

Paying for Performance*

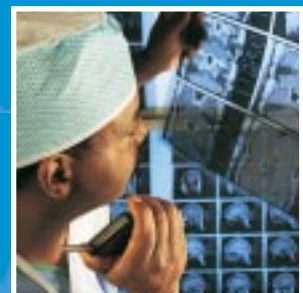
Incentives and the English Health System



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Executive Summary



Healthcare policy makers and payers around the world are currently experimenting with how to assure and improve the quality of healthcare systems. In recent years, some government and commercial payers have developed pay for performance (P4P) mechanisms, which reimburse organisations for achieving and maintaining performance objectives. This trend represents a fundamental shift away from other healthcare payment systems in which reimbursement tends to be based on the quantity of services instead of health system quality.

The United Kingdom is the global forerunner at developing and implementing P4P in primary care. The United States is the leader in secondary hospital care, with several large P4P schemes in place in which hospitals receive bonuses for reporting and in some cases, achieving, key quality targets. Neither system, however, has yet managed to develop a programme that incorporates the full spectrum of patient care.

Understanding the strengths and weaknesses of pay for performance is critical if it is going to be a meaningful tool for driving quality improvements across health systems. Recognising this, PricewaterhouseCoopers' Health Research Institute (HRI) has conducted a study, examining the theoretical, structural/operational and system-wide issues health systems face when trying to institute a quality improvement programme of this nature.

The research focused on the English experience with P4P. PricewaterhouseCoopers' research analysts conducted interviews with industry leaders across England, and supplemented findings with a review of current practice in both England and the United States. By examining both the English and US health systems' experiences in designing and implementing P4P, we were able to identify elements of best practice, which are relevant as England looks to expand P4P into hospitals. In addition, this report is also instructive for health executives and policy leaders in other countries that are interested in implementing P4P programmes.

The enthusiasm for P4P is largely due to its quality-based metrics that attract explicit reward. From a payer perspective, P4P represents a plausible option for stimulating providers to compete on quality. However, our research identified some fundamental issues with pay for performance. These included a lack of consensus about its potential scope, how it should be measured, and ultimately, how it should be regulated. For example, in expanding P4P to hospitals, some payers question whether they should pay extra for "quality," saying that it should be an implicit criterion when contracting with providers.

Following are the summary findings and recommendations that need to be considered when designing and implementing pay for performance programmes, which are detailed in the main body of this report.

Theoretical Issues

1 Finding: The definition of what constitutes good performance is not universally accepted.

Stakeholders disagreed about the possible scope of pay for performance, and whether P4P should be restricted to quality measures or be expanded to include efficiency and volume measures as well.

***Recommendation:** Prepare the operating environment before implementing pay for performance.*

By creating an environment that is ready for change, stakeholders can determine the appropriate scope of the programme and put the right enablers/drivers in place to push change forward.

Structural/Operational Issues

2 Finding: There is a lack of consensus about the type of measures needed to support hospital-based pay for performance schemes.

Deciding what and how to measure often proves the greatest stumbling block when designing new P4P programmes. While some clinical specialities have a sufficient evidence base to support the development of quality measures, others are struggling to catch up. This problem is compounded by methodological restrictions to measuring quality and the absence of appropriate data.

Recommendation: P4P measures need to be both actionable and flexible enough to adapt to the changing clinical and environmental landscape.

P4P measures need to be within the remit of care for those responsible for executing them. They also need to be adaptable to clinical changes in order to remain relevant.

3 Finding: Most hospital information systems in the NHS today are not ready to support pay for performance schemes.

Systems that were not designed to collect the information needed for pay for performance schemes, or which do not have the intrinsic flexibility to be adapted to do so, will hamper efforts to enhance quality. Stakeholders expressed little confidence in NHS legacy systems. Indications from the NHS Northwest Advancing Quality Initiative however, provide some grounds for optimism.

Recommendation: Information systems need to be upgraded or adapted to prepare for a quality-directed P4P system

Quality measures could be integrated into the English HRG system, which would introduce a quality component into Payment by Results (PbR). The specific information elements and processes for their reliable collection will need to be specified in order for the necessary IT upgrades to be procured.

4 Finding: Pay for performance schemes invariably incur significant start-up costs.

Pay for performance schemes incur both system and reward costs and may require a reorganisation of existing payment mechanisms.

Recommendation: Participating organisations should anticipate the initial start-up costs of P4P.

High incentive payments, such as those used in the QOF, are not necessary to achieve quality improvements. Although hospital-level P4P programmes will not necessarily require the same investment as the QOF, they will still incur start-up and administrative costs. Decisions will need to be made between central regulators and participating providers about how these additional costs will be financed.

5 Finding: For general practitioners (GPs), up to 30% of their salaries were generated by the Quality and Outcomes Framework (QOF), creating a clear link between performance and financial benefit.

This is more difficult to establish in hospitals, where responsibilities for performance are more complex.

Recommendation: Incentives need to be pitched at the right organisational level in order to maximise clinical engagement.

Hospital-level P4P programmes should offer business-unit incentives to encourage participation. This will require greater financial accountability on a business-unit level however, to be a viable design option.

6 Finding: Financial incentives are only one way of incentivising quality improvements and need to be considered along side other quality drivers.

To achieve long-term improvement, multiple sustained interventions are needed. This is also a useful tool for balancing the risks that different drivers carry.

Recommendation: Benchmarking, public reporting and patient choice can also drive quality.

Benchmarking and public reporting were cited as the most powerful quality drivers after financial reward. However, both carry methodological limitations. In addition, while they might incentivise change on an individual level, many organisations are as yet unprepared to compete publicly on quality standards.

Patient choice may also help drive quality improvements but it is still too underdeveloped to be able to determine its full potential.

7 Finding: Multiple quality drivers can create perverse incentives.

Misaligned quality drivers can create perverse incentives. One of the greatest challenges will be aligning different incentive schemes so that one mechanism is not favoured over the others.

Recommendation: Perverse incentives and risks need to be understood and anticipated when designing P4P programmes.

In addition to carefully designing reward structures, P4P programmes need to consider other risks, such as decreasing professionalism and compromising interpersonal relationships between patients and clinicians.

8 Finding: Pay for performance creates winners and losers, which generates tension for individuals and/or organisations signing up to the programme.

By definition, pay for performance rewards high performers and either directly or indirectly, penalises poor performers. This has raised some concern, given that poor performers may be in greater need of financial support to raise quality standards.

Recommendation: Quality improvement programmes need to incorporate a failure regime to support poor performers.

While politicians often do not want to buy into the prospect of possible closures for poor performers, quality improvement programmes need a system for allowing for them whilst facilitating ongoing care access.

System-wide Issues

9 Finding: Stakeholders want pay for performance schemes that are coordinated centrally but managed locally.

Developing metrics and designing reward structures should be centrally driven whereas primary care trusts (PCTs) should assume responsibility for mobilising their teams on the ground to effect change.

Recommendation: Primary care trusts need to improve their commissioning skills to drive the quality agenda more effectively. In addition, providers need incentives to encourage them to form effective partnerships with PCTs.

Primary care trusts need to develop better contracting with explicit quality criteria, better procurement and purchasing of services, including exploring various provider accreditation frameworks such as those used by some insurers, and better access to performance metrics to support decision making. In addition, providers need to be incentivised to form better partnerships with PCTs and other local services.

Conclusion

There are several key drivers that pave the way for hospital-level pay for performance in England and in other health systems.

Within the English National Health Service (NHS) in particular, critical components of success include:

An organisation committed to quality:

This means not only a commitment to quality and the development of a world-class health service but also an understanding of the initial start-up requirements needed to generate a long-term quality return.

Clinical engagement with evidence-based quality measures:

P4P happens at the front line of care but also requires system-level support in order to be effective. As such, engagement across the healthcare spectrum is essential.

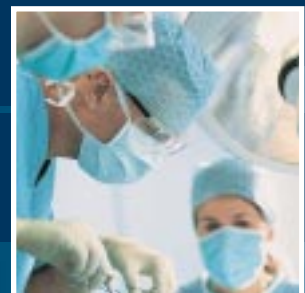
There should be incentives for participating as well as succeeding:

P4P is not simply a system for rewarding high performers and penalising poor performers. Creative design mechanisms are necessary to ensure initial uptake, which can be modified to accommodate the changing quality landscape.

P4P requires whole health economy cooperation with roles for commissioners:

While it is often assumed that quality improvements are executed by the healthcare provider, long-term change will depend on the relationship and arrangements with commissioners.

Introduction



Most global healthcare leaders and policy makers would agree that establishing and maintaining quality standards is crucial to the sustainability of any healthcare system. In PricewaterhouseCoopers' report, *Healthcast 2020: Creating a Sustainable Future*, transparency of quality and pricing information was cited by European and Canadian healthcare leaders as the most important feature of a sustainable healthcare system¹.

Although globally, improving quality continues to play a central role in the healthcare reform agenda, embedding quality into health services, treatments and processes still presents a monumental challenge at many levels. (See [Figure 1](#))

Quality in healthcare is notoriously difficult to define. A Commonwealth Fund International Working Group on Quality Indicators identified 1,000 potential indicators measured across different health systems. When these were compressed into 40 common quality indicators, there was still little consistency in the way quality and performance were measured². Furthermore, even once quality shortcomings are

identified, methods for addressing these gaps are undeveloped. A highly decentralised health system like the United States makes systematic efforts to address quality of care shortcomings on a national basis very difficult. However, while NHS payers are theoretically in a better position to directly promote higher quality care, the level of entanglement with providers can hamper efforts.

In the Institute of Medicine's influential report, *Crossing the Quality Chasm*, it is argued that in order to improve healthcare quality and safety, payers need to "align financial incentives with care processes based on best practices and the achievement of better patient outcomes."³ This cry has encouraged healthcare systems around the world to consider new strategies for driving quality, or quality-based purchasing. As the recent book, *Redefining Healthcare: Creating Value-based Purchasing on Results*, testifies, "when value improves, both capable firms and consumers benefit. The firms that find unique ways to deliver superior value are winners and are rewarded with more business, and customers also win as quality increases and prices fall."⁴

Figure 1: Quality is a Global Concern

| | AUS | CAN | GER | NZ | UK | US |
|--|--------|--------|--------|------|--------|--------|
| Overall Ranking (1=Highest, 6=Lowest) | 4 | 5 | 1 | 2 | 3 | 6 |
| Patient Safety | 4 | 5 | 2 | 3 | 1 | 6 |
| Effectiveness | 4 | 2 | 3 | 6 | 5 | 1 |
| Patient-Centeredness | 3 | 5 | 1 | 2 | 4 | 6 |
| Timelines | 4 | 6 | 1 | 2 | 5 | 3 |
| Efficiency | 4 | 5 | 1 | 2 | 3 | 6 |
| Equity | 2 | 4 | 5 | 3 | 1 | 6 |
| Health Expenditures per Capita | £1,457 | £1,507 | £1,504 | £947 | £1,120 | £2,828 |

Source: The Commonwealth Fund, "Mirror, Mirror on the Wall: An Update on the Quality of American Health Care Through the Patient's Lens," April 2006

What is pay for performance?

