Managing activity and expenditure in the new NHS market: evidence from South Yorkshire

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ABSTRACT

Objectives: To explore the role and perceived effectiveness of demand management strategies deployed in the South Yorkshire Strategic Health Authority area where Payment by Results has been implemented fully, ahead of the national timetable.

Methods: Data collection comprised semi-structured interviews and analysis of background documentation. A total of 18 interviews were undertaken with key PCT staff (Chief Executives, Contracting and Service Development Managers and Finance Directors), provider staff (Finance Directors and Service Development Managers) and GPs.

Results: We found that no single set of strategies was in place in South Yorkshire to deal specifically with the potential problem of managing activity and expenditure. Instead, various strategies were highlighted as having a role in managing demand. This “patchwork” of initiatives appears to be more a reflection of each locality’s historical situation, rather than a strategic response to an emerging problem. The majority of initiatives are recently introduced and have yet to be fully evaluated.

Conclusions: The lack of prescriptive central guidance from the Department of Health is likely to result in the piloting of a wide variety of demand side instruments at the local level. Whether these instruments will be adequate for PCTs to control activity so that they live within their budget allocations remains to be seen. The challenge is to ensure that the evidence base to support policy and practice is strengthened and shared for the benefit of the NHS as a whole.

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1. Introduction

The NHS in England has embarked on an ambitious programme of reforms aimed at making health care delivery more accessible, responsive and productive (1) . As part of wider system reform increased levels of hospital activity are being sought through various means, including expanding provider *capacity*, through investment in NHS and independent sector facilities; sharpened *incentives*, with providers paid for undertaking additional work under "Payment by Results" (PbR) (2); and greater patient *mobility* through Choose and Book, allowing providers to attract more work (3). The result is that the historic excess of demand over supply in the English NHS may be re-dressed, with the possibility of excess capacity across some clinical and geographical areas.

Primary Care Trusts (PCTs) are the local statutory organisation in the English NHS responsible for the commissioning of care on behalf of their resident populations. PCTs receive an annual budget based on the characteristics of their population and are required to achieve financial balance without the need for unplanned financial support. However, PCTs are facing increased exposure to financial risk, precisely because of the reforms designed to increase activity.

PbR has changed the nature of contractual relations between PCTs and providers. Previously, contracts between the two parties would stipulate a total payment for a specified volume of activity. There may have been a payment adjustment if outturn deviated from the contracted volume but, by and large, providers had to live within an annual budget composed of the sum-total of their contracts. These arrangements allowed for tight control of expenditure but provided little incentive for providers to exceed their contracted levels of activity.

PbR introduces strong incentives for providers to undertake more activity, because they are able to increase their revenue in proportion to the growth in activity. Moreover, whereas previously the price per unit of activity was simply the by-product of the negotiation around the overall contract, now prices ("tariffs") are set nationally on the basis of average costs across the country. This means that providers know in advance how much they will receive as activity increases. From a provider perspective, PbR relaxes the internal budgetary control previously exercised by hospital managers: managers and doctors now have a shared incentive to increase activity and, hence, income.

It is now more difficult for PCTs to ensure that expenditure equates to their budget allocations. This arises for two reasons. First, under PbR they are unable to negotiate lower prices, having to pay the set national tariff for additional work. Second, they have less control over volume, with Choose and Book allowing patients greater choice about where and when they are treated. This makes it difficult to specify volumes in advance with their contractual partners.

Under such circumstances, there is a greater onus on PCTs to exercise discipline in managing demand so as to ensure that their budget allocations are not exceeded. To be effective, PCTs will need to focus demand management on two sets of actors:

- GPs, who influence the level of demand by virtue of their treatment and referral decisions;
- and providers, particularly hospital consultants, who influence the extent to which demand is converted into activity by their admission and treatment decisions.

