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Health Policy Matters

HELPING DECISION MAKERS PUT HEALTH POLICY INTO PRACTICE

This issue **Do Those Who Pay the Piper Call the Tune?**

Introduction

There is clear evidence that the behaviour of professionals is affected by the ways in which they are paid. This is particularly important now, as reforms of the contracts for doctors aim to exploit these provider responses, to increase their activity and facilitate the achievement of the Government's access and quality targets for the NHS.

Will large increases in expenditure on doctors' remuneration augment clinical activity, reduce patient waiting times and improve the quality of care? Or are these pay rises merely increases in 'rents' for practitioners with no quid pro quo in terms of improved patient care? To what extent do those who pay the piper call the tune in the NHS?

The Government's Agenda

The Government wishes to 'modernise' the NHS, and is investing an additional £40 billion of NHS funding for the UK between 2002-3 and 2007-8, an average annual rise of 7.3 per cent above inflation. By 2008, over nine per cent of the Gross Domestic Product will be spent on health care.[1] This significant increase in funding contrasts with decades of relative parsimony in the hospital sector, during which revenue budgets were constrained and the infrastructure of the NHS allowed to decay. Previously workforce supply was also carefully restricted, both with tight controls of training places and relatively modest increases in remuneration levels.

In exchange for the current boost in funding, the government requires the NHS to improve activity and quality levels by 'acting smarter'. There are numerous targets relating both to elective procedures and the reform of emergency care. National Service Frameworks are in place for mental health, heart disease, older people, cancer, diabetes and children, young people and maternity services, and each includes clearly specified and timed targets or 'milestones'.[2-7] Access targets include plans that no patient will wait for an elective procedure for over nine months in 2004 and six months in 2005. Emergency cancer referrals must be seen within 14 days. Target 'door to needle times' for 75% of eligible patients entering hospital after a heart attack and receiving thrombolytic drugs were 30 minutes at the inception of the framework, reducing to 20 minutes from April 2003. At discharge, such patients should be in receipt of standard pharmaceutical interventions such as beta-blockers and aspirin. National Service Frameworks also require the reconfiguration of cancer treatment processes to exploit apparent advantages in outcomes related to scale, the establishment of stroke units which provide better patient outcomes and reduced waiting times for cardiac surgery.

There are also demanding targets in primary care. By 2004, all GP practices will be required to guarantee that patients will be able to see a primary care professional within 24 hours, and a GP within 48 hours.[8] Throughout the NHS, the National Institute for Clinical Excellence (NICE) provides recommendations about drugs and technologies as well as practice guidelines. Paradoxically only the former have to be funded by Primary Care Trusts (PCTs).

These requirements are complemented by the obligation to introduce systems of clinical governance and risk assessment to ensure quality. Such processes are monitored by a powerful inspectorate, the Commission for Healthcare Audit and Inspection (CHAI), an organisation that aims to

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It examines the effects of different systems of remuneration for doctors and the potential effects of an expensive revision of the contracts of general practitioners and consultants in the UK NHS. It concludes that the medical piper, rather than the NHS purchaser, still calls the tune.

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ensure adherence to NICE guidance, workforce management, and issues of quality and activity.

It is virtually impossible for this 'modernisation agenda' to be costed or prioritised. 'Modernisation' and the accompanying policies of structural reorganisation, with pay inflation and innovations such as Foundation Trusts and reference cost pricing systems cannot be implemented within increased budgets. Other significant causes of cost inflation are greater labour costs following higher rates of national insurance, and the European Working Time Directive,[9] which reduces junior doctors' hours. So, even though the planned expenditure increases are large, there is still a funding gap and the ubiquitous processes of rationing will remain.

As spending and service delivery pledges raise public and patient expectations of the health service, patients anticipate significant improvements in the NHS. An essential part of meeting these promises is a revolution in NHS workforce performance. Can doctors be incentivised to improve both their activity levels and the quality of care offered to patients?

