Understanding clinical autonomy through discretion: The case of NHS England

Puren Aktas
Department of Politics, The University of Manchester

MANCHESTER 1824
The University of Manchester

HOPE
Health Organisation, Policy & Economics

POLICY BACKGROUND

- Payment by Results (2008/9): Built upon diagnosis-related groups
- Clinical coders responsible of translating patient notes into ICD-10 diagnosis codes
- The English NHS is moving away from PbR towards block contracts – ongoing process

BACKGROUND

- Clinical decision-making
- Clinical autonomy – Space of discretion over diagnostic and treatment decisions (Harrison, 2015)
- Scientific-bureaucratic medicine
- Response of clinicians: gaming the system in the context of top-down regulations through their clinical autonomy

- Gap in the health policy literature on the interaction of organizational and individual factors shaping clinician discretion and the space of discretion

- Thomas theorem

- Schaffer (2015): Elucidation approach highlights a need to locate discretion of clinicians within the context of particular organisational reforms

RESEARCH QUESTIONS

- How do activity-based hospital reimbursement models in England shape the delivery of healthcare services as perceived by physicians?

- Which strategies do physicians adopt when reimbursement regulations conflict with the priorities of physicians?

RESEARCH DESIGN

- Semi-structured interviews
- 13 clinicians at English NHS hospitals (+4 interviews with local managers)
- Recruitment approach:
  - An announcement was sent to UoM Faculty of Medicine mailing list
  - I went through several hospitals' websites and sent emails to clinicians who fit to inclusion criteria (over 10 years experience)
  - Snowball sampling: Through my research group & previous interviewees

FINDINGS

- The PbR: '[…] Does not reflect good clinical practice'.
- An imbalance between reimbursement amounts and costs. Inadequacies in the tariff do not have any direct impact on the quality of healthcare services provided to patients, but related to departmental costs
- Problems caused by the divide between primary care and secondary care

- Clinical decision-making: Heavily consultant-led; 'informed patient' input
  - 'It's about doctors, patients, and their interaction with each other. […] It's about the benefit versus harm, and what are you trying to achieve. […] It's not a money thing it's just a harm thing.' (Consultant Paediatric Oncologist)
- Deviation from guidelines are based on medical knowledge
  - 'If we deviate from the care pathway, we always have discussions with our colleagues and those discussions are documented […]. It's not one random consultant deciding that 'I'm going to play this way'; it is still regulated.'
  - (Consultant Paediatrician)
- Multiple factors shaping clinical decisions: individual to clinician; individual to patient; institutional/organisational

- Policy restrictions – NPM mechanisms and hospital reimbursement regulations

- How are clinicians able to make decisions freely, under these challenges?

- ‘Adjusting coding’ as routine practice
  - ‘Coding doesn’t necessarily always recognise the kind of things that those patients would come in with. So, patients might come in with very, very vague symptoms of, you know, just not being quite right.’ (Medical Oncologist)
  - ‘I can sometimes make it sound more complex than it might be to get some patients treated.’ (Consultant Urologist, ENG_C8_Dec21)
- Reimbursement responsibilities allocated to the management
  - ‘Personally, if I deviate from the pathway, and if it has financial complications or financial implications for the trust, I would expect them to pick it up. […] Ultimately patients come first and last for me. (Consultant General Surgeon)

- Multiple stop care pathway to bring more money to the department

  ENG_C11_Dec21: It's actually, you bring in more money if you see them [patients] just at the appointment to examine, and bring them back for the scan, and then bring them back for a treatment or therapeutic option. If you just at one stop shop, which is best practice, you get less money for your trust.

  (Consultant in Community Gynaecology)

- Changing the care pathway described by the PbR: Collective decision-making

CONCLUSION

- Clinicians as ‘citizen-agents’, ways to work around regulations
- Clinician discretion to alleviate the workload, overcome bureaucratic structures such as time-consuming paperwork, provide the appropriate care to the patients
- Discretion granted by clinical autonomy, derived from their medical expertise – ‘Workarounds’
- Situating discretion within a complex web of individual and organisational factors allows us to understand how clinicians perceive and react to similar policies within different contexts, emphasising an elucidation approach in street-level bureaucracy research

Thank you!

Questions & comments?

puren.aktas@manchester.ac.uk