

Paying he who pays the piper: who calls the tune now? Incentives for commissioners of health care

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Abstract

The NHS White Paper ‘Liberating the NHS’ and subsequent legislation proposals have outlined the government’s intention to establish Clinical Commissioning Groups (CCGs). These will be led by General Practitioners and will receive a fixed budget based on weighted capitation for commissioning hospital care services for their registered populations. They will be paid a ‘quality premium’ for improving the quality of patient care and the outcomes this leads to including reducing health inequalities provided these improvements are achieved within budget. As the NHS moves further from PCT to GP-led commissioning, renewed consideration will need to be given to the incentives facing these new purchasers of secondary care. These new groups have some features in common with (and some that are distinct from) their predecessors; GP fundholders and practice-based commissioning consortia. Beyond these examples, relatively little is known about the use of incentives for purchasers in the UK NHS setting. We have reviewed the international evidence on the use and consequences of incentives for health care purchasers and identify lessons for Clinical Commissioning Groups (CCGs).

We find that purchasers face three broad categories of incentive: regulated competition for members; explicit financial incentives; and public reporting of performance information. We found that many systems have looked to competition between purchasers to drive quality and efficiency and that, unsupported, the market mechanism may have limited scope to increase quality. We found that there are very few examples in which the purchasing function has been financially incentivised, but there may be evidence to suggest that purchasers will react to such explicit incentives. Evidence on public reporting suggests that it is under-utilised by individuals and that this is caused by various factors including heterogeneity across purchasers and providers. We have also found clear evidence that GPs have responded to financial incentives in the past and that such incentive structures need to be designed with vigilance.

Evidence from GP fundholding and Practice-based commissioning has demonstrated that GPs control costs more tightly when they are moved closer to the consequences of budgetary decisions. There is also clear evidence that GPs respond to financial incentives. However, there may be cause to be sceptical as to whether broader system reforms are creating clear and strong incentives for purchasers of health care. Besides from the quality premium, for which the details are not yet fully understood, the extent to which the purchasing function in the NHS is incentivised looks set to remain broadly unchanged.

Introduction

The NHS reorganization will see the introduction of CCGs to whom fixed purchasing budgets will be allocated on an annual basis. These CCGs will be GP-led and will purchase healthcare for their registered populations. Past schemes such as GP Fundholding and Practice-based Commissioning have allowed GPs to purchase healthcare for local populations. However, CCGs are unique as they will be mandatory, and will be allocated 'hard' budgets. The incentive structure faced by these CCGs is unique and, in particular, they are set to be paid a 'quality premium' for achieving certain outcomes.

The incentive structure will be required to support CCGs to ensure that they purchase and deliver high quality patient care within the fixed budget they are allocated. This incentive regime is set to use a combination of financial and non-financial incentives. It should aim to facilitate the effective delivery of functions within the available budget and promote achievement of other stated objectives, such as minimising health inequalities. CCGs and the NHS as a whole are facing an unprecedented period of resource constraint as the government engages in reducing the deficit. The coalition government has promised modest real increases in annual NHS funding. However, such modest increases require the NHS as a whole to make unprecedented annual productivity gains of 6 percent over (at least) the course of the parliament in order to maintain quality (Appleby et al. 2010). In this paper, we describe the principles that should underpin incentive regimes and assess how regimes that have been adopted nationally and internationally compare to these principles.

This paper is organised as follows: Firstly, we describe purchasing organisations, their functions and the incentives they are subject to. Second, we describe how CCGs fit into this framework. We then assess evidence from the NHS and abroad in relation to how the commissioning function is incentivised. Then, we consider how GPs as providers have responded to financial incentives. Finally, we consider the implications for the incentives faced by CCGs given the NHS reforms.

What are purchasers and what incentives do they face?

Incentives are rewards or penalties designed to induce one set of economic agents to act in such a way as to produce results as desired by another economic agent (Black et al. 2009). Generally, in health care, purchasers (also known as commissioners) are economic agents responsible for purchasing health care services from health care providers on behalf of specific populations.

What strategic purchasing roles will CCGs need to perform?

In short, there are three principal components to strategic purchasing (WHO 2009): (i) what interventions to buy; (ii) from whom to buy them; (iii) and how to buy them.

Considerable analytic progress has been made in advising on what interventions to buy. The notion of cost-effectiveness enjoys widespread acceptance as an appropriate technical basis for priority setting, and some developed countries have put in place health technology assessment agencies to make the principle operational (Drummond et al. 2005). However, setting health service priorities is an intensely political process, and many countries and their purchasers find it very difficult to make explicit the limits to the services being offered. When the national health basket is specified explicitly, local purchasers are rarely given a great deal of autonomy to alter it, except perhaps at the margin.