Characteristics of the Medical Workforce

The number of hospital, public health and community health service medical and dental staff in England has grown by 26% since 1991 to 73,850 in 2001.[10] Despite these apparently large increases, the UK has a relatively low ratio of doctors to patients, overall 1.8 practising physicians per 1000 population, compared with, for example 2.5 per 1000 in Australia, 2.9 per 1000 in Sweden, 3 per 1000 in France and 3.4 per 1000 in Germany.[11] With large numbers of doctors approaching retirement age, as well as the desire for greater NHS activity, there is fear of a shortage of doctors in the NHS. Since its conversion in 1999 to the cause that the NHS was 'under funded' with shortfalls in human and physical capital, the Government has emphasised the need to recruit more doctors, nurses and other health care staff. In 2000, Health Secretary Alan Milburn said he wanted 7,500 more consultants and 2,000 more GPs working in the NHS by 2004. By 2002, a further target was announced: 15,000 more GPs and consultants working in the NHS by 2008. The Government has boosted medical school intake by 30 per cent.

These new doctors will take up to a decade to emerge into practice and their contribution to direct care will be reduced as it is proposed that the Senior House Officer trainee grade will involve more study and less patient care time. This, together with the Working Time Directive, will result in a further reduction in the input of non-consultant staff. One measure to mitigate this is an easing of the barrier between hospital middle grade staff and consultants, which will enable the former to acquire consultant status more easily. Whilst this will create apparent growth in consultant numbers (one of the Government's targets), the number of middle grade staff, who carry out many routine tasks, will decline, requiring more consultant cover.

In addition to increased domestic production of doctors, considerable effort has been invested in filling the short-term gap in doctor numbers by recruiting medical staff from overseas. This adds to the proportion of the current doctor stock that is foreign-born - at present over a quarter. The current government has condoned overseas recruitment, which is a form of reverse foreign aid that advantages individuals but penalises donor countries.

The third source of increased medical labour is the product of the blurring of the distinction between doctors and nurses. The creation of specialist nurse consultants and the development of nurse prescribers, perhaps with freedom to use the complete pharmacopoeia, are two examples of radical skill substitution being carried out with little evaluation and, in some cases, rather superficial training.

These radical innovations are very different from the continued reluctance of decision makers throughout the NHS to exercise good management of the existing stocks of doctors. Improved utilisation of existing doctor capacity requires better data and a willingness of management, clinical and non-clinical, to change their behaviour radically. The autonomy of self-employed ('independent contract') general practitioners is such that no national representative data exists about their activity. Whilst some practices have detailed and sophisticated information systems, these are not linked nationally to produce a uniform core data set. Ad hoc studies show considerable variations in the practices of GPs in terms of consultation and hospital referral rates, and their use of pharmaceuticals. The funders of GPs, currently PCTs in England, have generally been passive rather than active purchasers of primary care services. While clinical governance has emerged, particularly since the Shipman case, systematic consumer protection in primary care remains incomplete, largely because of the absence of validated data, management effort and national comparators with which to evaluate individual performance. Signs of change are evident in the personal medical services (PMS) system where salaried reimbursement, now covering over a third of GPs, has been accompanied by more rigorous management in some cases.

Information exists about hospital activity: Hospital Episode Statistics (HES) data have been collected for many decades. The problem with the HES information system, which reports GP referrals, hospital in-patient activity and mortality as well as proxies for case mix, is that it has rarely been used by policy makers, clinicians and managers, and, as a consequence, has not been well validated. HES data show considerable variation in activity of individual consultant surgeons.[12] This

variation may be due to different patterns in individuals' activity, but could also be associated with invalid data, inadequate adjustment for case mix, variation in availability of theatre sessions, beds and nurses, and variations in outside activity for the Royal Colleges and in the private health care sector.[13]

Some variation in activity levels is to be expected but, given the current shortage of NHS capacity, it remains remarkable that many local managers do not know the level of activity of their consultants, and these managers certainly cannot explain their practitioners' variations in practice. More active management of the relative performance of practitioners could produce significant increases in local medical activity, as has been emphasised by, for example, Yates.[14]