At least three factors may compromise the ability of PCTs to dampen demand inducing behaviour by these actors. First, PCTs currently have few levers with which to influence referrals of self-employed GPs, whose decisions are clearly crucial in ensuring that the PCT stays within budget. Second, the balance of power in the NHS has long rested with providers rather than purchasers (4) . PCTs are in a relatively weak bargaining position, because they lack timely and high quality information and analytical capability to monitor and hold providers to account for their behaviour. Finally, PCTs are facing an uncertain future due to re-organisation plans (5). This may induce organisational stasis and serve to limit clinical engagement with initiatives designed to manage demand pressures.

In this paper we explore the development and perceived effectiveness of different strategies for managing demand deployed within the South Yorkshire health economy. South Yorkshire is implementing of PbR ahead of the national timetable. This means that all acute hospitals are being paid for all their activity on the basis of the national, rather than local, prices. The remaining sections of the paper draw on the findings of an empirical study which explores the role and perceived effectiveness of demand management strategies in this local health economy.

The key objectives of the study were to identify:

- what strategies are being employed or developed locally to limit, manage and redirect demand for secondary and tertiary services;
- the relative benefits and drawbacks of different approaches for patients, PCTs, providers and the local health economy; and
- the facilitators and barriers to developing effective approaches for managing demand.

2. Methods

Data gathering comprised two main elements:

i. *In depth semi- structured interviews with a sample of key stakeholders*. The sample was selected following discussions with South Yorkshire Strategic Health Authority and via ‘snowball’ contacts once the project commenced. A total of 18 interviews were undertaken between late August 2005 and mid October 2005. The interviews were audio taped and were transcribed fully prior to analysis. Those interviewed included:

- PCT staff with an interest and experience in managing patient demand (including Chief Executives, Contracting and Service Development Managers and Finance Directors)
- Provider staff (including Finance Directors and Service Development Managers)
- Strategic staff with an interest in performance management and demand management.
- General Practitioners.

ii. A review of relevant background statistics and documentation related to Payment by Results and demand management strategies in the area.

The evidence from both these sources was combined to build a rich picture of demand management initiatives in South Yorkshire. It should be noted that many of our findings are based on the perceptions and subjective experience of key individuals and thus open to bias and rival interpretation. In order to improve the validity of the study we cross-referenced accounts between individuals and triangulated the evidence emanating from different data sources. The various sources of data were audited in order to search for evidence that appeared to contradict or was inconsistent with the emerging analysis. A draft of the emerging themes and evidence from the study was presented at a meeting of key stakeholders (including those interviewed for the study) and this provided an opportunity to discuss alternative interpretations of the evidence as well as serving to highlight gaps and areas for further investigation. The findings contained in the draft final report were presented at a later meeting of key stakeholders and the ensuing discussion informed the final report and the drafting of this article. Given the sensitive nature of the material and the potential for identification of individuals within the local health economy, we have sought to protect the anonymity of individuals and their organisations by not attributing quotes to individuals, their staff grade or specific organisations.

3. Results

Across South Yorkshire there are emerging examples of various initiatives that have a role in demand management. The first set of these are directed at challenging GP behaviour, namely better collection, monitoring and review of "real-time" information; improved patient management; and development of Practice Based Commissioning. The second set is focussed on the interface with the secondary care sector, with initiatives that allow for service substitution, prevent admission or facilitate discharge.

Review of information

All PCTs in the study were attempting to collect, analyse and share information on activity and referral rates of individual practices and GPs. The extent to which an "information strategy" can change behaviour is conditional upon at least three factors: the analytical capabilities of the PCT; the extent to which activity and referral information support performance management arrangements between the PCT and GPs; and the receptiveness of GPs to change their behaviour in line with external systems of checking, verification and measurement.

In the study we found examples of good analytical capacity, one being an information service which provides data collection and analytical support for four PCTs in the

area. However, evidence suggests that provision of even high quality information to GPs is insufficient to induce reflection and positive reactions. We heard reports that the majority of practices fail to use the data routinely, lack the technical skills to interrogate these data or are defensive when identified as having above-average referral rates (see box 1).