Commissioning is a weak function in most health systems. The reimbursement of providers is passive, involving payments for services rendered and little systematic effort to limit the range, volume or quality of

those services. Crude mechanisms may be used, such as lists of approved services, global budgetary limits and various types of quality assurance and accreditation.

What form do strategic purchasers take?

Strategic purchasing takes many different forms. It is possible to distinguish five broad categories of purchasing arrangements. In practice, most health systems in developed countries rely on a mix of such arrangements. However, it is usually possible to identify a dominant model in use: (i) private health insurers such as the United States who compete for business from individuals or organizations; (ii) employment-based social insurers, the Bismarck model still in use in Japan; (iii) competitive social insurers, a variant of the Bismarck model which introduces competition into social insurance, is used in Germany, the Netherlands and Switzerland; (iv) local health authorities are organizations charged with the local implementation of national health insurance which exists presently in the UK, New Zealand, Canada and various other countries; and (v) local government systems are systems in which local governments are responsible for statutory health care, such as in Sweden and Finland, and these local governments are accountable to local populations usually through electoral processes.

Holding commissioners to account: (i) Performance information

The breadth and quality of performance information is central to the effectiveness of accountability arrangements. Without extensive, high quality and timely performance information, it is rarely possible for citizens, patients, governments or regulators to hold commissioners to account. At the very least, public reporting of performance offers the prospect that the media, patient groups, healthcare professionals, researchers and individual citizens can scrutinize and comment on the effectiveness of commissioning arrangements. Comparative performance information should also act as the fundamental tool with which those charged with governing the commissioner are able to hold management to account. Whilst proponents of public reporting have explained its merits, the effects they hope it will stimulate rely on a set of assumptions (Rosenau & Lako 2008): (i) that good quality information about health plans, hospitals and physicians can be created; (ii) that no barriers to accessing and using this information exist; (iii) that the format in which the performance data are presented is comprehensible to the consumer such that she can make informed health care choices; (iv) that the information is trustworthy; (v) that the information provided fully captures dimensions upon which consumers make their health care choices; and (vii) that consumers actually use the information provided when making their health care choices. It is crucial to take such assumptions into account when considering that competition supported by public reporting might drive the efficient delivery of high quality health care.

Holding commissioners to account: (ii) Mechanisms

The two main external mechanisms for holding commissioners to account come from markets; and national governments and their regulators.

Markets - The pressures from markets arise when individuals, employers or other collectives have the option of changing purchaser when they are not happy with the incumbent. The incentives under such arrangements are crude but clear, taking the form of lost business, market opportunities, and ultimately business survival, if performance is poor. Whilst such contestability is likely to offer important pressures for quality and efficiency improvement, experience has shown that excessive reliance on markets in health insurance can

lead to adverse unintended consequences (Propper et al. 2008). In particular, in the absence of good clinical outcome data, insurers may place a low emphasis on clinical quality, instead focusing on visible characteristics (such as the availability of high technology equipment) likely to attract the target membership. Competition has also led to widespread evidence of insurers seeking to 'cream skim' healthier insurees, and to avoid higher risk patients, even in social insurance systems (Daley & Gubb 2007). Furthermore, the short time horizon associated with the enrolment period can militate against integrated care and preventative interventions.

National government and regulation - Whatever the design of the health system, national governments have an important stewardship role to play in assuring proper governance of all aspects of the system. They can place direct incentives on commissioners in the form of payment mechanisms, managerial rewards, and career advancement. Furthermore, they frequently put in place regulators to monitor the performance of commissioners. Whilst this function is necessary in most types of health system, it is especially important when those commissioners are local agencies of national government, as in the English NHS, for which there is an absence of direct market or democratic accountability. It is likely that the most effective regulation occurs when the regulator has genuine independence of government, as it will at times have to report poor performance by the government's own agencies.

Commissioner autonomy

A key consideration is whether the commissioner has some real autonomy over the actions it takes. The major dimensions of autonomy relate to the three main purchasing functions: the freedom to specify the benefits package; the freedom to influence the providers used by patients; and the freedom to amend payment schedules. Examples of limitations on the purchaser's autonomy include: (i) traditional systems of social insurance in which patients have complete freedom over which providers to seek care, inhibiting the ability of purchasers to direct patients to preferred providers; and (ii) systems of competitive social insurance in which the package of care and insurance premium is set by the national government. Commissioners may then be able to compete only on relatively marginal aspects of services

Of course, some of these constraints on purchasers may serve useful purposes, for the benefit of patients and payers, and may therefore be appropriate in some settings. However, if pursued to excess, the autonomy of commissioners is inhibited to the point where it has little meaningful scope to promote improved health system performance.