Pay for performance is a payment mechanism in which organisations are rewarded for achieving performance-based targets. As a metrics-based rewards mechanism, it represents one way to tackle the variation in processes and outcomes, and the lack of standardisation observed in all health systems.

Pay for performance is becoming an increasingly popular mechanism for incentivising quality improvement globally. All payment mechanisms carry incentives. For example, fee for service can incentivise providers to over-treat and capitation can incentivise providers to under-treat, both of which can also lead to the misuse of finite healthcare resources. P4P is the only mechanism whereby quality metrics are explicitly linked to reward, however. As such, it is arguably the most effective mechanism for incentivising quality over activity and/or volume.

Evidence suggests that financial incentives can prompt providers to appropriate action⁵. Internationally, as healthcare systems place more emphasis on quality-based purchasing specifically, P4P also creates both a strong currency for informing purchasing decisions and a transparent mechanism for reimbursement. As Mike Farrar, Chief Executive of the NHS Northwest Strategic Health Authority and a pioneer of hospital-targeted P4P in England claimed, P4P is about “making sure that when commissioners spend money with providers, that they’re using that resource to generate a quality return.”

We are still in new territory, however. P4P is a new payment mechanism and there are uncertainties about its long-term impact.^{6,7} Quality metrics are difficult to design as they need to incentivise the right kind of care and be actionable. There is also little agreement about the optimal P4P design structure. Many programmes have attempted different approaches, at varying implementation and reward/reimbursement levels. To date, there has been little research evaluating the impact of these design structures on quality improvement. As research from the US suggests, “the absence of good information about how to proceed means purchasers risk investing time, resources and goodwill without a reasonable expectation of achieving a good return.”⁸ (See [Table 1](#))

Pay for performance in primary care: The Quality and Outcomes Framework

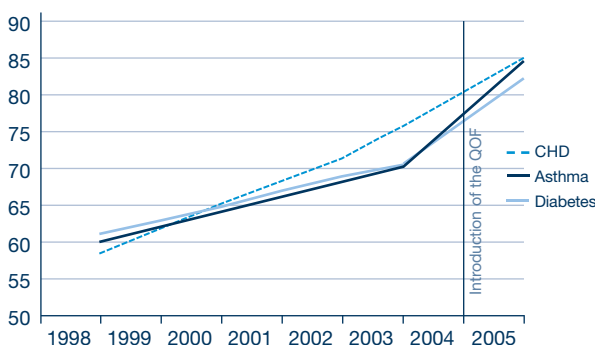
While globally, there have been a few attempts to launch pay for performance in primary care, the United Kingdom is the only country to successfully develop a national P4P scheme for its general practitioners (GPs). In 2003, the National Health Service (NHS) launched a

new pay for performance programme under the new General Medical Services (nGMS) Contract, called the Quality and Outcomes Framework (QOF). The QOF is a framework of clinical, practice organisation and patient experience measures, against which practice performance is assessed. The intention of the QOF is to raise performance standards through the reorganisation of the way care is delivered. For example, many practices had to hire additional clinical and administrative staff and increase the number of regular clinics in order to meet the rigid QOF requirements.

Under the QOF, points are allocated for reaching set performance thresholds for each indicator, the absolute number of which varies by indicator in order to reflect their importance and usefulness. In its first two iterations, GPs could earn a total of 1050 points, with each point worth approximately £125. After adjusting for the relative prevalence of disease, this could amount to a 33% increase in gross earnings per GP, depending on the level of individual investment back into their practice in order to maintain high quality standards.

In the first round of the QOF, English GPs exceeded expectations, achieving an average of 91% of total points⁹. This resulted in an average increase in gross income of £23,000 per GP across the country. Subsequent iterations of the QOF have yielded similarly high results. Emerging research suggests that rates of improvement in quality of care for both asthma and diabetes have increased significantly since the introduction of the QOF.¹⁰ In addition, there appears to be little variation in GP performance by practice location.¹¹ Although it is still too early to tell, this may indicate that like the introduction of immunisation and cervical cytology targets in the 1990s, the QOF could succeed in decreasing the care differential between practices. (See [Figure 2](#))

Figure 2: Mean Scores for Clinical Quality at the Practice level for Coronary Heart Disease, Asthma, Type 2 Diabetes, 1998 to 2005

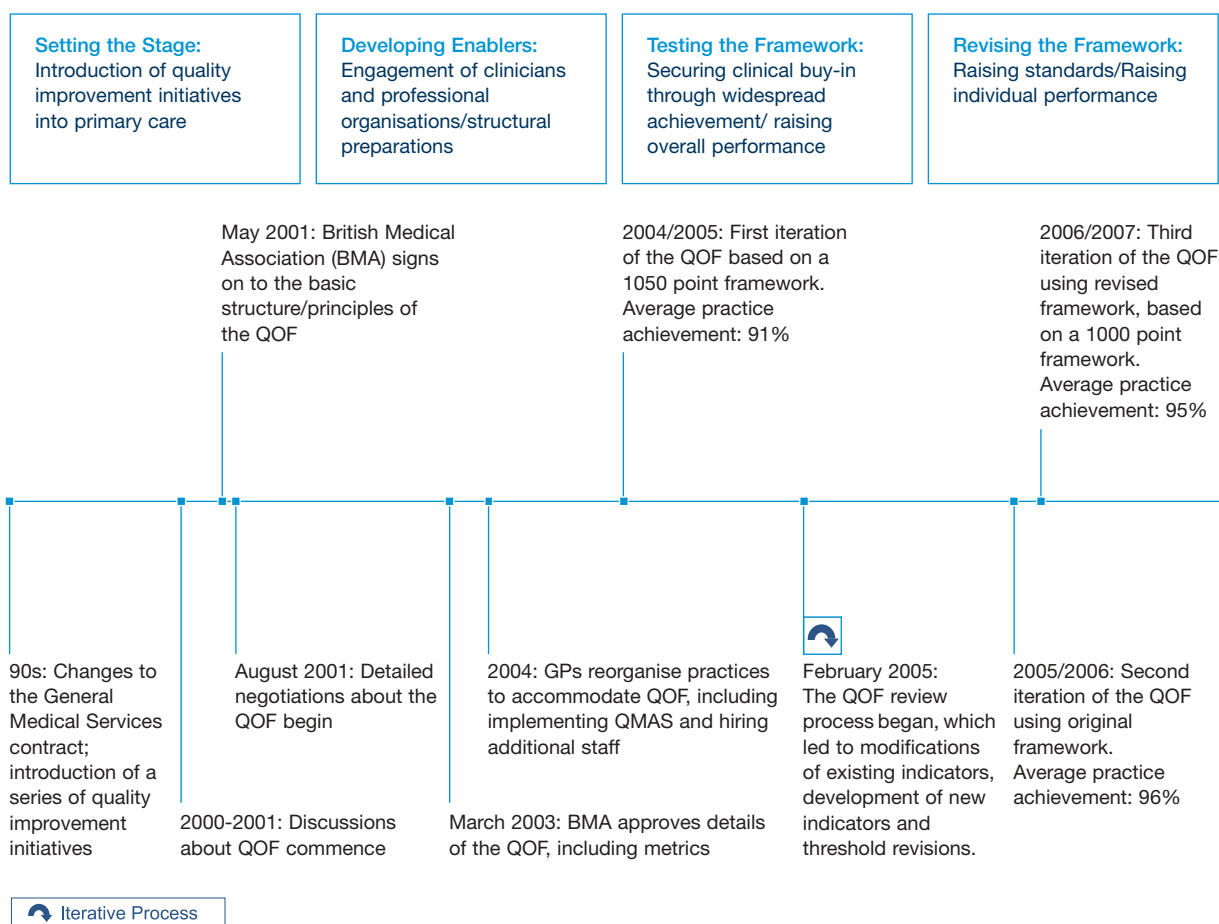


Source: S. Campbell, Ph.D., et al., “Quality of Primary Care in England with the Introduction of Pay for Performance,” *The New England Journal of Medicine*, July 12, 2007.

Table 1. P4P Design Considerations: Benefits and Challenges by Implementation and Reward Level

| | | Benefits | Challenges |
|-----------------------------|--|--|---|
| Implementation Level | Organisation | <ul style="list-style-type: none"> • Less fragmented • Allows for easier monitoring and evaluation of the system | <ul style="list-style-type: none"> • Difficult to secure business unit and/or individual buy-in • Difficult to determine how rewards are distributed throughout the organisation |
| | Business Unit | <ul style="list-style-type: none"> • Tangible benefits for investing time/resources in performance-related improvements • Metrics would require more input from professional bodies • Comparable, specialty-based metrics aligns with professional motivation and the desire to be the best • Shared risk pool | <ul style="list-style-type: none"> • Business-level reward schemes increase fragmentation within organisations and across professional bodies • Increased fragmentation may make it difficult to secure union and professional buy-in • Encourages siloed thinking within organisations and might detract from a systems approach to quality improvement |
| | Individual | <ul style="list-style-type: none"> • Tangible benefits for investing time/resources in performance-related improvements • Direct payment is a strong motivator for change | <ul style="list-style-type: none"> • May hold individuals responsible for results beyond their control, thus demotivating • Potentially expensive • Unrealistic for complex organisations, such as hospitals |
| Reward Level | Relative thresholds: rewards performance relative to other organisations in the network | <ul style="list-style-type: none"> • Aligns with the professional motivation to be the best • Can filter out common sources of uncontrolled variation • Provides strong incentive to improve continuously because there is no threshold level at which a reward is guaranteed | <ul style="list-style-type: none"> • May provide high performing organisations an unfair advantage and discourage lower performing organisations from participating • By introducing competition for rewards, may discourage sharing of best practice and collaboration • Because reward thresholds are undetermined, might discourage organisations from investing in pay for performance |
| | Absolute Thresholds: Rewards absolute performance, irrespective of improvement over time and/or performance relative to other organisations | <ul style="list-style-type: none"> • Rewards actual performance • No uncertainty for participants about whether they have achieved necessary thresholds | <ul style="list-style-type: none"> • May discourage lower performing organisations that are improving but not meeting threshold targets • May discourage higher performing organisations that have already exceeded threshold targets from improving beyond current practice • Does not acknowledge some of the nuances/barriers to quality improvements between organisations |
| | Improvement over time: Rewards internal organisational improvement | <ul style="list-style-type: none"> • Rewards improvement over time irrespective of threshold targets • Acknowledges some of the nuances/barriers to quality improvements • Takes into account unique characteristics of different organisations • Provides opportunity for rewards for all organisations, not just previously high performing ones | <ul style="list-style-type: none"> • More fragmented • Less competitive |

Figure 3 Evolution of the QOF



While heralded a success, widespread GP achievement raised concerns that QOF metrics focused too much on the easy-to-measure aspects of clinical care and that performance thresholds were set too low. In addition, with no baseline for comparison, there was some speculation whether observed quality improvements represented real changes in clinical behaviours, or rather, improved reporting.