Box 1

"We've tried publicising it [the information system] and making [PCT] people aware of it. People in PCT commissioning roles aren't numbers-and-analysis friendly souls, so there is a technical skill issue."

"I think we have a lot of information, but think we are rubbish at using it."

"As soon as you challenge GPs locally (eg by saying they have high referral rates) they immediately get defensive and say we never send anyone inappropriate."

Greater use of information may be engendered by aligning GP incentives to their clinical performance and referral behaviour. For instance, one PCT in South Yorkshire is using such information as a means of validating the points system associated with the new Quality and Outcomes Framework for general practice (6). However, in general we found little evidence of PCTs using formal incentives for GPs to routinely appraise their referral decisions.

Management of care pathways

Payment by Results provides strong incentives for GPs and PCTs to manage patients in the primary care setting instead of referring them to the secondary care sector, where the full national tariff would be charged. We identified a variety of different models being developed in South Yorkshire to enhance primary care, including chronic disease management; a range of intermediate care services (eg community intervention teams); and risk-based targeted attention to specific groups of patients, such as those who make frequent use of local hospital services ("frequent flyers") and those individuals at risk of staying in hospital beyond the payment trimpoint, after which they attract additional per diem payments (7).

It appears that the incentive to pursue better practice in primary care is influenced by the "all or nothing" nature of the national tariff. But there may also be potential negative implications. It was apparent in the study that the stark division this payment mechanism defines may be detrimental to patients who require ongoing support at the primary and secondary care interface.

Practice Based Commissioning (PBC)

PBC was viewed locally as the main tool that could be developed in the future to encourage GPs to consider the financial implications of their clinical decisions and to manage demand effectively. From April 2005 practices have been able to receive an "indicative budget" and take on responsibility from their PCT for commissioning services for their patients (8).

PBC was not well established across South Yorkshire at the time of this study and the interviews elicited mixed responses about the potential for PBC to aid demand management. There was a belief by some that PBC will be a useful vehicle for performance managing practices by providing them with incentives to be more

"demand management" conscious as they are allowed to invest savings to develop patient services. It was also thought that PBC would allow PCTs to manage GP behaviour and referrals through agreed targets as part of the budget setting process (box 2).

Box 2
"At the moment we [the PCT] have no formal performance management relationship with general practices regarding referrals. But the Practice Based Commissioning arrangements that have been introduced should allow us to do that because it will allow us to agree a budget with the general practice and we would agree targets in relation to that budget. It would allow us to have a more performance management relationship."

However, there remained serious reservations over the expansion of PBC for a variety of reasons:

- the incentives are not thought to be sufficiently high powered for GPs to take responsibility for their PBC budget
- GPs are not motivated to embrace PBC because their attention is focussed on adjusting to the new GP contract and the Qualities and Outcomes Framework (6).
- a belief that additional resources are required at the practice and locality level to fund the additional administrative burden.

Service substitution
A number of initiatives have developed in South Yorkshire to substitute for hospital-based based care. These initiatives include GPs with Special Interests (GPwSIs), Walk in Centres, and NHS Direct.

Their effectiveness as substitute services in South Yorkshire is in doubt, however, principally because much of their workload appears to stem from awakening of previously dormant demand. This is a similar conclusion to that reached by national evaluation of NHS Direct that found that the service did not reduce pressure on the NHS but attracted previously unmet demand for advice and information (9).

The NHS plan heralded the introduction of 1000 specialist GPs (GPwSIs), in the hope that these would relieve pressure on hospital services (10). However, concerns were raised, as they have been elsewhere (11), about the cost-effectiveness of GPwSIs, and that the expansion of GPwSIs in South Yorkshire may have actually increased demand pressures. We heard reports about a hospital that had witnessed a dramatic increase in dermatology referrals following the establishment of a GPwSI in the local area. This was believed to be due to local GPs increasing their referrals to the GPwSI who lacked the confidence and skills to deal with complex cases and therefore referred them to hospital (Box 3).