What kind of strategic purchaser will CCGs be?

The proposed health reforms are intended to implement the devolution of power and responsibility for commissioning services to local clinical commissioning groups (CCGs) (Department of Health 2011b). Primary care trusts are set to be phased out and their functions will be performed by: a centralised NHS commissioning board with powers to commission primary medical care services, dentistry, community pharmacy, specialised services and primary ophthalmic services; and CCGs which are expected to commission the majority of secondary care services including emergency care.

CCGs will be allocated budgets by the central NHS commissioning board by the use of weighted capitation resource allocation formulae based on data from the patient lists of their constituent practices. CCGs will be held responsible for the health of local populations including individuals not registered with a constituent GP practice (Department of Health 2011b). CCGs' main objectives are expected to be (Department of Health 2011a; Department of Health 2011b): (i) to manage the combined commissioning

budget of their constituent practices which comprises ensuring that revenue and capital expenditure do not exceed separate limits set for each year and ensuring that administrative costs do not exceed a proportion of the budget; (ii) to allocate resources efficiently to improve healthcare and health outcomes; (iii) to assist and support the NHS Commissioning Board in improving the quality of primary care; (iv) to provide information to the NHS Information Centre for the purposes of monitoring performance; and (v) to obtain clinical advice in relation to commissioning activities. CCGs will be accountable to the NHS commissioning board for their use of resources and for the outcomes resulting from their commissioning choices.

Initially, the plans seemed set to allow each practice, in principle, to join any CCG. However, this has been restricted as CCGs need to have 'sufficient geographical focus' for adequate agreement and monitoring of contracts for locally based services (e.g. urgent care services) (Department of Health 2010a), and for coordination with local institutions such as the proposed local health and wellbeing boards. CCGs will also need to be of sufficient size to allow for risk-sharing arrangements across practices.

The NHS White Paper proposed that a commissioning outcomes framework would be developed to allow CCGs to be accountable to the NHS Commissioning Board whilst simultaneously displaying to patients and local communities how and where they are increasing quality. It would also permit CCGs to identify priorities for improvement. At present, it is planned that the COF will become operational from April 2013. The COF is intended to be an important component of the wider accountability framework of the NHS. CCGs will be accountable to the NHS Commissioning Board and the legislation gives the Board a duty to undertake annual assessments of how effectively CCGs are meeting this range of duties. The framework also enables the Secretary of State to hold the NHS Commissioning Board to account for achieving certain levels of ambition where they have been agreed (Department of Health 2010c). Together, the Secretary of State and the NHS Commissioning Board will use a set of principles to underpin the negotiations about what the levels and pace of delivery should be.

The National Institute for Health and Clinical Excellence (NICE) in conjunction with the NHS Commissioning Board are developing quality standards which will set out the evidence based characteristics of a high quality service for a specific conditions (Department of Health 2010c). These quality standards will look across several of the domains of the NHS Outcomes Framework. The NHS Outcomes Framework is a key component in the NHS system-wide strategy for quality improvement and spans five domains (Department of Health 2010c): preventing people from dying prematurely; enhancing quality of life for people with long-term conditions; helping people recover from episodes of ill health or following injury; ensuring that people have a positive experience of care; and treating and caring for people in a safe environment and protecting them from avoidable harm. Drawing on the quality standards adopted by NICE, the NHS Commissioning Board will translate these national outcomes into outcomes and measurements that are useful at the local level in the COF. Certain elements of the COF will determine the quality premium paid to CCGs, which, it is proposed, will represent a proportion of GP practice income (Department of Health 2010a). These 'quality premium' payments for outcomes would be allocated to the CCGs, which will then be free to determine how they apportion it between their constituent practices. The exact details relating to the quality premium are yet to be published.

The health reforms have stated that Monitor will regulate the health sector. Licensing is the primary instrument by which Monitor can collect information to set prices, promote competition and safeguard the continuity of services (Department of Health 2010a). Monitor will also have a range of enforcement levers available including the power to fine providers (up to 10% of turnover) for failing to comply with license conditions and possibly powers to suspend or revoke a license for failing to comply with its conditions (Department of Health 2010a). The regulator is expected to use enforcement mechanisms to tackle practices, in particular anti-competitive practices, which do not promote and protect patients' interests. Monitor will

also have powers to charge providers fees to cover the costs of licensing available, and is expected to work closely with the quality control regulator – the Care and Quality Commission (CQC).

