



OECD ECONOMIC SURVEY OF THE UNITED KINGDOM 2004:

ACTIVITY-BASED FUNDING, INCENTIVES AND WAITING TIMES IN HEALTH CARE

*This is an excerpt of the OECD Economic Survey of the United Kingdom, 2004,
from the section on performance management, targets and incentives in public services, chapter 3.*

Getting incentives right is crucial to achieve targets

1. Even where central government has sufficient information to set relevant targets and measure outcomes, it still faces a basic implementation problem, because setting targets only affects behaviour by service providers, if they have an incentive and feel motivated to meet the targets. The main challenge for the UK performance management framework is therefore how funding mechanisms, organisations and the role of consumers can be adjusted to craft incentives to improve services and thereby meet the key targets, while reducing the need for detailed national targets and measurement.

2. The 1998 target on generic drug prescription illustrates that target setting, measurement and incentives can go hand in hand, but more can be done to craft incentives for service providers and users to change their behaviour. Pharmaceuticals currently account for about 15 per cent of UK health spending and, as in other OECD countries, this share has grown over the last decade. One way to contain spending is to urge physicians to prescribe generic drugs when there is no clinical difference compared with the more expensive brand-name drugs, and the 1998 Spending Review established a target for this.¹ Currently, patients that are not exempt from charges pay a fixed £6.30 per item irrespective of whether a generic or brand-name drug is prescribed.² Medical practitioners have some incentive to choose low-cost treatment as the price exceeding the fixed charge is carried by their Primary Care Trusts (the group of 50-200 medical practitioners to which they belong). Other OECD countries, including France, have introduced reference price systems setting the costs carried by the public purse at the price of a generic drug and letting the patient pay the difference if a more expensive drug with similar content and effect is chosen. Changing the way patients are charged in the United Kingdom in this direction would reinforce the incentives for making savings on pharmaceuticals without making access to the appropriate treatment dependent on ability to pay, as people with low income or chronic illness would continue to be exempt. Another option along these lines is to charge at least a symbolic amount from patients that do not show up for planned hospital consultations or surgery. Finally, broad exemptions from drug charges could be reconsidered as currently not only older persons with low income but all older persons are exempt from charges.³

3. Current health policy places greater emphasis on patient choice, performance incentives linked to the target framework and the transformation of NHS hospitals into Foundation Trusts. The first Foundation Hospitals will be in place by spring 2004 with some independence to borrow for investment and to depart from standard NHS employment conditions and pay levels. Granting public service providers more operational flexibility is an important element in health care reform in most OECD countries having public health services, but more freedom has to be complemented by stronger performance incentives. The main

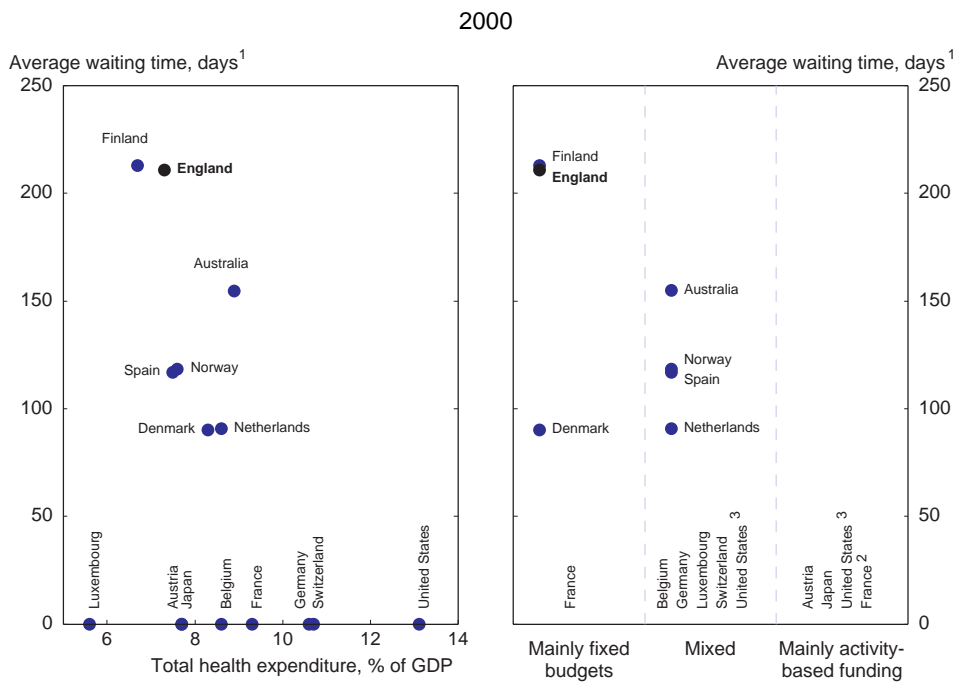
incentive to meet targets currently stems from the pressure on managers to perform, as their careers could be set back if the hospital lags significantly behind. Under these circumstances, benchmarking and target setting are effective by making it clear what is an unacceptable under-performance and by giving a clear deadline for service providers to improve.⁴ Good performers will be allowed to earn autonomy, and thus a condition for getting foundation status is that hospitals have acquired three stars in the rating by the Commission for Health Improvement. The intention is that all hospitals will acquire foundation trust status within the next five years. League tables such as the hospital star ratings, however, have been criticised for being overly simplistic, and it is probably too early to assess the effectiveness of incentives to earn this autonomy. One-off sums or “cigar box money” have sometimes been used to promote a target. For example a one-off sum of £14 million to pay ward housekeepers was allocated to those hospitals that demonstrated commitment to achieve the 2000 target for hospital cleanliness and food. But in general, NHS budget allocation and funding mechanisms are not designed with a view to create incentives to raise activity to the same extent as in other OECD countries.