It is remarkable that management of the medical workforce in hospitals and primary care has been relatively passive both in the UK and elsewhere in Europe. In the USA, managed care attempted more active management of medical practice with guidelines and utilisation reviews. This was a mixed success in the 1990s due to weaknesses in regulator frameworks and practitioner resistance.[15] The tradition of 'trust' in the profession should place an obligation on its members to be transparent and accountable in terms of activity and patient outcomes both to their patients and their funders.[16] This obligation is absent amongst those who represent doctors, including the British Medical Association, and the Royal Colleges whose role is to maintain quality and ensure consumer protection. There are, however, some signs of change, albeit slow.[17]

Methods of Remuneration of Doctors

Standard labour economic analysis of payment systems suggests that employers manipulate the level and structure of wages to induce workers to supply the desired quantity and quality of labour.[18] Two main pay structures are used, representing the extremes of a continuum from input to output orientation: time rates, where workers are paid for each hour of time they spend at work; and piece rates, where pay is related directly to output. In practice, firms often combine these methods. Where health care is concerned, these translate into salary (time rates) and fee-for-service (piece rates), but capitation payment forms an intermediate method (see Table 1). Robinson has noted, 'there are many mechanisms for paying physicians; some are good and some are bad. The worst three are fee-for-service, capitation and salary'.[19]

Fee-for-service payment gives the doctor a fee for each intervention provided. A capitation payment system means that fees are paid on the basis of being available to treat, rather than for individual treatments. The final payment mechanism used to reward doctors is salary, where they are paid to provide a certain minimum amount of their time to perform a broadly defined role, rather than a set of detailed tasks.[20] Some attributes of each payment system are summarised in Table 1.

These three main methods of paying doctors and other health care professionals are often mixed.[21] Three out of five British GPs are currently self-employed 'independent contractors', obliged to provide 24-hour care for their patients throughout the year. From 1948 their contract required general practitioners to provide 'those services generally provided in general practice'. This circular and vague 'John Wayne' contract ('a GP's got to do what a GP's got to do'!)[22] was reformed in 1990, but still allows great variation in activity and the quality of service delivered, particularly as external management of practice has been slight for over 50 years.

The independently contracted GP is currently remunerated with a mixed system, including a basic practice allowance (essentially a salary component), a capitation fee for each patient and also some fees per item of service for targeted interventions. Around sixty per cent of a practitioner's income is derived from capitation payments. It can be predicted that this may create incentives for practitioners to under-treat their patients and shift demand out of the sector into hospital diagnosis and treatment. Furthermore, with patient stability

Table 1: Doctor Payment Systems

Payment type	Definition	Incentive effects				
		Incentive to increase activity	Incentive to decrease activity	Incentive to shift patients' costs to others	Incentive to target the poor	Controls cost of doctor employment
Fee-for-service	payment for each medical act	yes	no	no	maybe*	no
Salary	payment per unit of time input (e.g. per month)	no	yes	yes	no	yes
Capitation	payment per patient for care within a given time period (e.g. a year)	no	yes	yes	no	yes

* if fee-for-service payments for treating poor patients exceed those for treating the middle classes

Table 2: Advantages and Disadvantages of Fee-for-Service Increments for GPs and Consultants

Advantages		Disadvantages	
i.	increased activity	i.	what is not incentivised is marginalized regardless of its cost effectiveness
ii.	motivates practitioners to ensure facilities are tailored to their needs (so as to increase their activity fee)	ii.	inappropriate and inefficient procedures may be incentivised
		iii.	what is incentivised may be institutionalised: changing fee-for-service may be difficult
		iv.	may be inflationary unless capped

in list composition, there is relatively little financial incentive for GPs to make their services user-friendly, for example by opening at hours convenient to consumers rather than providers.

Capitation payments (like salaries) do not reveal to payers what services are delivered, although they have the great virtue of capping expenditure and making it predictable. The 1990 revision of the GP contract introduced fee-for-service payment for the delivery of certain services, such as minor surgery and health promotion clinics. It also introduced bonus payments for the achievement of certain targets: thus, the greater the percentage of those eligible on the list for immunisation and vaccination and cervical cytology, the higher the bonus paid. These payments increased activity swiftly. Some of the services for which fee-for-service is available were not demonstrably cost-effective (e.g. health promotion clinics and yearly screening of those aged 75 and over), and once these are introduced it is difficult to remove them. Fee-for-service payment in general creates potential incentives for over-treatment, as doctors can influence demand for services.

