thirty years in cataract surgery. With IOL, patients could not only go home, they could use the eye the very next day."

BP thought the discharge policy had speeded up because *"of the demand from society on the one hand and the medical ego on the other"*, acknowledging that day-care had possibly played a role too. CZ put forward a hypothesis for an almost complete shift to day care from the beginning in hospital K:

"The beds were not ready when the new hospital started, so it had initially to go without beds at all. Afterwards, there was no need for them."

When questioned on the relation between organisational change and the widespread use of day care surgery and other new technologies, most of them did not think it to be an issue. On the whole, most surgeons thought it was medical technology and not so much the reforms that had made the shift to other cost-saving procedures possible. One of them summarised this as:

"The better quality of lenses and small incision techniques made day-care possible on a wider scale; but it was surely influenced by the reforms because of their impact on cost efficiency."

The views on the benefits of the use of new techniques (small incision surgery) were that there was no clear-cut answer because the learning curve was too long (at least one hundred cases per surgeon). WS thought that if patients stayed in the ward for three or four days then it would be possible to observe post-operative infection: *"It did not mean that the infection rate had decreased; it was just diagnosed later"*. CZ thought the complication rate was lower, as it was related to the higher volume of operations performed: *"Day-care has not had an impact on lack of complications."*

Surgeons asserted it was a mixture of factors, such as the higher productivity achieved due to the reforms and the money resulting from that, and the wider availability of technology. According to MH, the clinical director, the elements of competition introduced between hospitals led them to take on new technologies: *"It certainly had an impact on new forms of treatment adopted because the hospital had acquired own budget and could buy equipment provided, it was put out to tender and justified in terms of expected achievements."*

BP thought that, *"this was a matter of leadership"* but also explained that the reforms had made money available and the administration had been pushed to purchase equipment. It also helped doctors to realise their objectives *"to stay at the top"*.

WS, while seeing the impact of the reforms on the introduction and wider use of new forms of treatment conceded that other factors were also important. S/he elaborated at length on the causes of new technology adoption, asserting that the media played an important role in publicising technological achievements, which, in turn, influenced the public and also had an impact on technology adoption by the hospital:

"Patients' expectations and the competitive environment put pressure on hospitals to catch up with the newest technologies."

S/he also referred to the role of professional pressure from international competition transmitted through professional contacts, meetings and others, which *"was at least as important as pressure from patients, or even more so."* CZ supported this view by stressing that *"the philosophy of competition was necessary but the contribution of new technologies, was more important."*

MANAGERS' AND PURCHASERS' VIEWS

ENGLAND

The purchaser of unit S reckoned there were no changes in clinical outcomes following the reforms because they had been around too long in the medical profession and there were so many other factors influencing the quality of service. S/he also added how important the information work with patients was on why the changes had occurred in discharge policy:

"We have to work towards reassuring GPs and patients that they can go home, not because of a lack of beds but because it is acceptable from the medical point of view."

The manager at unit U said there had been a decrease in length of stay due to pre-admission assessment clinics. This could be seen as a crude efficiency gain caused by the reducing in waiting time, which could probably be attributed partly to the reforms. But, s/he explained, *"nothing happened just because of one reason; it was also due to the introduction of new technology and some other non-quantifiable things, which were made possible by the reforms."*

On the other hand, the connection between the changes in discharge policy and the readmission and/or complication rates *"never seemed evident"* to him/her.

The purchaser from T believed that the screening system used at the outpatient's clinic had improved greatly, due to the reforms, and more people were picked up as qualifying for surgery at the lower end of the spectrum than before. The introduction of day care had also speeded up the discharge of patients: *"We drive the provider towards this end by asking questions such as, 'why are the patients still in bed?'"*

When asked about the impact of technology in this process the manager in T thought it was difficult to define how great the impact of technology had been, as it was also related to the contracts. But day care and lasers had resulted in higher efficiency as well as effectiveness and s/he added, *"Technologies that supported the aims of the organisation were now given more preference"*.

A manager in S also thought that there was no doubt that wider use of some procedures had been influenced by competitiveness, stating, however, that *"it was not only the cost-effective ones that were promoted, because the other procedures were not researched nor were they investigated"*. S/he added that there was obviously a pressure on day care surgery, as there was a set target of 50% of procedures to be done this way:

"In the case of our hospital, it was surpassed and 62% of all cataract procedures were done as day cases. Other developments in surgical techniques, like small incision surgery, are more conducive and easy to convert into day care surgery."

A manager in hospital U referred to the introduction of new technologies, such as anaesthetics and day care surgery, as quite significant, though s/he added:

"It is due to all these and some other non-quantifiable things that the reforms made possible."

The purchaser from unit T believed that the reforms had speeded up the use of some preventive diagnostic procedures and the introduction of day care surgery:

"Of course, money played its role in that and reforms made everything much more explicit. For example, if providers want to invest in equipment, they have to justify its significance in terms of the population's needs and not just clinical practice."

The scientific collaborator with the purchasing agency in sample U argued that, for phacoemulsification surgery, long-term average costs were lower, its short-term average costs were higher and the equipment needed to be in full use for quick amortisation of the costs. S/he also referred to the problem of the learning curve, which, according to her/his, only decreased on average after 300 cases performed by a single surgeon:

"Before that is reached, the results may be slightly worse compared to conventional techniques."

SWEDEN

In hospital K, the management of the clinical and most of the non-clinical aspects of care (except for finance) was under the team of senior clinicians, as were other aspects, and their views were presented under the heading of consultants' views.

As a purchaser in district Z in the County Council of Stockholm area explained, a system aimed at recording outcomes had been developed, in the form of a national initiative known as "Quality Registers", conducted under the aegis of the National Board of Health and Welfare and also supported by the Swedish Medical Association and the purchasers. It was based on the collection of standardised information from each provider's unit. The indicators used for this process are summarised in Box 2 (Annex II).

S/he clarified that, before 1992, there had been a very large difference in the rates of day surgery and it had risen sharply after the introduction of the organisational changes, varying between 5% and 45% for different hospitals in Stockholm (e.g. for knee-replacement). This difference with the former period was that day surgery had been confined to the experiments and research activities of the professionals who were interested in gaining status by performing these activities. But after the introduction of the reforms, there were incentives for its rapid diffusion, which indeed happened in reality. The variation between different hospitals also decreased with equal speed, the specialist beds in the Stockholm County Council area decreasing by 30-40% between 1992-1996.

An executive from the County Council of Stockholm added that some forms of medical technology were swiftly introduced on a wider scale because of differences in reimbursement prices. One such was the dramatic shift to the phacoemulsification technique (the suture-less small incision surgery), the price of which was 5,838 SEK in 1994 when performed as a day care procedure and 14,294 SEK when performed on an inpatient basis (039C in KOKS system). The simple cataract operation (039B) was respectively priced at 4,572 SEK and 8,100 SEK (also see Tables 10.7&10.8).

KEY FINDINGS

- Increases in throughput were observed, although they could not be fully expressed because of the cash limits imposed by purchasers, which quite often resulted in idle time and were resented by clinicians in the UK. These increases were even more evident in Sweden, where reimbursement for surgical procedures was conducted on a per-case basis but there were no hard budgetary constraints. This led to higher throughput but also increased the amount of money spent on these services. In the UK and later on in Sweden purchasers also had to restrict the providers' drive to "over-perform". Again General Practitioners in both countries seem to be poorly informed on this aspect of change.

- There was no uniform trend in prices for cataract surgery and there were differences in charges for the same procedures according to block or per-case contracts in the UK. Only in the case of unit S, and less so in unit T and unit P, was a dramatic rise in throughput and a decrease in price clearly demonstrated this trend. In Sweden, prices showed an adjustment, after starting with an artificially high mark-up, and decreased by 20% during the three years of the reforms' implementation. Yet, the large providers were the price leaders and they also shifted to procedures that were financially attractive such as for example phacoemulsification technique in hospital S in the UK and K in Sweden.

- The clinical outcomes of care seem not to have been adversely influenced by efficiency drives or by the decrease in length of stay and there were strong convictions on the specialist providers' part that some technologies (less traumatic surgery) might even have improved them. The former seems to be confirmed by the small outcomes' audit conducted on the pilot site P, where no significant relation between the technique used and the grade of surgeon could be detected for the indicative sample of patients (n=53); if anything outcomes were invariably poorer only when co-pathology was involved. This maybe partly explained by another indirectly related finding that is linked to the lack of explicit or uniform system for setting indications for cataract surgery that is a norm in the

UK unlike in Sweden where the decisions who is to be operated are much more standardised and clear. This absence of universal criteria could in turn result in limiting the appropriateness of procedures performed, creating another type of inefficient behaviour on the surgeon's side whose assessment determines the demand for services.

- The relation between the adoption of efficient technologies and the relevant incentives introduced by the reforms were by no means recognised, either by GPs or by the consultant eye surgeons which was more obvious in the UK sample. Surgeons in the UK asserted it was a mixture of factors, such as the higher productivity achieved due to the reforms and the money resulting from that, and the wider availability of technology. In Sweden, the responses of most consultants implied that the widespread introduction of day care was a result of the reforms, although other reasons were also referred to, such as for example technological progress innate to medical sciences and transfer of the experience from elsewhere.

- Even the managers and purchasers especially in the UK, were not convinced whether reforms were at the root of change, despite the figures and purchasers' specifications in the contracts suggesting otherwise. Most clinicians ascribed the changes to technological progress already under way, and their delay in adopting some procedures when compared to Sweden, for example, was explained on the grounds of the innate conservatism of the British medical establishment. What can be concluded, is that is that there is a great degree of uncertainty as to the role that market mechanisms or the NHS Management Executive's directives played in speeding up this process; they could have also had synergy effects. One way or another reforms were instrumental in bringing about these changes either by means of introduced incentives and/or planning devices such as target setting.

IV. DISCUSSION AND POLICY IMPLICATIONS

CHAPTER 11

DISCUSSION

The assessment of changes in choice, information, quality, responsiveness and efficiency in the aftermath of the reforms' introduction was conducted to test whether the expectations placed on managed competition were happening in reality. The first two indicators were simultaneously looked upon as the tools for enhancing the market's effectiveness but also as important outcomes in their own right. Responsiveness and efficiency were both proclaimed as explicit goals of the reforms and quality of care was also expected to improve as a result of the market's work.

The research methodology relied on qualitative methods such as interviews with all involved actors: patients, general practitioners, eye surgeons, managers and purchasers. Their perception of changes on choice, information, quality, responsiveness and efficiency was analysed and then compared with the national figures or hospital data. This study was aimed at measuring changes expressed as process indicators in the periods before and after reforms. However, due to the lack of quantitative data from the time preceding the reforms this was not always possible. This chapter discusses the findings of the study with regard to all these indicators.

11.1 Limitations and constraints of the methodological approach used

Before proceeding with the discussion and interpretation of the findings, the limitations and constraints that this study faced should be repeated. They relate primarily to the qualitative approach, and in particular to the case study methodology that was adopted as the primary means of investigation, the bias resulting from the type and size of the sample, the problem of counterfactual evidence, and the constraints that are usually imposed on international comparisons. A clear delineation of the restrictions and a thorough description of

the methodology followed is essential in this type of research as they assist in the correct interpretation of findings and increase trust in the results generated.

The qualitative methods that this study used for its interviews with different groups of actors, the content analysis of interview transcripts and the contextual analysis of the most relevant documents were chosen as being the most appropriate for examining specific issues that this study investigated in detail and depth. The aim of the research was to acquire some understanding of the causes that underlie specific responses to policies that are often beyond control of those who enact them and to unearth some of the factors that influence these reactions. A case study approach is a form of qualitative research that isolates and defines categories that are under investigation and expects them to change as the research progresses. For this reason it was seen as the most suitable method for examination of the dynamics of health care environment that was in the process of continuous change even when this research took place.

However, in spite of the promises that this methodology yielded and fulfilled to a satisfactory degree, it also had its limitations. These were mainly linked to the generalisability of the results produced or rather to the concept of generalisability adopted. As Yin has convincingly argued, qualitative methodology aims at the 'analytic generalization' as opposed to the 'statistical generalization' typical of quantitative research methods. In the former, the previously developed theory is used as a template with which to compare the empirical results of the case study (Yin, 1994). This approach assists in understanding social phenomena in natural rather than experimental settings by giving due emphasis to the meanings and views of all participants (Mays et al, 1996).

However, inevitably, this methodology limits the size of the sample and the number of study sites it can realistically examine, especially when the resources of a single researcher are employed. In this project three study sites and an additional pilot site (all from the greater London conurbation) and one large eye hospital from the Stockholm area were studied. Although in selecting study sites in the UK every effort was made for them to meet the criteria of diversity and thus to ensure as great a degree of representativeness as possible, inevitably the

sample of respondents in each site was relatively limited. In addition, the characteristics of the sample of patients (median age 78 years for men and 80 for women) compounded the problem of its representativeness.

A further problem in the research aimed at establishing direct causality, which was also apparent in this study, is whether the proposed interpretation of events can withstand the test of counterfactual evidence. Quite often the answers given are speculative and the only ways of supporting the hypothesis is to examine alternative explanations rigorously for the phenomenon concerned and to provide the analytical framework that tolerates uncertainty. This limitation was acknowledged and was dealt with rather successfully. In fact, the agreement of the findings from data collected by means of this case study with some other published findings on similar issues corroborates the results yielded by the project and thus provides a positive indication of the robustness of the method used. Any disagreement with published research, on the other hand, was duly reported and used for testing the relevant hypotheses.

Finally, it is worth noting that the problems that usually bedevil international comparisons, such as difference in definitions of the indicators measured and variable quality of data are largely absent from this particular study. The qualitative method chosen investigated and compared the dynamics of response to changes in individual settings that shared common features and occurred in similar and yet distinct environments such as the health care systems of the UK and Sweden. These were collected by the same researcher who applied uniform methodology in both settings and used cataract surgery as a tracer condition for highlighting some of the changes.

11.2 Choice

The original intention of the reforms was to replace the notion of the patient as a passive recipient with the concept of a customer and, later on, the user of services. This presupposed an easier access to comprehensive and relevant information and freedom of choice, which would stimulate competition among providers within a regulated market environment. It was therefore expected that

increases in both information and choice would occur. Freedom of choice for purchasers was also intended to keep the less responsive providers on their toes (Abel-Smith et al, 1995). It meant that they would either have to modify their behaviour according to market signals (reflected in the combination of price and quality of services delivered) or be driven out of the market altogether if they did not respond effectively (Glennister et al, 1994a).

11.2.1 Evaluation of changes – the evidence

The evidence in the case of cataract surgery presented in this study shows that the expectations of the market reforms for an increase in, and a shift towards, freedom of choice have largely not been fulfilled. The answers received from almost all participant groups led to the conclusion that the degree and type of choice currently available is very limited, and is possibly less than before the introduction of the reforms. The purchasers - the District Health Authorities and the fund-holding and non fund-holding GPs in the UK, and the County Council of Stockholm, particularly support these facts although the reasons differ in each case.

Contracts have limited the referrals outside the catchment area because this would result in loss of income for the purchasers in both the UK and Sweden. On the one hand, giving choice to users proved to be expensive. In fact this was the reason why in Stockholm County choice of family doctor and specialist provider that was vigorously pursued in the beginning of reforms was then hastily abandoned. It also transpired that users of this particular age group were not too much in favour of enacting choices concerning their treatment should they be offered to them.

Choice of service/choice over the modalities of treatment

One of the dimensions of choice examined in this study dealt with changes in the options and/or the modalities of treatment of cataracts that were given to users. This aspect of choice is, in general, difficult to implement because patients who lack specialist knowledge are disadvantaged in putting forward their views when

compared to specialist doctors. It is particularly problematic in the UK, where there is no choice of the latter and patients have even less leverage over providers' responsiveness and/or their willingness to offer choices. All in all, patients felt that not too many choices existed especially when treatment was concerned but the majority of them did not feel that this was an important omission. Even in those few cases when they spoke in favour of choice they rather implied more information.

As this study demonstrated, General Practitioners usually showed little interest in this aspect of care and, as a rule, did not ask their patients for feedback. As a result, GPs were not providing patients with sufficient assistance and were not correcting for the inherent deficiency of the system by empowering their patients. Almost none of the GPs interviewed, whether in the UK or Sweden, could answer questions regarding choice of options of treatment given to their patients; hence, the assumption that agents were necessarily properly qualified to best promote users' needs and wants could not be validated. On the contrary, it became apparent that this might not always be the case as the GPs and family doctors themselves possessed insufficient information on important aspects of specialist care.

It has been known for quite some time that agents' presumed suitability to promote patients' needs in the best way is not self-evident, as their own concerns, priorities and requirements for choices and information may be quite different from patients' own perceptions and may even interfere with the former (Beaver et al, 1996; Luker et al, 1995). This could be linked to the broader assumptions that the post-war welfare state's construct (including health care services) rests upon. As Le Grand has pointed out it may be based on the not so realistic expectations that health professionals will, under all circumstances, be solely motivated by altruism and put their patients' good ahead of their own, something that he described as the behaviour of a knight (Le Grand, 1997).

Furthermore, it also transpired that the majority of patients in this study were not too keen to be involved in the type of decisions that high technology specialist care of cataract treatment entailed. Besides, many of the patients interviewed

either confused, or treated jointly, choice that was available with their need for more information. The explanation for this attitude may lie with the peculiarity of the study's sample of patients, where the median age measured at the national level in the UK was over 80, as reported in the large study conducted by the Royal College of Ophthalmologists (Courtney, 1992). Advanced age, with its consequent frailty and susceptibility, may partly explain patients' lower expectations and their limited inclination in assuming a proactive stance and make choices regarding their treatment.

It is also possible that elderly patients have stronger attachment to the universally and freely but also collectively provided health care, which has its roots in wartime solidarity and immediate post-war social order according to Klein's argumentation (Klein, 1995). This may, in turn, make them feel that individual involvement and pursuit of personal needs are incompatible with the philosophy of the system and that it could jeopardise these values. A number of patients in the UK (although less so in Sweden) spoke in terms of gratitude for whatever was provided to them and their references to their own limited competence for taking such decisions (the latter was equally stressed in Sweden) had also rendered support to this view.

The above factors, taken together, may perhaps explain why patients were not as interested in being active participants in their care as might have been expected (Shackley et al, 1994). The issue of patients' competence and willingness to be involved in treatment-related decisions, as well as their readiness to handle the information when it was given, used to be a relatively under-researched area with, according to some authors, only scant or outdated evidence available (Charny et al, 1990; Shackley et al, 1994).

However, it was known that the seriousness of the disease was negatively associated with patients' willingness to participate in medical decisions (Cassileth et al, 1980), but the latter was positively associated with educational status (Deber, 1994; Deber et al, 1996). Waldenstrom et al, who looked into 1527 pregnant women preferences in choosing alternative maternity care in the

Stockholm area also found that age, educational and professional status were crucial in this process (Waldenstrom et al, 1993).

Some of the new empirical studies have provided more insight into the specific factors which determine patients' wish for involvement, such as the severity of the condition itself (Ovretveit, 1994a), the timing of information provision (Beaver et al, 1996; Luker, et al, 1996) and also educational status and - of more relevance to this study - age (Anell et al, 1997; Waldenstrom et al, 1993). On the other hand, there were also attempts to link attitudes towards health related decisions to more generic behavioural patterns.

Ryan et al for example, applied the logic of regret theory first developed by Bell and Loomes & Sudgen after observing people who faced uncertain monetary outcomes who, it was found, anticipated not only the likely financial gains but also the possibility of experiencing regret (Bell, 1982; Loomes & Sudgen, 1982). She argued that patients acted similarly when deciding whether to undertake medical procedures and that they also considered the disutility that might result from wrong decisions, which could explain why patients wanted information but usually preferred to defer the decision to the doctor (Ryan et al, 1995; Ryan, 1994; Ryan, 1992).

Changes in choice of primary and/or specialist care providers

The factors that influence patients' choice of primary care providers are considered to be very important because of the key role that GPs play in the UK's health system, a structure that has also been recently attempted in the Swedish health system (Charny et al, 1990; Saltman, 1992). The primary care providers of the NHS assume a double and somewhat contradictory role, acting both as agents or "advocates" on the patients' behalf and also as the gatekeepers of the system. However, the wishes of patients for the amount and type of care may conflict with the latter.

The results of this study support some of the findings of previous research, which looked into uncertainties related to patients' willingness and ability to choose

primary care provision, along with arrangements that would best facilitate it (Shackley et al, 1994). The study's respondents from the UK were not inclined to travel while pursuing their choices and were rather uninterested in this aspect of care, a finding supported by another study (Mahon et al, 1994).

On the whole patients, in the UK seemed also quite unwilling to change the hospital they were accustomed to and the proximity of location played a crucial role in the process of choosing it. One can extrapolate with a relative degree of confidence that the similar held true when the case of choice of the GP was in question. However, this could be because the availability of choice of GPs in the UK, though always existing in theory, was rather muted. Even in the context of the reforms, it was stressed only for a relatively short time during the immediate post-reform period, after which more collective forms of purchasing - or, as it soon became known - "commissioning" took over (Goodwin, 1998).