One of the key design features of the QOF is that it is intended to be an iterative framework, so that metrics can be easily reviewed and updated in order to accommodate and reflect changes in the healthcare environment. QOF supporters maintain that metrics in the first iterations deliberately focused on the less controversial, easy-to-measure aspects of care as a way of both securing clinical engagement and testing the framework. They further intimated that subsequent iterations would be more challenging, focusing on changing clinical behaviours. Indeed, in 2006/7, performance thresholds were raised and indicators in eight new clinical areas were added to the original cast of 10 chronic diseases. As a result, points were redistributed to accommodate new targets, without increasing the overall pool of incentive payments. Despite these changes however, using the revised framework, GPs still managed to receive an average of 95.5% of total available points¹². (See Figure 3)

Pay for performance in secondary care: The US Experiment

Where the UK has led the way with pay for performance in primary care, the US remains one of the few countries to successfully implement aspects of P4P at a hospital level. As of 2006, there were approximately 160 P4P programmes in operation across the country, in which providers who delivered high quality, patient-centred and efficient care were reimbursed at a higher rate than lower performing counterparts. These programmes are estimated to cover more than 39 million beneficiaries¹³.

Several of the larger, more established US P4P programmes, such as Bridges to Excellence and Integrated Healthcare Association's P4P programmes, operate on the physician level. The most influential hospital P4P initiatives are run by the Centre for Medicare and Medicaid Services (CMS), which administers the government's two healthcare programmes, Medicare and Medicaid.

CMS is currently running two major P4P projects, the Hospital Quality Initiative and the Premier Hospital Quality Initiative, in which hospitals receive bonuses for reporting quality and some are paid for achieving certain quality targets. Like the QOF, CMS P4P programmes are iterative and new ways to drive

quality and efficiency are being sought. For example, in 2007, CMS implemented new severity-adjusted DRGs and said it would no longer reimburse hospitals for ‘never’ events, such as wrong-site surgery¹⁴. Payers are also looking to CMS to drive efforts to create a reimbursement mechanism for the coordinated and evidence-based care management of chronic conditions, in order to shift the burden of caring for the cronically ill from acute centres back to primary care.^{15, 16} (See [Appendix 1](#) for more detail on US P4P programmes)

Research Methodology

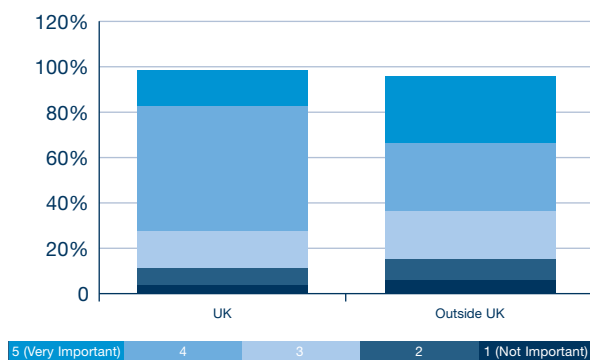
To provide research-based insight, PricewaterhouseCoopers’ Health Research Institute (HRI) conducted in-depth interviews with thought leaders and executives representing hospitals, academic associations and regulators to gather insights on current challenges and best practices in pay for performance. This research was supplemented by a thorough literature review of reports and guidance from associations, industry leaders and academics.

Forging the way for pay for performance in English hospitals

While the UK and the US have both emerged as industry leaders within primary and secondary care respectively, neither have managed to establish a comprehensive quality reimbursement scheme that covers the full breadth of patient care.

According to the PricewaterhouseCoopers Healthcast 2020 survey, over 70% of UK health leaders stated that reimbursement was an important lever for driving quality and safety improvements. This suggests that irrespective of its challenges, P4P will grow in importance as a key driver of quality improvements. Recognising its importance, this report examines the strengths and weaknesses of previous P4P experiments in order to determine both the feasibility of developing pay for performance across English hospitals and the preparedness of the NHS to do so. In particular, it addresses the theoretical, structural /operational and system-wide issues that need to be considered in order to successfully implement P4P across English hospitals. (See [Figure 4](#))

Figure 4: Level of importance UK healthcare leaders gave reimbursement as a lever to promote safety and quality



Key Findings and Recommendations



Theoretical Issues:

1 Finding: The definition of what constitutes good performance is not universally accepted.

Some stakeholders argued that pay for performance should be limited to identified, measurable aspects of quality, particularly clinical quality. Others argued that efficiency and activity levels are also performance measures and financial mechanisms to incentivise improvements in these areas should also be considered P4P. For example, some stakeholders believed that because Payment by Results (PbR) incentivises increased output, thereby changing the behaviour of an organisation, it should be classified as pay for performance. However, the majority of stakeholders disagreed, maintaining that P4P implies reimbursement for improving performance, not just changing it. (See [Appendix 1](#) for a brief overview of Payment by Results)

A common understanding of what constitutes good performance is essential to deciding the scope and structure of pay for performance. As Duncan Innes, Public Affairs Manager at the insurer BUPA, stated, “You’ve got audiences with radically opposed views of what high performance is and therefore, you’ve got radically different versions of what success looks like and therefore, what recognition looks like.”

Recommendation: Prepare the operating environment before implementing pay for performance.

Pay for performance invariably entails a cultural and behavioural shift. As such, several preconditions and processes need to be established before trying to implement P4P. These will help identify the appropriate programme scope and the technical and structural levers needed to support it.

For example, prior to the introduction of the QOF under the 2003 nGMS contract, primary care was undergoing many changes. These changes prepared GPs for the QOF challenge, which enabled its overwhelmingly successful uptake:

- n **GPs were generally amenable to the concept of evidence-based medicine:** Several stakeholders mentioned that prior to the 1990s, many GPs were sceptical about the concept of evidence-based medicine. As a result, early P4P efforts, such as the Good Practice Allowance were dismissed by the GP community. In the 1990s however, the belief that quality is variable and that certain care pathways lead to better outcomes than others, began to spread throughout the medical community. This belief was critical to ensuring clinical buy-in to QOF indicators, most of which assume that there is a ‘right’ way to administer care.^{17, 18}
- n **GPs had previous exposure to pay for performance:** Changes to the GMS contract in the 1990s introduced payment for achieving cervical cytology and immunisation targets. This scheme was very successful and led to the narrowing of the social inequalities gap between affluent and poorer catchment areas in specified areas.¹⁸
- n **Ongoing quality initiatives set the tone for a robust quality improvement framework in primary care:** Many of these initiatives were introduced in the 1990s and included national guidelines and National Service Frameworks, the introduction of clinical audit, quality feedback schemes, primary care trust driven financial incentives schemes and GP appraisals. As a result, GPs were very familiar with quality improvement efforts when the QOF was first introduced.¹⁷
- n **GP practices had the infrastructure in place to help implement the QOF:** As a result of earlier pay for performance programmes, most GP practices held Electronic Medical Records (EMRs) by 2000. Although practices used computerised systems relatively superficially (e.g. for prescriptions), the technology was in place to allow for a smooth upgrade to the QOF data management system, Quality Management Analysis System (QMAS).

11 **GPs had a double incentive for improving quality within their practices:** Most GPs are not only clinicians but also own part of their general practice. While the QOF is often discussed in clinical terms, it is as much about improving the management processes and effectiveness of the entire organisation. Because of this double investment in their practices, GPs had an added incentive to improve performance, given their roles as both doctors and as business managers.

The hospital environment needs to be equally prepared before trying to implement pay for performance. This will inform key decisions, such as the proposed scope of the programme, and key design features that will determine its effective uptake and ability to drive change.

Structural/Operational Issues:

2 **Finding: There is a lack of consensus about the type of measures needed to support hospital-based pay for performance schemes.**

The backbone of any pay for performance programme is robust metrics. However, deciding what and how to measure often proves the greatest stumbling block when designing new P4P programmes. For many specialties, there is a large body of well-circumscribed research on the appropriate quality measures to use. For other areas, like mental health, this is still largely undeveloped. Indeed, one of the most common criticisms of the QOF is that certain clinical areas are over represented while others are neglected. Yet, as one stakeholder argued, this is not necessarily a fault of the QOF, but rather, an intrinsic challenge of some of the more difficult-to-measure clinical areas.

This problem is compounded by methodological restrictions to measuring quality and the lack of appropriate data. Where data does exist, there is also a level of distrust about its reliability and validity.

Recommendation: P4P measures need to be both actionable and flexible enough to adapt to the changing clinical and environmental landscape.

Within a hospital setting, there are a huge number of quality measures that could be developed. The first step to devising P4P metrics is deciding which of these measures to use. Historically, P4P hospital metrics have been restricted to relatively straightforward measures that are both easy to capture and to aggregate into quality indicators. Metrics also tend to be tailored to the individual needs of the organisation, such as measures around either high cost or volume conditions, or those of particular clinical significance.

Performance measures should have demonstrated effectiveness in invoking positive change. Otherwise, they run the risk of either wasting money through unnecessary processes or procedures and potentially, rewarding people for poor clinical performance. Measures should also be actionable and incentivise areas that are under the control of those responsible for achieving targets. The failure to achieve targets for reasons beyond clinical reach or remit of care runs the risk of acting as a disincentive.

In addition, performance measures should be flexible enough to adapt to a changing clinical and environmental landscape. This is essential so that measures stay current with innovation and push quality improvements forward. The inherent flexibility of QOF indicators, coupled with the QOF's in-built review cycle, was continually cited as one of its primary selling features. This will also be increasingly relevant for complex organisations, where performance frameworks need to be aligned with changing statutory requirements.

Developing clinical measures

The first step to developing clinical measures is establishing best practice. This is done by examining the evidence base around the clinical effectiveness of interventions. Evidence tends to be more robust for clinical interventions that have been shown to have a direct impact on outcome.

Restricting clinical measures to areas where there is a strong evidence base is essential to securing clinical buy-in. Because clinical performance measures may require clinicians to change the way they practice, they need to be aligned with the professional desire to administer the best care.

Once best practice has been established and agreed, the next step is deciding how to measure performance against this standard. Much of the literature on pay for performance discusses whether to use process or outcome measures. However, both types of measures will be required for the foreseeable future.

Outcome measures seek to determine whether the right outcomes have been achieved. In some circumstances, they are the preferred measure, but only if the outcome is achieved within a reasonable timeframe from the provision of treatment and can be directly linked to specific care processes. In most cases, particularly in a hospital setting where care is administered by several front-line staff and can be influenced by a multitude of other uncontrollable factors, outcome measures are simply not realistic. As such, process measures, which assess the extent to which care processes adhere to best practice, are the best measure.

Despite the clear role for both types of measures, they are often discussed in opposition to one another. Particularly within a policy context, it has been argued that more outcome measures are needed to drive long-

The Lesser measure? Making the case for process measures

Discussion of “process measures versus outcome measures” is sometimes presented as though process measures are a mere stop-gap, pending the development of suitable outcome measures. While the ultimate goal of improving outcomes is unequivocally the right goal, it does not follow from this that outcome measures are always the best metric to use in managing health services performance. The following examples help to illustrate why this is the case:

1 Diabetes management:

Arguably, ‘maintenance of good vision and preservation of both feet’ is a crude but real outcome measure for effective lifetime diabetes management. However, in managing the quality of diabetes care services at any point in time, such ‘metrics,’ which generally concern people who have had diabetes for many years, are not helpful in managing the month-to-month performance of services. The typical timeline from disease onset to eventual outcome is simply too long. While

such outcomes data will be of epidemiological value, a better way to assess diabetes services is to monitor adherence to care management guidelines. This, by definition, inevitably means process measures - though, some commentators consider important blood values such as Haemoglobin A1C levels as ‘interim outcome measures,’ rather than indicators of adherence to process.