Box 3
"It's a mixed bag with GPwSIs. In dermatology there are something like 3 or 4 GPwSIs established locally, but we've actually seen as massive increase in dermatology referrals over the last year. What seems to be happening is that, because there is a GPSI, GPs are sending more patients to them, but they have limited

experience and if they have anything they are not sure of they are sending them to hospital.”

“There’s a GPwSI working in dermatology who does minor surgery and essentially we still receive the referrals but the consultants hive off the referrals that can go to that service. So that’s expanding our capacity in effect”

Preventing admission
It is very difficult for GPs and PCTs to influence what happens to patients once they are admitted to hospital. Influence can be brought to bear, however, prior to admission. Under PbR, PCTs have a very strong incentive to prevent admission, because they retain the full national tariff. Some of the PCTs in the case study had developed systems to assess whether admission is appropriate and, if not, to direct patients to alternative providers. An example is to have GPs working in A&E departments, who act as a first point of contact with patients. A pilot scheme in one Foundation trust used GPs who work for the Out of Hours service to provide a primary care medical assessment of patients who present in A&E and do not require secondary care intervention. In the pilot most of the patients selected by GPs were patients with fairly minor complaints (patients walking into A&E).

Facilitating discharge
We found examples of GPs and PCTs working closely with hospitals to facilitate earlier discharge to more appropriate settings (eg step-down beds; discharge liaison teams). While the financial incentives associated with preventing admissions are obvious, they are not so clear cut with respect to better discharge planning, where some form of cost sharing agreement may be required between PCTs and hospitals in recognition of the changing boundary of responsibility. There are some reports that co-operative working between PCTs and hospitals is being discouraged by the current structure of the tariff.

4. Discussion

We found that no single set of strategies was in place in South Yorkshire to deal specifically with the potential problem of managing activity and expenditure. Instead, various strategies were highlighted as having a role in managing demand. This “patchwork” of initiatives appears to be more a reflection of each locality’s historical situation, rather than a strategic response to an emerging problem.

It is clear from the case study that PCTs viewed PBC as key future demand management tool. The effectiveness of PBC depends on how budgets are determined; the incentives GPs have to live within their budget; and the incentives GPs have to work together to manage care effectively. Evidence from the GP fundholding experience about the effectiveness of budget-holding at practice-level is mixed (12) . GPFHs were able to achieve some benefits for their patients, notably with respect to better access (13, 14). But observed differences in referral rates between GPFHs and non-GPFHs were due more to other characteristics of practices and the more generous funding received by GPFHs, than to holding a budget (15, 16).

The Total Purchasing experiment, in which groups of practices co-operated across localities to manage primary care and commission secondary care, found that the level of GP engagement was a key indicator of success (17) . Active engagement was more likely when small groups of practices (5 or 6) worked together, but tailed off as the organisation grew larger.

PCTs appear to be too large to ensure that GPs feel a sense of commitment to organisational objectives and to secure active participation of sufficient numbers of GPs. PBCs may engender a narrow practice-based focus at the expense of co-operative working across practices. This implies that attention should be given to assessing the most appropriate model with which to secure GP participation in the commissioning process.

Design and communication failure may also undermine the effectiveness of PBC. The experience in South Yorkshire is that this is a challenge for introducing PBC budgets, with some GPs (perhaps recalling the fundholding experience) possibly *increasing* their referral rates in the mistaken belief that they will receive larger PBC budgets.

Elsewhere, other PCTs or Strategic Health Authorities have developed other tools to help manage activity levels. Two approaches hold promise, being designed to manage thresholds for referral and for admission.

First, a number of health economies have established clinically-based referral management systems, so that appropriate referral thresholds can be safeguarded. Rather than referring directly to a trust or consultant, all GPs in an area forward their referrals to an area-wide clinical assessment centre. This strategic co-ordination of referral practice has four key advantages over practice-level referral management.