At the same time, the study disproved some others findings when referring to Sweden. For example, research relatively recently conducted by Anell concluded that patients in Sweden made limited use of opportunities made available by the reforms because of the scarce or complete lack of information provided on the existing options (Anell, 1996). In its absence, convenience became the most important factor for selecting or, as it turned out quite often, not selecting a new provider. However, approximately one third of patients in the Swedish sample of this study (n=29) reported a change of primary care provider (known in Sweden as a house or family doctor).

It indicated that a more positive relation existed than Anell assumed, which allowed for conclusions to be drawn, despite the relatively small size of the sample. His later study, which looked into factors that influenced patients' choice, concluded that elderly and young, uneducated and well-educated patients alike wanted to participate in decision making, although they would consider different perspectives. The former were keener on choosing a physician; the latter were more likely to have been involved in treatment decisions, and education had played an important role in their involvement (Anell et al, 1997).

Changes in choice of provider and factors influencing it

The results of this study demonstrated that choice over the place of referral for non-fund-holding GPs and their patients in the UK was limited, in practice, to providers contracted by the Health Authorities. As a result of this, and the tendency to conclude contracts on the basis of patterns of previous co-operation, there were no incentives for the Health Authorities, and consequently for the non fund-holding GPs, to enhance choice of specialists for their patients.

This was worsened by the additional difficulty of referring patients outside each their catchment area using the mechanism of Extra Contractual Referrals, as it would result in a cross-boundary flow of money in favour of another Health Authority. Limited funds for this purpose were allocated to each Health Authority from the central government and they were meant to cover all health care needs of their respective populations.

In fact, one third of the total number of GPs - and all non fund-holders - claimed that they had more freedom to refer patients outside their catchment areas during the pre-reform period, although, as most of them agreed, they had rarely used it. As a consequence, the choice of hospital in the UK was hampered by powerful barriers raised by contractual obligations, which determined the referral patterns for specialist care "*purchased*" by GPs on behalf of the Health Authority.

The theoretical analysis would indicate that the opposite should hold for GP fund-holders because their freedom of purchasing was not limited by financial considerations taken into account by some, as was the case for GPs not enrolled in the fund-holding scheme. On the contrary, their referrals could be decided on their own and should be solely guided by the best interests of their patients (Glennister et al, 1994a). Yet four out of five of the interviewed fund-holding practices established an almost exclusive relationship with only one provider, which according to them, was based on the combination of price and quality of services offered to their patients. There is also some support for the findings presented here from related research which demonstrated that, while fund-

holders were more willing to offer choices to their patients, a change of providers rarely took place in reality (Ellwood, 1997).

This lack of choice over the hospital is a direct result of the organisational part of the reforms and transformation process that formerly DHA-run hospitals have undergone in becoming competitive trusts and constitutes an example of how services were “*marketed*” to purchasers. The proliferation of outreach clinics, usually conducted at the site of the fund-holders practice, serves as one such example. While it is unknown whether the combination of price and quality offered by those providers was, in fact, the best (Gillam et al, 1995; Maynard and Bloor, 1995), it is certain that it limited patients’ choice.

A more general point is that consultant eye surgeons, both in the UK and Sweden, confirmed this view when referring to the factors responsible for decreases in options of treatment available to patients. They claimed that the established departmental policy, based on the best standards of care, was followed in most cases, which left no room for patients’ choice. It is also likely that operations had to be produced in high volumes to obtain the benefits resulting from economies of scale and to achieve efficiency gains (as happened in some of the eye units in this study), which in turn resulted in a lack of choice. Some consultant eye surgeons’ views (of whom more than half admitted that choice over the procedure of treatment was not really given to patients) gave support to this hypothesis.

Their argument was that, in the case of cataract surgery, the most cost-efficient option for its delivery was when it was performed as a day care procedure under local anaesthesia, a view that is also supported by the evidence available (Perceival et al, 1992, Effective Health Care Bulletins, 1996). However, this was achieved at the expense of other quality indicators, such as the time that could be devoted to patients to explain the options of treatment and, quite often, choice.

A comparable situation involving a decrease in available alternatives occurred in the County Council of Stockholm region, although the reasons were different. In

1991/92, the eye departments of three hospitals merged into one big specialist hospital established on the site of a previously closed general one. While its creation was not directly related to the market oriented reforms of the Stockholm Model, the big specialist eye hospital clearly benefited from them, becoming also their representative success story. It is not insignificant, either, that K is considered to be a likely follower of another hospital which took the unprecedented step of rejecting its public status and changing ownership to become the first hospital to be privatised in the County Council of Stockholm region, in 1999.

Market incentives, combined with a cost per case remuneration system and economies of scale accruing from its size, have enabled the specialist eye hospital to provide an impressive volume of services of the highest quality and at competitive prices, and eventually made it a DRG (a costing system for treatment procedures) price leader. Nonetheless, the choice of eye services for purchasers and patients alike in the County of Stockholm was not very high when this study was conducted. Hospital K captures 70-80% of the market, with the remaining 20-30% left to a few smaller private eye clinics, where the operations are often performed by the same senior eye surgeons that work in the publicly owned hospital K (see Table 10.10, Chapter Ten).

The purchasers from Z District of Stockholm County Council and the Health Authorities of London have also realised that the introduction of contracts has made referring outside the County's/Authority's boundary less flexible because it would mean cash flowing into another County's/Authority's purse. This, in turn, had a limiting effect on the choice of providers. County Councils in Sweden are administrative units whose borders were quite often defined in an era when geographical isolation played a crucial role. In some parts of the country (i.e. in Western Sweden), this historical administrative division is quite often disregarded due to the proximity of healthcare facilities, and cross-referrals between the counties occur regularly (Rhenberg, 1997).

In several other County Councils in Sweden, where different forms of public competition have been introduced (Anell and Svarvar, 1993; Saltman, 1990) and,

in particular, in the selected study site of Stockholm County, "*money followed the patient*" - in the literal sense of the phrase. This was a result of the freedom given to patients to decide where to purchase care (for both primary and secondary services). They could follow their preferences for a provider regardless of private or public sector, though usually within the County boundaries and limits of set DRG prices (Anell, 1995; Charpentier and Samuelson, 1994), which was rather quickly discontinued because of its high cost implications for the County Councils.

11.2.2. Comparison between the UK and Sweden

It seems, so far, that the spirit of the reforms of the Swedish public competition model (regulated and monitored at a local or regional level by elected politicians) may correspond more closely to the objective of patients' choice acting as a tool to encourage their active participation than to the UK's internal market. In fact, all Swedish politicians have attached importance to the issue of individual choice of health care providers and Swedish patients have always had more choice in comparison with British patients (Saltman and Van Otter, 1992a). Accordingly, different forms of pluralistic models promoting this objective were implemented in thirteen counties in Sweden, although their effects on patients' choice were mostly confined to urban areas (Anell, 1995; Rhenberg, 1997).

On the other hand, in the UK's internal market, which is regulated and monitored centrally with agents acting on the patients' behalf, there seems to be less scope for citizen's direct participation. It may arguably be regarded more as an attempt to respond to users' increasing consumerist expectations (although limited by given budgetary constraints) than as a creation of real mechanisms for them to have control over health-related decisions. According to the policy makers' design, direct choice was never meant to be an issue under consideration and even less so a subject to be acted upon by the British patients themselves. In fact, opting out of the NHS in favour of private care continues to be their only real choice, something that had already existed for a long time prior to the reforms, as pointed out by Klein (Klein, 1989; Klein, 1995).

This assumption was, however, carefully omitted and not explicitly stated in any of the respective documents (DoH, 1989a; DoH, 1989b; DoH, 1991a); neither was the possible lack of alternatives openly discussed during the period preceding the announcement of the reforms. On the contrary, *“the availability of choice for patients”* was heralded with a large degree of publicity and NHS users were promised a major breakthrough in this respect (DoH, 1989a), albeit defined in rather vague and nebulous terms. In this study, the overwhelming majority of respondents across all groups highlighted its conspicuous absence in reality.

This conclusion becomes even clearer when one notes that, five years after the introduction of the reforms, half the patients in Britain (n=52) had acquired no knowledge of the reforms; nor were they in a position to comment on their likely impact on the choices that would be made available to them. Although one should be wary when attempting to quantify qualitative data from rather small samples nevertheless, the indication that this finding provides is an important one and cannot be easily ignored on the grounds of its lack of representativeness (see discussion on this aspect following on in this chapter pages 356-357).

Sweden is somewhat different in this respect. Not only were patients better informed (see Figure 6.3, Chapter 6), but also the choice of family/house doctor in Stockholm constituted a notable exception, demonstrating patients' increased empowerment within *“the monopolistic integrated system”*, as it is succinctly described by Anell (Anell, 1996). Moreover, the innovation mentioned above - whereby specialised care could be chosen from both the private or public care providers, regardless of the patient's residence area as long as it was within the same County - may serve as another example of an attempt to increase patient choice. Reimbursement was, in this case, paid by the County up to the level of prices set for each service.

Another (unintended) increase of choice for patients was caused by the combination of excess capacity and the per case remuneration system introduced by the reforms that have created clear incentives for the specialist eye hospital in Stockholm County Council to attract as many patients as possible thus making the self-referral an acceptable option.

Other differences concern factors that influence the patient when choosing a provider. In the UK, when choice was given in quite a limited form - such as the possibility of changing GP or having a say over referral to a specialist - and the most important aspect that patients referred to rather frequently was travelling distance. This could be because choice over such matters is considered to be insignificant or because it is really of no consequence without information on what the different options entail.

However, it is also very likely that patients from the Outer London area were less often in favour of travelling any distance than those in Stockholm, because of the comparative distances faced by the residents of the two areas, which in the former case were significantly bigger. The latter is confirmed by other studies (Rhenberg, 1997; Anell, 1995), which refer to the ease of movement across county boundaries in Western Sweden, resulting from the low cost of travelling to receive treatment. Furthermore, the highly subsidised taxi prices from and to hospital that visually impaired Swedes are entitled to probably played a role, too. It may also serve as an indirect reinforcement of the priorities that the elderly patients of this study indicated when choosing a hospital in which have their operation.

As this study has demonstrated, and other findings have confirmed, patients responded enthusiastically to this novelty (Saltman, 1990). Nonetheless, overall patients' awareness of existing choices and also their actual availability was subject to significant regional variations and depended essentially on the density of population and also on the concentration of facilities (Rhenberg, 1997; Anell, 1995).

11.2.3 Conclusions

In the extracts from government documents in the UK (DoH, 1989a; DoH 1989b), a general commitment to better freedom of choice is pronounced, which is seen as both a means and an end of the market. Furthermore, a new role for the patient, based on her/his sovereignty and behaviour as a good consumer, is envisaged. The first conclusion resulting from the analysis of the evidence

presented in this study suggests that these statements ended by becoming pure rhetoric throughout the reforms' implementation. A hypothesis put forward is that they were never intended to be anything else, at least in the UK's case. By contrast, in Sweden, during the life span of the Stockholm Model there was some real commitment to offer choice of provider to the users, though this was quickly abandoned because of the cost it entailed, among other reasons.

Second, clearly in the UK and less so in Sweden, purchasers were to be the ones to exercise choices that would ultimately benefit the patients; but the transferability of empowerment by the intermediaries (fund-holding General Practitioners acting as the patients' agents) to the users themselves was rarely envisaged. The validity of the assertion that agents could fulfill this role is incomplete, if not fundamentally flawed, as it rests on the notion of benign paternalism. It therefore needs to be carefully re-examined in the light of the findings this study presents and the evidence available from elsewhere (Audit Commission, 1996; Coulter, 1995a; Dixon et al, 1995; Mays et al, 1996a).

Third, as far as the choice of provider is concerned in both countries, it is uncertain how much willingness and ability to exercise it exists on the patients' side (Chamy et al, 1990; Saltman, 1992) or what arrangements would facilitate it. In addition, the analysis of the implications of policies aimed at increasing patients' direct participation showed that there is a need for differentiation between the services, which are more compatible with patients' direct involvement. For this purpose, the definition of the appropriate level and the content of choice to be exercised by the different groups of patients may need to be attempted by the policy makers.

Fourth, there is a broader point of difficulty in establishing a reform process that would simultaneously lead to the attainment of all the desirable objectives. The potential for conflicts entailed in the reforms' agendas has been recognised in both countries (Anell, 1996; Dawson, 1995). The findings of this study illustrate how the pursuit of efficiency resulted in choice being impaired, with additional negative consequences for certain aspects of quality of service provision in the UK, with the reverse phenomenon occurring in Sweden. To sum up, the evidence

provided in this study highlights the difficulty of pursuing conflicting policy objectives, even if they are deemed desirable for reasons of political expediency.

Finally, there were recently arguments voiced against freedom of choice in health care, which, according to some, can be substituted by high regulatory standards to secure quality (Saltman, 1999). It is not implausible however, that arguments against choice have won because costs of health care services are better controlled in this way. In any case, limited choice by intermediaries instead of users themselves was always seen as the most preferable option by policy makers in the UK, something that was retained even when pro-market reforms were introduced, for this arrangement was believed to contain them more successfully.

However, choice not only of the provider but also of the mode of treatment and/or of the option of no treatment at all and health care decisions more generally, can modify attitudes and behaviours and bring about the desirable shift towards provision of more efficient and appropriate care. Arguably, this can only be achieved through the participation of well-informed and empowered users. In addition, the concept of service users' rights are now more tangible issues (Luker et al, 1995) and the possibility for patients to enact their preferences is an essential component of these rights, without which patients' participation in decision making in health issues would be meaningless.

11. 3. Information

Information was not an explicit aim of the reforms in either the UK or Sweden. However, information about the prices and outcomes of services that is made available to purchasers is a necessary precondition for achieving market effectiveness while information on the options of treatment given to patients is also an important function of quality of care, contributing to a user-friendly approach and making rational choice possible.

On the other hand, asymmetry of information, both on the side of the providers and of the users, is inherently associated with health care markets and it is quite

uncertain whether perfect or even sufficient information can be achieved at all (Arrow, 1963). The reforms raised big expectations that the scheme of newly created purchasers would correct these market imperfections because at least General Practitioners were assumed already to possess, or be able to obtain, the relevant information and were therefore regarded as suitable intermediaries between providers and patients.

The other tenet was that collective agents would manage the competition using different tools, such as standardised prices and benefits, to counteract market failure related to imperfect information. However, apart from the inherent deficiencies that these beliefs involve (such as the creation of incentives for agency relationships explored in the insurance literature), they could also severely test the theoretical assumptions underpinning the suitability of collective agents, whether District Health Authorities or County Councilors, and lead to the re-examination of their role in delivering efficient and effective care.

Arguably, this concern has also prompted the movement towards establishing criteria for the effectiveness and appropriateness of medical procedures, measurements of the outcomes of procedures, and the standardisation of clinical practice that was initiated by the Department of Health. However, the hallmark of government policy with regard to information was proclaimed in "The Patient's Charter". It explicitly stated that patients had a right to obtain information about his/her treatment and to be involved in these decisions should s/he wish to be so (DoH, 1991a; DoH, 1995b).

Although the launch of the "The Patient's Charter" is not an inherent part of the quasi-market reforms and, in the view of some, represents a dilution of the spirit of the reforms and a return to the *dirigisme* (Le Grand, 1995; personal communication), because of its importance for the issues considered and the frequent reference made to it by the respondents, it was examined in parallel and as a part of the original reforms.

11.3.1 Evaluation of changes – the evidence

The impact of the quasi-market reforms on information available to purchasers and users seems to be more positive than that for choice. Almost all parties involved agreed that the information provided has improved over the last five years. Even so, less than half of the ophthalmic surgeons and GPs interviewed in the UK considered that this was a result of the reforms; it was rather a manifestation of other changes, which were already under way. Despite that, almost all the representatives of purchasers and providers in the UK and Sweden did admit that the systematic provision of information and its distribution in written form was a new development. It seemed that the views of the majority of actors involved (purchasers, doctors and patients) coincided on this point, although their degree of satisfaction with it varied.

It was decided that, when referring to the provision of information, it is useful to make a distinction "*between the type of information and for whom it is provided*". This need for differentiation was also recognised for choice and was therefore incorporated into the research methodology. The approach adopted in this study has been justified by the results obtained. It was shown that, while most purchasers (GPs, Health Authorities and County Councils) seem to be rather satisfied with the information contained in activity data and the quality reports, less than 50% of patients in Sweden and approximately 40% of patients in the UK felt the same way. In the view of the other group of patients, representing 50% and 60% of respondents of the respective samples from Sweden and the UK, the amount and type of information given to them by providers was not perceived to be sufficient.

Furthermore, the trend for giving out printed leaflets for patients markedly increased after reforms, which indicates that they may have had some impact on this aspect of care. However, the quality of information and sometimes the way and the stage it was given away was often irrelevant and occasionally inappropriate. On the other hand, purchasers felt overwhelmed by providers' data but little of these could be turned into meaningful information.

Information provided to purchasers and patients

The UK's purchasers (both Health Authorities and GP fund-holders) were more satisfied in terms of the information provided to them and were less interested in what information was provided to their patients about issues such as the health problem, the existence of treatment alternatives and the risks associated with them.

However, provision of information in both oral and written form is one of the important dimensions promoting good health. Coulter et al, point out that good information for patients about health problems can help in preventing disease, in promoting self-help and supporting treatment choices, as well as in improving the effectiveness of clinical care (Coulter et al, 1998). There is also evidence that patients may value information not only because of its utility in reducing anxiety but also for the sake of knowledge as such (Ryan, 1992; Ryan et al, 1995).

However, findings from all the study sites (with the slight exception of U) clearly indicated that General Practitioners in the UK and family doctors in Sweden were both uninterested and unable to comment on these aspects of patients' care. GP fund-holders were equally ill prepared to answer questions about the type and quality of information given to their patients when they underwent specialist treatment.

Therefore, a source of concern is not only the surprisingly modest or non-existent awareness of change in these aspects of information that General Practitioners' demonstrated, but also the little amount of anxiety that they expressed over this lack of knowledge. What can be inferred is that General Practitioners placed a different value on the importance of written information when compared to their patients' views. There was no discernible difference in sample U, where half of the respondents were fund-holders; their responses did not markedly differ from those of the samples where no, or very few, fund-holders operated.

Why were primary care providers were so little interested in the aspect of care that represents the most common reason of patients' complaints is an issue that

is open to debate. Certainly, time pressures that GPs continuously face in conjunction with the limited sample of specialist eye patients they encounter in their routine appointments and absence of information from the frame of the monitored indicators have all spelt poor outcomes for this aspect of care. However, it could also be because health professionals are traditionally trained in an environment that, not so long ago, followed the military type of command-structure, with the patient being at the lowest rank of the chain, defined by his/her lay status as described by Axelsson (Axelsson, 1999).

It could be because the assumption that doctors, unlike other human beings, will always behave like knights and sacrifice their own priorities, which as Le Grand has demonstrated does not withstand the reality test (Le Grand, 1997). As it turns out, these priorities can be as trivial and mundane as convenience and leisure maximisation at work. It can also be because doctors are not taught to cross-identify with their patients' needs and empathy is not commonly thought of as a skill that is required of doctors. Rather, a degree of distance is perceived to be necessary for them to perform their therapeutic tasks.

Nonetheless, consultant eye surgeons in Sweden believed that, in most cases, sufficient information had been successfully obtained from the media. Almost all of them expressed the view that the majority of patients already had good information about the procedure when referred for specialist care. However, a few consultant eye surgeons, in both the UK and Sweden, admitted that the quality of information provided could be improved if there was less pressure to increase productivity and if more resources were made available (i.e. to increase the number of appropriately qualified staff).

Moreover, the views of providers and purchasers were something of a contrast to patients' opinions, where more than half of them in the UK (32 out of 50) reported that no sufficient and/or adequate information was given to them. This was further reinforced by the replies of Swedish patients reported in this study, as less than half of them could confirm that they possessed sufficient information on their treatment beforehand.

Even fewer (a quarter of the total number) felt that they did not need any additional information over and above what the specialist doctors could give them in the hospital. Thus, unsurprisingly, these outcomes are in line with findings from other studies, where the patients' most often voiced complaint is the lack of information (Calnan et al, 1994; Stizia and Wood, 1997). A study from the UK that looked into ophthalmic patients' understanding of their diagnoses found that 70% of patients (152 out of 219) required more information and suggested that access to it needs improvement (Sudesh et al, 1994). The most recent study from Sweden, which examined factors influencing patients' choices, found that, even when they did not want to take part in decisions about treatments, patients were strongly in favour of more information (Anell et al, 1997).