2 Cervical smear targets:

The assessment of GP practices by tracking the proportion of their eligible female patients who have had appropriate cervical smears constitutes a process measure. It is arguably a very good measure, and would not be improved by seeking to replace it with an outcome measure (such as cervical cancer incidence or risk-adjusted cervical cancer mortality) as an indication of performance, due to the time separation between intervention and onset, and the myriad of other factors that could have contributed to the outcome.

term quality improvement, as they provide a more holistic view of patient care. However, the tension between process and outcome measures may be a false dichotomy. Indeed, the idea that process measures are ‘lesser’ measures is subject to both theoretical and practical objections. Furthermore, pressure to use outcome measures may compromise clinical buy-in, given understandable reluctance of those being measured to agree to a performance scheme that is unrealistic given a certain timeframe, or potentially too readily influenced by factors beyond their control.

Other considerations include whether to measure absolute or relative performance and how to set clinical performance thresholds (see [Table 1](#)). For the QOF, a linear measurement scale was used, which reflected both absolute performance and improvement over time. This was a significant change from previous primary care P4P schemes, in which relative improvement was not rewarded, providing a poor incentive for GPs caught between performance thresholds.

Performance thresholds were also set quite low in the first iterations of the QOF, which is cited as one of the reasons the majority of GPs were able to attain maximum point values from the onset. Concern about low thresholds is further compounded by the use of exception reporting. Exception reporting is used to exclude non-compliant patients or patients for which standard care processes do not apply from measurement denominators. As a result, clinicians are not penalised for lapses in care beyond their control or

incentivised to administer what they deem to be inappropriate care. As Dr. Martin Roland, Professor of General Practice at the University of Manchester and the Director of the National Primary Care Research Development Centre argued, “evidence-based medicine has never been intended to apply to every patient. Therefore, if you provide a powerful incentive to do something to a patient that that GP believes to be the wrong thing, you have the external motive running across internal motivation and that’s a bad thing.”

Critics worry however, that the combination of low thresholds and exception reporting could discourage GPs from targeting the harder to reach segments of the population. Although preliminary evidence suggests this is not the case, some stakeholders maintained that QOF thresholds should be raised to prohibit the possible abuse of the framework.

Developing organisational measures

P4P is not just about measuring clinical performance. It should also measure organisational performance, which encapsulates management and business processes. This is particularly true of National Health Service (NHS) hospitals, which need to be able to demonstrate their sustainability as businesses along with their clinical excellence. An additional challenge is aligning organisational P4P metrics with politically set targets, which requires flexibility and strong informational input and output. This will require better input at the business-unit level, which is currently unavailable in most trusts.

Developing patient experience measures

Current English health policy emphasises a more patient-centric health service and it is reasonable to assume that this trend will be lasting. The operational elements of this policy take the form of PCT-led commissioning and more patient choice (of provider). Both elements require that the experience and the preferences of the patient are measured and considered in strategic planning by organisations across the health service. As such, it is probable that any hospital-level P4P programme will have to incorporate patient experience into its metrics. At present, however, the tendency is to relegate patient experience measures into the 'too hard' basket because they challenge the traditional methodological approach to designing performance metrics.

In addition, historically, it has been difficult to get clinicians to sign on to a scheme where patient experience influences the level of financial reward. This is due to a range of theoretical and practical factors. While the evidence base is growing, there is still a lack of understanding about what patients want from their health service. Many clinicians also believe that they know what is best for their patient and that patient preference is peripheral to quality care. This problem is exacerbated when patient preference and experience contradict best available clinical evidence. In PwC's *Healthcast 2020: Creating a Sustainable Future*, cultural divisions on this issue were particularly pronounced, with US respondents to our survey rating patient influence as much more important than their European counterparts¹⁹.

The un-preparedness of many clinicians to include patient experience in a performance framework was demonstrated when negotiating the first iteration of the QOF. While it was agreed that points would be allocated for executing patient surveys, clinicians decided that actual performance on the survey should not be included in the framework. As Angela Coulter, Chief Executive of the Picker Institute Europe, stated, "If you look at the QOF indicators, they are doctor-centred. There isn't a single indicator that gives any reward for being able to show, for example, you've involved patients in decisions about their care... So the QOF has missed the point. It has missed the central thrust of health policy, which is supposed to be patient-centred."

Practically, there is limited information available at present to support the use of patient experience metrics at the hospital-level. There have been many discussions about how to bolster patient experience data, however. Patient Reported Outcome Measures (PROMS), in particular, are receiving a lot of attention at the Department of Health. On the back of a successful pilot involving 2,400 patients across 24 sites, the Department of Health has recently modified the Standard NHS Contract for Acute Services to include patient reported outcome measures. As of April 2009, hospitals will be required to collect PROMS data for elective NHS patients undergoing primary unilateral hip or knee replacements, groin hernia surgery or varicose vein procedures²⁰.

The feeling from stakeholders however, is that despite this success, at present, patient experience and PROMS measurement tools are still not refined enough to support a P4P programme across the care spectrum. Several stakeholders mentioned the possibility of incorporating patient experience measures at the business-unit level into P4P. The impression was that this might be easier to accomplish, using a range of tried and tested methods, such as the standardised SF-36 form to a short patient experience survey given at discharge, similar to those used by BUPA, Kaiser and other large US providers²¹.

3 Finding: Most hospital information systems in the NHS today are not ready to support pay for performance schemes.

Effective P4P requires responsive and clinically-rich information systems, which are capable of producing trusted, high quality data from which to derive quality measures. Ideally, such data should be generated as a by-product of the clinical process, to minimise the collection of data that serves no other purpose but to support the P4P schema. Additionally, information systems should be flexible enough to be adapted to meet future information requirements without excessive burden to healthcare providers.

Many stakeholders suggested that hospital information systems in use in English hospitals today would not be able to support the coding and reimbursement framework of a sophisticated P4P programme.

Even as the NHS's relatively new IT initiative Connecting for Health (CfH), continues to implement systems across England, some stakeholders question the readiness of such systems to support a P4P agenda. The requirements for the systems being implemented were established over five years ago, and their readiness to provide the features ideally required to support P4P in secondary care is not clear. While they may be upgraded to do so, the effort this will require has not been established. There is thus little confidence in the IT infrastructure upon which a robust P4P scheme would rely.

Many hospitals have chosen not to wait for the CfH package and have begun to purchase information systems outside the CfH programme. The specifications of such new acquisitions may be easily modified to support emerging P4P models. However, the inevitable fragmentation of IT solutions across the NHS may exacerbate the challenges of collecting comparative data across the NHS and hamper efforts to maintain flexible P4P systems as new measures are introduced. The possibility that CfH may be regionalised accentuates these concerns.

Recommendation: Information systems need to be upgraded or adapted to prepare for a quality-directed P4P system

Assuming metrics are well-defined and that their collection is realistic within the operating context, several stakeholders claimed that attaching some form of quality measure to the current HRG system would not be terribly difficult, particularly for HRGs that have obvious processes that should be followed. While it may be simple to add a quality component to a HRG tariff scheme, the 'upstream' information management requirements – such as who initially captures the data, when, how, and with what other data it is combined – all pose potential challenges. Such requirements may make considerable demands on clinical IT systems, and most stakeholders interviewed were sceptical about the readiness of the systems in use in the NHS today. However, the NHS Northwest Advancing Quality Initiative should provide valuable clues about the kind of informational support needed to sustain a P4P programme. Mike Farrar, who is overseeing the initiative, suggested that once operational processes are fully functional, it should be relatively easy to upgrade underdeveloped informational strands, providing a basis for more optimism about future challenges in implementing P4P. (See [Overview of NHS Northwest Advancing Quality Initiative \(AQ\)](#) below)

4 Finding: Pay for performance programmes invariably incur significant start-up costs.

Pay for performance schemes can be costly. Costs include system costs, such as design and implementation costs, IT upgrades and monitoring and evaluation expenses, and the overall increase in expenditure that may occur as a result of reward payments. This can have an impact on income levels from the provider-level through to the SHA-level. Estimating individual provider costs, in particular, will be difficult, given the varying levels of investment required by participating organisations to meet quality targets. In addition, depending on the way the reward is structured, poor performers could also see their operating budgets cut.

In 2004, the government committed £1.8 billion additional funding over three years to subsidise the QOF. As a result, although individual practices incurred some initial start-up costs to cover IT upgrades and the hiring of new staff, the introduction of the QOF did not require any restructuring of existing payment mechanisms to cover the nearly 25% increase in GP salaries. As Dr. Martin Roland suggests, it is unlikely that the programme would have been as popular among GPs had it altered existing payment mechanisms or been budget neutral²³.

Overview of NHS Northwest Advancing Quality Initiative (AQ)

The NHS Northwest Strategic Health Authority is currently running the Advancing Quality Initiative. Based on the CMS/Premier model, AQ is a voluntary incentive scheme, in which financial and reputational incentives are used to drive quality improvements across participating organisations. It is believed that AQ will result in increased data sharing between PCTs and providers, provider efficiency gains and ultimately, improved patient care across the SHA.

The scheme is funded from 0.1% of PCT recurrent baseline allocations. At the moment, the programme covers five clinical areas: acute myocardial infarction, coronary artery bypass graft, heart failure, community-acquired pneumonia and hip and knee replacements, all of which have agreed care pathways and process and outcome measures that have been tested by CMS/Premier. As Mike Farrar, the Chief Executive of the SHA suggested, the project

will eventually seek to expand into other clinical areas, in cooperation with the National Institute for Clinical Excellence.

Under the new initiative, the first wave of pilot hospitals will begin collecting data in spring 2008. The system will be rolled out to all participating hospitals by October 2008, with the first incentive payments being paid the following October.

As the first SHA to attempt a pay for performance programme of this size and rigour, it is likely that the Department of Health and other SHAs will be watching closely in order to determine its roll-out potential.

*Information from interview with Mike Farrar, Chief Executive of the NHS Northwest SHA and The Audit Commission²².

Recommendation: Participating organisations should anticipate the initial start-up costs of P4P.

It is likely that any hospital-level P4P programme will involve substantial start-up costs. As such, decisions will need to be made about how the programme will be funded. In particular, it will need to be decided whether the introduction of P4P will require a redistribution of existing payment mechanisms to accommodate the programme or if it can be effectively structured as a bonus scheme, the costs of which could be more realistically shouldered by PCTs and providers. For example, a payer could choose to maintain a static level of funding, but introduce a quality differential to the payments to any given provider. Discussions of this nature will not only require negotiation between the central coordinating body and participating providers but also a unilateral commitment to the quality improvement agenda.

It is important to note however, that critics of the QOF maintain that the same quality returns could have been achieved for significantly less cost. This suggests that hospital P4P programmes do not need to introduce the same level of reward as those used in the QOF to achieve a similar result. For example, the CMS Premier project offers rewards for top performers of 2% above normal Medicare payments. Similarly, the NHS Northwest Advancing Quality Initiative suggests that P4P programmes can be affordable. In addition, although evidence on the return on investment is still scarce, it is further likely that quality improvement efforts will ultimately reduce overall hospital costs.