The 1990 GP contract reform demonstrated that financial incentives affect practitioners' behaviours and increase activity. There is also some evidence of significant effects of GP fundholding on behaviour. For instance Dusheiko et al[23] demonstrate that the incentives to economise in fundholding led to reduced levels of hospital admissions.

Nearly two fifths of GPs and all hospital doctors are paid salaries. Salary payments do not contain incentives to over-treat, and so they maintain cost control. They may however contain incentives to withhold care, or to shift costs. Salary payment systems (time rates) are effectively opposite to fee-for-service systems (piece rates) in terms of incentive structures: salaries contain no explicit incentives for activity. If salary is used without any supplementary explicit incentives (such as bonus payments), regulation or implicit incentive structures may be required to increase activity rates, which requires the collection of performance data. Hospital consultants in the UK have a payment system largely based on salaries, but also with some bonus payments (discretionary points and distinction awards) and with access to private sector income, which is paid fee-for-service.

So, which is the best way of paying providers? The answer to this is that it depends on the goals of policy makers. Mixed payment systems with performance management may offer greater potential success if activity is monitored. Salary and capitation systems create effective cost control, but with the possibility of under-servicing of patients. Complementing these with constrained, evidence based and cash limited systems of fee-for-service can increase activity and may improve quality if accompanied by local micro-management. Countries such as the USA and the UK have implicitly acknowledged the problems of single payment methods and have moved to mixed systems.

Reforming Doctors' Contracts

The contracts of employment of both GPs and hospital consultants are changing in the most radical way since 1948. The objectives of these reforms are to ensure recruitment and retention in the profession, and also to increase NHS activity and deliver the 'modernisation' agenda by using fee-for-service complements to existing contracts. The latter will require detailed performance management by the profession and managers.

The consultant contract

Methods and levels of reimbursement of medical specialists have been matters of intense policy debate for many decades. Enoch Powell, when Minister of Health, noted that 'the unnerving discovery every Minister of Health makes at or near the outset of his term of office is that the only subject he is ever destined to discuss with the medical profession is money'.[24]

Attempts to reform consultant contracts have historically been met with substantial resistance. In the 1970s, a combination of government attempts to phase out NHS pay beds and discourage private practice through reforms to the consultant contract was 'explosive', resulting in 'the most bitter political struggle since the inception of the NHS'.[25] On two fronts, government was thought by the medical profession to be threatening their personal income and professional autonomy. This was strongly contested in ever more acrimonious meetings between ministers and consultants' representatives. Finally, the medical profession embarked on a 'vitriolic campaign' against the policy, 'backed up by a threat of industrial action including mass resignation from the NHS'.[26] A mediator was introduced, and negotiations over the contract 'dragged on for the remainder of the Labour government's term of office',[25] with a hastily negotiated

contract eventually being implemented by incoming Conservative ministers in 1979. The current Labour government optimistically hoped to overcome the problems of the past but also encountered similar resistance.

The NHS Plan[27] expressed the government's aim of a fundamental overhaul of the national contract for UK hospital specialists, 'to reward and incentivise those who do most for the NHS'. Proposals for achieving this were initially published in February 2001,[28,29] influenced by the view that private medical practice reduced NHS productivity. As a consequence, it was proposed that newly appointed NHS consultants would be obliged to serve a period of seven years working exclusively in the NHS. The rationale was that the training of doctors is largely publicly funded, and they are consequently obliged to pay back some of that cost with a period of indenture to the NHS. In addition to this condition, the initial new contract offered career payment scales which were related to NHS activity and the possibility of considerable enhancements in pay. However, both the junior grades and the consultants were, unsurprisingly, opposed to enhanced control of their public-private time allocations and 'management interference' in their autonomy.