The findings of this study indicate, that health professionals' perceptions of patients' needs for information may be different from their own, which is also supported by evidence from other studies (Luker et al, 1995; Beaver et al, 1996; Luker et al, 1996). The divergence in views between patients and doctors is important for at least two reasons. First, patients may receive treatment, which is inappropriate to their needs (Cockburn and Pit, 1997; Coulter et al, 1994). Second, there is an increased interest in shared decision making (Coulter, 1997; Ovretveit, 1996), which is one way of counteracting the phenomenon of institutionalized disempowerment of the patients, which so far seems to be largely inbuilt in the system of health care provision.

However, this study also demonstrated that a similar phenomenon also took place with purchasers who, regardless of patients' satisfaction with the type and quality of information provided in leaflets (which for quite few of them was quite high), seemed not to be aware of, and/or interested in, this information aspect at all. On the contrary, they paid quite a lot of attention to the data and information that was designated for their own use, even though they did not always find it satisfactory. The latter could be interpreted in the light of a marketing strategy adopted by providers operating in a competitive environment, whilst the former constituted possibly the most evident case of the reforms' impact on providers embracing a more user-friendly approach.

On the other hand, the results of this study only partly confirmed the findings of another piece of research with a sample of elderly patients carried out at the early stage of reforms, which found that they did not often recall receiving information, at least where the provision of primary care was concerned. By contrast, many patients interviewed in this study recalled the type and amount of information given whether it concerned leaflets or verbal explanations. In the same time some improvements in personal contact with hospitals were already being observed at the early stage of the reforms (Jones et al, 1994) were further supported by the findings of this study.

Provision of written information and its content

There was virtually unanimous agreement among respondent groups in both countries that systematic provision of written information in the form of leaflets started to occur only after the reforms. Most doctors felt this was rather a result of the standards and targets that were explicitly formulated in "The Patients' Charter" (DoH, 1991a; DoH, 1995b) than the work of market incentives *per se*. Others considered it to be a development that was partly introduced as a response to purchasers' demands and partly constituted an attempt to adopt a more user-friendly approach to users.

However, the content of the written material was considered useful by only one third of the patients, although there were differences among units in the UK. Paradoxically, there was a wide degree of disagreement among respondents as to what the leaflets actually contained, which implicitly indicates the limited use that was made of them. This confirms the findings of another study from the UK which after examining 50 booklets for patients with breast cancer concluded negatively as to their usefulness for patients (Beaver et al, 1997). In addition, the differences in evaluation of written material - and even in recording its existence - that were observed between different units and reported by patients, provide some indications of the quality of material and/or the form in which it was presented to the patients, which could, in turn, have had an impact on its effectiveness.

The views of patients and doctors seemed to broadly coincide on one point: there was no reference to the likely side effects or even to the degree of discomfort that patients might experience afterwards, nor was there any discussion about the options of treatment. Leaflets usually included some more or less comprehensible description of the health problem and/or some usually very general information on the way it is treated. These findings are confirmed by research conducted by the King's Fund Institute in the UK, where different materials for several specialties were examined as to their quality and usefulness from the point of view of users and specialists alike. It found that on the whole, patients had difficulties in accessing the information about their condition and treatment in the form in which it was presented to them (Coulter et al, 1998).

Another quite specific problem identified by the respondents in the study related to the accessibility of written material for people with some (often significant) degree of visual impairment. Most patients also complained that no consideration was taken of the crucial, in their view, aspect of after care. The importance of self-care is recognised in both controlling symptoms and enhancing recovery (Gibson et al, 1997; Sudesh et al, 1993). It is, therefore, surprising that this element of care, requiring so little effort, was so often neglected.

11.3.2 Comparison between the UK and Sweden

All groups of respondents came up with similar responses in the UK and Sweden. Although over half the number of patients in both countries were satisfied with the quality and amount of information they received in hospital about the issues concerning their health problem, the options of treatment, after care and the likelihood of complications, another 40% were not. Patients in Sweden were more active in seeking information on their own, which may be explained by their higher educational status and degree of emancipation of women who, in this age group, had a more frequent history of working outside the home when compared to their British peers. The possibility of self-referral and, thus, lesser contact with the primary care provider in Sweden, could have also contributed to this outcome.

Consultant eye surgeons in both countries acknowledged changes, but some of them felt there was room for much more improvement. The reasons this was not happening were variously ascribed to a lack of time resulting from high pressure to produce efficiently and to a somewhat patronising disbelief in the importance it represented to patients.

The difference between British and Swedish consultants was that the former were less likely to interpret even modest changes as being the result of the reforms. This could be a consequence of the fact that quasi-market incentives in the Stockholm Model were made more explicit in the area of choice (though for a rather limited period of time), which made doctors respond to them by providing better information. It could also be because of the well-entrenched mentality and tradition of collecting and analysing information that Swedish respondents felt was the case.

General Practitioners and family doctors were equally poorly informed, which in the case of Sweden maybe ascribed to the relative novelty of the scheme, unlike in the UK. By contrast, the purchasers in both countries had seen an increased flow of data, which, especially for the purchasers from the UK, was often quite unintelligible. As one purchaser put it, *"we often have no clue as to how to transform this stream of data into meaningful information"*.

This clearly indicates that the providers could easily have given data which they themselves possessed and/or produced, though this would not necessarily have meant that they were really catering for the purchasers' needs; quite often the purchasers did not know exactly what to ask for, so the providers would rather mechanistically respond to what they felt was asked of them. Managers in the UK felt that the introduction of the scheme of competing purchasers was the agent of change in this domain, which they saw as a significant development.

A final issue is the significant difference in the level of patient satisfaction with the information received between the four UK provider units and hospital K in Sweden. A possible explanation is that units oriented towards high productivity (such as S in the UK and K in Sweden) might have had to sacrifice the amount of

time spent on giving information, making, instead, an extra effort to provide continuity of care in pursuit of the efficiency objective. The consultant eye surgeons working in all UK units and also in Stockholm's hospital K supported this hypothesis.

11.3.3 Conclusions

General Practitioners and family doctors seemed to be equally ill informed about changes in the information provided to their patients, as was also the case for choice offered to patients. The first conclusion is that the predictions that fund-holding General Practitioners in the UK would have plenty of incentives for seeking data and monitoring whether or not their patients were properly informed by the specialist doctors, did not prove to be the case for the respondents represented in this study. In fact, they knew no more about this aspect of care when compared to their non fund-holding peers, which is somewhat perplexing in the light of theoretical analysis stating otherwise (Glennerster et al, 1994; Glennerster et al, 1994a; Le Grand, 1994).

Second, it raises the issue of the agents' limitations in representing their patients' interests, which has already been raised over choice gains. The assumption of agents' largely idealised suitability to act on the users' behalf has to be further adjusted for the limitations posed by the imperfect information possessed by them.

The question, whether doctors are uninterested in the single-minded pursuit of their patients' benefit because their own priorities are primary, as is suggested by the theorists of public choice for example (Niskanen, 1971), or whether it is because they fail to realise the difference between their own and their beneficiaries' perception of good and utility, is a difficult one to answer. In any case, more empirical work in this area is needed to fully substantiate either view. What can be said for certain, however, is that the generalised assumptions should not be used as a guideline for policy making if they are not grounded in proper empirical evidence.

Third, patients in both countries have an overwhelmingly unfulfilled need to receive information, without necessarily wanting to act upon this (Anell et al, 1997; Coulter et al, 1998). Information about the health problem, the alternatives of treatment and the likely outcomes represent a value in itself (Ryan, 1992; Ryan et al, 1995). This aspect of care has, therefore, to be taken seriously into account by policy makers who aspire to bring empowerment to the users and respond to their needs. It still remains unclear, however, how well informed the consumer may be if no other mechanisms for overcoming the problem of informational advantage governing the exchange between the health provider and the patient/consumer (known as the agency relationship) are foreseen (Shackley et al, 1994; Ryan, 1994).

The fourth, and possibly most important, conclusion is the need to devise methods and incentives that would stimulate and motivate agents to use their informational advantage in favour of those whom they are meant to represent in all the cases where their use is indispensable. This is especially relevant for public health systems, which rely on the intermediaries and/or agents for their efficient operation.

11.4 Quality

Soon after the reforms' introduction, there seemed to be a lot of disagreement as to their impact on quality. Some claimed that the efficient provision of care should have a positive spill over effect and should, in fact, be considered as one of the dimensions in a broader concept of quality of care (Overtveit, 1992). Others thought that the priority given to budgetary considerations by the GP fund-holders on the one hand (Keeley, 1993) might lead to under referral and, on the other hand, under treatment and conflict of interest between trusts could adversely affect the continuity of patient care (Wall, 1994). However, the proclaimed intention of the government with regard to quality was nothing less than remarkable improvements that could serve as a proof of the healing effects of incentives and competition.

GP fund-holders were seen as the properly motivated agents to enact these principles and bring the expected gains to their patients in terms of improved quality (Goodwin, 1998). The elements of competition for contracts among trusts would also create a favourable environment for improvements in quality (Hamblin, 1998). However, there was a conspicuous absence of any explicit definition from the government's statements as to what was meant by quality of care and, moreover, what the scope of its likely enhancement would be (DoH, 1989a; DoH, 1989b).

It is well known that quality is a multidimensional concept (Donabedian, 1966; SPRI, 1990) and that the different aspects dealing with inputs (resources and skill-mix of the staff), processes (waiting times, friendliness of the personnel) and outcomes (improvements in health status) can be measured to make inferences about the manner in which it changes. If universal criteria for assessing changes in quality existed, or if there was agreement on the most important aspects for its measurement, modifications in quality could be used as a meaningful indicator of the reforms' impact that pro-market reformers claimed would be brought about.

However, as this is not the case, selected process indicators were used as proxies for quality of care in this study. One such was the evaluation of changes in waiting times at the outpatients' department, which was known to be common problem in both the UK and Sweden during the period preceding the reforms (Dixon, 1998; Hanning et al, 1998). In addition, the availability of contact with senior clinicians and sufficient notice of the operation date given to patients beforehand were examined to provide indications on changes in quality. All these aspects are concerned with changes in friendliness towards the users.

11.4.1 Evaluation of changes – the evidence

Several aspects that were used as proxies for quality indicators examined in this study pointed in the same direction. These factors indicated patients' relatively limited expectations, while providers and purchasers demonstrated their unstructured approach and fragmented awareness of the importance of quality

issues which extended beyond the set of mechanistic targets (for example, waiting times).

However, even when the latter were examined in order to draw conclusions on process indicators of quality, the net effect for all the units was that they were only realised in less than half of the cases. Thus for example the targets for waiting times at the outpatients were successfully met only for unit S in the UK and K in Sweden (which reached app.90%). The remaining three units fell short of the 30 minutes target and unit U for example could not even remotely approach this target.

The reasons for this situation are many and various. First, it was the use of mechanistic and not always realistic standards promulgated by "The Patients' Charter", which, as Ham argued, were meant to demonstrate the reforms' tangible successes (Ham, 1997). It seemed as if the government that had devised and engineered quite an innovative set of reforms had, less than half way through the process, lost its belief in the effectiveness of market means in bringing about the desired outcomes and so decided to provide a helping hand by devising standards, which had to be met.

The idea of setting explicit yardsticks against which the project would be measured, on the one hand, and outlining patients' entitlements in written form, on the other - as represented in "The Patient's Charter" - is an important and desirable objective. However, their use as a substitute for the "invisible" but existing and otherwise operating mechanisms was a quite apparent shift in policy, which took place before the market-oriented reforms could prove or disprove their merits.

Another reason may relate to the fact that the set of conflicting objectives that the reforms incorporated created a situation that was conducive to conflicts and confusion. One example was the situation in U, where a clash between the management and the consultant eye surgeons' team led to a disruption of service provision for quite some time and its impact was recognised by both patients and General Practitioners. However, it could also be because the

reforms, with their imperfect incentives, brought into light, and made explicit, forms of inefficiency that were no longer tolerable.

Another finding was that patients were, on the whole, grateful - irrespective of the quality of service provided. This seemed to undermine any notion of rights being exercised or demands for a certain quality of care to be provided and was also repeatedly referred to by patients from other units, both in the UK and Sweden. One British patient summarised this attitude in a succinct way by saying:

"It is a matter of a long culture within the NHS, to teach patients to be grateful for anything that is done to them."

This was especially acute in the context of the closure of hospitals and increased uncertainty about the future of care, which was often perceived as a threat by the elderly. As has already been discussed above, this may have been a result of the frailty that was a characteristic of many of the aged patients represented in this study, though it may also have been a culturally conditioned attachment to collectivist values especially in the UK.

Some respondents in the consultant sample, in both the UK and Sweden, reported widely cited anecdotal evidence (referred to also by some patients and General Practitioners), that the increased productivity pressure may have had an adverse impact on the quality of care. They usually referred to the medico-technical aspects of quality of care, but also had in mind the inconvenience incurred by patients when they were dealing with inappropriately prepared community services. However, as far as the example of this service is concerned, this study has largely disproved the fears that efficiency considerations had any negative impact on the clinical outcomes (for details see below: section 5. Efficiency).

However, there were also less comfortable findings. The most uncomfortable one was that GPs, both fund-holders and non fund-holders, were little or not at all aware of any changes with respect to quality provided in secondary care settings although it is known that both fund-holders and Health Authorities have introduced quality standards in the contracts (Coulter, 1995b). This applied not

only to the features examined in this study, but also to all other aspects of quality. While Goodwin states that fund-holders acquired better services for their patients on the site of their practice - primarily referring to outreach clinics (Goodwin, 1998) - it is evident that they did not use their clout to fulfil an important aim of the reforms, which was to improve care at the hospitals.

Although conclusive evidence about the impact of outreach clinics is hard to come by and the effects of outreach clinics on quality has so far never been a subject of in depth evaluation, there are some indications that this may not be the most efficient option in the provision of care (Gillam et al, 1995; Harris, 1997). In addition, there were more general questions posed as to whether primary care is under any condition more cost-effective in comparison with the hospital care (Coulter, 1996).

At the beginning of the reform process, Maynard warned against the indiscriminate embrace of procedures, of whose efficacy there was little evidence, referring to outreach clinics in particular (Maynard and Bloor, 1995). Later evidence by Kerison and Corney confirmed that there was no means of monitoring the impact of outreach clinics on the quality and efficiency of the care that was being offered. They also found that there was significant private provision taking place on their site (Kerison and Corney, 1998).

However, if quality offered at the outreach clinics would prove better this would appear to be an example of a less expected outcome where quality of care in primary care settings could be improved at the expense of choice of hospital, at least when direct users were concerned. In this case, it would also give raise to a number of questions as to whether high quality of care necessarily coincides with the availability of choice and, more generally, whether loss of choice inevitably leads to poorer outcomes or lesser satisfaction with care. However, in an absence of evidence on the subject this issue cannot be concluded either way.

There are cases where trading-off some aspects of quality of care against efficiency took place in reality and it relates to after care, routinely reported as being inadequately handled. This happened either when elderly patients were

too hastily discharged to undermanned community services, or when they had to come for the next morning follow-up session without having a say over this issue. Many patients referred to the substantial inconvenience incurred while travelling to the hospital with vision only poorly restored at that point.

Availability of the contact with the senior specialist

The contact of newly admitted patients with senior staff, and the provision of information during the course of the consultation, can be safely regarded as one of the quality process indicators which, in the absence of more sensitive ones, are often used as proxies for the outcome of care. This was acknowledged in a number of documents attempting to set quality standards in the form of patients' entitlement to contact with the senior doctor, as stated in "The Patient's Charter" (DoH, 1991a; DoH, 1995b) in the UK and in the quality standards set by the Swedish Medical Association for ophthalmology (Federation of County Councils; 1994) (for details see also Annex II).

While patients were quite unaware of whom they saw on their first and subsequent visits - the majority did not attach any importance to this issue - it also seemed that GPs were equally unaware and uninterested in this matter. As the findings demonstrate almost no GP in the UK and Sweden could provide any indication on this issue. The question of why General Practitioners are so little interested in these aspects of care, which are aimed at safeguarding quality (even if they are imperfect measures of it), is an important one.

One explanation may be that patients referred for the operation constitute a significant minority of those they see on a regular basis, something that was reported by some GPs. However, the most important reason must be that GPs, both the fund-holders and non fund-holders, were able to devote no more than 7-10 minutes on each follow up visit and approximately 12-15 minutes for each new patient on average. In this context, it would be quite unusual if they could afford the time for anything more than performing the absolutely necessary procedures. Apparently, under the circumstances finding out under what conditions care is provided in secondary settings is not one of their priorities.

This happens against the backdrop where the information given by providers refers mainly to waiting times and can hardly be used as a source of comprehensive information on the quality of health care that is provided to patients. Besides, the quality specifications when included in contracts by the purchasers are, on the whole, quite generic and were rarely specialty specific. In the majority, they were designed for a "typical" surgical specialty, which occasionally led to discrepancies, as with, for example, the inclusion of standards such as the absence of bedsores. In unit T, for example, the quality standards followed were even more generic and were a combination of "The Patient's Charter" standards of care and could be adapted to any service.

The other perplexing finding is the contrast between consultant eye surgeons' views as to how often they saw patients on their first visit and what patients actually remembered. This may be the result of the relative unimportance of this issue to the patients, which was especially marked in the UK. However, the senior doctors may also have tended to overstate their availability for all new patients in order to avoid appearing unwilling to fulfill the standards set explicitly by some purchasers and implicitly by "The Patient's Charter" (DoH, 1991a; DoH, 1995b). Swedish consultants seemed to be more open about this issue and, therefore, their responses were closer to the views of their patients, which must also be a matter of cultural difference where admission of imperfection is likely to be more tolerated in some places than in others.

One hypothesis put forward as to the reasons for both primary care and specialist doctors' limited awareness of what was important to their patients - and for the tendency of doctors to follow a rather mechanistic approach to fulfilling the standards set by purchasers (and prompted by government directives) - argues that this could have resulted from the impact the reforms had had on the working environment.

This seemed to be an overall message that primary care doctors and consultant eye surgeons expressed when they were questioned as to the effects that the reforms had had on their own work. As another study found that fund-holders themselves felt dissatisfied with the workload and pressures that were imposed

on them (Leese and Bosanquet, 1996). Furthermore, hospital doctors in one study in Sweden noted that the time they spent with patients had been negatively affected a result of pressures introduced by the reforms (Forsberg et al, 1998).

On the other hand, there were also indications of decrease in satisfaction with changes on the users side. One study in the UK concluded that there were negative effects on patients' care that accrued from the change of roles. After undertaking a review of the literature, Hoey claimed that fund-holders, in particular, were out of touch with patients' views (Hoey, 1995). In addition, a Consumers' Association survey found patients of fund-holders to be less satisfied than those of non fund-holders (Consumer Association, 1995a; Consumer Association, 1995b) and Howie et al also found the satisfaction of patients from six fund-holding practices in the UK to have slightly decreased (Howie et al, 1995).

Although the latter study could not deduce whether this was necessarily a new development or whether it applied to fund-holders' practices more than to others, it is easy to understand in this context why the complaint voiced by the majority of GPs in this study (both fund-holders and non fund-holders) dealt with the unrealistic, and sometimes even irrelevant, demands placed on them. While some of the non fund-holders did not join the scheme because of the overwhelming demands it presented, all of the five fund-holders interviewed in this sample made it clear that their decision to join the scheme had been determined by the overall trend and by a fear that neighbouring practices would supersede them. In any case, it was not because it signified their choice or their belief in how things should be run.

Waiting time to be seen at the outpatients'

There is rather a big variety in waiting times between the units examined, which reflects the responses adopted by them. Thus, waiting time targets at the outpatient's department were only successfully met in one unit in the UK (S) and in hospital K in Sweden; were only partly met in a second unit (T) and totally failed in a third unit (U). This study puts forward a hypothesis that, on balance,

the eye units that followed rigid policies in order to become efficient producers were also successful in meeting certain quality or responsiveness indicators (e.g. waiting times for the operation, adherence to the appointment time, written information given to the patients and friendliness of the staff).

It also became clear that most patients who had to face unreasonably long waiting times at the outpatients' department complained strongly about this aspect of service which was felt to cast serious doubts on their impression of quality of service. Such was the case, for example, for the amount of waiting time at the outpatients' department at the unit U, which on average exceeded one hour and quite often was significantly longer.

An impression is that waiting at the outpatient was an every day reality long before it was raised through the reform agenda. It seems that policy makers did not fully acknowledge of the problem of prolonged waits to be seen in the hospital, conveying a message that this was an issue of lesser importance. This, however, might not have reflected patients' perceptions and level of satisfaction as the evidence presented demonstrates. It is, therefore, surprising that General Practitioners did not have any idea of what the waiting time at the outpatient's department was like (except for one who rather assumed than knew what should be the approximate figure).

One may wonder whether this was happening because it was not considered to be an important quality indicator of service provision by the hospital, or because waiting to be seen by the doctor was acceptable for General Practitioners because it was not an infrequent situation within their own practices?