In sum, CCGs are set to be a form of local health authority; charged with the implementation of national health insurance. At present, however, the exact rules on geographical organisation are not completely clear. CCGs will be required to purchase health care efficiently from providers in order to meet the local population health needs within their allocated budgets; improving population outcomes and the quality of care. They will each have a governing board which includes an ‘accountable officer’ who will be held to account by the NHS commissioning board based on published performance information (the COF). It is also argued that CCGs will compete for enrolees and that this contestability will increase incentives to efficiently deliver high quality care. Experiences in countries that have introduced competition into their health system (such as risk selection) have demonstrated the importance of regulation in competitive health care markets. The regulator, Monitor, is charged with ensuring that competition in the NHS is harnessed to benefit patients. This might, for example, include ensuring that CCGs purchasing decisions are not anti-competitive.

Evidence on incentivising the commissioning function

In seeking to obtain relevant research for this assessment, we asked an information specialist to search for literature on the following countries: Australia; Germany; the Netherlands; Switzerland; the United States of America; and the United Kingdom. We did not adopt a specific search strategy as one might expect in the construction of a systematic review. Instead, we primarily sought descriptive literature of the incentives faced by commissioners of health care in different health systems and, where possible, analysis of the effects of any changes in the incentives faced by commissioners. We were also interested in the implications of past experiences of English GPs facing pay-for-performance types of incentives. We utilised the knowledge base within the research team to find relevant literature, and we allowed this knowledge base to inform the searching undertaken by our information specialist. The remainder of this section describes the key findings taken from a review of the literature.

Public Reporting

There have been many quality reporting initiatives in the US. Performance information is readily available to individuals in the US including data on insurance plans, individual physicians and hospitals. There has been robust debate as to how the information is reported, what dimensions are measured and how they are measured (Marshall et al. 2003). Evidence cited by Marshall et al. (2003) demonstrates that individuals in the US do not engage with performance information – that individuals do not search for it, have difficulty in understanding it and under-utilize it. A systematic review recently undertaken by Fung et al. (2008) found mixed evidence as regards the effect of public reporting on outcomes. The effects on some dimensions of performance, such as patient safety and patient satisfaction, remain unknown because few studies have assessed these dimensions of care. Most studies focus on mortality rates and cardiac treatments for hospitals. There is clear evidence that quality reporting initiative brought about, in some cases, unintended consequences. For example, a retrospective cohort study of American data demonstrated that insurance plans with lower performance scores were more likely to withdraw from voluntary publication of performance information than those plans with higher ranking scores. Fung et al. (2008) provided potential reasons for the imbalance between the interest and resources being directed towards public reporting and the evidence regarding its effects. Effective public reporting requires a reporting system appropriate for its purpose. Poorly constructed report cards may weaken individuals’ grasp of performance measures and

distort individuals' capacities for meeting their goals. Fung et al. (2008) propose that a long term strategy to simplify and standardise reporting is required to affect a rise in engagement with quality information resulting in an increase in the incidence of choices based on quality criteria. Heterogeneity of quality reports across providers and insurers in the United States further complicates matters for individuals seeking to make informed choices regarding their consumption of health care.

Regarding hospitals in the Netherlands, evidence suggests that a third of Dutch consumers report that quality ratings are not available for the hospitals that they seek to access (Rosenau & Lako 2008). However, Rosenau & Lako (2008) suggests that presentation varies widely, as does the rating systems used across providers and insurers; and there is little evidence regarding whether the capacity to use performance data to make optimal choice varies across population groups. Whilst focus groups and large representative studies have implied that consumers want performance data to be available, there is also evidence demonstrating that the extent to which consumers actually use this information is limited – and that health researchers have been seemingly reluctant to report this result in their research (see Fung et al. 2008). Like in the US, evidence from the Netherlands suggests that divergence of hospital ratings is unsettlingly common. If the agencies that are being relied upon to provide consumers with insurer and provider data are offering inconsistent and unfamiliar information then it will be tremendously difficult for consumers to make 'optimal' choices. For example: location, familiarity, and physician advice (not quality metrics) have been shown to be very important factors that consumers consider in their health care decisions (Rosenau & Lako 2009).

In Switzerland, information as regards insurers is disseminated to individuals through the media and journals such as 'Beobachter' (Herzlinger & Parsa-Parsi, 2004). Whilst some provider benchmarking exists in Switzerland, it is not made publicly available (Herzlinger & Parsa-Parsi 2004). As with the US and the Netherlands, Herzlinger & Parsa-Parsi (2004) state that individuals in Switzerland are more inclined to select provider on the basis of word of mouth (GP, family, friends, etc.) and provider location in relation to individuals' homes than on the basis of quality metrics. Again, consistent with our previous findings, Colombo (2001) notes that Swiss health care consumers do not seem to make their decisions on a 'well-informed basis'.