A revised framework for the contract was eventually published by the Department of Health in June 2002.[30] This eliminated the seven-year indenture clause but was accompanied by indications of an intention to manage practice in a more detailed way. It also required practitioners to agree that the NHS had a first call on any overtime, with established consultants having to offer the Service four hours and new consultants eight hours before they could undertake private practice. The Human Resources Director of the Department of Health signalled this in the now notorious 'slide nine' of a published presentation he made in September 2002, explaining how the contract might be managed in the NHS. This included a statement that the contract would be managed, 'only paying extra for work already done to the deserving few who do the most'. Some in the profession saw this statement as highly provocative.

The new contract was accepted in Scotland and Northern Ireland but a large majority of English and Welsh consultants rejected it. The Secretary of State refused further negotiation and published new proposals.[31] Where there was support for the published contract framework, Trusts and consultants were encouraged to implement it. Elsewhere, Trusts and PCTs were asked to introduce a new system of annual incentives, 'to reward consultants who achieve the most for NHS patients'.[32] Local incentive schemes were encouraged, with payments to consultants in the form of annual non-recurrent bonuses, based on 'objective measures of performance' in relation to NHS modernisation targets. The potential benefits of such a fee-for-service supplement to NHS consultant salaries could be considerable.

It was not until July 2003 that a new Secretary of State compromised, and achieved agreement with the BMA consultant negotiators.[33] The compromise included concessions on the obligatory NHS overtime commitment (to four hours for all consultants), removal of the obligation to carry out evening and weekend work, the reduction in length of out-of-hours sessions to three hours, and some additional holiday allowance. This outcome is a considerable defeat for those in Whitehall seeking to improve performance management. If the contract is accepted by the consultant body, as expected, the proposed fee-for-service package appears to be redundant.

Given variations in surgical activity as seen in the HES data (see Figure 1, and Bloor and Maynard[12]), there is considerable scope to augment activity by shifting the mean and increasing practitioner activity. Whether this is better done by fee-for-service, target payments and/or more active management of workload and activity is an empirical matter. It is essential to evaluate any reforms so that future policy choices are informed and cost effectiveness ensured. The advantages and disadvantages of fee-for-service are set out in Table 2.

The 2003 consultant contract demonstrates that, temporarily at least, the demand for clinical autonomy (defined as the absence of detailed and effective local management of activity and outcomes) has triumphed. At the same time, the personal income of consultants has been substantially enhanced. This BMA 'victory' should ensure that consultants do not disrupt the NHS modernisation plans, but do little to address the large variations in activity (which may be indicative of under-utilised NHS capacity) that remain. However, more vigorous and systematic local management of clinicians is inevitable as the new NHS pricing system is developed and Foundation Hospitals are established. The apparent victory of the profession in the contract 'skirmish' is a possible precursor of further battles to come.

The new GP contract

In 1990, the Thatcher administration introduced GP fundholding and made marginal but important revisions to the contract, including some fee-for-service payments and some target payments. The current Government has now proposed radical alterations to the contract.[34] The new agreement is contracted not with individual practitioners but at practice level. Practices will be contracted to deliver varying levels of care: essential, additional and enhanced. The first two categories will normally be provided by all practices and will be funded with a global sum, paid to practices. Enhanced services will be subject to contract between the PCT and the practice. The basic contract will be for the period 08.00 until 18.30 hours from Monday until Friday, and outside those hours there will be additional payments to practitioners. GPs who give up out-of-hours work will have their incomes reduced by £6,000 but may, if they wish, then contract with their PCTs to do this work selectively and perhaps with higher rewards.

Table 3: The New GP Contract's Quality Framework

A.	**Clinical indicators, categories and points**	
1)	Coronary heart disease including left ventricular dysfunction	121
2)	Stroke or transient ischaemic attack	31
3)	Cancer	12
4)	Hypothyroidism	8
5)	Diabetes	99
6)	Hypertension	105
7)	Mental health	41
8)	Asthma	72
9)	COPD	45
10)	Epilepsy	16
		550
B.	**Organisational indicators**	
	records	85
	patient communication	8
	education and training	29
	practice management	20
	medicines managed	42
		184
C.	**Additional services**	
	cervical screening	22
	child health surveillance	6
	maternity services	6
	contraceptive services	2
		36
D.	**Patient experience**	
	patient survey	70
	consultation length	30
		100
E.	**Holistic payments**	**100**
F.	**Quality practice payments**	30
	Sub total	**1000**
G.	**Access bonus**	50
	Overall total	**1050**