The amount of notice before the appointment for the operation

This is a type of service specific indicator that was intended to approach quality issues by proxy. It is important, though, because the elderly need to make quite substantial preparations for an operation and need support from family and neighbours that has to be planned in advance. Patients were, on the whole, moderately satisfied with what hospitals could provide in this respect, but it again

differed greatly among units, where the efficient ones were also the most responsive.

This indicates that incentives, even the weak ones that the reforms promoted and produced some kind of expected results in terms of quality. Unit S in the UK and hospital K in Sweden took efforts to adopt a user-friendly approach as much as possible; they were also kinder and more responsive to the details that were important to the elderly. Again, the views of eye surgeons diverged from those of their patients and, again, the GPs were unaware of what was really happening in this aspect of care.

The difference between GPs' awareness of this matter in the three study sites shows that either the General Practitioners in sample U did eventually consider it to be a relatively important factor for assessing the quality of care and that they therefore attempted to obtain this information; or it could have been that their patients communicated their views to the doctors more eagerly. This may be actually the other side of the same issue, though it may also be related to the differences in the characteristics of the sample, with more affluent and more highly educated patients, who are usually known also to be more articulate, and who were also prevalent in this area (Goodwin, 1998).

It has to be remembered, however, that in the sample where GPs were more sensitised to whether the patients got proper information, the fund-holders' proportion was the highest. However, even fund-holders knew little about this aspect of care and it seemed they did not consider it a high priority. Thus on the whole this lack of clear and qualified opinion on the side of GPs, "*the patients' best advocates*", is puzzling.

This study had no intention of using the General Practitioners' limited knowledge about the notice of appointment time given to patients as the single yardstick of their grasp of changes in information and quality of care and more generally to make conclusions about their suitability to promote patients' needs. Nonetheless, the little awareness that GPs have of the patients' experience of treatment at the

hospital may well suggest a lack of doctor/patient communication about such matters, except in the event of a complaint.

Of course, the usual clinical letters dispatched by hospitals do not go into detail about the amount of notice given to the patients about their operation date, so the feedback has to come very much from the patients themselves. That this is not happening either indicates a perfect system, in which patients feel no need to mention to their GPs concerns in this area, a lack of interest on the part of GPs, or poor patient/GP discussion. Another matter is that patients may not always complain, even if they are seemingly not satisfied with the quality of service provision.

Finally, the response of consultant eye surgeons in both the UK and Sweden differed according to the unit. Nevertheless, the majority of consultant eye surgeons mentioned that, during the period following the reforms, they and/or their colleagues had had to rethink their attitude towards the patients. This involved issues such as taking steps to diminish patients' anxiety through the provision of relevant information and reducing unnecessary waiting at the outpatients' department. Patients' views moderately supported the efficacy of these efforts.

11.4.2 Comparison between the UK and Sweden

Respondents in Sweden maintained even more strongly that changes in the working environment were the result of productivity pressures and the lack of time that had resulted from the purchaser-provider split. Eye surgeons claimed that this was the reason behind having less opportunity to discuss at length different aspects of care with patients personally, and primary care providers felt they could not fulfill all the overwhelming and occasionally conflicting demands that were placed on them.

Another study that reached a similar conclusion has shown that many health professionals have experienced a decrease in influence and control over their work situation. They have felt that much of their previous power has been

transferred to other groups, like managers and administrators, and that their freedom to plan their work has been seriously curtailed. This situation has become even more stressful as it has been accompanied by staff reductions and an increasing workload (Forsberg et al, 1994; Forsberg et al, 1999).

Many supporters of the purchaser-provider models in Sweden have, on the other hand, claimed that the service to the patients has been improved as a result of the different market-oriented models of reforms. According to this view, freedom of choice, for example, has given the patients more power and therefore forced the health care providers to become more "*customer oriented*" (Axelsson, 1998b).

All groups of respondents interviewed in Sweden substantiate these views by providing ample evidence and citing numerous examples of how this was manifested in practice. The most dramatic change in this respect was the total disappearance of waiting times at the outpatients' unit and the exemplary courtesy of the personnel and doctors, both of which were repeatedly referred to by respondents.

The former was most likely the result of one of the care guarantees introduced in the Stockholm Model, namely that waiting time at the outpatients' should not exceed half an hour from the given appointment time. If this was not kept to, the patient could claim back the amount of 180 SEK that was paid to the hospital as a co-payment for the specialist visit. The difference in philosophy of what "customer orientation" meant for even the best performing unit in the UK and Sweden was considerable.

It could also be a result of the approach to quality assessment, which is reflected in the standards-setting procedures for eye services and cataracts as well as for other services. These are much more systematic and form part of the "Quality Registers" initiative, which was conducted under the aegis of the National Board of Health and Welfare and the Federation of County Councils of Sweden (Federation of County Councils, 1994). Every spring and autumn, a randomised survey of one hundred people is conducted, which is aimed at investigating the

quality of care according to the adopted indicators that are set with the assistance of the Swedish Ophthalmological Association.

These indicators are concerned with both the processes and outcomes of care for ophthalmology and, in particular, for cataract surgery. There is also provision for addressing complaints, which are dealt with by the National Board of Health and Welfare (the approximate number is 300-400 a year for 1993); if need be, they are addressed to the Medical Disciplinary Board, which was the case for about 100 complaints in 1993 (Bergman, 1994).

By comparison, "The Patient's Charter" is the only document dealing with quality standards in the UK, though they are treated in quite a general and not too specific a manner. Moreover, as Calnan et al commented, they are dependent upon the procedures that need to be developed to give substance to the "Charter" principles (Calnan et al, 1998).

11.4.3 Conclusions

For many observers, one of the main achievements of the purchaser-provider split was the clarification of the roles of different actors in the health care system. In both the UK and Sweden, this has been manifested in some quite powerful responses to the incentives from all new and old actors. However, the results of this for quality have been quite mixed, according to the evaluators' views. In the UK, there were a few studies that investigated some of these aspects but similarly no definite answer as to whether major shifts occurred was provided.

This study found quite a high degree of difficulty experienced by GP fund-holders and non fund-holders but also by primary care doctors in Sweden in completing all the tasks that were expected of them. This finding was supported by one of the studies, which found that a percentage of fund-holders and General Practitioners were dissatisfied with increases in their workloads and with efficiency pressures (Leese & Bosanquet; 1996). These, I think, were two of the chief reasons for poor information on different aspects of the quality of care in

secondary settings and for the quite insufficient time devoted to the concerns of their own patients.

The other finding was that units, which responded more vigorously to the reforms' incentives, attempted to adopt a more user-friendly approach and provided services of higher quality. Despite the tendency to replace even the weak markets incentives by standards that were rarely realistic, yet even in this limited form, the pattern of small successes that were observed gave some indications of how powerful these instruments could be if used adequately.

11.5 Responsiveness

The principal indicator of responsiveness used in this study was the change in waiting times for cataract surgery itself and for the first specialist appointment. Waiting lists have been a permanent feature of the NHS throughout its history. While their absolute numbers were subject to fluctuations over the years, their percentage of the total throughput remained virtually unchanged. It was even proposed by some that they should be considered as an attribute and not as an anomaly of the system (Frankel and West, 1993). The existence of long waiting lists for some hospital procedures (mostly for elective surgery) was widely documented in the UK (Goldacre et al, 1987; Frankel and West, 1993) but also in Sweden (Hanning, 1996; Lundstrom et al, 1996; Hanning et al 1998).

Cataract surgery, along with some other elective procedures, repeatedly appeared as one of the main items on the waiting lists throughout the country, although it was subject to significant inter and intra regional variations (Williams et al, 1993; Davidge et al, 1987). At the beginning of the 1990s, there seemed to be a widespread agreement as to the fact that demand for the service had significantly outpaced its supply, although the explanations proffered varied.

The main culprits were sought in the shortfall of qualified surgeons (College of Ophthalmologists Audit Commission, 1988), the insufficient use of cost-effective procedures such as day care (Williams et al, 1993) and the imbalance in, and/or inefficient use of, available resources (Drummond et al, 1991; Mason et al;

1993). Moreover, the variations in surgery rates (Williams et al, 1993) and perverse incentives incorporated in reimbursement systems (Iverson, 1993) as well as other unknown factors related to artifacts and the internal dynamic of waiting lists (Goldacre et al, 1987) were referred to.

In Sweden, the phenomenon of waiting lists and the explanations proposed were not very dissimilar to those of the UK. Some commentators proffered the familiar argument that the long waiting lists for some surgical specialties were common for publicly financed health care systems because of the absence of pricing mechanisms (Hanning, 1996; Hanning et al, 1998) and others claimed that increasing demand for services was responsible for the long waiting lists (Lundstrom et al, 1996). The unpopularity of this situation with the public, in conjunction with the ideological convictions of the Conservative government led to the launch of a waiting list initiative in 1992, and a temporary amount of 500 mln SEK was made available for this purpose (Berleen et al, 1994; Bergman, 1994).

The preliminary evaluation of the reforms' effectiveness in reducing waiting lists in the UK attracted criticism, as data for demonstrating the reforms alleged success at six months after their introduction were patchy and fragmented and interpretation of them deeply superficial, for which it was severely criticized (Radical Statistics Health Group, 1992; Radical Statistics Health Group, 1995). The immediate periods before and after the reforms were used for comparison and they indicated little difference in numbers that would have had any statistical significance worthy of proper analysis, which, in fact, was not even seriously attempted. The government of the UK was politically motivated and, in order to prove the reforms' success, it decided to proceed with this self-initiated and hazy evaluation while, at the same time, restricting access to independent and more rigorous assessments, at least at the initial stages (Ham, 1997; Dixon, 1998).

In Sweden, the first attempts at evaluating the impact of the reforms were similarly devoid of rigour and were too often politically motivated and/or produced at the request of the County Council Federation or other government authorities. Consequently, their reliability was not uniformly recognized and they were open to criticism.

11.5.1 Evaluation of changes – the evidence

In the analysis of data from the settings participating in this study, it was immediately understood that it would be very difficult to ascertain the size of the change for individual hospitals on the basis of quantitative data analysis, as, before the reforms, there was no recording of this type of information. In the rare cases that this took place, it was not done in any uniform manner and, even after the reforms, the eye units of the four hospitals examined - and the hospitals themselves - used to keep data in a very different way.

Waiting times for the specialist appointment

The waiting times for the first specialist appointment seem to be the shortest in the units that have embraced the reforms and have benefited from them, such as unit S in South London in the UK (for details see Fig. 9.6).

The waiting times were exceptional for unit U in North London, which could be explained by the conflict between the team of clinicians and the management of the hospital, which eventually led to the resignation of the former and the effective closure of the eye services department. These services were shortly afterwards either taken over by T or moved to another hospital in the same Health authority area.

The reduction in waiting times for a specialist appointment was a result of the innovations adopted which, according to many consultants, the reforms made possible. Such were the examples of primary care eye clinics run by the hospitals, where pre-screening of patients was carried out (hospital T) and certainly the adoption of cost saving technologies, such as day care and sutureless surgery phacoemulsification (discussed more in detail in section 5. Efficiency).

Unlike for outpatient waiting times, GPs gave an impression that they were relatively well informed, possibly as a result of the input from local providers, which is confirmed by the fact that not even a single doctor named patients as

the main source of information on this issue. However, even the awareness of this issue had its limits and there were exceptions to this rule. Although the real waiting time during the period of this study (1995/96) was three or four months on average, with six months for one consultant, a GP in area T referred to an alarming figure of 30 months, which could have been his/her recollection of the past. Nonetheless, this ignorance is more worrying because this doctor held a teaching position and lectured on General Practice at the Medical School attached to the same hospital.

On the whole, the replies coming from doctors in sample U (half of whom were fund-holders) and other samples constituted a fair description of the real situation; some of the respondents also demonstrated a good understanding of the issues involved in waiting time for specialist referral. There were two other interesting points raised by some fund-holders, in particular. First was the reference to the existence of outreach facilities in the period preceding the reforms (although this could not be confirmed by any other source). The second dealt with the awareness of the conflicts taking place between the team of specialists and management of unit U with its likely implications for care delivery.

These findings again confirm the impression that providers, and also purchasers, were directed not to respond to market incentives as originally intended, but rather to act upon what the government felt were the priorities at any given time, which were issued in the form of directives from the Management Executive (NHSME, 1993; NHSME, 1994). This can possibly shed some different light on the question of why the GPs and hospitals demonstrated more responsiveness and sensitivity to some aspects of the reforms than to others. It can also explain why GPs fund-holders and non fund-holders alike were poorly informed, or not informed at all, about the information and choice aspects, for example, but had reasonable knowledge of what the government had decided to monitor and held the providers and purchasers accountable for (i.e. waiting times).

Waiting times for the operation

On the whole, reductions in waiting times for the operation were not uniform. It took about one or two years after the reforms' implementation before any decreases started to be manifested, and they were again short-lived as, by the end of 1996, waiting times overall started to increase. This was the result of decreases in additional funding that followed the first two years of the reforms in the UK (Ranade, 1998) and Sweden (Hanning, 1996).

It could also have been a result of more patients being treated (Timmis, 1997), or because the internal dynamics of the waiting list had changed and the amount of patients waiting for a long time had diminished at the expense of a higher number of patients waiting for a shorter time (Ham, 1997). Appleby also claimed that a decrease in waiting times stimulated doctors to refer more patients (Appleby, 1994), a view that has been repeatedly voiced by most consultant eye surgeons in this study.

A consultant in sample T gave estimates that were somewhat longer than those reported by patients who were interviewed. The consultants' average was between three and six months while the patients' average was only eight weeks. This might be due to the significant difference in waiting times between consultants that existed, and continues to exist, in this particular unit, which is also given to the GPs and purchasers.

All consultant eye surgeons demonstrated a good grasp of the intricacies and possible reasons behind the phenomenon of the "inexorability" of waiting lists. While seeing the difficulties involved in tackling this issue, they came up with numerous proposals, of which quite few were innovative. The message that came most strongly from the well performing units (S of South London and P of West London) was the fact that market incentives which could bring about higher productivity and consequently some visible reduction in waiting times, were hampered by the cash limits applied by purchasers.

The conflicting nature of some of the objectives that were pursued through the reforms was well understood by the providers, who felt disconcerted and confused. In their case, it meant that responsiveness to need (or to demand, even if this was imperfectly defined) contradicted the objectives of increased efficiency and it was therefore perceived rather as an *"indicator of agreed supply"*, as one doctor put it. Still, the picture painted by the respondents in face-to-face interviews seems to be somewhat rosier than the data reported by them to the Audit Commission to be used in Performance Tables (DoH, 1994; DoH, 1995a; DoH, 1996, DoH, 1997).

For example, it seemed that there were quite numerous patients who had to wait for more than thirteen weeks to be seen, even during 1995/96. However, in U (with half the number being fund-holders) it seems that figures included in the Performance Tables were over-optimistic when compared with the reports of patients and also with the information provided by consultants or managers. Purchasers recognised their responsibility in influencing the phenomenon of waiting lists and also seemed to be aware of the limitations involved in the use of waiting lists as a main tool for their purchasing activities. The need to devise other indicators that would deal with the appropriateness of care and evidence-based purchasing was also anticipated.

Given that waiting lists were regarded as a central cause of dissatisfaction with the health service, it did seem odd that the GPs were, all in all, not too much aware of developments in this area. One respondent from the non fund-holders' group acknowledged that decreases in waiting times, from which fund-holders benefited the most, had also had a spill-over effect on other General Practitioners who were non fund-holders. Overall, however there was an impression of a good understanding, even among GPs, of the complexity of the issues involved in the waiting list and of its limitations as an indicator of demand, although not all respondents fully shared this understanding.

It is also worth bearing in mind that while the primary care doctors held seemingly contradictory opinions, they were referring to their own experiences with different providers, and did not give their opinions on the general picture.

Opinions expressed by some of the respondents highlighted different aspects of the changes, which had occurred in recent years.

11.5.2 Comparison between the UK and Sweden

As in the UK, Swedish purchasers realized that they had to operate in an environment of excess capacity on the providers' side and that the removal of obstacles in the form of disincentives included in payment systems made it evident. It also became explicit that the build up or absence of waiting lists is largely a matter of political decision relating to the level of care to be provided from public funds and more generally to deal with priority setting in health care delivery. For example, in 1992 in Sweden 500 mln SEK was given to reduce waiting times to three months, a pledge included in the care guarantee for the whole country (Berleen et al, 1994; Bergman, 1994)

These findings are also supported by research findings from both the UK (Appleby, 1994; Ham, 1997) and Sweden (Lundstrom et al, 1996; Hanning, 1996). It was argued, for example, that waiting times were reduced only when pressure from the government (Ham, 1997; Hanning et al, 1998) and/or additional resources for this purpose were made available and, in any case, the gains were in both cases rather short-lived (Hanning, 1996). Concerns were voiced that where longer waiting lists existed or reappeared, rationing within the waiting list could still be the practice, especially given that listing patients for surgery is at the surgeon's discretion in the UK and is not based on any explicit guidelines or standards.

A positive correlation between the length of waiting list and the rate of cataract surgery does not always exist, as one study from Finland has demonstrated (Nordberg et al, 1994), suggesting that the lack of resources were not the only reason for the long waiting lists. Nonetheless, they agreed that both long waiting lists and high rates of operations (such as in cataract) result from high demand for surgery, which they argued should lead to more rigorous and critical re-examination of the indications for surgery (Nordberg et al, 1994).

The most significant difference dealt with the care guarantee for four and a half specialties (half being cataract surgery), which was introduced simultaneously with the Stockholm Model. This meant that if a patient did not receive care within three months in his/her catchment area, s/he could be referred for service elsewhere, including private facilities. The cost of this would be covered by the County Council of his/her residence, up to the level of the set DRG price. Exclusively, in Stockholm, the care guarantee was provided for cataract surgery in both eyes and not for the "best one", as was the principle in the rest of the country (Malm, 1994; personal communication). The latter could possibly be explained, "*by the political clout that voters of this particular County Council were able to command*" as one respondent from the County Council remarked.

The introduction of this care guarantee created some impressive results at the very initial stages of the reforms (Hanning, 1996; Hanning et al, 1998; Lundstrom et al, 1996); but, as most of the observers agreed, as soon as the additional money for tackling this issue - and, in effect, for commissioning extra services - became unavailable, the likely gains also withered away. In fact, the waiting lists in both the UK and Sweden have almost been restored to their pre-reform levels.

The other important result that this study demonstrated is that in both the UK and Sweden the success of the different units in reducing the waiting times was related to their overall success in meeting the reforms' objectives (such as high productivity, efficient provision and quality of care), which as this study argues, was somehow conditioned in their enthusiastic embrace of them. These findings seems to be confirmed by another study from Sweden where the less successful units with regard to the decrease of waiting times are those who had low operation rate or those who chose not to follow the care guarantee (Hanning et al, 1998).

11.4.3 Conclusions

First, waiting times for the first specialist appointment and also for elective surgery changed and were in most cases reduced, although not impressively. Second, this was the result of a political decision to focus on these issues and

provide extra resources, and not so much a result of market forces. For example, the reduction in waiting lists was chiefly related to more generous funding. Thus, in this context, it was quite difficult to disentangle the effects of organisational changes introduced by the reforms from the effects of the extra funds made available, which could possibly have resolved the issue temporarily even without the reforms. However, a pattern of added value of the reforms seems to emerge despite these other confounders.

This renders support to the argument of the importance of competitive market elements in improving the provision of public goods versus the desirability and the degree of regulation required for this type of imperfect markets. The argument against the appropriateness of using of market elements to improve the deficiencies of public delivery seemed to be negatively resolved in this case. Rigidly planned systems, where there is no observance of basic economics, tend to create passivity, engagement in rent-seeking behaviour in the form of bidding for resources in addition to infrastructure and capacity being disconnected from the results produced because the targets are at best outdated and at worst irrelevant. These phenomena arguably contribute to the formation of the waiting lists.

On the other hand, even the introduction of some basic market elements, such as incentives, made this situation explicit. For example, the excess capacity of certain facilities and, conversely, the lack of others for a number of areas has been noted and could not be ignored. However, in this case, even this substitute for the market was not allowed to work. No possibility for exit from the system was envisaged and when it was, in fact, contemplated the resulting attempts were usually half-hearted because government at least in the UK case bailed out hospitals, which would have to close down if the results of the competitive incentives were manifested.

In addition, the undesirable phenomenon of replacing old disincentives already present in the system with new disincentives seems to have occurred in many cases. Such was for example "the dead period" in the operating theatre, which

resulted from meeting the performance targets few months ahead of the end of financial year.

Third, regardless of the success or failure of policies driven by “*achieving better value for money*” within given resource constraints, the dilemma of how to find best ways to match the demand and supply of services remained unresolved within the framework of quasi-market reforms. According to Maynard, this is not bound to happen until the issue of using payment methods to promote only technologies and procedures of proven cost-effectiveness is thoroughly re-examined (Maynard, 1993a). Then the debate about the appropriate level of funding and strategies for achieving it can and will have to be seriously re-considered in the light of the evidence made available.