Pay for Performance

The clearest attempt to introduce explicit financial incentives for purchasers of health care (sickness funds) in Germany involves disease management programmes for chronic illnesses (for example see Gress et al. 2006; Kuhlmann & Allsop 2008). As a consequence of health care reforms in 2003, sickness funds and health care providers in German social health insurance are exposed to increased financial incentives to enrol patients in disease management programmes (similar to managed care plans in the US) as they receive higher payments from the risk adjustment system. The introduction of this financial incentive through changes to the risk adjustment mechanism was a response to the clear disincentives faced by sickness funds to enrol individuals with demands for chronic care packages. In the medium term, sickness funds were liable to incur financial losses as savings accrued by actively managing care for chronically ill patients were wiped out by attracting more patients with chronic conditions (Gress et al. 2006). Thus, the purpose of the financial incentive was to counterbalance incentives for sickness funds to engage in risk selection and to provide an incentive to actively manage care; and to further incentivize sickness funds to enrol chronically ill patients in disease management programmes and improve quality and efficiency of delivery in chronic care. This programme has resulted in virtually all sickness funds establishing (broadly homogenous) disease management programmes and has thus largely achieved its stated objective.

Public dissatisfaction with the quality of care provided by the Veterans Health Affairs in early 1990s in the United States led to scrutiny and review of the system, with serious concerns raised regarding the sustainability and role of the system in the future (Kizer 1999). Consequently, the VHA underwent a radical redesign in 1995 in order to move towards higher quality and less variable provision of health care. To meet these ends, VHA embarked upon reforms including the inception of Veterans Integrated Service Networks (VISNs) and the introduction of more than a hundred quality improvement initiatives (Kizer 1999). These reforms combined central direction or regulation with competition and rewards for good performance.

Over one hundred measures of structures, processes and outcomes are now used to monitor performance in the Quality Management Accountability Framework (QMAF) according to ten overlapping and interrelated dimensions. Each dimension has an associated strategy (objective) that relates to a subset of indicators in the QMAF, and thus it is organised into a management accountability framework which can be used to devise and implement policies and processes and to hold different levels and units in the organisation to account. By collating and reporting quality information achieved by VISNs and providers and by offering an array of rewards and recognitions for high quality (such as the \$1,000,000 Quality Achievement Performance Grant), the VHA hoped to stimulate competition between VISNs that would result in improvements for patients (Kizer 1999). One example of implementing financial incentives designed to stimulate innovation was the 'VHA Patient Safety Improvement Initiative (PSII)', introduced in order to reduce 'avoidable' deaths and reductions in patients' health statuses originating from physician mistakes. Two key components of the VHA's PSII were financially incentivised: (i) a new Patient Safety Improvement Awards Programme (PSIAP); and (ii) the National Patient Safety Partnership (NPSP). These initiatives were intended to encourage health professionals to identify areas in established processes which could be changed and added to in order to improve the effectiveness of controls in minimizing the risk of physician error and an untoward medical outcome. Under this programme, awards of up to \$25,000 per facility and \$5,000 per person were available for the introduction of controls that eliminated serious patient risks and had the potential for system-wide application.

Studies have mostly examined the change in the clinical performance of the VHA, but there are studies examining other aspects of performance such as patient safety (for example see Hallan 2000). Evidence of the effect of these reforms on both processes and outcomes is subject to attribution problems. Asch et al. (2004) demonstrated (by comparison to a national sample) that improvements in care occurred mainly for conditions that were being monitored: comparative performance of the VHA was best in the areas measured and monitored by the VHA with a positive spillover effect into conditions related to those covered by performance monitoring. However, there was no evidence of positive or negative spillover into unrelated aspects of care (Kerr & Fleming 2007). The experiences of the reforms to the VHA system could provide important lessons for the NHS. There are clear examples of utilizing explicit financial incentives to encourage commissioners of health care to achieve specific objectives on behalf of denoted populations in the VHA experience; and evidence of the requirement for advanced monitoring and accountability frameworks to support incentive mechanisms. In addition, it is worth considering that financial and prestige incentives were geared towards increased contestability between VISNs.

There have also been experiments with GP-led commissioning in the English NHS before. In 1991, the Conservative government introduced the 'internal market' into the NHS under John Major, creating a split between purchasers and providers. As part of these reforms, general practices could elect to become 'fundholders'. These practices were given a budget to purchase certain categories of elective care, and a budget surplus could be retained by practices. Practices were meant to reinvest these savings for the benefit of their registered populations. However, as many GPs own their own property, GPs could strategically reinvest any surpluses into practice assets from which they as individuals benefitted financially.