- The centre assesses clinical need and operates a triaging system. This ensures clear and consistent referral thresholds;
- The centre is better placed than the practice to identify alternatives to secondary care;
- Those patients that satisfy the threshold for referral are offered a choice of secondary care provider. This allows central management of the Choose and Book system;
- Any perceived loss to clinical freedom is compensated by the reduced managerial burden on practices.

Second, some health economies are exploring mechanisms to monitor and manage thresholds for admission to hospital. Utilisation reviews can be used to check on the appropriateness of admission criteria and treatment and can take a variety of forms, including concurrent or retrospective review. In general, this involves:

- Establishing “appropriateness criteria” that justify admission and the length of stay in hospital.
- Reviewing what actually happens to patients in relation to these criteria in order to determine whether the admission or continued stay is appropriate.
- Helping providers make best use of their capacity and helping commissioners identify the need for alternative services that may help prevent inappropriate admissions.

The strength of utilisation review is that appropriateness criteria are explicit and are clinically acceptable. However, the review itself can be a fairly costly endeavour. The United Health Group, which insures 14.5 million people in the US, abandoned its utilisation review programme in 1999 (18). The programme was expensive, costing the equivalent of £5.50 per insured person, because prior authorisation had been required before carrying out most medical and surgical procedures. Despite the intensity of the review process, fewer than 1% of requests for approval were denied.

Other models may be less expensive. For instance, rather than reviewing all patients, a focussed review of practice can be undertaken, perhaps by reviewing a selection of patients in hospital over a set period of time to identify practice that fails to meet the appropriateness criteria.

Whether these demand-side instruments will be adequate for PCTs to control activity so that they live within their budget allocations remains to be seen. However, there are signs that PCTs are struggling (19). The structure of tariffs under Payment by Results provides highly powered incentives for providers to increase activity because they are rewarded for activity in hospitals, not for co-operating in service re-configuration. Providers appear to be responding to these incentives, as evidenced by our study. Interviewees commented that providers were attempting to maximise their income under the new tariff, not merely be undertaking more activity but also through increased "consultant to consultant" referrals and increasing the depth of clinical coding (Box 4). In view of this, placing *sole* reliance on demand-side initiatives to ensure appropriate management of activity and expenditure may be misplaced.

Box 4
"The Foundation Trusts are attracting in new business as being an important part of their strategy and therefore, you know, while on the one hand the commissioners are saying 'We can't afford this, more of this or this' the providers are saying, 'Isn't it great, we've seen a rise in referrals', and so they're encouraging work."

In order to moderate the risk of increased demand having excessive implications on PCT expenditure, the payment system needs to be carefully designed to allow for a more sharply focussed incentive regime. One option would be to impose caps on activity, though this should be resisted because it is incompatible with incentivising efficient behaviour and with the Choose and Book policy.

An alternative is to introduce marginal payments for activity above pre-specified thresholds. This would dampen, but not eliminate, the incentive providers have to increase activity. Such arrangements are in place in most other countries that have introduced PbR-type payment mechanisms (20-22). Unless similar modifications are implemented in England, rising levels of activity are likely to become increasingly unaffordable.

Notwithstanding the use of supply side measures it is clear that any successful strategy for addressing unplanned increases in demand must identify what factors are likely to drive demand pressures in the future. Research is therefore urgently needed to: identify what behaviours are most likely to increase demand in the new NHS

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market; quantify the likelihood of such risks (costs); and develop counter measures to address areas of high risk.

The lack of prescriptive central guidance from the Department of Health is likely to result in the piloting of a wide variety of initiatives at the local level. The majority of initiatives are recently introduced and have yet to be fully evaluated, and there is currently little information available on the relative effectiveness or cost-effectiveness of these strategies. It is therefore important that different approaches are subject to economic evaluation, such as has been applied to GPwSIs (11, 23). The challenge, therefore, is to strengthen and expand the current evidence base, identify "best practice" and share this more generally across the NHS.

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