5 Finding: For GPs, up to 30% of their salaries were generated by the Quality and Outcomes Framework (QOF), creating a clear link between performance and financial benefit.

Most general practices across the UK administer similar kinds of care. This has facilitated greater clinical engagement in the QOF, given its relevance across the professional body. Hospitals, on the other hand, include many specialisations under one organisation. Indeed, one of the criticisms of hospital quality improvement initiatives to date, is that they have failed to engage clinicians on a business-unit level. For example, the previous star rating system and English Patient Survey Programme awarded quality scores at the organisational-level only. Due to their inability to demonstrate service-level performance, clinicians felt little ownership over results and were thus provided no real incentive to change. In addition, top-down quality initiatives tend to be misaligned with the clinical motivation to administer good care. Often, managerial and financial incentives compete with clinical incentives, particularly in the new PbR environment. As such, colleagues and peers are much more effective advocates of change than management staff. As Peter C. Smith, Professor of Economics at the University of York testified, “Doctors think in terms of their speciality and tend to look sideways to their peers. They take less

notice of managers in their hospitals; rather, they look at other colleagues in their professional domain, in neighbouring hospitals and in the Royal Colleges.”

Recommendation: Incentives need to be pitched at the right organisational level in order to maximise clinical engagement.

Many stakeholders believed that one of the strongest features of the QOF was its focus on clinical engagement from the initial design stage through to its renegotiations and subsequent redesign. They also believed that hospital P4P programmes should attempt to mirror this process.

Stakeholders maintained that while the primary P4P interface is between the PCT and the provider, P4P programmes should incorporate incentives at the business-unit to encourage maximum clinical engagement. This would be a particularly useful mechanism for engaging disaffected consultants into the reform agenda.

As several stakeholders stated however, greater financial accountability is necessary before deciding on the appropriate business-unit incentives, financial or otherwise. At the minimum, this entails improved service-line financial reporting mechanisms. This is already happening among Foundation Trusts, which are required by the regulatory body, Monitor, to track spend by business unit. At the moment however, the majority of acute trusts do not track revenue and loss by business unit, making it difficult for managers to isolate department or areas at a threat of financial loss or investigate efficiency opportunities.

Aligning business-unit budget data with quality and outcome data could be a powerful tool for securing clinical engagement in incentive schemes to improve quality. Improved access to this kind of information would also facilitate greater experimentation with business-unit financing schemes, such as devolving medical budgets to the Medical Directorate level, similar to practice-based commissioning in primary care. Using incentive programmes to facilitate these kinds of experiments were commonly cited as one of the most effective ways of driving long-term quality and efficiency improvements across hospitals. As Dr. David Colin-Thomé, National Director for Primary Care at the Department of Health, commented, “If it’s all right for GPs to have devolved budgets, why not clinical directors in hospitals, offering them incentives and rewards so that if they do rationalise, say, how much they pay for hip prostheses, they could afford to provide extra nursing care?”

Although using business-unit incentives was cited as the most effective strategy for securing clinical engagement, there was some concern about the fragmentation that would ensue without if individual specialities were allowed to manage their own P4P package. In particular, it was mentioned that trade unions and professional bodies would probably be reluctant to accept an approach that could effectively localise consultants’ pay packages.

There is also a risk that speciality-based P4P programmes could further encourage clinicians and managers to work in professional silos. There is a growing body of research which suggests that in order to improve patient quality and safety, a systems approach is needed. This is founded on strong network of communication and information across organisations. There is a legitimate fear that business-unit incentive schemes might discourage this process, by encouraging professional, or specialty-based autonomy at the expense of the larger institution.²⁴

6 Finding: Financial incentives are only one way of incentivising quality improvements and need to be considered along side other quality drivers.

Stakeholders agreed that multiple interventions are necessary to support long-term quality improvement. Practically, the use of multiple interventions also helps mitigate some of the difficulties of managing P4P, particularly in a hospital environment where providers have better access to real time data than payers. As Julian Le Grand, Richard Titmuss Professor of Social Policy at the London School of Economics noted, “Given that we (payers) have a problem with monitoring quality and patients have a problem monitoring quality, if you (the provider) were driven entirely by financial incentives, the danger is that you will cut quality and patients, or purchasers (payers) will not know, because we cannot monitor it.”

Recommendation: Benchmarking, public reporting and patient choice can also drive quality.

Stakeholders consistently cited benchmarking and public reporting as the strongest incentives to change after financial reimbursement. In simple terms, nobody wants to be the worst, and these incentives align well with clinicians’, in particular, sense of professionalism and competition.

As with any metrics-based incentive, the limitations of benchmarking and public reporting are the quality and availability of data and the ability to disseminate information quickly and effectively. While there is some hospital-level data available, for benchmarking in particular, to be effective, metrics need to include speciality-based measures. Because national efforts have been slow to develop these measures, some of the Royal Colleges are devising their own metrics and publishing performance data independently.

Furthermore, while benchmarking and public reporting may be effective drivers on an individual level, several stakeholders acknowledged that some organisations are not prepared for the challenge. As Dr. David Colin-Thomé said, “There’s an international evidence base that shows information garnered from comparative data is a huge incentive of itself. The trouble is that some organisations don’t seem to demonstrate an awareness of such evidence.”

This problem was demonstrated by the Bristol Inquiry, where the right data to identify high risk areas was available, but was ignored, interpreted incorrectly or used ineffectively to motivate change.

The Department of Health is also focusing on the role of the patient as a driver of healthcare reform. Previously, this referred almost exclusively to the patient’s ability to choose their provider but it has since evolved to encompass the full patient experience. It remains to be seen whether patient choice and patient experience will be sufficient drivers of quality improvement. Although the Choices website and other initiatives have been launched to support this process, it will take several years to determine their effect.

Many stakeholders suggested that providers’ fear of choice, rather than patient choice itself, could be enough to drive quality improvements within hospitals. There is the possibility that once patients have access to information on hospital quality, they might change their provider, opting for high performers. As one senior policy adviser has noted “only five percent of patients have to exercise choice for 100% to benefit”. Given that patients demonstrate preference for local services, it is unclear how quickly (if at all) this will push hospitals to improve services. It is as likely that the role of the GP as both patient advocate and gatekeeper to hospital services, could be enough to drive change. As several stakeholders commented however, at the moment, GPs, like patients, do not have access to data on hospital quality to inform their referral decisions.

7 Finding: Multiple quality drivers can create perverse incentives.

Multiple drivers are necessary in order to achieve long-term quality improvement. Because these drivers are not mutually exclusive, one of the greatest challenges will be aligning different incentive schemes so that one mechanism is not favoured over the others. There is a danger that P4P, in particular, could undermine other quality initiatives, where benefits and/or rewards are not as clear.

Several stakeholders maintained that tension between incentives can be a good thing, as it acts as a critical checks and balance system. A commonly cited example was the implicit tension PbR creates between payers and providers as a means of driving strong commissioning on the payer end and quality on the provider end. However, it was also noted that in order for this tension to be effective, it needs to be managed effectively.

Importantly, misaligned drivers can lead to the creation of perverse incentives. This problem has been demonstrated by misaligned accident and emergency wait time targets and PbR initiatives, which are blamed for a 20% increase in emergency admissions in the last five years, at an estimated cost to the NHS of £2 billion.²⁵ This increase in unnecessary admissions is not only an inefficient use of resources but also suggests an inappropriate level or type of care is being

administered, which has a negative impact on the quality of care in and of itself.

Recommendation: *Perverse incentives and risks need to be understood and anticipated when designing P4P programmes.*

One way to manage perverse incentives is through the careful design of the reward structure. Reward levels should be high enough to motivate change but low enough that they do not compromise the way in which care is delivered.

Since changes in clinical process depend on the actions of individual clinicians, there is an argument for making individuals the recipient of the reward. However, because quality improvement often requires collective action, it is possible that group level reward is more effective. Business-unit or organisational-level reward also gives individuals less personal incentive to manipulate the system. As Dr. Stephen Dunn, Acting Director of Provider Development, at the East of England Strategic Health Authority and one of the original architects of the Foundation Trust programme, asserted, “What I think I’d seek to do is try to make sure incentives operate on a team or an organisational level rather than an individual physician level and then leave it to individual teams or organisations to decide on the precise incentive structures that they want to cascade down.” This has been the tactic employed by most hospital P4P programmes in the US and is the model being used in the the NHS Northwest Advancing Quality Initiative. In addition, although the QOF offers high-level rewards, they are also allocated at a practice rather than an individual level.

The PricewaterhouseCoopers HealthCast 2020 survey identified perceived risks associated with P4P. (See Figure 5) Stakeholders further emphasised the following risks:

1 Gaming:

Under the QOF, for example, this manifests itself through abuses to exception reporting. Early research has shown however, that while exception reporting rates in the first iteration of the QOF varied significantly, from 2% to 25%, the average rate was only 5%. Many stakeholders defended the use of exception reporting, stating that it made necessary allowances for patient variation in care processes and helped secure clinical buy-in. Stakeholders further believed that exception reporting abuses are not indicative of a QOF design flaw but of a management failing at the PCT-level.

2 Decreased quality for unincentivised aspects of care:

Research on the QOF suggests that while unincentivised aspects of care have not improved on the same trajectory as incentivised areas, they have not become worse. Other research suggests that as care improves for some processes, there will be a halo effect across all aspects of care.

3 Loss of interpersonal care between clinicians and patients:

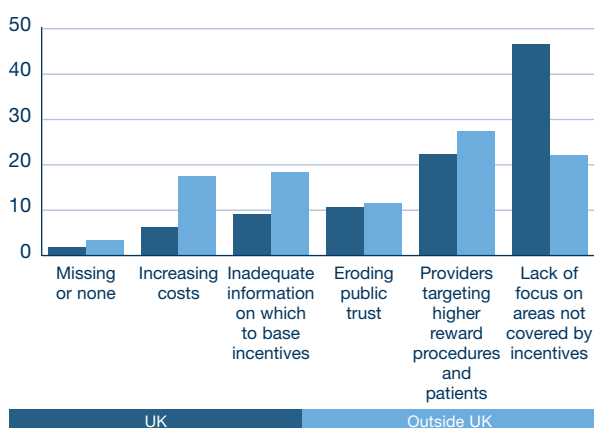
P4P schemes tend to rely on clinical process measures, which may encourage clinicians to prioritise those processes over interpersonal relationships with their patients. However, this may be less relevant as P4P is rolled out into hospitals, given that most patients do not necessarily establish the same relationships over time with consultants and hospital staff as they do their GPs.

4 Widened social inequalities:

There was concern that the QOF, in particular, would contribute to the Inverse Care Law, by discouraging GPs from both working in difficult catchment areas and targeting hard-to-reach patients within their actual practice. It was believed that the use of exception reporting would exacerbate this risk, given that GPs would not be penalised for excluding the most difficult patients from their targets.

Evidence suggests that many of these fears were unsubstantiated. Contrary to expectation, early P4P experiments in the 1990s showed that cervical cytology and immunisation targets significantly narrowed rate differences between affluent and deprived communities across England. Although it is still too early to tell whether the QOF will achieve the same result, high achievement across practices irrespective of location suggests that it may improve equity between practices as well.