Fundholding was abolished under New Labour on the premise that it had created a ‘two-tiered’ system. Dusheiko et al. (2006) found that the removal of financial incentives to hold a budget increased elective admissions for those practices substantially, by between 3.5 and 5.1 percent. Gravelle et al. (2002) also conclude that GPs responded to financial incentives as a simple model of economic behaviour would predict.

Practice-based Commissioning was introduced in the NHS in 2004 with the aim of engaging clinicians with commissioning. The scheme involved the delegation of indicative commissioning budgets to groups of GPs. The coverage of these budgets varied, from a minimum of budgets for secondary care activity and prescribing, to the devolution of the majority of the commissioning budget including community services and mental health. PBC offered two different types of monetary incentives to GP commissioners. Firstly, PBC groups were entitled to keep 70% of any savings made on their indicative budgets. This money could only be spent on developing services, and in practice proved contentious, as it was not always clear exactly what constituted a ‘saving’ (Checkland, Coleman et al. 2011). Second, PCTs were instructed to develop monetary incentive schemes for practices. These were locally determined, and usually included payments for engaging with the scheme as well as payments tied to specific changes in behaviour relating to such things as prescribing and referral management¹. Typical schemes included payment for changing prescriptions to a cheaper alternative, or payments for engaging in peer-review of referrals. Compliance with the terms of the schemes was monitored, and money paid could be treated as practice income (Coleman, Checkland et al. 2009). In addition, there were more indirect incentives, such as those associated with open sharing of information relating to referral and prescribing behaviour.

Both fundholding and PBC provide an objective basis for stating that GPs purchasing decisions are, at least in part, responsive to financial incentives. However, the exact effects may well depend on who is the beneficiary of the incentive.

Competition for members

The Netherlands reforms in 2006 sought to use consumer choice to put competitive pressure on insurers and providers. National guidelines define a broad basic benefit package for acute care. Insurance market regulations seek to focus competition between insurers on quality and cost, and to limit the scope for adverse selection of individuals by insurers on the basis of their risk profiles. Insurers are compelled to enrol individuals seeking an insurance plan during the annual open enrolment period, and insurance premiums are ‘community-rated’ – insurers may not set premiums according to, for example, age or sex (Leu et al. 2009). Market competition driven by consumers choosing between insurers is, hypothetically, meant to give insurers incentives to contract with providers who provide efficient, high quality care. Prior to the health care reforms of 2006, sickness funds in the Netherlands were required to contract with any willing provider and were prohibited from integrating vertically with providers. However, since 2006, insurers have been allowed to selectively contract or vertically integrate with providers, and the extent to which prices are negotiated between providers and insurers has increased (from 10% of provider revenue in 2005 to over 30% of revenue in 2009) (Bevan & van der Ven 2010). Nonetheless, whilst selective contracting has been

¹ Examples of specific incentives found in the study include:

- changing prescribing behaviour, such as switching patients onto simvastatin (the cheapest statin drug) from other statins, switching to generic drugs
- working as a practice to scrutinise referrals and redirect or prevent if possible
- reducing the number of follow up appointments patients received in outpatients by scrutinising letters and cancelling those deemed unnecessary
- agreement to review and validate budgetary data monthly
- succeeding in saving money against allocated budget

introduced in principle, the extent to which purchasers have contracted selectively is limited: insurers have been reluctant to selectively contract due to a lack of information on the quality of providers of care (Van der Ven 2010). This limitation on commissioner autonomy undermines the capacity of competition and choice to bring about the efficient delivery of high quality care.

The evidence regarding freedom of choice and actual switching between funds by individuals in Germany suggests that a high proportion of individuals changed their sickness funds within a few years of the introduction of free choice (Gress et al. 2002). When asked why they switched funds, the most frequent and influential reason stated by policyholders was the contribution rate (price). Additional experiences regarding the type, extent and quality of coverage of the sickness funds are often stated as secondary (sometimes primary) reasons for switching and, thus, a significant proportion of the individuals switching sickness funds are exploiting the opportunity for selecting funds on the basis of quality (Gress et al. 2002). It is clear that the profile of persons changing their sickness funds is distinct from a representative sample of the population: persons with higher socioeconomic and health status switch funds more frequently. This, as noted by Gress et al. (2002), underlines the importance of a well-developed risk adjustment mechanism to ensure that adverse selection of funds by enrollees is ameliorated.