11.6 Efficiency

The system of quasi-markets introduced in the UK in 1991 and in Sweden in 1992 had the achievement of improvements in efficiency of service delivery as its most important goal. The former meant either a decrease in the cost of inputs for a given outcome or an increase of outputs produced at the same cost, which derives from the industrial production process. The latter that is more often used in the domain of public policy, would occur when the benefits gained from the use of given resources were maximised. Although this was not explicitly articulated in government manifestos in either of the two countries, it can be assumed that the reforms were ambitiously targeted at tackling both aspects of efficiency.

This study has considered efficiency in order to ascertain whether improvements in quality, responsiveness and choice were achieved at the expense of efficiency and if they were achieved at all. As has been suggested by Propper et al in reference to the US health-care market, purchasers in competitive markets who do not face hard budget constraints tend rather to compete on quality than on price, which leads to higher costs (Propper et al, 1998). The opposite effects on quality by reforms that were driven by efficiency considerations were also examined without, however, investigating all the detailed aspects and links

between quality and efficiency. In order to draw conclusions on changes in efficiency throughput, the cost of the procedure, the clinical outcomes and the adoption of cost saving technologies were examined.

11.6.1 Evaluation of changes – the evidence

Changes in throughput and the cost of the procedure

There was no uniform pattern observable in the changes of the prices for cataract surgery although it differed among the four units in the UK, with those that were more successful and keen on the reforms lowering their prices for services as a whole. They were able to achieve this because of higher throughput and, more importantly, because of their spectacular shift to day care surgery and almost total disposal of beds. Such was the case in unit S in the UK and hospital K in Sweden.

One of the features of the reforms, known as the Stockholm Model, was the introduction of a system of costing services on the basis of the American DRG system, which was adopted by Sweden and became known as the KOKS system. Initially, there was very little experience with costing procedures and the setting of prices was done in quite an arbitrary manner and was therefore readjusted every following year. The purchasers (the County Councils) applied a benchmark of a 10% discount on the previous year's prices.

This was not a simple and straightforward process as the story of cataract surgery illustrates. The evaluation of prices was done twice a year - in May and December. Thus, for example, in 1992 the price for cataract operations was set at 15,500 SEK on the 1st of January 1992, and went up to 16,400 SEK on the 1st of June of the same year. They were lowered to 15,250 SEK on the 1st of January 1993, and went up again to 16,010 SEK on the 1st of July of 1993.

This steep climb in prices illustrates the uneasy process of costing services with no previous practice in this area and also the role that the bargaining power of the profession played in setting prices. The latter was manifested in price

fluctuation (going up and down within a period of less than one year), which meant uncertainty for providers and an inability to make longer-term plans and was, therefore, resented by them. In addition, the provider units, which were more experienced in delivering certain procedures came out as price leaders at providing the services in which they specialised. Such was also the example of the specialist hospital, which participated in this study.

However, this increase could not be attributed to the increases in cataract operations, as the numbers remained relatively stable, ranging between 7,271 in 1993 and 6,600 in 1996. Moreover, the DRG (KOKS) prices for services were set at 10% less than the previous year's value and the hospital had to find ways to save money while maintaining this turnover. This was not easy according to the management of the hospital K because the labour cost had increased, though the cost of disposables and materials used had decreased. The latter was achieved as a result because of negotiations with the suppliers, which led to better deals, and also because of more careful purchasing of new equipment. It was also because instead of purchasing a new item, there was more of a tendency to rent it from the County Councils.

The other notable feature in the Stockholm County Council area was the decrease in the number of operations performed by all hospitals in the fourth year after the reforms' introduction by between one sixth and one fifth, which can be observed for all the hospitals. This represents a sharp shift in the trend of remarkable increases that were observed after the introduction of the Stockholm Model (see Table 10.11) and can be explained by the relatively rapid fall in the initial level of enthusiasm following the rise in productivity gains that the reforms achieved during the first years of their implementation. This enthusiasm was soon replaced by an appreciation of excess capacity and of the necessity for the introduction of rationing despite the concomitant political difficulties it entailed.

The rival explanation is that this decrease could be due to the reduction in demand once the backlog in waiting lists has been dealt with. This holds partly true but only for the two first years of reforms when additional funds for clearing it were made available in either country. However, after these funds ceased to flow

and hard budget constraints were imposed on the number of operations performed, waiting lists reappeared both in the UK (The Economist, 1999) and Sweden (Hakansson, 1999), suggesting that initial productivity gains that seem to have resulted from reforms have disappeared when the incentives and structural mix of inputs were reversed to the previous patterns. This reversal or inconsistent follow up of perceived gains in productivity understandably had a negative impact on staff morale, something that representatives of providers in the UK and Sweden referred to on several occasions.

In the UK the similar problem was differently expressed or rather muted because hard budget constraints imposed by purchasers made it impossible for these to manifest openly. However, as the responses of the providers presented in this study suggest, the potential for higher throughput was internally realised and manifested itself as the "dead theatre time" for some eye units, which meant that no eye operations were performed for prolonged periods of time (several weeks) usually before the end of the financial year.

In case of the GPs in both the UK and Sweden but especially in the former, the overall impression was that they took very little notice of the changes which were occurring, as even the very significant ones were either not at all, or very little remarked upon by the primary care providers from all samples, and, in particular, by those in sample T (Inner London).

When GPs were asked for their views on cost-saving measures introduced by the reforms, some of them referred to the spillover effects that the reforms (which were aimed primarily at fund-holders) had had on all GP practices. This was especially important for those considering becoming fund-holders. But it also seemed that some General Practitioners, in their own perception at least, were already aware of the need for efficient use of scarce resources, so the new cost-consciousness mentality did not have any serious impact on them.

The conclusion is that cost-consciousness was not such a novelty for most General Practitioners as might have been expected. Most doctors were already attempting to prescribe generics when possible and the potential for savings

seemed to be higher for fund-holders as incentives (such as the possibility of investing savings back into the practice) were there. The latter was succinctly outlined by one of the non fund-holders who stated that the effects of the reforms on making doctors more cost-conscious were contradictory, as more money was made available although findings from other research seem to disprove this (Goodwin, 1998).

The answers here demonstrate a trend, which dominates most of the GPs' answers. General Practitioners in the inner city area seemed to be less informed about aspects of care, and could not speak about their relationship with organisational changes. General Practitioners from south London (which contains a mixture of residential and deprived areas) were somewhere in the middle of the spectrum, with GPs from north London (almost exclusively residential and relatively affluent areas) being the best informed.

Changes in clinical outcomes

The clinicians, both General Practitioners and especially the consultant eye surgeons, did not perceive the organisational changes introduced by market oriented reforms as having any impact on clinical outcomes. In short, they regarded them as non-existent or as marginal at the very best. They seem to share an almost unanimous belief that outcomes have improved, which in their view was due to the influence of technological developments. By these, they meant advancements in surgical techniques, the improved quality of local anaesthetics and lenses, and possibly the wider introduction of day case surgery.

The same was true where readmission rates were concerned. As was asserted by one of the doctors, *"eyes were not a very good example for readmission rates while in other specialties, such orthopaedics, day care could be held responsible for readmissions"*. The view represented by the few GPs who gave an answer was also confirmed by other sources (consultant eye surgeons and also by a small pilot study carried out within the framework of this research). However, again the limited

knowledge of General Practitioners about the outcomes of care provided to their patients was manifested, which remained a worrisome trait.

The views of clinicians have been confirmed by the findings of a small audit (n=54) of the clinical outcomes performed at one of the study sites (P) where there was no correlation found between the surgical technique, the grade of surgeon or the age of the patient (for details see Annex I). These findings confirm what other studies have suggested (Schein et al, 1993) pointing, as expected, that the only factor having a negative impact on the outcomes was the existing co-pathology, which other studies also confirm (Courtney, 1992).

In the past few years, the emphasis has been on building outcome measurement into routine clinical management of departments and hospitals in the UK through the identification of outcome measures based on existing data. These were usually conducted under the banner of evaluating the targets of the "Health of the Nation", but also tried to follow the recommendations from "The Patient's Charter" (DoH, 1991a; DoH, 1991b; DoH, 1995a).

There were also attempts to link the processes to outcomes by using indicators such as Consultant Completed Episodes, which included the concept of continuity of care and necessity for readmission after the procedure was completed. In this case, however, concerns were raised that this might result in creating incentives for both sides to "*play the system*", with providers assigning multiple CCEs by patient and purchasers concentrating excessively on measuring quality by applying "*efficiency index*" on the other (Gill, 1993). However, this study could not provide any evidence of their influence in clinical practice in the units examined.

The change in adoption of new technology and its consequences for efficiency

Quasi-market reforms introduced into planned health care systems seem to have speeded the pace of adoption of day case cataract surgery especially where its previous level of diffusion was unexpectedly slow and where the utilisation rates

were very low, such as the UK (Perceival et al, 1992). Changes in the pre-existing payment system that, according to some analysts, created constraints and disincentives for both clinicians and the management (Beech et al, 1992) were expected to result in a respective response on the providers' side.

The reaction of providers to the changes introduced was noticeable. This was mainly manifested in their attempts to reduce the cost per unit of services and to tailor them to purchasers' quality specifications, as expressed in contracts. The primary responsibility for achieving these objectives rested with the managers, but the close co-operation of clinical directors became crucial for successful outcomes. These dynamics have clearly been expressed in the case of technology adoption examined in this study.

The forces that encourage or impede technological development and its adoption are multiple and interact with each other on many levels (Geijlins et al, 1994). It is widely recognised, however, that positive or negative payment incentives have a significant impact on the adoption of new technologies (Steinberg et al, 1993), which may even result in the phasing out of procedures of proven clinical value when their cost is not reimbursed by a third party payer (Kane et al, 1989).

Formerly, any efficiency gains in the budgetary use would make no difference or would have an adverse effect on increases in the hospital budget, as the system of resource allocation basically followed previous years' patterns with adjustment for inflation. Under the new competitive arrangements, however, the productivity of the hospital was to be reflected in the income earned (Le Grand et al, 1994; Charpentier and Samuelson, 1994). Furthermore, those providers who delivered services more efficiently (that is at a lower cost per unit) and within the requested quality specifications, would be rewarded by an increase in the number of contracts attracted. It was assumed that this would also apply to day case cataract surgery if the combination of an open-ended payment system and an excess capacity on the providers' side existed.

However, despite most of these predictions happening in reality, the majority of consultant eye surgeons in the UK (over 60%) and almost all of them in Sweden,

while acknowledging the widespread use of day case surgery during the 1990s, had not linked its adoption to the introduction of the reforms. The typical explanations given would be that this type of technological innovation was already under way or that possibly the reforms might have to some degree contributed to their increased diffusion.

Only very few of them regarded the set of incentives introduced by reforms, such as the freedom to organise their workloads more efficiently and the ability to respond to clients' needs, as a strong positive force speeding up innovation at all levels of everyday clinical practice. These included the adoption of cost saving technologies as well as managerial procedures. This also holds true for the overwhelming majority of General Practitioners, both fund-holders and non fund-holders, who were not able to comment on this issue at all (12 out of 16). Even those who could see some positive link between changes in the adoption of day case surgery and the reforms still considered it as only one of the factors influencing this process.

The situation in Sweden was quite different although most actors interviewed in the County Council of Stockholm area (doctors, purchasers, managers) could not ascribe the use of day care for cataract surgery to the Stockholm Model reforms either. The reason for this was that already in 1992 the diffusion rate of the day care in cataract surgery for Stockholm County Council was over 90% (see Fig. 10. 4) while the national average was 52% of all cataract operations performed (Swedish Ophthalmological Society, 1993; Swedish Ophthalmological Society, 1994; Swedish Ophthalmological Society, 1995; Eckerlund et al, 1992) as compared to 5% in the UK (Effective Health Care Bulletins, 1996; Williams et al, 1994). Some of the respondents, however, indicated that reforms could have influenced this process in other places since the beginning of 1990s a number of Counties had experimented with different forms of managed competition.

On the whole however, health professionals interviewed for the purpose of this study, who were aware of cost implications and fully involved in management activities aimed at increasing efficiency in their respective units'. However, they did not, in their majority, ascribe the diffusion of day care cataract surgery to the

introduction of the reforms. Their perception about the factors influencing the diffusion of new technologies seemed still to be dominated by the importance of medical and clinical factors. This has proven to be the case even for units where the data extracted from hospital and departmental registers reported a massive change which could not simply be justified by the clinicians' interpretation, who tended routinely to undervalue the impact of determinants other than medically, oriented research and development.

It is suggested that this is could be possibly caused by the lack of a self-auditing or self-evaluation tradition within the medical profession which would extend beyond the rigorous clinical and basic research studies and would also deal with other aspects of care (Long et al, 1993a; Long et al, 1993b; Shanks et al, 1993). Of course the supremacy of empiricism in which medical sciences are deeply rooted which is based on "hard" investigative methods and the importance of professional dominance plays an important role too. Furthermore, the relative lack of awareness of research findings (Dawson, 1995; Potamitis et al, 1994) combined with the disbelief in their effectiveness contributes to this outcome (Dawson, 1995).

Another finding of this study, which is the inability of a majority of GPs to comment on links between organisational changes and the adoption of day case surgery must also be related to these limitations. Here, at least, GP fund-holders who tend to make extensive use of services provided on ambulatory basis (due to their cost-saving implications), were expected to be more aware and more closely involved in the monitoring of these changes (Glennister et al, 1994a) which was, however, disproved. The GPs' limited awareness of crucial developments in ophthalmology services, for which they commonly referred their patients, was also supported by another study (Potamitis et al, 1994).

As has been discussed elsewhere (Rosen, 1996), both clinicians and managers have an incentive to promote jointly the introduction of new technologies in order to obtain extra income through Extra Contractual Referrals and per-case contracts with GP fund-holders in addition to their block contracts with Health Authorities. Thus efficiency benefits resulting from day care surgery that were

already known of (Audit Commission 1990, Audit Commission 1992) could now fully be realised.

There is a caveat to this, however, which has also been illustrated by this study: the pace of its adoption is dependent on a number of factors, such as the pre-existing level of diffusion of certain technology in the department, commitment to its introduction on the part of the clinicians, and co-operation between management and clinicians. This can clearly be seen in the case of the two of the four selected study sites, where unit S demonstrates the reforms' success and unit U their failure story. In the latter case, the lack of smooth co-operation between clinicians and the management of the hospital led to acute conflict, resulting in the resignation of the whole team of consultants, which had a marked impact on the overall performance of the department for the years to come and has eventually resulted in its closure.

As far as managers were concerned, it was found that - while attempting to demonstrate their commitment to increasing the percentage of operations performed as day care procedures - when asked about the impact of the reforms on this process, they seemed to be influenced by the views of the surgeons from the respective units. Moreover, the decision-making process for technology adoption also tended to be strongly influenced by the clinicians' views on the technology's effectiveness. More importantly, managers' requirements seemed to be determined by ad hoc priorities that prevailed and which usually coincided with the short-term efficiency gains (Rosen, 1996). It transpired, that there was very little serious consideration of the long-term effects of introducing new technologies.

On the other hand, it is known that purchasers used to specify the desirable level of procedures performed on an ambulatory basis, which were explicitly stated in the contracts. Purchasers in the UK increased their demand for day care procedures, which was expressed as a growing percentage of services that had to be performed on an ambulatory basis in comparison to the previous year. Nevertheless, the purchasers of the Health Authorities did not always specify the

required day care rates by specialty, as the type and volume of services they bought were mostly in block contracts.

It also transpired that purchasers experienced a significant degree of confusion about their role in promoting the appropriate level of diffusion of medical technology. They did not seem to follow their own policies in this respect, but rather adopted the directives and recommendations elaborated on a central level, such as the Management Executive (NHSE, 1993; NHSE, 1994a; NHSME, 1993; NHSME, 1994; Audit Commission 1990, Audit Commission 1992). It is argued that purchasers' real involvement in technology evaluation activities is not, in fact, compatible with their being guided by centrally set directives referring explicitly to a desirable type and level of service provision.

Although the implications of technological innovation may be cost reducing, cost increasing or neutral and may manifest themselves differently during its life cycle, the usual long-term net effects of introducing new technology are associated with an increase of total health care costs regardless of its positive effects on the quality of life because it becomes available for a larger number of patients who would otherwise go untreated. Such is for example the benefit associated with restoring binocular vision, which is the preferred treatment for patients with cataract-induced visual impairment (Javitt et al, 1993).

The escalating cost of health care expenditure on the other hand, has commonly been attributed to the rapid growth and diffusion of biomedical technologies (Newhouse, 1992; Rettig, 1994). In order to counteract this process, there is a necessity for a structured and systematic approach to health technology assessment, which would inform the debate on appropriate policies; this has increasingly been realised within the political, regulatory and academic community (Battista et al, 1994).

11.6.2 Comparison between the UK and Sweden

The utilisation rates of day care cataract surgery in the UK were significantly lower than those of Sweden and the USA, constituting only a modest 20%

expressed on a national level (Effective Health Care Bulletins, 1996) as compared with a respective 50-60% and 80% (Steinberg et al, 1990). These figures refer to the period of two to three years after the introduction of the reforms, while in the period preceding the reforms in three out of the four units examined in the UK there was no day care cataract surgery performed at all.

The national differences in utilisation rates of day care cataract surgery between the UK and Sweden as well as other comparable countries, may only partly be explained by regional and geographical variations characterising medical practice (Steinberg et al, 1990) and incentives incorporated into the reimbursing system (Steinberg et al, 1993).

A more relevant explanation, which was pointed out by some of the study's respondents, refers to the British medical establishment's traditionally cautious approach to innovation. The conservatism of the medical profession was strongly demonstrated when the likely effectiveness and efficiency gains which would result from the more widespread use of day care surgery were evaluated by the Royal College of Surgeons (Royal College of Surgeons, 1985). Dawson has argued that doctors are frequently unaware of the results of research and development and even when they are aware they are often skeptical about the feasibility of general application (Dawson, 1995).

Surprisingly, doubts about savings resulting from the use of ambulatory care in connection with the required support from community services and reservations related to clinical outcomes (the latter were not supported by hard evidence), outweighed its likely benefits for the evaluators (Royal College of Surgeons, 1985). This explanation is further supported by the fact that cataract operations in the UK were still being performed under general anaesthesia in the majority of cases as late as the beginning of the 1990s (Rassam et al, 1989) while it is known that the same practice has only rarely been used during the last 10-15 years in countries such as the USA or Sweden. This study's data also confirm all the above views.

Despite this, a growing number of well designed studies conducted in recent years in the UK have established that day care surgery produces outcomes equal or even superior to inpatient care (Lowe et al, 1993; Effective Health Care Bulletins, 1996). Such procedures are also reported to enjoy a high level of patients' acceptance (Davies et al 1992) and can have an effect on decreasing the hospitalisation rate due to the postoperative infection (endophthalmitis) (Javitt et al, 1994). Of most importance are its significant efficiency implications (Strong et al 1991; Williams et al, 1994; Perceival et al, 1992), which are achieved through savings made on the number of beds and staff required and the increased number of patients that may be treated within a given time frame.

It is predicted that the trend initiated by the market oriented reforms within the NHS will continue unabated and the use of day care cataract surgery will reach its optimal potential, which is estimated to constitute 80% or more of all the cases performed on a national level (Effective Health Care Bulletins, 1996).

11.6.3 Conclusions

The first conclusion is that, there was no unanimous decrease in prices of the service examined although on the whole the expected increases in the number of operations performed ensued (with an exception of unit U, which was closed down after some years of reforms). Prices seem to fluctuate and this can possibly be explained by lack of previous experience with costing and accounting which brought some arbitrariness at least in the initial stages of reforms. Again there were differences among units and the most successful demonstrated more marked increases in throughput but which was not necessarily commensurate with the decrease in prices.

The second conclusion is that, despite these changes, the majority of contracts between large providers and Health Authorities in the post-reform period were still based on patterns of past co-operation. This can be partly explained by the oligopolistic and oligopsonistic position that large providers and purchasers respectively occupy in the market, which may lead to cosy arrangements between them as outlined by Propper (Propper, 1992). In Sweden on the other

hand, there were views expressed that the arrangements were never meant to be really competitive and that they rather resembled “ a *game within a family*” (Axelsson, 1998a, personal communication).

Another impediment to the full realisation of competition objectives was related to the fact that the majority of services requested by purchasers were still defined under block contracts, which made it difficult for more efficient departments to feel fully motivated to increase their activities. The evidence provided by this study also supports the latter view, which was often referred to by a number of clinical directors interviewed. In addition, government in the UK intervened whenever a threat of closure of the hospital became real either because the excess capacity in the area was realized or because it could not withstand even the minimal competitive pressures.