Figure 5: Greatest Perceived Risks of an Incentive Based Payment System



Source: PricewaterhouseCoopers Healthcast 2020 Survey

8 Finding: Quality improvement creates winners and losers, which generates tension for individuals and/or organisations signing up to the programme.

By definition, pay for performance is structured so that high performers receive reward. Many people have argued however, that it is the poor performers that require additional financial incentive and/or investment, in order to make quality improvements. As such, a combination of reward thresholds should be considered, so that the possible changes to payment mechanisms and bonus structures do not further dichotomise quality between organisations.

Fundamentally, as Peter C. Smith attested, “any change to payment systems creates winners and losers. You can call a reward a bonus for good performance, or you can also formulate it as a penalty for bad performance and it’s exactly the same strategy, but the effect on professionals may be different. So I think there’s a lot of psychology about how you present financial incentives.” The QOF, for example, was designed to make everyone a winner, which was instrumental in engaging clinicians from the onset. The NHS Northwest Advancing Quality Initiative has also been designed to be rewards-based rather than penalty-based, so not to make providers feel at risk for signing on to the project. However, the implicit tension that P4P could introduce needs to be effectively managed, so that competition is constructive, rather than destructive.

Recommendation: Quality improvement programmes need to incorporate a failure regime to support poor performers.

Any pay for performance programme should include a failure regime to support poor performers. However, as several stakeholders mentioned, historically, one of the problems with the NHS is that they have been unable to develop a failure regime for organisations in trouble. As one stakeholder claimed, despite constant discussion about the NHS being a market system, it hasn’t completed the market process because there is no failure regime.

According to a King’s Fund report, the combination of PbR, patient choice and practice-based commissioning may push 20% of trusts into deficit over the next few years²⁶. As hospitals lose resources, this is likely to have an adverse impact on quality. Understandably however, hospital failing has significant social and political implications and politicians are often unwilling to vote on a policy that may result in the closure of their local hospital. Yet, as one stakeholder pointed out, failure is often presented in too stark terms. It is unlikely that the identification of quality issues, in particular, would lead to closure. Even if closure were inevitable, it is more likely that poor performance would lead to departmental, rather than organisational closure.

In response to the above problems, a strategy for managing financially challenged trusts has been included in the NHS 2008/2009 Operating Framework²⁷. Whether this could and would be extended to incorporate organisations with identified quality issues, remains to be seen.

System-wide Issues:

9 Finding: Stakeholders want pay for performance schemes that are coordinated centrally but managed locally.

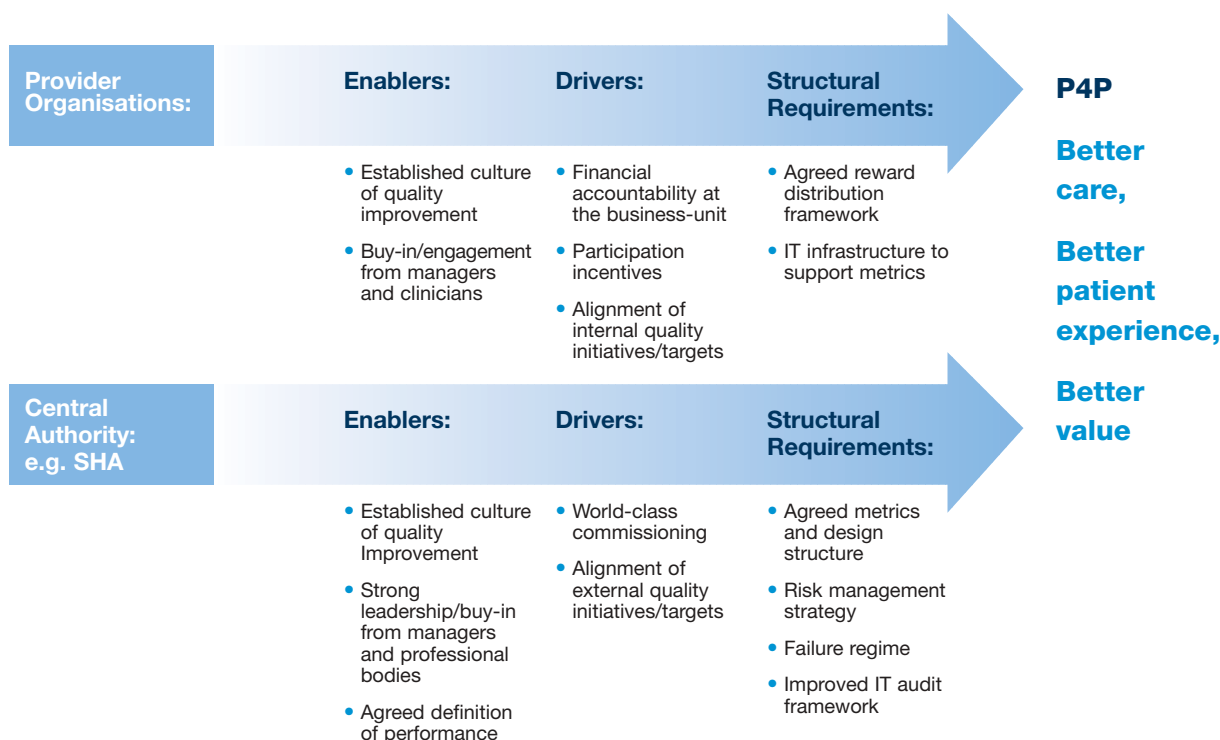
While most stakeholders believed that the government should take the lead in promulgating the quality agenda, there was concern that central directives designed to drive local improvement would be unsuccessful, particularly in a constantly changing political environment.

Stakeholders were very clear about division of labour necessary to manage P4P effectively. The general consensus was that designing and standardising pay for performance metrics should be centrally driven, either at the Department of Health or Strategic Health Authority-level. As Mike Farrar claimed, “unless you’ve got clinically credible standards which everybody’s signed up to, with an authoritative source underpinning it, rather than just setting your own local standards... with clinicians having huge rows over whether an indicator is a good measure of performance, it (P4P) will fall into disrepute.”

However, metrics also need to be flexible enough to adapt to local populations, given the move towards local targets. Yet, this further reinforces the need for a strong, centrally-coordinated base system. As Peter C. Smith emphasised, “The more you decentralise a health system, the more you need to make uniform the information it provides. You replace command and control with money going one way and information coming the other. Without that information, I don’t see how you can regulate the system and assure that it is performing in line with objectives.”

Designing the appropriate reward structure should also be centrally driven. Many US hospital schemes NHS Northwest Advancing Quality Initiative have used a central authority to manage incentive payments across participating hospitals. However, the Californian based IHA P4P programme, which involves 228 medical practices and 40,000 physicians, allows participating health plans to determine their own budgets and methods for calculating reward payment. Within the NHS, it is likely that a centrally determined rewards structure would be more effective, as a means of securing engagement at all levels and driving standardisation. While determinations about how much and at what level to reimburse should be centrally driven, deciding what to do with the rewards once received, could, and should remain a local decision.

Figure 6: P4P Division of Labour



Lastly, stakeholders felt that the Department of Health should continue to provide guidance and disseminate best practice information on purchasing and contracting between PCTs and providers, which should help drive quality initiatives.

PCTs, on the other hand, should assume responsibility for mobilising their teams on the ground to affect change. As Dr. David Colin-Thomé said, “You need to get clinicians on board to explain the changes to the population and you need to have managers and clinicians who are prepared to make decisions using up to date clinical evidence because it leads to a safer and more effective way of using NHS resource, rather than just protecting the status quo of the care offered by an institution.” (See Figure 6)

Recommendation: Primary care trusts need to improve their commissioning skills in order to drive the quality agenda more effectively. In addition, providers need incentives to encourage them to form effective partnerships with PCTs.

Although some organisations have implemented local quality improvement programmes, many have failed to make them a priority. As one stakeholder maintained however, for many hospitals, it is not that they do not know how to drive quality improvement; they simply do not have the money or the resources to do so.

Similarly, although the Department of Health continues to push quality reforms, particularly in the form of new targets, constantly moving goal posts and variable execution means that many organisations are falling

short of the mark. A recent Healthcare Commission report, for example, citing poor hygiene and infection control practices in three Maidstone and Tunbridge Wells NHS Trust hospitals as the cause of 1,200 MRSA cases and 90 deaths in three years, is testament to this shortcoming²⁸.

When asked how to drive quality improvements more effectively within hospitals, many stakeholders suggested changes to PbR, from attaching a quality measure to HRGs to restricting reimbursement to one care episode per patient only, so that any additional costs as a result of readmissions or complications are incurred by the organisation. A recent report by the Audit Commission also makes several suggestions about how to introduce quality into PbR, such as normative tariffs based on high efficiency costs rather than average costs, flexibility to set local costs that account for innovations not supported by the tariff, and a flexible tariff structure that can be unbundled or set to price for a pathway of care, rather than a single patient episode²⁹.

Despite the powerful business case for a revised HRG system, most stakeholders believed that the real solution lay in improved commissioning. The consensus was that PCTs need to create a market whereby providers feel they need to compete on quality and efficiency to secure future contracts. However, PCTs are still very weak commissioners and do not have the capacity or the capability to drive these changes at the moment. PbR has exposed this weakness, as most PCTs have been unable to manage the competing incentives it creates. This problem has been greatly

exacerbated by the fact that providers tend to be stronger organisations, with better business skills and better access to information. Due to this imbalance of power, which favours providers, the incentive for them to form effective partnerships with PCTs has been weak.

Improved commissioning entails better contracting with explicit quality criteria, better procurement and purchasing of services, including exploring various provider accreditation frameworks such as those used by some UK insurance companies, and better access to performance metrics to support decision-making. In addition, mechanisms such as utilisation reviews to validate hospital claims and actuarial forecasting to ensure that contracts reflect the projected health needs and costs of a captive population, like those regularly used in the US and by insurers, should be incorporated into standard PCT practice.

The success of the QOF and programmes such as the South Central Strategic Health Authority initiative to develop world-class commissioning capabilities in 2007 suggest that PCTs may be ready to up their game. Hospital-level pay for performance programmes, in particular, should appeal to PCT managers, as they would provide currency to support more honest transactions with powerful providers. Furthermore, to a large extent, PCTs no longer have a choice. As Duncan Innes from BUPA noted, “the increase of funds have tailed off so that efficiency and productivity are not options, they are essential. So PCTs, perhaps for perverse reasons, because they can’t pour more money at it because they don’t have it, are starting to have the incentives to contract and commission and get into the detail a lot more strongly than they did before.” Indeed, recognising the need for PCTs to step up to the challenge, the Department of Health has recently announced a Towards World Class Commissioning Programme for 2008, which will roll out a PCT development programme and a corresponding quality assurance framework.