In Switzerland all individuals are required to purchase the basic package, insurers are not permitted to refuse enrolment to any individual and are required to set a uniform price for a given basic health plan, a risk equalisation system reallocates funds from health plans with lesser risks to plans with higher risks (according to age and gender of enrollees). In 2004, there were 87 registered insurance companies offering a range of diverse premiums and varieties of health plans that individuals are able to select between (Herzlinger & Parsa-Parsi 2004). Individuals are able to switch insurer twice annually and an entire information industry dedicated to the evaluation of individuals' insurance options has evolved over time. In principle, competition exists between insurers offering the basic package as they compete for enrollees; and within the basic health coverage, individuals can choose on the following dimensions of the package: (i) premiums (price); (ii) choice of Managed Care Organisations (MCOs); (iii) fixed fees (costs over and above individuals' excess payments are paid by the insurer with a ten percent contribution from individuals); and (iv) deductibles (excess payments).

Risk adjustment in Switzerland is based on age and gender alone and, consequently, insurers have substantial incentives to select risks. In response to those advocating the introduction of morbidity-based risk adjustment, legislators argued that the obligations of insurers to accept all applicants were of sufficient strength to prevent risk selection; and that high consumer mobility would lead to steadily converging risk profiles within insurers' memberships (Gress 2004). However, risk adjustment based upon age and gender fails to allow for variations in need for health care resources within combinations of age and gender. This is clearly a flawed assumption and there is insufficient evidence that the benefits accrued as a result of risk adjusting on these two, simple criteria outweigh the costs of doing so (i.e. the costs of risk selection undermining competitive incentives). Subsequent risk selection by insurers was evidenced by the introduction of mechanisms designed to incentivise individuals to reveal their risk types. An example of this is the optional high no-claims bonus offered by insurers (Daley & Gubb 2007). This selection mechanism is only attractive to low risk individuals, as high risk individuals will not wish to be exposed to a higher portion of their utilization costs (given clear evidence of individuals' risk aversion).

Competition on price and quality has not been firmly established (Colombo 2001). Evidence as regards switching incidence suggests that switching is rarely undertaken on the basis of performance information, and that low risks such as young people switch more frequent due to lower switching costs (Colombo 2001). Evidence from these market-based reforms in Switzerland on the impact of the capacity for markets to drive higher quality and efficiency suggests that it depends on a number of key factors, including: (i) open

enrolment of individuals into insurer/sickness fund; (ii) barriers to switching between insurers; (iii) the incidence of switching benefits; (iv) employer influence on switching and choice sets; (v) selective contracting of providers by purchasing groups; (vi) capacity of purchasing groups to freely negotiate prices and budgets with providers; (vii) accessibility of performance information on provider and insurers and the extent to which individuals take this into consideration in making their choices; and (viii) effectiveness of regulation including ensuring insurers/purchasing groups cannot select risks using mechanisms such as high no-claims bonuses. These findings are consistent with the theoretical considerations we have already discussed.

Evidence on the effects of competition in the NHS

Over the past twenty years, governments in England have increased the role of competition in the NHS. In 2006, reforms gave patients choice of provider for secondary care and thus allowed providers to compete for patients. These ‘patient choice’ reforms were controversial as the relationship between clinical quality and competition is not firmly established. Cooper et al. (2010) assessed the impact of the increased provider competition and 30-day AMI (Acute Myocardial Infarction) mortality, finding that competition improved quality – a result consistent with Kessler & McClellan (2000) and Kessler & Geppert (2005).

Evidence from GP provider behaviour

Financial incentives have most often been used for providers in pay-for-performance programmes. There is therefore more we can learn from the evidence on provider-directed financial incentives in addition to the evidence on commissioner-directed incentives. The key problem in this literature is attribution– for example, there is evidence that diabetes care can be improved by P4P but it is difficult to disentangle effect of UK QOF from other initiatives. While there is some evidence of positive effects of P4P for providers, especially on chronic disease management of process aspects of single conditions, for example in the US and the UK respectively (Doran et al. 2006), these effects are often short-term (Eccles et al. 2010; Christianson et al. 2008; Campbell et al. 2008) and worldwide the evidence base for provider P4P is not compelling (Peterson et al. 2008; Christianson et al. 2008). Data from the VETS scheme in the US suggests a positive spillover from measured to non-measured outcomes (Asch et al. 2004; see VETs case study). However, this is contrary to evidence from the UK QOF which has shown positive spillovers only for targeted patients and small detrimental effects on non-incentivised patients (Doran et al. 2011).