Second, the importance of clinicians' commitment and their involvement in decision making, aside from purely medical issues, seems to bring rewards in terms of organisational effectiveness and the quality of care provided, as has been demonstrated in the case of S and also unit K in Sweden. In both cases, clinical directors are strongly involved in managing the budgets of their departments and their overall performance, measured in terms of the efficiency of production, the quality of services provided and the users' satisfaction with care, is higher than average. A hypothesis about the role of clinicians acting, as the “*cadre decide*” for improving organisational effectiveness and efficiency in their departments, should possibly be further explored.

Third, there is some evidence that quite a few providers were prepared to sacrifice the cost-effectiveness considerations of service provision, which this option entailed, in order to attract extra income in the form of per-case contracts from GP fund-holders, even from distant areas, by conducting an outreach clinic at the GPs' surgeries (Gillam et al 1995). Ophthalmology services were well suited for attracting GP fund-holders to refer patients almost exclusively to a certain provider in exchange for outreach clinics conducted by consultants on the site of the GP's practice.

them the major ones deal with equal consideration of rival explanations, the search for negative cases for testing hypotheses and triangulation techniques that use different data collection sources and different research methods to strengthen the analysis (Patton, 1987).

In this research project all these methods were applied. Triangulation was assured by both employing the different perspectives of the main actors and the complementary use of quantitative methods to elucidate some of the issues that had been drawn out by the qualitative methodology of semi-structured and in depth interviews. Although different results were obtained through qualitative and quantitative methods – as to why or whether changes in day care surgery rates occurred for example - this was possibly because different methodologies investigated different aspects of change. While quantitative methods looked for an indication of the increase in absolute numbers of day care cataracts, qualitative interviews aimed at understanding how and if this change was perceived by main actors and whether this increase was linked in any way to the reforms and/or other causes.

In the former, change in frequencies of occurrence was measured while in the latter perception of change was recorded and analysed. Similarly, another study of elementary school classrooms, which analysed potential conflicts between two sets of data and concluded that difference among them resulted from measurement of different things that were not readily apparent, which has indirectly confirmed the reasons for this “inconsistency” (Shapiro, 1973 quoted in Patton, 1987).

Rival explanations on the other hand, were seriously considered even when they were inconsistent with the line of interpretation offered and they could not be refuted by it. This is especially evident in the discussion chapter when for example the attributability of increases in day care surgery to the internal market reforms in the UK is considered alongside with the account of diverging views of clinicians on the same subject. It can also be seen when the alternative explanation for the lack of information by GPs on the different aspects of care of

their patients is put forward, or finally when limited choice over treatment or hospital site that is available to patients in the UK is discussed.

Negative and deviant cases were carefully recorded and incorporated into the framework of analysis, as they are regarded particularly helpful in testing the hypothesis (Patton, 1987; Silverman, 1993). As a result the initial hypotheses were revised, such as, for example, in the case of divergent views among doctors and patients on the priorities of the latter in choosing a hospital or when views of patients on the availability and content of printed leaflets differed significantly. Only after repeated exploration of hypotheses for their potential of generating alternative explanations was the most plausible theoretical interpretation then given.

The problem of generalisability is another issue that has to be addressed when case study methodologies are used. The generalisability of findings – also known also as the external validity of the case study method - has been a contentious issue since the inception of the method. Many proponents and opponents of the method alike seemed to share their views on either the impossibility or unattainability of this objective or both (Hammersley and Gomm, 2000). However, Yin amongst others has argued in favour of the case study's potential for replicability. He pointed out that as long as the methodology used in this type of research was clearly described it would be possible to replicate it elsewhere thus increasing the power of its findings (Yin, 1994). This latter approach guided the methodology adopted in this study.

Extensive notes were kept throughout all the stages of interviewing process, which were then transcribed without the aid of a tape recorder. The decision to avoid the use of a tape recorder was intended to create a relaxed and informal framework that would facilitate the interview and to promote the sharing of information that was often confidential in nature. The voluminous data produced were organized and simplified into meaningful and manageable categories, which were then coded using content analysis techniques. Subsequently, logical analyses aimed at the cross-classification of data and obtaining new insights, together with an iterative process, under which the categories were applied to the

data and amendments to them were made according to what they revealed, were employed.

CHAPTER 12

POLICY IMPLICATIONS

The research question examined in this study has dealt with the impact of market-oriented reforms on different aspects of health care delivery especially: choice, information, quality, responsiveness and efficiency. Competitive market elements and the separation of functions between producers and buyers of care were introduced into the health systems of the UK and Sweden, which had previously relied on planning and central budgeting, respectively, as methods of operating the system and allocating resources. The reforms were intended to enhance the responsiveness of health services bringing it closer to the users' needs and wants, and also to increase its efficiency (in the UK) and its productivity (in Sweden).

In the view of the reforms' proponents, quality of care, choice and responsiveness were seen as highly desirable attributes for health care service delivery in consumerist societies. It was expected that these would be equally highly regarded by the users of health services in industrialised countries and would come either second to, or even ahead of, technical effectiveness in their valuation. On the other hand, policy makers in the UK saw increased efficiency as a desirable end in itself but more importantly as a necessary means to achieve technical effectiveness. In Sweden, increasing productivity and, later, efficiency were the primary considerations behind the reforms, which were independent of the Liberal Government's genuine commitment to patients' choice.

The proper evaluation of structural changes introduced by means of pro-market reforms is fraught with difficulties. They relate to methodological and political constraints alike. On the one hand, the evaluation is too often tainted by ideologically motivated criticism of the reforms or exaggerated praise of the market elements introduced into health care. On the other hand, too few resources were devoted to the creation of appropriate tools for a proper

evaluation that would have provided information and input for decision-making by national and local politicians, or even by purchasing authorities. In addition, a sound evaluation requires time, which again may not coincide with the priorities of politicians.

The first question that this chapter considers is the extent to which the reforms fulfilled the expectations placed upon them and whether or not they vindicated the associated fears and reservations. The reasons and causes for their success or failure are also investigated. A second question is why this relatively modest attempt at innovating the system had such a short life and why it was terminated before it had the chance of proper evaluation. The final question deals with the legacy of this experiment for the future of publicly operated and financed health care systems and how, if at all, this experience has paved the way for future developments. In another words, did this set of reforms serve as a basis for future developments or did it constitute an isolated attempt and, in effect, a cul-de-sac?

12.1 Expectations fulfilled, failed or neither?

This thesis investigated the impact of the reforms on choice, information, quality, responsiveness and efficiency under the market oriented reforms in two countries, which followed similar policies. The first conclusion resulting from this comparative analysis is that quasi-markets in health care may have an adverse impact on choice of the provider and the modalities of treatment alike. These findings confirm the earlier indications from the UK (Mahon et al, 1994; Jones et al, 1994) and provide some novel insight into the developments in the eye service in the Stockholm County Council.

Second, it was also demonstrated that the quasi-market reforms could only moderately stimulate the increase in information, at least where direct users were concerned. The increase in information, which was very modest, seemed to be primarily tailored to meet purchasers' requests. This is an original contribution of this research as no other published studies dealt with the aspects of information

under the market oriented reforms either in the UK or Sweden. This study also indicates that policy makers had even less awareness and comprehension of agents' limited success in promoting users' need for an adequate standard of information, both in terms of amount and quality.

Third, although it was very difficult to ascertain whether there was an obvious improvement or worsening in the quality of care, except for an increased awareness of its importance, quality indicators used in this study suggest that some positive changes did take place. The transformations were expressed as a change of attitude and the provision of more user-oriented care, both of which were more likely to have occurred in units, which had benefited from the reforms and which could also demonstrate efficiency gains. This indicates that incentives, even the weak ones that the reforms promoted, produced some kind of improvements in terms of quality of process; the latter is also confirmed by another study in Sweden that investigated quality of care (Garpenby, 1997).

Fourth, units that adopted reforms enthusiastically such as hospital S in the UK and hospital K in Sweden took efforts to adopt a user-friendly approach as much as possible; they were also kinder and more responsive to the details that were important to the elderly. This supports one of the main arguments that this study puts forward: that those units who were more positive about reforms, either because it reflected the attitudes of the leadership or because they were in a position to benefit from the reforms, were also more successful in their implementation. An alternative explanation could also be that units thriving under reforms were more innovation oriented already in the pre-reform period, which seems to be the case for both S in the UK and K in Stockholm.

The fifth conclusion is that responsiveness to need, which in this study was measured by the changes in waiting times for surgery and the first specialist appointment, was more pronounced in units that represented the success story of the reforms. This hypothesis is again supported by some other studies mainly from Sweden (Hanning et al, 1998; Lundstrom et al, 1996). Meanwhile, it is also recognised that government initiatives, complemented by extra funds provided to

ameliorate the problem of long waiting times, played a crucial, if not the most important, role in reducing them.

Sixth, while efficiency gains were difficult to evaluate, as, in both cases, significant increases in resources followed the introduction of the reforms, productivity did improve in some cases, especially in the initial stages of the Stockholm Model in Sweden. In the UK, there is no straightforward answer to the question as to whether or not any expected efficiency benefits happened in reality, although some indication of a more efficient provision of care in hospitals (Soderlund et al, 1998) and primary care by GP fund-holders (Goodwin, 1998) can be found in some of the evaluations conducted.

The prediction that competition at micro-level, which is believed to have quality enhancing potential and could therefore have a positive impact on the cost-effectiveness of service provision, was not investigated in this project. The case studies used did not, on the whole, provide any empirical evidence in support of this claim; but, again, there were some indications that increased throughput by the well performing units led to the decrease in the price of the service.

Seventh, incentives incorporated in the reforms stimulated and speeded up the diffusion of cost saving techniques such as day care surgery. This relation has not been so far investigated in any published research that is known to the author.

What are the general conclusions to be drawn from the results of this experience and what could be the possible explanations as to the reasons of these outcomes? More importantly, what do they signify in terms of lessons to be learned and conclusions to be drawn for the future policy options?

The first conclusion is that changes in the control system and the incentives' structure resulting from reforms highlighted the complexity and multiplicity of facets involved in choice, information, quality and responsiveness issues within the dynamics of health care environment.

Second, for cataract surgery, which was used as the tracer condition, the lack of choice induced in Stockholm was primarily due to the decrease in alternatives resulting from the merging of existing eye units into one specialist hospital. In the UK, it represented a conscious decision by at least one type of purchaser, the Health Authorities, most of whom adhered to previous patterns of co-operation with the providers, only more strictly.

Third, liberally minded policy makers seem to have overestimated users' willingness to opt for choices in health care while giving little attention to their largely unmet need for usable and appropriate information. It also turned out that patients' motivations for participating or not in health care decisions depend on various factors, which are only partly understood. This implies that provisions for enabling patients to defer choice to the provider has to be taken into account when designing framework for choices around treatment within a public health care system. In another words users should be given the opportunity to choose how much they want or do not want to know about their treatment and condition of health.

Fourth, as far as information is concerned, in this instance it became apparent that market incentives alone were not enough to generate it sufficiently and that there is a need to establish effective mechanisms within market oriented systems facilitating the process of obtaining relevant and adequate information on options available, by all concerned. As a result, it can be concluded that the rhetoric and statements proffered for the inevitability of enhanced choice and better information following the introduction of market elements into health care provision were shown to be false.

Fifth, this study indicates that General Practitioners (both fund and non fund-holders) in the UK demonstrated only a limited success in promoting users' need for an adequate standard of information, both in terms of amount and quality. It is therefore argued that intermediaries such as GPs for example, should not be blindly counted on to act exclusively and under any circumstances as the perfect defendants of the patients' needs. This consideration is especially relevant when plans are being made to entrust extended and vast powers to primary care

doctors, along the lines of the most recent change introduced by the new NHS White Paper (DoH, 1997).

Sixth, this study has also demonstrated that policy makers, somewhat inconsistently and/or naively thought all these occasionally mutually exclusive goals such as for example choice, quality and efficiency could be achieved at the same time. Already in the aftermath of the reforms' introduction, it was quickly recognized that the simultaneous objectives of the reforms could be in conflict with each other.

Moreover, even before the reforms had been introduced, the emblematic concerns of the publicly funded systems had been articulated in the form of reservations as to whether higher efficiency could be achieved without affecting equity of access to the services. In addition, fears were voiced as to whether the economic incentives, new to planned health systems, would not be too difficult to manage in the public sector, especially if they posed threats to medical ethics and medico-clinical aspects of quality as well as equity (Berleem et al; 1994; Bergman, 1994; Whitehead, 1994a; Scheffler, 1989). In the UK, it was predicted that different trusts had conflicting objectives, which could damage the continuity of patients care (Wall, 1994).

According to the early critics of the reforms, this was likely to happen because standards and specifications of services and criteria for their evaluation were ill defined and designing them would be a very lengthy process (Keeley, 1993). However, there seemed to be no realisation that the goal of increased choice, information or responsiveness might involve trade-offs against efficiency considerations, and views on this subject were muted. In Sweden, Anell pointed out the inherent contradictions in the reforms' objectives and their half-hearted commitment to pluralism, which, in his view, would ultimately doom them to failure (Anell, 1996).

The conventional view is that increased choice, information, responsiveness and quality will promote efficiency (Ovretveit, 1992). Nonetheless, the unequivocal implications of this project which were explicitly articulated by health care

providers is that improvements in efficiency and quality were mainly or only possible because there was limited choice and no time consuming investment for providing sufficient information.

This study has demonstrated that the fears about the likely detrimental impact of the market ethos on the quality of care have been largely disproved. In both countries so far there seem to be no negative signs about quality; if anything there was an increased interest in recording it, as it had previously been ignored. Meanwhile, the use of cataract surgery has simultaneously revealed how these contradictions were evoked and provided an illustration as to the extent of the trade-offs and substitution effects that were involved in choice, information, quality and occasionally responsiveness versus efficiency. It also exposed the explicit nature of the resources required to increase choice, information, quality and responsiveness, which even in a managed market environment could be expressed either in monetary terms or as opportunities forfeited.

Thus the difficulty, if not the impossibility, of attaining the conflicting objectives stated in the reforms' agendas, was once more reiterated. The conclusion is that it serves as a reminder of the need for clarity in defining policy objectives beforehand, especially when they are visualised and launched on a large scale, as was the case in the UK.

Seventh, an overall conclusion to be drawn from this thesis is that quality, responsiveness and efficiency are more likely to improve when providers can identify gains for themselves that will accrue together with achievement of these results. Therefore, it is essential that specific policy objectives are sustained by appropriate incentive structure for all those whose support is indispensable for the successful implementation of the reforms without which they may not be successful. There is empirical evidence from other studies that support this hypothesis (Garpenby, 1997; Hanning et al, 1998).

Nonetheless, on the whole, there was an opposite trend observed during the short life of reforms, which became an overt policy statement in the immediate post-reforms period. Policy makers demonstrated their ambivalence when facing

the results of the markets' work and attempted either to blunt the incentives in the weak form they already existed or decided to abandon them altogether. All along they seemed compelled to complement and/or altogether supplant for the invisible hand of the market in almost every step, as if they were driven by disbelief in reforms' effectiveness.

This happened on more than one occasions; soon after the reforms were introduced in both countries the tendency was to replace more intangible and flexible market mechanisms with more rigid and not always realistic standards and mechanistic targets. Also the governments fuelled additional funds to smooth the implementation of reforms during most of their stages. As a consequence, market elements even in its embryonic form were hardly allowed to work: competition, incentives and freedom of choice were hardly given a chance to demonstrate their success or failure.

Despite these many strictures and the unfavourable environment, the power of incentives, even those reluctantly introduced, was demonstrated and both providers and users of services exercised them. As the experience of this study has shown, the providers attempted to maximise their profit or simply to survive by providing more efficient care while the users attempted to improve the conditions of service by choosing the most suitable provider. Notably, the response to incentives was more vigorous in Sweden where incentives were sharper but also the users of service were more articulate in expressing them.

Summing up, the effects of introducing incentives into health care systems should be seriously considered beforehand because they are powerful; they work and have to be adequate to achieve their purpose. It is argued, that the experience presented in this study has offered a better understanding of the limitations entailed in the introduction of competitive incentives into regulated markets, which allocate public goods. The necessity for thorough and proper evaluation of the multiple facets entailed in this experience and their integration into the future reorganizations is hence emphasised.

There are also some other ways in which this study contributed to enhancing knowledge on the effects of the market reforms. The most important and novel input was the use of the example of the specialised service to serve as a tracer condition of changes that occurred in similar yet distinct environments of the UK and Sweden. This approach gave the opportunity to unearth the specific aspects of changes that might otherwise go unnoticed. In addition, the element of the study involving an international comparison provided some added legitimacy to the findings, which in their majority seem to function in spite of the peculiarities of each setting. This supports the presumptions of liberal philosophy concerning the universal dynamics of much human behaviour.

12.2 Policy implications of the actual findings of research

Although pro-market reforms were widely expected to promote greater choice, there was no greater availability of it in any respect of care. On the contrary, there were quite a few indications that choice of hospitals in both the UK and Sweden may have been curtailed. The reasons for this were many and various. In Sweden they seem to have resulted either from the new contractual arrangements and/or from the closure or merging of hospitals. In the UK, the confusion that was inherent to the mutually exclusive set of policies, an exaggerated belief in patients' desire to be proactive under any circumstance and a lack of an appropriate framework that would enable them to enact their choices should they wish to do so, were the main reasons that impeded choice.

The implication that this research has helped to highlight is the need for clarification of policies as to whether choice is a desirable objective in the first place, and, if so, with regard to what aspects of care was it most relevant (choice of GP, hospital, forms of treatment). It would also be desirable to establish the appropriate level of input on the patients' side and to ascertain whether this would vary according to the type of condition.

In addition, if an increase of choice is indeed a sought-after goal, the costs and the trade-offs involved in the process of its pursuit need to be defined, as do the organizational and other frameworks required to implement and support it. As

this study has demonstrated, the omission of those basic requirements turned policies aimed at promoting choice into pure rhetoric.

The other proposition that has to be taken into account in policy design process and that the aspect of international comparison highlighted by this study is that choices are enacted where the incentives are evident (i.e. patients in Sweden) but this may not lead the most efficient outcomes for the publicly financed health systems. This experience has provided some evidence that proactive policies with regard to increasing patients' choices pursued in Sweden for the first two years of the implementation of the Stockholm Model increased the overall costs of service provision beyond the point of socially desirable outcomes. In another words, there were indications that benefits were achieved at too high a cost, which was seen as being incompatible with the priorities of the publicly funded health care systems although no proper evaluation of how far this was happening in reality was ever conducted.

A further implication accruing from this study concerns the complementary policies necessary in this process. One of them is the existence of relevant, readily available and accessible information. High quality information for patients and purchasers is an essential and desirable objective in its own right. The lessons for policy makers that this study has demonstrated, and provided evidence for, is that patients value this aspect of care highly even if they do not want to use it to enact their choices. This aspect of care seems to empower them to undertake after and self-care, to improve their compliance and thus possibly speeding their recovery. Therefore, the implications for policies as to the extent, type and quality of information provision in health care services are several.

First, there is a great potential for improvement in all aspects of information provision for patients and purchasers alike, as to both its content and form. In the case of patients their views and expectations for information have to be taken into account in designing structures and even materials to ensure that they contain and respond to what is needed. In this context, it is worth noting that multiple sources of information oral and written seem to have synergy effects on the intended users.

As far as purchasers are concerned, they have to assume a more proactive role and request data only of use to them instead of being flooded with meaningless information from the providers, as seems too often to be the case at present.

Finally, various perspectives and angles have to be considered to acquire a sense of what relevant information consists for different categories of users and to tailor them in order to secure their effectiveness. As various other studies have suggested (Luker et al, 1996; Beaver et al, 1996; Anell et al, 1997) patients' needs for information and their ability to make appropriate use of it depends on their age, education and severity of condition. Policies aimed at promoting this aspect of care should therefore be designed in such a way as to include patients' requirements for knowledge while respecting their wishes for deferring some of this to the professionals.

The indicators of the quality of care that this study has measured - changes in waiting time in the outpatients' department, the timing of information provision on the operation date, the availability of contact with the senior specialist doctor in the hospital and change of attitude of providers towards patients – showed positive changes for units that were eager to implement reforms. This, on the one hand, implies that clearly defined and measurable issues that the reforms tackled explicitly were met with a relative success when the response of those who were to implement them was adequate. On the other hand, it indicated that the less tangible aspects of care related to user-friendliness and concern for patients needs could be positively or negatively influenced by different providers, which in turn depended on how successfully they have adopted the reforms.

The factors that influenced the particular type of response provide some guidance as to the conditions for successful implementation of the specific policies. They boil down to shared vision and values that provider could identify with, ability to recognize rewards, organizational culture and pre-existing level of preparedness for adopting particular changes. This in turn, suggests that a broad support and involvement of key actors based on an understanding of policies, in addition to a clear incentive structure for those who will implement them, is an essential precondition for their successful accomplishment.

Finally, the results of this study in its small way demonstrated that correctly applied incentives could improve both the more and the less tangible aspects of quality of care. This was in spite of the fears that competition with its punishments and rewards could do more harm than good when the relationships among key actors are governed by the asymmetry of information on the specifications of the product delivered by the providers.