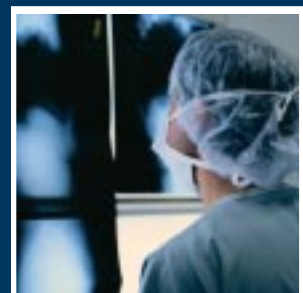
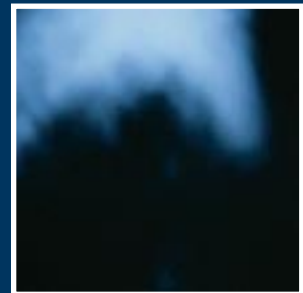
Yet, PCTs are still generally resistant to the concept of P4P specifically, given that it incentivises processes that they feel should be an implicit part of the service offering. As Dr. Stephen Dunn articulated, “I suppose what we’re implicitly saying is that they’ve not met national quality standards, national service frameworks, and incentives, and we’re going to pay them again, twice, for hitting quality standards that they should automatically be hitting as part of the Healthcare Commission-led quality framework. That is an issue.”

There are several complications from the provider perspective as well. Although evidence suggests that PbR actually shortens length of stay, it may also reinforce incentives to keep care in the hospital, rather than delivering it in a community setting. While some of the Foundation Trusts may have an incentive to support this move, as they strive to develop tertiary services, many district and acute trusts are disinclined to support commissioning objectives that may negatively impact their own finances.

Research suggests that the greatest improvements in healthcare outcomes and efficiency will come from sustained, team-based focus on carefully selected areas of strength, rather than expanding the breadth of provider service offerings³⁰. In order to encourage providers to make this transition and form local partnerships with PCTs and other local services, new incentives need to be explored. These efforts could be largely driven by the regulatory bodies, such as Monitor. For hospitals however, their fixed cost system will continue to make it difficult to allow for rewards-based quality improvement programmes specifically.

The consensus among stakeholders was that for commissioning to drive quality improvements, PCTs need to become more powerful than providers. Assuming this shift in power was to occur, providers would also be incentivised to improve practice in order to compete for contracts in a new quality-led environment. As Dr. Stephen Dunn attested, “That’s part of a market system. You don’t get paid if you don’t deliver what the customer wants and if you don’t deliver what the customer wants, you get into financial problems and that affects your overall future.”

Conclusion



Stakeholders agreed that pay for performance is an effective way of changing behaviour and driving quality improvements across the health service. Importantly, a well designed P4P programme can also create a currency for improved quality-based purchasing. However, if poorly planned, designed and executed, P4P carries a number of risks and can destabilise other ongoing quality initiatives. Like any payment mechanism, it also requires close regulation to ensure its continued effectiveness and to prevent its abuse.

Table 2 lists key transferable lessons from previous P4P experiments in the US and England. These lessons should be applied when health managers are considering P4P as a plausible quality improvement option.

As a bottom line for NHS organisations looking to design and implement P4P as part of their quality improvement programme, critical success factors include:

An organisation committed to quality

A pay for performance programme has, at its core, the desire to improve performance and attain better health outcomes for patients. Better care and better outcomes save money for health systems in both the short and the long run. Any new programme, however, will have inevitable start-up and administrative costs and a purely 'bottom-line' objective is not enough to justify such a programme. The critical success factor for implementing an NHS P4P programme is an organisation and culture that is committed to quality improvement and seeks national and international reputation for world-class service.

Clinical engagement with evidence-based quality measures

Both the mechanisms that make a pay for performance programme possible and the benefits of a successful programme are experienced at the front lines of clinical care. This means that a new pay for performance programme will fail or succeed based on the engagement of individual clinicians. The engagement of clinicians and front-line staff is not only essential but requires special skills and experience. The structures that engage these people are unique, with direct representation to Board level but without direct command authority.

For example, when analysing data from two hospitals with considerable differences in quality or productivity, it would be reasonable to expect clinicians to question the validity of the data and whether a proper case-mix has been taken into account. Fighting against that response will not lead to change; working through the data with clinical task groups will lead to greater understanding of the underlying issues and acceptance of the need to change.

In addition, experience in the US and, indeed, with the QOF, highlights the importance of a programme that is based on well-established metrics, agreed by clinicians and supported by a strong evidence base. This will also appeal to the professionalism of clinicians, which is essential to minimise some of P4P's associated risks.

There should be incentives for participating as well as succeeding

Because GPs performed much better than expected on the QOF, there was an early, positive experience with the programme. Although this is sometimes seen as a failure, securing early buy-in to a P4P scheme is vital to the NHS. There are several ways this can be accomplished and not all financial. As previously discussed, a graduating reward threshold that rewards the majority of participants early on is one option. Thresholds can then be revised and rewards can be redistributed in subsequent years. This will help enlist early support and effectively jumpstart the programme by boosting overall performance. As the programme becomes more challenging, not only will quality differentials between organisation become more apparent, thus continuing to drive change forward, but it will also help cap overall programme costs.

Because a pay for performance programme is based on data, access to information about other organisations' performance may be incentive enough for participation. Careful stakeholder management by a third party facilitator, probably the SHA, will be crucial.

P4P requires whole health economy cooperation with roles for commissioners, providers and a central facilitator

Above all else, a pay for performance programme ultimately creates both a mechanism for improving quality outcomes and a currency for quality-based purchasing. To do this effectively, key players across the healthcare spectrum need to be involved, from clinicians through to senior NHS management. While clinical quality is executed by the health care provider, much of this behaviour will depend on the relationship and arrangements with commissioners and the facilitation and support of Strategic Health Authorities.

Table 2. Pay for Performance Design Features: Considerations for Healthcare Managers

| Solution Driver | Description | Transferable Lessons |
|-----------------|--|---|
| People | To make P4P successful, a cultural commitment to change is necessary. In addition, strong leadership and engagement across the healthcare spectrum is needed, including professional bodies, senior NHS managers and clinicians. | <ul style="list-style-type: none"> • Co-opt professional bodies as advocates for change, e.g. by adopting professional best practice guidelines endorsed by them. Once their support has been received, they can be the primary champions of the new scheme. • Consult clinicians about metric design, e.g. by providing evidence-based guidelines and related literature as starting points for discussion and including them on an expert panel for metric negotiations. • Design a reward structure that has clear metrics, and tangible benefits. |
| Metrics | Well-designed P4P metrics are essential to establishing a credible programme that can drive measurable quality improvement. | <ul style="list-style-type: none"> • Make sure metrics are evidence-based and within the remit of care of those responsible for them. • Use a combination of clinical, business and patient experience metrics. • Establish a process for continual evolution of metrics, e.g. by establishing regular review cycles in partnership with professional bodies such as the Royal Colleges. Individual users should also be given the opportunity to provide feedback on metrics. • Initially, concentrate on process measures that can be readily derived from existing systems and can be clearly tied to clinical practice. Measures can be expanded to include appropriate outcome measures at a later date. |
| Design | P4P design needs to be carefully considered in order to maximise quality return while mitigating the potential risks. | <ul style="list-style-type: none"> • Determine the right level of reward or combination of levels to evoke the desired response • Use a combination of absolute and relative performance thresholds that also recognises individual improvement. • Incorporate participation rewards to attract all providers, even lower performers • Develop a risk management strategy that is reviewed annually and overseen by senior leadership |
| Technology | IT infrastructure needs to be able to collect, aggregate and disseminate quality metrics as part of the clinical process. Collecting and analysing data should not be unduly burdensome for the provider. | <ul style="list-style-type: none"> • Involve IT in metrics design, by engaging national and local health IT leaders in practicability discussions at an early stage. • Improve IT audit and coding framework by reviewing current framework and comparing against best practices • Consider including incentives for effective IT adoption within the P4P framework. |
| Finance | Decisions need to be made about how P4P is financed and whether it should be used as a payment mechanism or a bonus scheme. Improved business-unit finances are also required to determine the most effective use of rewards and the level of reinvestment required to meet quality targets. | <ul style="list-style-type: none"> • Make business-unit financial accountability at a provider level a prerequisite for participation • Consider creative uses of P4P rewards at the business-unit level, such as reinvestment in new technology, additional support staff, etc. • Allow business-units the autonomy to manage their own rewards and reinvest as they see fit. |
| Process | In essence, P4P is a currency for quality-based purchasing. As such, it is a critical tool for commissioners looking to become 'smarter' purchasers. | <ul style="list-style-type: none"> • Develop world-class commissioning skills. • Enlist provider support through the creation of new incentives. • Make providers accountable by developing a robust failure regime. |
| System | In order to manage the risks of P4P, it needs to be aligned with other quality drivers, e.g. national targets. It is also important that P4P is incorporated into larger, policy initiatives. | <ul style="list-style-type: none"> • Encourage local partnerships as a means of aligning quality improvement initiatives and sharing of best practices. • Regulate P4P centrally but mobilise locally. • Ensure an open and accessible feedback mechanism exists to solicit updates on experiences and lessons learned. |

A natural outgrowth of changing policy, in 2002, the Department of Health outlined its plans to introduce a payment system for hospital activity. This system, called Payment by Results (PbR), is essentially a rules-based system whereby trusts are paid according to the number and complexity of cases they treat. This is a significant change from the historic funding method of fixed budget allocations ('block contracts') to providers.

PbR is based on the Diagnosis Related Groups (DRG) system pioneered in America and now in use in most modern health systems, including much of Europe and Australia. In the English system, acute hospital activity is paid according to Healthcare Resource Groups (HRGs) the DRG equivalent. Each HRG is costed according to a casemix-adjusted tariff that is set by the Department of Health based on average hospital costs of care.

PbR was phased in from 2003/2004 and developments are on-going to improve the system, focusing on HRGs that differentiate by case complexity. This increased sensitivity is reliant on accurate and consistent classification and coding of clinical activity. There has been legitimate concern expressed about the ability of current information systems to capture the kind of information necessary to support the robust data requirements of PbR.

PbR means that hospitals are only reimbursed for the work they do so there is an incentive for efficiency and productivity that did not exist in the days of 'block contracts'. Because providers are paid a fixed average cost per HRG, known as the tariff, acute providers can review their actual costs against PbR income to identify performance improvement opportunities.

In a recent review of Payment by Results, the Audit Commission found that it has increased fairness and transparency of the payment system. It has also encouraged both PCTs and providers to improve their IT systems and their financial, performance and contract management. There is concern however, that PbR has yet to achieve the activity and efficiency gains that it promised. This is partially due to capacity constraints, limitations of current IT systems and revisions to the tariff during its first two years. In addition, it has also been suggested that some of the implicit risks of a PbR system have not been fully realised at this stage.³²

An additional aim of PbR is to drive quality improvement by removing the need for local price negotiation and allowing PCTs to focus on quality of care. It was also believed that patient choice of provider would compliment the PbR system, driving quality improvements in order to maintain sufficient patient volumes, although this has yet to be demonstrated. Because PbR relies on consistent, accurate data relating to clinical activity, there is also scope for commissioners to contract with providers based on specific clinical behaviour. In this way, the PbR payment mechanism is a critical enabler of hospital-level pay for performance.

Despite this potential, PbR has yet to drive tangible quality improvements in hospitals. In fact, it has been suggested that PbR actually impedes quality. This is largely due to the way the tariff is constructed, which is based on the average of averages. As such, many Chief Executives from Foundation Trusts in particular, have argued that it is inadequate for high-end services, because it fails to account for the added value costs of teaching hospitals and the transition costs of innovation. While many FTs are able to find alternate income sources to supplement the development costs of high-end services, it is feared that PbR could stifle innovation among local hospitals and trusts. This would in turn, increase the quality differential between FTs and other providers.