Potential unintended consequences of the QOF were predicted prior to its introduction and included deleterious effects on provider behaviour and service provision. For example, the new scheme might have a negative effect on continuity of care and result in care fragmentation and a less holistic approach to patient care by doctors, as well as reduced quality for non-incentivised conditions and damage to doctors’ professional motivation (Roland 2004; Roland et al. 2006). Research suggests that unintended effects did occur including the emergence of a dual QOF-patient agenda within consultations, potential deskilling of doctors due to an enhanced role for nurses in managing long-term conditions, a decline in personal/relational continuity of care between doctors and patients, resentment by team members not benefiting financially from payments and concerns about an ongoing culture of performance monitoring in the UK (Campbell et al. 2008). Possible unintended consequences, such as a focus on the remunerated areas at the cost of unremunerated areas or gaming, need to be thought through and managed carefully. Although there are anecdotal reports of unintended consequences, few empirical studies examine potential adverse consequences of pay for performance (McDonald & Roland 2009; Lester et al. 2011). Evidence on GPs responses to financial incentives as providers of health care demonstrates that, as with fundholding and practice-based commissioning, GPs are responsive to financial incentives. However, past experiences have

yielded both intended and unintended consequences and these could be expected from any new financial incentive scheme.

Concluding remarks

What are CCGs and what incentives will they face?

CCGs will be purchasers of health care for defined local populations. They will seek to meet the health care needs of their local populations efficiently, within budget, and with a view to improving quality. In principle, CCGs will be primarily held to account using a combination of the following mechanisms: regulated competition for members; financial incentive payment; public reporting of performance information; and scrutiny from the NHS commissioning board. CCGs will also be held to account by the NHS commissioning board based on their performance indicators. The commissioning board will in turn be held to account by the Secretary of State.

What incentives do other purchasers face?

Our international comparison demonstrates that combinations of various incentives are adopted in health systems worldwide. Regulated competition for members and public reporting of performance information are (almost) universal mechanisms that have been adopted.

Our review of the evidence suggests that over-reliance on market mechanisms does not drive health systems towards efficiency and improving quality. Evidence from countries such as the Netherlands, Switzerland and the United States demonstrates this: underlining the importance of effective regulation in market based health systems (for example, advanced risk adjustment is required to diminish incentives to select risks). Furthermore, for individual choice to drive competition based on quality, the public must take into account published performance information in making their decisions. Evidence we have cited suggests that whilst providers are motivated by public reporting of performance data, the extent to which individuals use these data in making their health care choices is limited. In addition, competition is undermined as a lever when the autonomy of the commissioner is restricted: (i) without the capacity to selectively contract with providers, there may be much weaker incentives for providers to become more efficient and strive towards higher quality; and (ii) purchasers are often limited in their capacity to differentiate their health care packages.

What are the implications for CCGs?

The explicit financial incentive (the 'quality premium') will be an almost unique method of incentivising purchasers – there are a few lone examples from international evidence. This financial incentive is no longer set to be taken as private income by CCGs and their use of the funds must be transparent. Given the lack of evidence on this method of incentivising commissioners and the change in the beneficiaries of the premium, it is difficult to assess how the quality payment will affect CCG behaviour/performance. Past experiences in the NHS with financial incentives suggests that the design of the quality premium will need to be painstakingly cautious. These payments should be cost-effective and policymakers may wish to pay ardent consideration to possible unintended consequences. It is, as yet, unclear whether the payments will be made at the discretion of the payer or whether there will be clear rules.

The extent to which CCGs will be competitive will depend on the rules regarding geographical contiguity. They will have (some) more autonomy and more GP influence than PCTs, but the extent to which they compete for members may be extremely limited. There are still significant restraints on

purchaser autonomy: they have little freedom to define care packages and they cannot selectively contract with providers. As a result, CCGs will be limited in their capacity to differentiate from each other. This is not the hallmark of a competitive market.

Public reporting of performance information can lead to improvements in quality of care provided. However, the quality indicators used by the NHS in the past and proposed in the future have apparent dual purposes: accountability; and bolstering patient choice based on quality. Evidence suggests that the extent to which individuals make their health care choices on performance information is limited. This further undermines incentives for competition between providers and purchasing groups based on quality.

Evidence from GP fundholding and Practice-based commissioning has demonstrated that GPs control costs more tightly when they are moved closer to the consequences of budgetary decisions. There is also clear evidence that GPs respond to financial incentives. However, there may be cause to be sceptical as to whether broader system reforms are creating clear and strong incentives for purchasers of health care. Aside from the quality premium, for which the details are not yet fully understood, the extent to which the purchasing function in the NHS is incentivised looks set to remain broadly unchanged.

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