Within the contract, practices will be rewarded for the achievement of sixteen targets. There are to be ten clinical targets, five managerial and one patient target. The ten clinical targets are set out in Table 3. For example, rewards will be related to the measurement of hypertension, but also to its control, to target levels, for the practice population. The five managerial targets are in records, communication with patients, medicine management, practice management and education and training of practice staff. The patient target will be measured by surveys of their satisfaction.

Practice level rewards will be related to a system of points, the maximum of which will be 1050. In 2004-5, 550 points can be earned in the clinical area, 184 in the patient satisfaction category and the rest in relation to additional services (30), quality (30) and access (50). The contract suggests that each point may be worth around £75.00 per practice in an average weighted population (rising to £120.00 in 2005-6). The contract's principle of 'volunteerism' means that the practice is free to choose where to focus its efforts, but 'breadth of achievement' will be rewarded by holistic care (£100.00) and quality practice payments (£50.00).

How will activity be audited? The system appears to be highly dependent on trust. Investment in automated records and the creation, over time, of national record systems and performance review will help management of this expensive settlement. Patient satisfaction surveys may inform the local PCT about the existence and quality of service delivery, but it seems likely that Parliamentary Committees and audit bodies such as CHAI, the Audit Commission and the National Audit Office will require systematic and detailed data if they are to be convinced of value for money. The management challenge for PCTs is substantial, and beyond the skills and IT systems of most of these organisations as they are now constituted.

How will quality be audited? The new contract will focus on primary care in isolation, rather than evaluation of the delivery of integrated, high quality patient episodes of treatment. Linking primary care data with hospital episode statistics, Office of National Statistics mortality data and health related quality of life measures (e.g. as experimentally used by BUPA[35]) is required, but slow to be implemented.

The new contract will be delivered in part by GPs but also by the employment of even larger numbers of nurse practitioners in primary care. It is unclear how this increased demand for nurses will affect retention and recruitment in the hospital sector. Out-of-hours work may lead to more physical and activity integration of walk-in centres, GP out of hours co-operatives and hospital A&E departments, as emergency triage systems are centralised and systematised. The price paid for such services provided by PCTs may rise if they are not well managed.

When this contract was proposed, a radical new primary care budget allocation formula was announced.[36] The redistributive effects of the Carr-Hill formula are considerable, and GPs were given a guarantee that there would be no immediate loss in income (a practice income guarantee) to ensure their acceptance of the new contract.

The new contract has been costed to fall within a defined expenditure. However, the 'knock-on' effects of the contract have not been quantified. Thus, as clinical targets are achieved, pharmaceutical and hospital costs may rise. For example, to treat and monitor high blood pressure it will be necessary to provide drugs (e.g. statins and beta blockers) and test blood regularly in pathology. Many GPs will give up out-of-hours cover and lose £6,000 cash. However, such savings will be insufficient for PCTs to buy replacement specialist cover. The 'gap' will be met by skill dilution and the diversion of patients to hospital A & E services.

The clinical standards set are systematic but not radically new.

