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Accounting Forum 30 (2006) 359–376
ACCOUNTING FORUM
www.elsevier.com/locate/accfor

Delivering patient choice in English acute hospital trusts

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Abstract

The role of the patient within the NHS has changed from supplicant to consumer to active participant. A demand-side patient-led approach is combining quasi-consumerism and participative democracy to inform and facilitate patient choice. On the supply-side funding and incentives coupled to reform and performance will deliver additional hospital capacity and patient choice. This paper argues from both a demand and supply-side perspective that there is a large gap between the rhetoric and reality of delivering patient choice in acute hospitals.
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Keywords: NHS reform; Patient choice; Public management; Acute hospitals

> The NHS now has the capacity and the capability to move on from being an organisation which simply delivers services to people to being one which is totally patient led—responding to their needs and wishes.
>
> (Department of Health, 2005, p. 5)

1. Introduction

Patient choice within the UK National Health Service (NHS) is a hybrid, a combination of quasi-consumerism and participative democracy. While the new arrangements could become the basis of a self-sustaining and beneficent system (Luhmann, 1995; Morgan, 1997), the argument here is that that these reforms designed to bring greater choice to the patient are technically and practically flawed. It is not our intention to argue for or against patient choice because on balance we are 'for' it in principle but we have reservations in relation to what 'choice' means within the NHS at the present time.

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doi:10.1016/j.accfor.2006.08.004

Over recent years the role of the patient within the NHS has formally changed from supplicant to consumer to active participant and the current focus reflects one aspect of the current apparent shift by the British government from bureaucratic control of the unitary state to governance by networks (Rhodes, 1997, 2000; Stoker, 1999, 2000; Bevir & Rhodes, 2003, p. 41). Our reservation as to whether this shift to networks is actually happening is not to deny that a serious attempt is being made, for instance, with the establishment of Foundation Hospitals, and a whole range of public–private partnership programmes and initiatives. Rather, while the organisational form may be network-like its control and management reflects external hierarchical control or what Courpasson (2000) has labelled 'soft bureaucracy' (see also Courpasson & Reed, 2004; Sheaff et al., 2003, 2004). This concept of 'soft bureaucracy' Courpasson informs us, is one that 'tries to express the emergence of a political *centralization* of organizations, in line with the development of *decentralized* ways of conducting their activities. . .' (2000, p. 155 *emphases added*). It is also called 'soft' because of its legitimation, which may be one of more of the following (2000, p. 158):

1. *instrumental*—being based on impersonal indicators, e.g. performance indicators;
2. *liberal*—being external, credible but 'soft' coercion, e.g. clinical governance;
3. *political*—resting with the 'trust board'; governors or other governing body.

'Soft bureaucracy' describes those autonomous public sector organisations, including hospitals, clinics and general practices, which are constrained by a regulatory framework that attempt to ensure some commonality in the standard of services but without the need for direct controls. Patient choice is part of the 'soft bureaucracy'.

In 'The NHS Plan' (Department of Health, 2000) the Government outlined its commitment to an increase in funding for the NHS. In real terms funding would increase to a level in GDP of roughly 8% so bringing financial commitment to a level equivalent to the European average. This funding commitment was coupled with accountability to ensure treasury and regional political interests were satisfied in respect of sound financing, value for money and an efficient allocation of resources.

> The provision of substantial additional resources for the NHS makes improvements in the system of public accountability more necessary. The NHS now needs to more coherently account for how resources have been used and how performance has improved, both nationally and locally.
>
> (Department of Health, 2002, p. 37)

Consolidating the Audit Commission function, National Care Standards Commission and Commission of Health Improvement (CHI) into one body the Commission for Healthcare Audit and Inspection (CHAI) served a dual purpose; simplifying the process of inspection and consolidating a financial treasury audit function with clinical performance and accountability to the patient. Within CHAI the interests of the Treasury could also be consolidated with those of the individual patient/taxpayer. However, at a local level it is the Primary Care Trust (PCT) that will be charged with disbursing over 70% of NHS funding and will be required to publish an annual prospectus which will inform local GPs and patients about hospital performance.

> This will mean that for the first time, citizens will have independently validated information about how their money has been spent on healthcare in their own area and what progress has been made. The prospectus will outline future plans, and explain how people can get

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