On a more general note, this study highlighted that policy makers in the UK and Sweden alike seemed to be driven by an ambivalent mixture of beliefs in the power of market attributes (such as incentives and competition) on the one hand and the reliance on target setting – as for waiting times for example where extra funds were seen as instrumental in meeting them - on the other hand. This rather confused approach was likely to produce ephemeral gains that would wither away when tight monitoring and optional money ceased to apply as reduction of waiting times for the case study considered in this project has illustrated.

The same conclusion seems also to apply for the results expressed in terms of changes in waiting times, which this study uses as a proxy for responsiveness to patients' needs. On the whole, here again units with an overall success in meeting reforms objectives presented the most marked (although not permanent) reduction for all waiting times. In addition, some other findings on the dynamics of changes in waiting times, such as, for example, their fluctuation in accordance to the availability or the lack of additional funds suggest together that policies require focus, an unambiguous formulation and consistency in their implementation to produce lasting results.

The modest efficiency gains that the reforms seemed to have achieved in terms of the overall higher throughput of operations performed and a relative (although uneven) reduction in prices indicate the lack of experience in costing health service that existed prior to reforms' introduction and the impact that market oriented reforms had in initiating this process. A more optimistic and straightforward conclusion is that they suggest that the market achieved at least one of its key aims.

However, even when moderate efficiency gains occurred (defined as increases in productivity for given inputs) this improvement in technical efficiency did not inevitably coincide with improvements in allocative efficiency, which means that not necessarily the resources were used in the most efficient way. For example the appearance of the necessity to constrain the number of operations performed has resulted in “dead time” in the operating theatre for weeks or even months (where no operations at all were performed in hospitals in the UK), which in turn had negative effect on the morale of the surgeons and staff and could lead to other inefficiencies in the long run.

One other implication of the experience with changes in efficiency under the reforms is that increasing efficiency or even more so the pursuit of higher productivity (an original goal of the Stockholm Model) cannot be taken up as a policy goal in isolation because it produces tangible consequences that have to be acted upon. Such was, for example, the realization of the excess capacity for performing cataract operation in the respective populations for the given public funds, which was especially marked in the inner cities and in the heavily populated urban areas in both countries.

Another implication of the study is that the criteria used for operations even when they are defined in medico-technical terms are subject to variations among surgeons and possibly units (especially in the UK). There is no input on indications for surgery from purchasers other than limits on budgets and in consequence a crude constraint on the number of operations performed without taking into account any appropriateness related criteria. This is a policy area that purchasers need to address. First, they need to acquire some understanding of how the decisions on whom to operate are made and, then, attempt to influence them in accordance to clearly defined priorities. This is a necessary course of action to promote appropriateness of care and to maximize the gain for population for the resources available, in effect fulfilling the goal of allocative efficiency.

A final remark on the impact of the market oriented reforms in adoption of innovations with cost-saving potential and its implications for policy, is that it was

quite unclear whether this rapid increase in the implementation of day care procedures in cataract surgery that was clearly visible in the UK and this study examined, resulted from the quasi-market work or from the directives of the NHS Management Executive that explicitly promoted it.

If anything can be concluded from this experience, which also pertains to the other aspects of appraising the value of the market experiment which this study assessed, is that, in an environment with so many simultaneously occurring and complex changes, one can only cautiously assert the probability of synergy effects in an absence of any obvious conflict between them; but one can not prove that a definite positive link existed.

The straightforward implication is that this uncertain causation linkage maybe of rather limited value for helping the policy making process. However, more careful consideration suggests that that this provides a real picture of the ambiguity that permeates the interactions between new and pre-existing policies and highlights the dynamics of responses to them that occur in the real life settings. The next section reflects on how far the results reported in this study and policy implications identified above were taken up (if at all) in the subsequent restructuring of health care systems in the UK and Sweden, which replaced the internal market reforms.

12.3 Experience learned, abandoned or neither?

On first inspection, the developments in health policy in the UK and Sweden that followed the market reforms reflect the ideological differences of the incoming governments (Labour and Social Democrats respectively) with their predecessors. The first indications were that politicians in both health care systems decided to abandon market experiments in public health care provision and go back to the old ways, with control and planning regaining its prominence.

One of the initial and marked transformations in this direction was manifested in the change of language, with "competition" being replaced by "co-operation", "contracts" by "care agreements" and "purchasing" by "commissioning". Although,

the terminology of buying and selling borrowed from the commercial market somewhat simplified the reality and was never meant literally, this change signified a more important shift in policy, reaching beyond the redress of semantic imbalances.

Social Democratic government in Sweden made an attempt to achieve its targets of which the most important was to contain the cost of health care, by means of a literal pull-back of the system, while promising its constituency that no closure of hospitals would be necessary because other structural changes would resolve these problems.

Radical moves took place, such as the withdrawal of the private GP scheme, in which 25% of the total number of primary doctors had already enrolled, and the withdrawal of the concession given to some hospitals, which had become limited companies. More crucially, the government envisaged that profits and risks should be shared between providers and contractors, which meant that the system of imperfect competition would be diluted yet further. This, amongst other factors in Stockholm, meant that the surplus, which the hospitals were initially allowed to retain, was substantially reduced.

Similarly, in the UK, "The New NHS" White Paper published in December 1997 and implemented in the spring of 1998, dispensed with the competitive elements in contracting procedures, which were replaced by care agreements (DoH, 1997). The new agreements are of longer term and provide more security to hospitals, enabling them to foresee and plan the type of financial cuts required in order to follow the political mandate of the day. In both countries, contracts or care agreements are meant as tools to define and secure the appropriate level of care, as well as mechanisms for quality assessment and follow-up. The intended use of contracts in Sweden is as steering tools for achieving productivity, while in the UK they are to serve as the framework for commissioning all types of care-related services and activities.

The most prominent, and according to many also the most successful part of the reforms, the GP fund-holding scheme, has been abandoned and replaced by

Primary Care Groups (PCGs), compulsory associations of several GP practices which are responsible for the joint purchasing of services for populations of between 200,000 and 500,000 people within a Health Authority. The integrated perspective is also aimed at encouraging co-operation between primary and secondary care, while containing the cost.

In Sweden, a similar transformation took place where the concept of the cross-sectional chains of care was developed. These were divided between the two tiers of the service with the joint management of the whole budget shared between the hospital and the primary health care settings. In the UK, this shift towards Primary Health Care was more radical as a power for shaping the volume and type of hospital care, with money assigned for this purpose being almost exclusively managed by the primary care representatives (PCGs).

This partial departure from market principles is to some degree a result of political motivation. According to some, the moves aimed at "turning back the tide" were politically driven steps, because procedures such as selling, buying and contracting out of services were unpopular with Social Democrats and the Labour government alike. Equally important however are also the increases in spending that reforms brought about (especially in Sweden).

This was on the one hand, caused by the higher expectations that reforms unleashed and provided a framework for users to articulate. On the other hand, the freedom given to purchasers (GP fund-holders in the UK) to refer patients to any hospital and the ability given to patients to chose a provider (in Stockholm County Council and other county areas in Sweden) created a situation where there was no possibility of controlling the volume of reimbursable services, with the only exception of more or less hard budgetary constraints. In addition, the political rhetoric about increases in choice, responsiveness and quality of services somehow managed to raise the standards against which the successes or failures of the reforms were measured.

Also incentives for providers had as a result that some hospitals tried to obtain the highest possible share of the market instead of delivering only the volume of

care set in the contracts. This occasionally led to the phenomenon of expansionist hospitals, which was especially evident where per case reimbursement system operated such as in the Stockholm Model. The reverse was also true, as lack of control and follow-up on contracts resulted in hospitals running out of money and posed the threat of closure, which in turn caused grave dissatisfaction on the part of the users - something that neither government was fully prepared to accept.

In the event, and in order to counteract these undesirable outcomes a new Supervisory Hospital Board was created in Stockholm County Council to oversee the type and amount of services purchased and to control the management of each hospital's budget. The providers were made responsible for breaking even within the budgetary limits and the framework of the contract. The Regional Boards (the political bodies of the county councils) were supposed to co-operate with all hospitals but only some of them could buy specialist care on behalf of all the others. Thus, the shift of power from the elected local politicians moved to an administrative body with quite extensive powers.

Similarly, in the UK, the flexible purchasers (fund-holders) have been replaced by cumbersome assemblies of GP practices, which had jointly to decide which services to purchase for their sizeable populations, while, as argued elsewhere, they possessed scant or no information on users' needs and wants.

All these changes point in the direction of strengthening control *in lieu* of creating incentives, which is the emblematic device that planners notoriously resort to in order to solve efficiency problems, despite its demonstrated failure in most sectors of the economy. In this case, it is manifested as a centralisation of purchasing and a reinforcement of regulatory grip over these decisions. Although both theory and empirical evidence suggest that trust and co-operation are essential conditions for efficient organisation of arrangements similar to those under publicly provided health systems operate (Goddard et al, 1998), these can not alone assure that these outcomes will be accomplished.

Thus, despite these initial and rather obvious changes, quite a few of the structural elements introduced by the market-oriented reforms, and even more so the changes they brought about, have been retained. Apart from the separation of providers and purchasers or planners-contractors that are to stay in both systems, further development of the costing and accounting procedures is continuing as is the establishment of quality frameworks and a refinement of the mechanisms for their evaluation. New features introduced by the reforms, such as the indexation of budgets, the freedom of choice of provider, the purchaser/producer split and the exchange between them to be based on buying and selling have, in essence, remained, but they have been renamed and diluted.

In addition, even staunch critics of the reforms have to acknowledge the positive results brought about by these relatively short-lived developments, even though they differed from the original predictions. The overall conclusion is that, on the whole, developments turned out to be different in comparison with the spirit of the reforms implemented at the beginning of the 1990s. However, they were possibly necessary in order to proceed with the changes that are now needed. The critical goals, then, were to move away from the command economy, to introduce freedom of choice for patients and to increase the efficiency and/or productivity of hospitals. While many, if not most, of the forecast developments failed to materialise, there were other important and indirect results of the reforms.

Possibly, the single most important consequence, and an indirect result of the changes that took place in the UK between the years 1991-97 and in Sweden between 1992-1996, was that the real costs involved in health care delivery were made more explicit to all the actors involved. This fact had several powerful implications.

From the start, it led to the implementation of economic mechanisms for the purpose of steering the system and the follow-up, for establishing a framework for monitoring financial activities, and for better planning of human resources. It also resulted in an increase in the use of information technology and in the auditing of clinical practice, which may have been long overdue developments,

but which were, nonetheless, introduced to support the implementation of the Stockholm Model in Sweden and the quasi-market reforms in the UK. Furthermore, it became evident that, in order to secure the likely efficiency gains, there was a need to build strong management capacities into the system, which was achieved to a degree unknown before.

Another important and, again, indirect result was the restructuring of health care, which became indispensable in progressing the reforms and also in maintaining operational efficiency within the system. For example, it became clear that the real issue in the Stockholm area was over-capacity in the number of big hospitals and beds, which, according to an executive from the Stockholm County Council interviewed in this study, *“was such a very politically sensitive area that no one dared to tackle it”*. Similar was the situation in central London, where a report on the effectiveness of the hospital sector, which used economic criteria for an evaluation of hospitals' performance, posed a threat to the survival of many and prompted some significant changes.

Additionally, the realisation of the importance of the PHC, which has been reasserted through the experience of the reforms, has served as an impetus for initiating a debate on the need for structural changes and for implementing co-operation between large and small hospitals to bring some of the changes into effect. Examples of these changes were the shift of care from specialist to primary care settings, the use of telemedicine solutions in PHC, and the introduction of outreach clinics with a back up of specialist consultants visiting primary care centres.

Another complementary and related axis of change initiated as a result of the reforms is the shift of procedures previously carried out by hospitals to the surgeries of GPs and/or the clinics of private doctors providing primary care. In this respect, the devolution of power into fund-holders' hands introduced in the UK, although abandoned, has stimulated other developments in this direction. One of its long term results is that General Practitioners became politically as well as professionally involved in quality assessment and their more proactive

role, is being discussed in Sweden, alongside the changes taking place in the UK.

The experience of the reforms also showed that the principles of reimbursement had to be generally reconsidered. The reimbursement systems used within the framework of the reforms in Sweden created incentives for under-performance by GPs, while having the opposite effect on some hospitals specialities which over-performed in order to attract as many as possible per services that were reimbursable on the per case basis. Thus, while satisfaction with the DRGs used for pricing elective procedures was widespread, they proved ineffectual for the pricing of long-term care (e.g. cancer).

The reforms also helped to reveal that hospitals, in their turn, need to provide standardised information on quality and prices and need to forecast their future developments, all in a form that can be used easily by the purchasers/commissioners and also, possibly, by the users. The reforms have highlighted this need and indicated the ways in which it could be achieved.

It was also made transparent that, in publicly provided and operated systems the first and indisputable goal of the commissioners/purchasers is to meet the needs of their populations within the given budget. Providers, on the other hand, may not necessarily agree to provide the same level of care for substantially less money. In this context, competitive elements and pseudo-market rhetoric can be an obstacle to achieving the former, as even market proponents tacitly accepted.

Additionally, the power of incentives, even those reluctantly introduced, was once again demonstrated, and both providers and users of services exercised them. As the experience made clear, providers attempted to maximise their profit, while the users strove to improve the conditions of service on their own, which was notably manifested in Sweden where the incentives were clearer and patients were less restricted to make use of them.

Finally, the increase in users' expectations were realised to a greater extent than before by doctors and planners and also policy makers. This led to the

establishment of a proper framework for the discussion of needs' assessment, of the infinite character of the demands placed upon the health care system, and of the necessity for an explicit setting of priorities. As a result, a proper debate on this subject was initiated. The counter argument quite often articulated by the respondents especially doctors in this study, is that these changes would anyway have happened even without the reforms. Nevertheless, the role of the political elites in giving shape and promoting expectations by means of implementing appropriate policies or conversely in disregarding or worse even impeding them can be crucial.

The latter was especially important for the UK where no honest and open discussion on this subject had been possible, even though the implicit rationing of care had continued unabated almost from the inception of the NHS and had become an everyday reality for most of its users (New and Le Grand, 1997). In Sweden, the fundamental problem that Stockholm Model helped to reveal was the necessity for clarification of the goals that the public system should cater for, as it became apparent that the needs of the population and the services demanded by the population did not necessarily coincide.

One way out of this situation is a return to the old issue of rationing (UK), which, while being a relatively new reality for Sweden, came in explicit form into the political arena. There is an indication that this trend is likely to be followed. Soon after the shift in policy, waiting lists reappeared and started to build up in both countries, and in Sweden, there was increased criticism of the care guarantees, which could no longer be kept. The other way out for the public sector is to provide only for determined needs that are assessed in accordance with well-defined and explicit criteria.

One of the most important issues from the point of view of this thesis is concerned with the impact of this experience. Thus the question posed is have the lessons of these latest reforms been learned? Is it really only the elements that worked kept, and were those that did not discarded, as proclaimed in the most recent NHS White Paper? In another words, is this only a superficial semblance to the pre-existing structures or do the similarities go deeper?

Some of the overall implications resulting from this experience is that the outcomes of the reforms were quite different from their proclaimed objectives and expectations. This happened partly because of half-hearted commitment by the policy makers who introduced the reforms, and partly because the goals were somehow readjusted during the process of implementation, as if prompted by a self-correcting mechanism. However, despite the fact that the outcomes of the reforms were the result of a compromise, the forces they unleashed made more explicit the structural failings of the systems in a relatively short time.

It was also demonstrated that the shift from planned system to a pro-market even a regulated or managed one is not a cost-less exercise. There is a need for good information on cost and quality specification of services both for buyers but also users and it is a time and resource consuming process to build such a system. The market oriented reforms made explicit the issue of costs involved in any genuine transformation of the system on the one hand and the costs that accrue from the specific policies (such as improvements in quality of care and freedom of choice) on the other hand.

The role of the pro-market reforms in this process although not direct served as a hallmark that highlighted the need for change while identifying some alternatives how this could be achieved. Most importantly, this experience reiterated the power and the role of incentives as policy instruments, which have to be appropriately used by the policy makers otherwise the other actors concerned may respond to them quite unpredictably. Also the need for priority setting for the level of care and type of services to be provided through public funds became explicit. It was also made clear that needs and wants of users are not synonymous which poses a dilemma about the role of the public health system and more broadly the role of the state in this process.

Despite all these rather obvious changes brought about by the market oriented reforms there are also crucial similarities to the pre-market reform period, which are attempted in the round of the latest transformations. As a result the developments during the post market-reform period in the UK and Sweden could

be characterised as a compromise between proclaimed intentions and economic necessities.

The most important is that the state openly re-assumed its role in the provision and organisation of health care, something that in both the UK and Sweden voters largely endorse while at the same time allowing for expression of their dissatisfaction at the governments' performance in the task, which they, the voters have delegated to it. I think this links into a broader consideration that has its roots in the ambivalent attachment that Western Europeans display where state provision of welfare is concerned. This leads to the acceptance of a "*one size fits all*" philosophy despite its incompatibility with the trends and progress in all other walks of life.

On the one hand, the most urgent goals in reforming the health care system, that the reforms made explicit in Sweden, was to increase efficiency and to find new ways of saving, even if it meant cutting down on the capacity of the hospitals, their duplicated accident and emergency facilities and out-patient departments. Therefore, despite the promises and commitments to the contrary, the bed capacity in the Stockholm County Council area decreased by approximately 40% during this period (Hakansson, 1999), which was achieved by shifting facilities to the day care service and merging and closing down some of the units, thus reducing the workforce employed in the health care system.

In the UK, on the other hand, the government found itself in the position of being strongly committed to living up at least to the promises of its predecessors and also to its own declarations to deliver health care of modern quality standards attuned to the developments and expectations of a post-industrial society. Initially, it was hoped that the usual "window dressing" measures, like the NHS Direct novelty, and the familiar centralisation of control would bring about the desired results in terms of savings (the latter) and increased satisfaction (the former). However, lengthy waiting lists for elective procedures and referrals to the specialists, a familiar device of implicit rationing, have made their reappearance (The Economist, 1999).

The autumn crises of 1999 in service provision of the British NHS exposed beyond any doubt the deep structural problems that were well known but not always articulated. These have their roots in the parsimonious funding and conceptual backwardness on which the foundations of the NHS rest, and which impede the functioning of the system in terms of a modern service. While the crises were nothing new - if anything, they were something of a cyclical and seasonal phenomenon - the reaction to them was novel.

It became clear that the users of health services at the turn of the century were not prepared to put up with the mentality of scarcity and below-standard quality in public service. The usual arguments of its high return, in terms of the benefits yielded for the money spent, could be no longer sustained, as it became clear that that this assertion rested on the faulty presumptions rooted in benign paternalism and were distant from many aspects of care that users considered important. This forced the government to end its procrastination and commit itself to more radical measures, such as sound investment and an examination of the different possibilities for introducing a public-private mix for both the financing and delivery of services.

Despite some tacit compromises, the developments of the post-market reform period seem on the whole to be hardly compatible with the objectives that the original market reforms attempted to promulgate, albeit with quite limited success as this study has demonstrated. Choice of provider and/or form of treatment for the users has been removed from the reforms' agendas in both countries as it seems to be no longer an issue and less so it appears to be a desirable goal.

The arguments against choice in health care and its substitution by high regulatory standards securing quality of care seem to have won, although it is known that control over health care decisions can modify attitudes and behaviours and possibly also bring about the desirable shifts in the patterns of utilisation of health care services. As far as the provision of appropriate and high quality information, a glaring omission from the agenda of the quasi-market reforms, is concerned it has been articulated as an explicit aim in the current reforms. Many more of elements regarding information for patients are

incorporated in the quality debate and patient-centred care that has achieved quite a high profile in the framework of recent developments (DoH, 1997).

However, one can be justifiably pessimistic on how far the latter can be achieved in the context of the sole reliance on the framework of targets and standards that are centrally enforced. Similar conclusions apply for the responsiveness to needs and of course they are much more reinforced when expectations of efficiency gains are concerned. To illustrate the self-evident nature of these predictions when referring to the NHS most recent changes, one cannot resist the temptation to reflect that if targets and directives were an effective method of achieving efficient outcomes than the Soviet Union's economy would have by far surpassed the United States.

12.4 Concluding remarks

To sum up, the market oriented reforms in the UK and Sweden may not have had the impact that their advocates hoped. The changes resulting from them have, nonetheless, stressed the necessity for a more elaborated approach, since they have exposed the mechanistic nature of the theoretical assumptions that underlie many of the policies concerned. In addition, they have brought to light and articulated the need for change while stimulating developments towards necessary directions.

What should then the governments of the UK and Sweden do with regard to their experience with markets in health care?