PbR Development Timeline

PbR Development

| | |
|-----------|--|
| 2002 | DH announces plans to develop PbR |
| 2003/2004 | PbR phased in, focused on elective care only with a limited number of HRGs |
| 2004/2005 | Primary Care Trusts asked to commission most of services with Foundation Trusts via PbR. |
| 2005/2006 | All acute specialist trusts expected to participate in the new system |
| 2006/2007 | All non-Foundation Trusts using PbR for both non-elective and outpatient care. About 60% of acute hospital income comes under PbR. |
| 2007/8 | Further refinements based on HRGv3.5 |
| 2008/9 | National tariff further developed, covering acute and specialist hospital services and un-bundling some HRGs. |
| 2009/10 | HRGv4 introduced to better differentiates between routine and complex work. HRG4 also established new currencies for some services |

Appendix II Overview of Key US P4P Programmes

Bridges to Excellence (BTE)³³:

In response to the Institute of Medicine's influential report, *Crossing the Quality Chasm*, a non-profit coalition of large employers founded Bridges to Excellence in 2002. BTE's mission is to create incentives that will transform care processes in order to reduce mistakes, waste and inefficient uses of resources, and increase accountability through the release of comparative provider performance data. Their programmes are designed specifically to provide incentives that reward physicians and practices for adopting better systems of care that result in physician practice reengineering, better information technology and ultimately, improved patient outcomes.

BTE currently runs several programmes across 13 US states. Programmes include a Physician Office Link programme, which enables physician office sites to qualify for bonuses based on their implementation of specific processes intended to reduce errors and increase quality. A report card for each site describes its performance on programme measures and is made available to the public. Other programmes reward performance in relation to management of specific conditions, including diabetes, cardiac and spine care. Participation in programmes is voluntary for physicians, as they are required to pass assessment exams established by the National Committee for Quality Assurance before enrolling.

As of December 2007, there were 9,642 participating physicians from 1,838 practices, receiving a total of \$10.7 million in rewards.

Integrated Healthcare Association (IHA)³⁴:

California-based Integrated Healthcare Association runs the largest pay for performance programme in the US, representing 228 medical groups and 40,000 physicians and providing care for 12 million HMO members. In addition, seven California health plans participate in both public reporting and incentive payments, with an additional plan participating in public reporting only.

IHA uses a quality scorecard structure that covers three broad categories: clinical quality, patient satisfaction and information technology investment, which account for 50%, 30% and 20% of the total score respectively. Programme results from 2005, the third year of operation, show quality improvement on all clinical measures and increased use of information technology among physician groups. For example, compared to 2004, physician groups reported that they screened 60,000 more women for cervical cancer, tested 12,000 more individuals for diabetes and administered 30,000 more childhood immunisations.

In 2004 and 2005, the seven participating health plans paid out more than \$90 million in P4P bonuses. Each plan determines its own budget and methodology for calculating bonus payments to medical groups, but uses the common IHA set of performance metrics.

Centre for Medicare and Medicaid Services (CMS):

CMS has two major hospital P4P programmes under way: the Hospital Quality Initiative and the Premier Hospital Quality Demonstration Project. Under the Hospital Quality Initiative, initially, eligible hospitals received their full annual update under the inpatient prospective payment system if they submitted data on 10 quality measures for acute myocardial infarction, heart failure and pneumonia. Otherwise eligible hospitals that did not participate in the initiative by reporting the required data by the established deadlines received a 0.4% point reduction in their annual Medicare payment update. As of 2007, hospitals not reporting on an expanded set of 21 measures received a 2.0% point reduction in their payment update³⁵.

CMS's second hospital incentive programme, the Premier Hospital Quality Incentive Demonstration Project is a three year pilot, which began in 2003. It currently involves more than 260 hospitals and is managed by Premier, a national group purchasing organisation. The project collects data on more than 34 quality measures relating to a five clinical areas: acute myocardial infarction (AMI), heart failure, coronary artery bypass graft, pneumonia and hip and knee replacement.

Hospitals are scored on the quality measures related to each condition measured in the demonstration. Composite quality scores are calculated annually for participating hospitals by "rolling-up" individual measures into an overall quality score for each clinical condition. CMS then computes the distribution of hospital quality scores into deciles in order to identify hospitals with the highest clinical performance for each of the five clinical areas. Hospitals in the top 20% are given a financial reward, a 2% and 1% bonus of their Medicare payments for the measured condition for those in the top first and second deciles respectively. Additionally, there is a potential payment penalty after Year Three of the project, if a hospital is below a certain threshold, established based on Year One performance.

In early 2007, after two years of the three year project, 115 hospitals have received quality incentive payments, totalling approximately \$8.6 million. Quality improvements have been observed across all hospitals and clinical areas, with significantly higher hospital quality scores than the national average (85% compared to 79%). In particular, it is estimated that patients have received 150,000 additional treatments and that AMI improvements in particular, have saved 1,284 patients³⁶.

Glossary

| Acronym | Expansion | Meaning |
|---------|-----------------------------|--|
| | Acute Trust | Acute trusts are state owned hospitals which deliver secondary care to NHS patients under central government direction. |
| BMA | British Medical Association | A trade union established to represent the interests of individual members and the collective interests of doctors. Over two-thirds of practicing UK doctors across all branches of medicine are members. |
| | Consultant | A senior member of the medical profession, typically hospital-based, with defined responsibilities. A consultant, whether trained as a physician, surgeon or some other specialty, typically has advanced qualifications beyond their medical degree, such as membership or fellowship of the appropriate Royal College. Such certification by a Royal College is roughly equivalent to Board certification in the US. |
| DRG | Diagnosis Related Group | The classification of patients by diagnosis or surgical procedure into major diagnostic categories, in order to determine hospital payment. Originally developed by Medicare in 1983, DRGs are based on the premise that treatment of similar medical diagnoses generates similar costs. |
| DH | Department of Health | The Department within the UK government that oversees the entire health system. Responsibilities include securing tax funding via HM Treasury, setting national standards, shaping the direction of the NHS social care services and promoting healthier living. |
| GP | General practitioner | A medical doctor that provides primary care. The synonyms family practitioner or family physician are widely used across Canada and the US. |
| FT | Foundation Trust | First introduced in 2004, FTs are a new type of NHS hospital run by local managers, staff and members of the public. They have more financial and operational freedom than other NHS trusts and represent an aspect of the current Government's attempt to decentralise the control of public services. FTs are licensed and regulated by the oversight body, Monitor. |
| HRG | Healthcare Resource Group | Within the English NHS, an HRG is a group of health-related activities that have been judged to consume a similar level of resources. The prime purpose of HRGs is to assist the Department of Health to implement the policy of Payment by Results, a tariff-based financial rewards system for hospitals akin to DRG systems in other countries. |
| Monitor | | Established in 2004, Monitor has two primary functions. Monitor receives and considers applications from NHS Trusts seeking Foundation status. Once Foundation status has been achieved, Monitor regulates trusts, making sure they comply with their terms of authorisation and are well-managed and financially sustainable. |
| NHS | National Health Service | The publicly funded health care system in the UK, which provides the majority of healthcare across the country. The policies of the NHS are now devolved so that England, Scotland, Wales and Northern Ireland have different systems in place for reward and delivery of health care. |

| Acronym | Expansion | Meaning |
|---------------|--------------------------------|---|
| | Payer/commissioner/purchaser | The administrative entity financially responsible for purchasing healthcare services for a finite population. The term 'commissioner' is used in England to indicate that the role entails more than financial administration, including elements of healthcare needs planning and quality management. |
| PbR | Payment by Results | A payment system for hospital activity where trusts are paid according to the number and complexity of cases they treat, as determined by HRGs. Please see Appendix 1 for more information. |
| PCT | Primary Care Trust | PCTs are responsible for organising and delivering healthcare to a finite population. Their three main functions include engaging with the local population to improve health and wellbeing, commissioning a comprehensive and equitable range of services within allocated resources across all service sectors, and directly providing high quality and efficient services where necessary. There are 152 PCTs in England. |
| QOF | Quality and Outcomes Framework | Introduced as part of the 2004 new General Medical Service Contract, an annual reward and incentive programme in which GPs receive payment for meeting healthcare quality targets. |
| Royal College | | The term 'Royal College' is commonly applied to the medical professional societies, such as the Royal College of Surgeons and the Royal College of Physicians. These colleges enjoy a special status and can confer titles comparable to degrees, e.g. Fellow of the Royal College of Surgeons. They are also frequently granted statutory licensing, regulatory and other disciplinary powers over their members. |
| SF-36 | Standardised Short Form 36 | A 36 question health survey developed in the US. It is currently one of the most popular tools for measuring health status due to its reliability and validity. The SF-36 is also popular due to its universal applicability, given that its questions apply to people of different health statuses receiving a variety of treatments. In particular, it is considered a strong tool for measuring the often subtle changes in health that follow medical interventions, such as surgery. Currently, many other PROMS tools are being tested for use in the NHS although the SF-36 remains the most common. |
| SHA | Strategic Health Authority | SHAs serve as the regional headquarters of the NHS. Their three main functions include providing strategic leadership to local services, organisational and workforce development and ensuring local services operate effectively and deliver improved performance. There are 10 SHAs in England. |

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Health Research Institute

Simon Leary
Partner, Health Research Institute
simon.m.leary@uk.pwc.com
+44 (0)20 7804 9969

David Chin, M.D.
Partner, Health Research Institute
Dr. David.chin@us.pwc.com
+1 (617) 530-4381

Sandy Lutz
Managing Director, Health Research Institute
sandy.lutz@us.pwc.com
+1 (214) 754-5434

Nick Beard, M.D.
Director
nicolas.beard@us.pwc.com
+1 (206) 398-3293

Benjamin Isgur
Assistant Director
benjamin.isgur@us.pwc.com
+1 (214) 754-5091

Kara Allen
Research Analyst
kara.y.allen@us.pwc.com
+1 (312) 298-2767

Contributing Authors

Kira Levy
Advisory
kira.a.levy@pwc.uk.com
+ 44 (0)20 7212 7777

Rachel Abbott
Advisory
rachel.abbott@pwc.uk.com
+44 (0)20 7212 7777

Principal Contributors

HRI would also like to acknowledge the following participants in the research process and their contributions:

Angela Coulter: Chief Executive, Picker Institute Europe.

Howard Carstairs: Financial Director, Southampton Primary Care Trust.

Dr. Stephen Dunn: Acting Director of Provider Development, East of England Strategic Health Authority.

Mike Farrar: Chief Executive, NHS Northwest Strategic Health Authority.

Duncan Innes: Public Affairs Manager, BUPA

Julian Le Grand: Richard Titmuss Professor of Social Policy, London School of Economics

Malcolm Lowe Lauri: Chief Executive, King's College Hospital NHS Foundation Trust

Dr. Martin Roland: Professor of General Practice at the University of Manchester and the Director of the National Primary Care Research Development Centre

Dr. David Payton: Medical Director (for Commercial Directorate), Southampton Primary Care Trust

Peter C.Smith: Professor of Economics, Centre for Health Economics, University of York.

Dr. David Colin-Thomé: National Clinical Director for Primary Care, Department of Health

Dr. Tim Wilson: Partner, Healthcare Advisory, PricewaterhouseCoopers.

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