4. Reforming the way budgets are allocated within the NHS, towards activity-based funding mechanisms is therefore likely to be a fruitful avenue and, the payment by results policy is a significant step in this direction. The experience from a number of OECD countries using activity-based funding for health care is that it raises activity, sometimes significantly, and thereby is a key factor for reducing waiting times (**Box 3.4**). Moreover, reducing long waiting times via funding incentives to raise activity rather than trying to enforce maximum waiting time guarantees by targets, would leave more room for hospitals and doctors to take local circumstances and patients’ individual needs into account. Some of the conflicts between maximum waiting time targets and clinical prioritisation frequently reported by physicians might then be avoided.⁵ The NHS began the phased introduction of activity-based funding for hospitals in April 2003. Funding will continue to flow from central government via Primary Care Trusts on a capitation basis, but whereas Primary Care Trusts today typically pay hospitals based on historic cost levels, they will increasingly allocate funding among hospitals based on activity. In their agreement with each hospital, Primary Care Trusts are to stipulate caps for the maximum activity they will fund, in order not to overspend their budget. The incentive for hospitals to raise activity thereby hinges on how the tariffs are set and adjusted over time, because if tariffs are too high, hospitals have only limited incentives to raise activity, as they quickly hit the cap on funding. To avoid this barrier, budget control could instead be ensured by adjusting tariffs automatically in response to total activity to match the budget envelope, as done in Austria. Or a part of the overall NHS budget could be reserved as additional (partial) funding where hospital activity increases beyond a benchmark. Experience from Denmark shows that this model can help raise activity and bring down waiting times (Clemmesen and Hansen, 2003). The plans to implement activity-based funding for hospitals should therefore be strongly endorsed. They will also support the wider choice for patients to be introduced in 2005, which can help address quality aspects that are difficult to quantify but easy to experience for users (Lundsgaard, 2003). Finally, the plans to involve a broader mix of public and private providers seems promising such as with the Fast Track Surgery Centres, where a handful of foreign firms are to provide elective surgery such as hip replacements on contract with the NHS. While competition can in some instances be problematic in health care, it is likely to work well in the case of such standard treatments.⁶

Box 3.4. Activity-based funding, incentives and waiting times in health care

Making funding for hospitals and doctors' individual pay depend on activity can bring an important contribution to tackling waiting times by creating incentives to use existing capacity better and treat more patients. A recent OECD study has compared countries with and without waiting times for elective surgery and found that countries are less likely to report problems with waiting times if they rely mainly on activity-based funding for hospitals rather than mainly fixed budgets and if they pay hospital doctors on a fee-for-service basis rather than a salary basis. The difference is statistically significant when controlling for other factors affecting supply and demand of health care including public and private spending, hospital capacity (number of beds), number of doctors and population age structure (Siciliani and Hurst, 2003). The finding is illustrated in **Figure 3.9** which shows that higher spending helps to reduce waiting times as France, Germany, Switzerland and the United States which do not report waiting time problems all spend a large share of their GDP on health care. However, spending differences are not a sufficient explanation as for example Belgium without waiting times spends no more than Denmark, Netherlands and Australia all of which have substantial waiting time problems. What appears to be equally important is the incentives provided by funding mechanisms and *none* of the four countries that had mainly activity-based funding in 2000 reported waiting time problems – despite the fact that Austria and Japan had comparatively low levels of spending. A correlation of average waiting times with doctors' pay being either mainly salary, mixed or mainly fee-for-service gives similar results to that in **Figure 3.9**. For the NHS to achieve a durable reduction in waiting times, increased funding as well as improved incentives would be necessary. Other policy levers to reduce waiting times include clinical guidelines for prioritizing patients as applied in New Zealand (Hurst and Siciliani, 2003).