One radical but also an untenable proposal for either of the two countries in the present political context, would be to take into account the results of sound evaluations as an input in policy formulation and genuinely let the markets fulfil the tasks they can instead of retreating from them in prejudice driven by irrational motivations. If this approach was followed it would also represent a decisive shift towards much needed evidence-based policy making (Viennonnen et al, 1999). However, as the market proponents failed to embrace wholeheartedly their own policies and did not allow the reformed system to work properly, even in its quasi-

market form, it would be highly unrealistic to expect that its opponents would adopt the market philosophy without reservations.

After all rationality is but one and possibly not the most important factor that determines and shapes policy making processes. Quite often it seems policy makers are driven by deeper and less understood motives. Despite or maybe because of this they are often found to be in a position of rejecting some of the ideas in words while having to follow at least some of the key concepts in deeds despite their ambivalence about them as seems to have been the experience of markets in health care in the UK and Sweden.

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14. APPENDICES AND ANNEXES

Appendix I Indicators of the market's impact

Table1 Indicators used for measuring the impact of market oriented reforms

<i>Indicators used for measurement</i>	<i>Method of measurement</i>	<i>Source of data – UK 1990/91 – 1995/96</i>	<i>Source of data - Sweden 1990/91 - 1995/96</i>
1. CHOICE	1. Choice over the hospital site 2. Choice over the procedure (form of anaesthesia, day care)	Interviews with consultants and GPs Interviews with managers Interviews with indicative sample of patients (15-20 persons)	Interviews with the primary care providers As in the UK case where relevant
2. INFORMATION	Information on available options of surgical procedure and details about the treatment	Interviews with consultants and GPs Interviews with indicative sample of patients (15-20 persons)	As in the UK excluding GPs which are replaced by respective PHC providers (house doctors and non-operating eye specialists)
3. QUALITY	1.Waiting time at the outpatients 2. Timing of the operation date 3. Grade of the doctor/nurse seeing patient for the first time 4.Change of the attitude of doctors	Interviews with consultants and GPs Interviews with indicative sample of patients (15-20 persons) Interviews with managers	As in the UK Interviews with consultants and GPs Interviews with indicative sample of patients (15-20 persons)
4.RESPONSIVENESS-WAITING TIMES	1. Waiting times for the operation 2. Waiting time for the first specialist appointment	Interviews with eye consultants, ophthalmic nurses, GPs and managers Analysis and interpretation of hospital and departmental data if available Analysis of national league tables Interviews with purchasers and GPs	As in the UK case where relevant Interviews with consultants, eye specialists and managers Hospital and departmental data Interviews with purchasers (County Council representatives)
5. EFFICIENCY- <i>Clinical outcomes</i>	1. Readmission and complication rates in relation to improvements in visual acuity	Departmental data (case notes audit) Interviews with consultants and GPs	As in UK case where relevant
<i>Discharge policy – introduction of technology</i>	1. Qualitative assessment of changes in terms of day care 2. Quantitative data on day care	Interviews with consultants and managers Hospital and departmental data	As in case of UK where relevant
<i>Throughput – productive efficiency</i>	Number of operations in years 1990-1996	Departmental and hospital data Interviews with consultants and managers	As in case of UK where relevant
<i>Cost of the procedure</i>	Prices of service in years 1990-1996 (comparison of numbers)	Hospital and departmental data	As in case of UK where relevant

Table 2 Aspects of indicators asked of different respondent groups

	<i>Consultant eye surgeons</i>	<i>General Practitioners</i>	<i>Patients</i>	<i>Managers</i>	<i>Purchasers</i>
Choice	Modalities of treatment offered to patients	-Modalities of treatment offered to patients by providers -Choice of hospital offered to patients -Choice of provider	-Modalities of treatment offered to patients by providers -Choice of hospital -Choice of GP /family doctor	-Modalities of treatment offered to patients by providers	-Choice of provider - Choice of GP /family doctor
Information	-Information on the modalities of treatment, alternatives side effects given to patients -Information about the date of operation -Type of information and form it is given (oral/written)	-Information on the modalities of treatment, alternatives side effects given to patients (themselves and the hospitals) -Information about the date of operation -Type of information and form of it (oral/written)	-Information on the modalities of treatment, alternatives side effects given to patients (themselves and the hospitals) -Information about the date of operation -Type of information and form it (oral/written)	-Information on the modalities of treatment, alternatives side effects given to patients (themselves and the hospitals) -Information about the date of operation -Type of information and form it (oral/written)	-Information about the quality specifications -Information about the waiting times -Information about the cost of services
Responsiveness waiting times	-Waiting times for operation -Waiting times for specialist appointment -Waiting at the outpatient's department	-Waiting times for operation -Waiting times for specialist appointment -Waiting at the outpatient's department	-Waiting times for operation -Waiting times for specialist appointment -Waiting at the outpatient's department	-Waiting times for operation -Waiting times for specialist appointment -Waiting at the outpatient's department	-Waiting times for operation -Waiting times for specialist appointment -Waiting at the outpatient's department
Quality	-All waiting times -Attitude of health providers -Quality of outcomes	-All waiting times -Attitude of health providers -Quality of outcomes	-All waiting times -Attitude of health providers -Quality of outcomes	-All waiting times -Attitude of health providers -Quality of outcomes	-All waiting times -Attitude of health providers -Quality of outcomes -Other quality indicators
Efficiency	-Prices of service -Number of operations performed -Clinical outcomes -Impact on technology-day care	-Prices of service (for GPFH only) -Clinical outcomes -Impact on technology-day care	-Clinical outcomes as perceived by patients	Prices of service -Number of operations performed -Clinical outcomes -Impact on technology-day care	Prices of service -Number of operations performed -Clinical outcomes -Impact on technology-day care

Appendix II Questionnaire

Questionnaire for consultants/GPs

1. Choice

1.1 Have there been any changes resulting from reforms in choice over the procedures that are available to patients?

- a) Day care surgery option
- b) Form of anaesthesia
- c) Hotel facilities
- d) Other

2. Have you noticed any changes in the level of empowerment of your patients during the last five years, manifested for example as the wish to exercise more choice?

- a) There is a visible difference in the level of choice that patient exercise
- b) There may be a slight difference in their attitude
- c) Can not see any change

3. Do you think that after the introduction of reforms your patients are given increased choice over the preferred hospital site where the surgery can be carried out? (For GPs only)

- a) Yes
- b) No

4. If yes, which are the factors that mainly influence their choice?

- a) Travelling distance
- b) Waiting time
- c) Other

5. What are the factors that you take primarily into consideration when buying a cataract surgery service from certain provider? (For GPs fund holders only)

- a) Previous patterns of co-operation
- b) Price of the service
- c) Waiting time
- d) Travelling time
- e) Other

2. Information

2.1 Have there been any changes regarding the type and amount of information available to patients your clinic since the introduction of reforms and if so what are they?

- a) Yes
- b) No

2.2. More specifically, are patients given printed leaflet with detailed explanations referring to one or more of the following and if so are these leaflets used more commonly now?

- a) The health problem and procedure of treatment
- b) The likely post-operative complications
- c) Available options of surgery/anaesthesia

3. Quality

Waiting time to be seen

3.1. Since the introduction of the reforms have there been any changes in the waiting time at the outpatients' department?

- a) Waiting time has been reduced
- b) Waiting time has been increased
- c) There is no major change

3.2. More specifically, could you indicate approximately what is the average waiting time at the outpatients' department?

- a) Less than 30 min.
- b) Between 30 min - 1 hour
- c) More than 1 hour

Timing of the information provided to patients

3.3 Is the information also given personally by?

- a) Consultant
- b) Junior doctor
- c) Staff nurses on the ward

3.4. How far in advance are patients informed about the date of operation? Have there been any changes in this policy since 1992?

- a) > 2 months before
- b) > 2 weeks before
- c) < 2 weeks before

Change of Attitudes to the patients

3.3 In what way has the introduction of reforms influenced your relationship with patients?

- a) I can devote more time to my patients
- b) I can't devote the time I used to because of higher productivity pressure
- c) It helped me to understand that my perception of their needs may be different from theirs (i.e. in the form of procedure they may choose) and cater better to meet them.
- d) Hasn't changed

4. Responsiveness to need (expressed as a proportion of met need - through analysis and interpretation of numbers on waiting lists)

4.1. Have there been any changes in the length of waiting list for the first appointment with consultant, which could be attributable to reforms?

- a) Waiting time has been reduced
- b) Waiting time has been increased
- c) There is no major change

4.2. More specifically, could you indicate approximately what is the average waiting time for the first appointment?

- a) Less than 6 weeks
- b) Between 6 - 10 weeks
- c) More than 10 weeks
- d) Other

4.3 Since the introducing of reforms have there been any changes in the length of waiting list for the cataract surgery at your unit?

- a) Waiting time has increased
- b) Waiting time has decreased
- c) There is no major change

4.4. If yes, what actions have you taken to tackle this problem? (only for consultants)

4.5. Have the reforms affected more generally your ability to promote developments in your clinic? For example:

- a) Launching a waiting list initiative
- b) Establishing an outreach clinic

- c) Merging day care facilitates in one site
- d) Other

4.6. What in your opinion is the relation between the length of waiting list and higher efficiency (defined roughly as throughput/cost ratio) that you may have achieved at your unit?

- a) Waiting time decreases with increased efficiency
- b) Waiting time increases with increased efficiency
- c) There is no close relation between them

4.7. How far do you think can the waiting list be used as a sensitive measure of demand for cataract surgery? Would you like to suggest any better one?

4.8. Have there been any changes (probably following changes in your policy) in waiting time for second eye cataract surgery?

- a) Waiting time has increased
- b) Waiting time has decreased
- c) There are no major changes

5. Efficiency

Throughput

5.1 Have there been changes in number of operations performed since the introduction of reforms at your clinic?

- a) Yes
- b) No

5.7. If a) is yes, has there been decrease of length of stay (please define) that is mainly due to:

- a) Changes in trends of discharge policy
- b) Introduction of new technology (please name)
- c) Other

5.8. Is there any relation between the decrease of length of stay and readmission or complication rates?

5.9. Have you changed the range of treatments in comparison to what you did before the introduction of reforms or have you introduced or increased one or more of the following:

- a) Day cataract surgery versus inpatient surgery
- b) The use of local anaesthesia
- c) Phacoemulsification technique of cataract extraction
- d) Other

5.10. If the answer to the former question is positive, than how far would you attribute the changes in new forms of treatment to the introduction of the reforms and how far to the diffusion of new technology?

a) It is entirely attributed to the introduction of reforms as a) and b) have been proved to be more cost-efficient than previous forms of treatment and therefore reforms have significantly speeded up their use.

b) There is an impact of reforms on introduction/wider use of new forms of treatment, although there is rather indirect relation between those two

c) New forms of treatment would have been introduced regardless of the reforms

5.11. Do you think that the element of competition introduced among competing self-managed trusts had enabled you to adopt and/or experiment with some new forms of medical technology? If yes, please specify

5.12. Have the reforms simplified/made more difficult the follow up of your work and its evaluation? (e.g. through the use of clinical audit)

Cost of the procedure

5.13. Do you have an idea of how reforms influenced the cost of each operation at your clinic?

a) Increased b) decreased c) hasn't changed

5.13. Have you put in practice different ways of saving at your clinic, which in your opinion result from reforms? If yes, name the main.

5.14. How have been the aspects of reforms introducing market mentality accepted at your clinic?

a) Enthusiastically

b) Positively

c) With reservation

d) Negatively

How would you explain this?

5.15 Have reforms brought an increased profitability mentality to your clinic? If yes, can you give examples how this mentality has changed behaviour at your clinic? For example are the economic calculations made more frequently now than previously?

5.16. Have reforms caused your clinic to run at a profit?

If yes, what do you intend to do with this profit? For example would you buy new equipment?

Appendix III Characteristics of the samples of respondents

1. General Practitioners in the UK and Sweden

Box 1.1 Sample of the site T (n=5) all non fund-holders, four male and one female

- *GR a member of a practice run by two doctors with a list of 4 000 patients working there for five years in an area that is "not a very typical inner-city with mixed population and not very many ethnic minorities, a relatively well defined community and not high level of deprivation".*
- *bUN working for 4,5 years in a practice shared with two other colleagues who referred 1/3 of his patients to the hospital T.*
- *AR, single-handed practice, retired one year after reforms' introduction, a GP for 40 years, non fund-holder. He was introduced by one of the interviewed consultants eye surgeons and willingly volunteered to be part of the study which was considered a contribution to sample's diversity.*
- *KS, working for 2,5 years in this particular practice but being a GP from 1985. Referring patients "always to the Moorfields (Eye Hospital) as it is the closest".*
- *PW, working for thirteen years as a General Practitioner, in a six partners practice, s/he is also working part-time at the university (he sees only 700-800 patients a year).*

Box 1.2 Sample of the site S (n=5) four non fund-holders, one fund-holder and all male.

- *RE was a General Practitioner for 14 years, from Redhill in a practice with six partners, a non fund-holder.*
- *TR a General Practitioner for 10 years, in a practice with three partners, worked before in another two practices in the area (one consisted of two partners and one was single-handed), s/he is a GP in one of the deprived areas of the sample S and is a non fund-holder.*
- *NO a General Practitioner from deprived part of S with five partners in the practice, non fund-holder.*
- *AU an Australian, a General Practitioner since 15 years, in a practice with five partners and a middle deprivation area, soon to become a fund-holder.*
- *OL a General Practitioner for 30 years from a well to do part of S in a four partners practice, is the only fund-holder represented in this sample.*

Box 1.3 Sample of the site U (n= 6) three non-fund-holders, two fund-holders, one to become a fund-holder in April. Three male and three females.

- *DC General Practitioner from 1982, worked in two practices before, In this practice (which is situated in the residential part of U) there are six GPs of which four are fund-holders of the second wave, they all share list of 9000 patients. She could not say whether people moved while claiming "we do not loose too many patients because of high satisfaction".*
- *GG fund-holder since three yeas in a practice of three partners situated in a middle class area*
- *PE General Practitioner since 1969, the practice situated in an affluent part of U ("at least 50% of practice's patients have also a private insurance"), in April will become a fund-holder.*
- *LB a General Practitioner for thirteen years, single-handed practice in a middle class area, non-fund-holder and active participant in alternative purchasing schemes.*
- *CA a General Practitioner for fifteen years, in a practice situated in well to do part of U with two non-fund-holder doctors and 6000 patients.*
- *HW a General Practitioner since thirty years, a non-fund-holder in a practice with three partners in the big health centre shared with other group practices and 8,400 patients.*

Box 1.4 Sample K (n=5) Sweden (three male and two female)

- *MK works 20 years as a GP, has some organisational experience in healthcare and teaches Community Medicine at Social Medicine Department. Her practice has quite a lot of old people and she is also responsible for social, crisis line and preventative care.*
- *NB is a foreign doctor, Greek and works as a GP for 3 years. Before he was a paediatrician and specialist in internal medicine for 10 years in total. He sees a lot of ophthalmic patients, as there are many elderly in his practice.*
- *PG is a GP for 21 years and worked in different places (he came in 1993 from Norway. Currently a private GP in the area where the majority of the population comes from the countryside (numerous islands of Stockholm Archipelago) with very low density of population. He sees about 400-500 patients monthly and is assisted by one nurse. The premises are rented from County Council for one or two years.*
- *JS is a medical ophthalmologist who is specialised in medical retina. He explained that many people go to the ophthalmologists to check their eyes regularly and are then referred for specialist care when needed. The only cost they incur these to pay a fee of 180 SEK with the full cost being reimbursed by the County Council.*
- *CH is a nurse working for about a year in the eye services and app. 20 years in health care.*

2. Consultant eye surgeons in the UK

Box 2.1 Consultants characteristics in England samples S, T, U and P

Sample S	Sample T and U	Sample P
<p>1. HS is a clinical director, has been a consultant for 10 years. She is Irish, in her early forties.</p> <p>2. DA has been a consultant for three years, is in his late thirties, and is an Asian male.</p> <p>3. AL has been a consultant for one year, is in his late thirties, British male.</p> <p>4. JO is a service grade associated specialist but with significant experience. Suggested by the clinical director. He is in his mid-thirties, British male.</p>	<p>1. BL, male, mid-forties, consultant since 3-4 years.</p> <p>2. MJ, male, mid-fifties, consultant since 10-15 years.</p> <p>3. CD, woman, early forties, clinical director, consultant since 10 years.</p> <p>4. MH, male, early forties, a consultant since September 1995.</p> <p>All are of English origin and all except for MH worked in both T and U (following the recent merging of some of their functions) in 1995/96.</p>	<p>Clinical Director who is working as consultant for more than 10 years a woman in early-mid forties, British of Caucasian origin with very foreign surname.</p> <p>2. A woman working as consultant for more than 15 years. She is a Sri Lankan approx. 50 years old.</p> <p>3. The most recently appointed, aged 37 is a Jewish man (he insists on his religious identity)</p> <p>4. British Caucasian male in his early forties recently appointed.</p>

Box 2.2 Consultants' characteristics – Sweden Stockholm Eye hospital

MH - Clinical Director since 10-12 years, already a medical director of the whole hospital in Karolinska since 1982 a male, 60-65 years old.

WS - Anterior segment surgeon since 20 years, worked before in 3 other hospitals a male in mid-forties.

BP - Anterior segment surgeon for approximately 20 years a male in mid-fifties.

CZ - Anterior chamber surgeon for 15 years, a woman in early forties.

BC - Deputy Clinical Director, anterior chamber surgeon for 30 years, a woman in mid-fifties.

*BC - A woman in mid fifties a senior eye surgeon, vice president of the hospital
All eye surgeons were Swedish.*

Annex I Audit results on clinical outcomes in hospital P, UK

Box 1: The impact of age, gender, technique and surgeon's grade on clinical outcomes

Age	Gender	Pre-op. V.A.	Post-op. V.A	Technique	Surgeon's grade	Discharge Period	Complications/type
76	1	6/11	6/6	1	1	8 hours	0
70	2	6/9	6/9	1	1	8	0
79	2	6/12	6/6	1	1	2	0
84	2	6/36	6/18	2	1	9	0
62	1	C.F.	6/9	1	1	2	0
62	1		6/18	1	1	4	0
89	1	C.F.	6/9	1	1	2	0
85	1	6/36	6/9	1	1	8	0
83	1	6/18	6/9	1	1	4	0
66	1	6/60	6/5	1	2	8	0
76	2	6/24	6/9	1	1	4	0
64	2	6/18	6/9	1	1	4	0
80	2	6/18	6/12	1	1	8	0
81	2	6/9	6/12	1	1	8	C.M.O.
61	1	9	6/5	2	2	8	0
81	2	6/18	6/12	2	1	9	0
81	1	6/24	6/18	1	1	8	D.R.
9	1	6/9	6/6	2	2	8	0
87	2	C.F.	6/12	2	1	9	0
61	2	6/18	9	1	1	9	0
78	2	6/12	6/9	2	1	8	0
61	2	6/9	6/9	1	1	8	0
83	2	6/24	6/9	1	1	4	0
68	1	6/12	9	2	1	9	0
72	1	6/24	6/9	1	1	2	0
9	2	6/12	6/24	2	2	8	0
64	2	6/12	6/9	1	1	8	0
82	1	C.F.	6/9	1	1	6	0
79	2	6/60	6/9	1	1	8	0
90	2	6/60	6/12	1	1	8	0
84	2	6/18	6/9	2	1	8	0
86	2	6/36	6/6	2	1	8	0
76	2	6/9	6/9	1	2	6	0
79	2	6/12	6/9	2	2	8	0
77	1	6/12	6/9	1	1	8	0
64	1	6/12	6/18	2	1	8	0
79	2	6/18	6/9	2	2	8	0
82	1	6/9	6/9	2	1	8	0
76	2	C.F.	6/9	1	1	8	0
89	2	C.F.	6/9	1	1	4	0
60	1	H.M.	6/12	2	2	8	0
84	1	6/60	6/60	2	1	8	0
64	1	6/18	6/18	2	1	4	0
72	1	H.M.	6/9	2	2	2	0
71	2	C.F.	6/9	1	9	8	0

Source: Data from the Eye Unit in hospital P

C.F. Counting fingers, H.M. Hand movements, C.M.O. Cystoid macula oedema, D.R. Diabetic retinopathy

Annex II Indicators of clinical outcomes used in Sweden

Box 2: Indicators of clinical outcomes for cataract surgery used in Sweden

- *Visual acuity, which is simply translated as "sharpness of vision" (continuous recording of all patients with different visual acuity groups).*
- *Frequency of resulting complications, such as iris prolapse or vitreous loss that results in 'leakage', calculated as percentage of total operations performed (the use of special instruments for removal of vitreous defines the latter condition).*
- *Patients' satisfaction survey applied in the six-month period after the operation for every tenth patient and measuring his/her perceived benefits from surgery.*
- *Clinical programmes for quality and programmes for quality monitoring which involve a follow-up of the cataract operation every 2-3 months*

Source: Swedish Medical Association, 1994