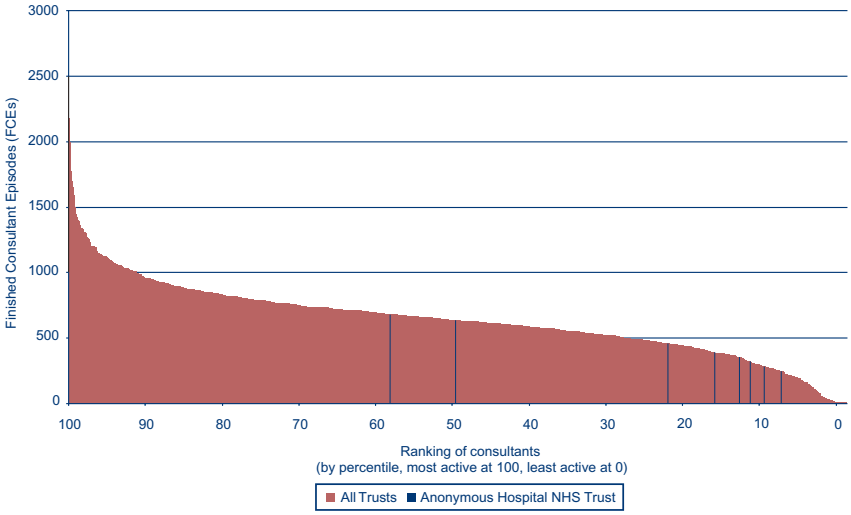
It is unclear, due to gross data deficits, how many practices meet these targets already and will only be rewarded for what they already do now. Some practices will move up to these standards. It is also unclear how practice will be developed beyond these standards in the future. There is an obvious risk that what is not incentivised will tend to be marginalised, regardless of its cost-effectiveness and value to patients. Pain control, services for drug users and incontinence services are potential examples (Table 1).

Conclusions: Will Contract Reform Increase NHS Activity and Quality?

The NHS modernisation programme has produced a sharp rise in the demand for doctors, and short-term recruitment needs to meet NHS activity targets are high. The time lags in achieving greater medical school output, together with the difficulties of recruiting from overseas has led the Government to adopt contract reforms to improve retention, recruitment and activity. There is no indication that these are evidence-based and evaluation of their success is essential.

The impact of the new contracts on performance in terms of improving activity and quality to maximise improvements in population health is uncertain. There is some evidence[37] that consultant activity, for reasons unknown, has been declining since the mid 1990s. The new consultant contract gives no assurance that activity will be maintained, let alone increased, by shifts in the mean of the distribution and pressure on low outliers to become more productive (Figure 1). Practitioners assert anecdotally that low activity levels may be a reaction to the Bristol Inquiry and other quality problems, and that by working more slowly, quality will increase. But there is no evidence of a causal relationship between working more slowly, reduced activity and patient

Figure 1: Ranked activity per consultant surgeon, FCEs, Trauma and Orthopaedics



outcomes. Assertions such as these and the mysteries of the secular decline in consultant activity should not be allowed to persist in an increasingly expensive service where the Government and taxpayers require transparent 'value for money'.

The new GP contract is explicit with regard to 'good practice' targets in clinical care. This may represent payment for what is already delivered by practices (in which case, they are to be paid more for what they already do), and incentives to develop practice in these areas by groups who do not already deliver such services. The policy question with regard to the latter is what do they give up which they now provide, to deliver the new national targets? It is difficult to answer this question because of the deficiencies in existing information systems. With all fee-for-service systems, it is necessary to recognise that what is not incentivised is marginalised and to be clear how systems will be developed in future and how cost and activity will be managed and monitored. Pursuing quality, with and without financial incentives, is always costly.[38]

Whatever the use of fee-for-service payment in primary and hospital care, its impact on activity and outcomes will have to be planned and managed. The literature on the intended use of targets and performance management gives little cause for optimism. Pessimism about such approaches is the primary reason for looking to financial incentives (e.g. fee-for-service) as the engine of change, in an NHS required to act 'smarter' by Government.

A tentative conclusion about the new contracts is that efforts to manage performance in the UK NHS, with increased emphasis on financial incentives, are now established. However, the outcomes of these initial skirmishes are unclear, expensive, contentious and indicative of more change to come. Medical practitioners have an obligation not only to their patients, to whom they should deliver timely, good quality and humane care, but also to their funders, Government (taxpayers) or private insurers (policy holders). Health care funders are guardians of householder's resources and have an obligation to ensure that the medical workforce delivers value for money. Inevitably, doctors should be under obligation to keep accurate records of their activity rates and outcomes to facilitate comparative review. After recent medical scandals, the trust of patients and funders must be earned by transparent, measurable accountability. The new contracts for GPs and consultants, with increased financial incentives, shift the NHS only marginally in this direction. In general, it appears that the NHS pipers may continue to call their own tune.

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