Figure 3.9. Waiting times, spending and incentives



1. Mean waiting times for persons admitted for inpatient surgery. Simple average for hip replacement, knee replacement, cataract surgery, varicose veins, cholecystectomy, and inguinal and femoral hernia.
 2. In France, public hospitals have fixed budgets, while private hospitals treating publicly funded patients receive activity-based funding.
 3. In the United States, Health Maintenance Organisations use mixed funding mechanisms, while the public Medicare programme uses activity-based funding.
- Source: OECD Health Data 2003 and Siciliani and Hurst (2003).

5. In parallel with activity-based funding for hospitals, rewarding extra work via individual pay could help compensate for the shortage of doctors and counteract the decline in average hours worked by doctors. Today, doctors employed at NHS hospitals are paid a fixed salary, and only if treating private patients after normal hours will their income depend on activity. The consequence is rather adverse incentives for doctors to avoid reductions in waiting times in order not to lose the extra income from high-paying private patients wishing to avoid the queue. In this context, paying hospital doctors a mixture of salary and fees as for example in Austria, Switzerland and with managed care in the United States, would seem to not only help motivate additional effort, but could also balance the adverse incentive to keep waiting times long. Unfortunately, the three year agreement with hospital doctors finally accepted in late October does not include standard elements of incentive pay, and therefore a key recommendation is to move ahead with piloting and implementation of incentive pay for hospital doctors faster and more broadly than currently planned as this would help reduce waiting times (**Box 3.4**). In primary health care, a new contract for general practitioners will relate a substantial share of pay to quality and outcome measures supplementing the traditional capitation based payment.⁷ The new contract implies that general practitioners will have less incentive to refer to hospitals in cases where it is possible to treat the patient in primary care, and this will help realising the cost savings associated with shifting from in-patient to ambulatory treatments that are made possible by advances in medical technology including pharmaceuticals.

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1. Generic drugs can appear when a patent expires and other producers can copy a particular drug. The original producer may often be able to charge a higher price because of its well known brand name and hence enjoy an economic rent. Consequently, getting physicians to prescribe the generic drug can bring down costs, in some cases considerably.
2. It is also possible to purchase a pre-payment certificate for £32.90 for four months, and holders of this certificate are not charged per item.
3. Another illustration of the issues of balancing measurement and targets *versus* incentives is the way the problem of high sickness absence in the Department of Health was addressed in 1998. The quantitative target listed in **Table 3.3** presumably helped to raise awareness about the problem, but the fact that it has taken a new computer system which is still today in a pilot phase illustrates the difficulty and transaction costs associated with measurement. The alternative would be to alter the way budgets are allocated among divisions of the department to give them a stronger incentive to economize on resources internally and in doing so reduce sickness absence. With stronger incentives in place, the need for centralized monitoring of the exact extent of sickness absence would be limited. Also employees could be given an incentive to keep sickness absence low, either by not paying salary for the first day of absence or by giving a bonus to those not being on sick leave for extended periods.
4. The apparent importance of managerial career concerns is an important aspect to note for other countries considering adopting targets for performance management in publicly funded services. The effectiveness of targets depends crucially on the rules and culture surrounding job security for managers in public services, and the UK framework might therefore be much less effective if implemented in other European countries.
5. One example of this was given by a hospital director to the Public Administration Select Committee explaining that over-ambitious targets for waiting times reductions has led to systematic cancellation of follow-up appointments after eye surgery with the consequence that some patients lost vision.
6. Involving a broader mix of providers can stimulate productivity as public and private providers learn from each others innovations, and consequently a recent study found for the United States, that public expenditure were lower in areas where some hospitals are run as private firms (McClellan and Kessler, 2002).
7. Capitation based payment gives general practitioners a fixed payment per payment on their “list” with adjustments for factors such as age and gender.