1. **Summary and possible policy implications**

1.1. Building on work that NHSE conducted in 2013, Monitor undertook research to understand what mix of financial and non-financial incentives may drive the best outcomes for patients and enable a sustainable and responsive NHS. This paper summarises the results of our research, outlines possible policy implications.

1.2. A wide range of factors impact the behaviour of individual actors and organisations within the NHS, and in turn effect patient outcomes. These factors can take the form of incentives that promote given activities or disincentives that may restrict or discourage action. For the purposes of this document “incentives” include both financial and non-financial drivers of behaviour. Further, as used here, “incentives” include intrinsic and extrinsic drivers, and disincentives as well as incentives.

1.3. The key focus for this research was to understand how the payment system can impact behaviours in the sector and best drive positive patient outcomes. However, the payment system is far from the only factor impacting behaviour within the NHS, and it is vital that we did not consider it in isolation. Indeed, the ability of the payment system to enable the desired outcomes is directly impacted (positively or negatively) by other types of incentive within the system. We, therefore, looked at a wide range of incentives in the context of our work.

1.4. In the past, there was a drive to promote quality and activity within the NHS – improving quality and driving down waiting times. The payment system that developed in this context was focused on activity and quality. Today the NHS is facing flat funding in real terms as well as increased demand for services driven by demographic changes and technological advances. There is a need to enable quality, efficiency and innovative service delivery. A key aspect of this will be developing a more patient-centred approach to care within the system, providing the right treatment at the right time and at the right place.

1.5. Given the challenges facing the sector through 2021 and beyond, high-level policy implications emerging from this work suggest that the payment system should have a limited role in actively driving sector change; however, the payment system should enable (and not hinder) needed developments. Non-financial incentives should have a much larger role to play with regard to driving change within the sector.

1.6. Research findings indicate the appropriate mix of (or “framework” for) incentives, would be:

   i. Fund services to a level that represents efficient cost recovery for providers [in the context of a hard budget cap for the system as a whole]
   ii. Include a small positive financial incentive to drive quality patient outcomes. These should be clinically driven and aligned with system-wide objectives. Payment should not impact operating costs, but may impact margins and, therefore, investment
pools. At present, CQUIN payments can account for 2.5% of provider income and some evidence suggests this value is within the optimal range for such financial incentives. However, more work is needed before such recommendations can be made.

iii. Use reputational incentives to monitor and ensure quality, safety and innovation. This will include internal reporting, submissions to regulatory bodies and publication of certain indicators (or groups of indicators). Associated sanctions for poor performance are not tied to financial penalties, but result in a loss of autonomy and/or support being provided to improve performance.

iv. Use principles-based rules to ensure that within organisations serving NHS patients all staff fully “own” a mandate to provide good outcomes for patients and support coordination and innovation of services. This will include empowering all staff to optimise care as well as creating a system that continues to learn and improve. For example, within the pricing function this may involve up skilling staff through the provision of quality Reporting and internal governance requirements can promote this change and support the needed culture change.

1.7. It is clear that not all providers and commissioners have the same capacity to deliver needed outcomes, and may not be starting from the same platform. Organisations that are high performers should be encouraged; those that are underperforming should be held accountable and face increased oversight. However, the centre should do more to help foster sharing of ideas and information across the sector, and ensure struggling organisations receive support/advice to help them improve.

2. Background

2.1. The NHS in England faces significant challenges. Demographic changes and technological advances mean the demands on the health system and cost of meeting the care needs is due to rise. However, the system is facing flat funding in real terms, which means the way health care is delivered needs to change if we are to maintain a quality, accessible service that is free at the point of use.

2.2. There were two elements to our research (i) mapping exercise identifying key incentives currently impacting actors within the NHS; and (ii) academic review of theoretical and empirical literature around incentives, conducted by Adam Oliver at the LSE. To inform our work we engaged with a number of stakeholders through workshops and bilateral discussions to better understand their experience, and their key drivers. We contacted a range of organisations requesting bilateral discussion. Those we spoke to included: Royal College of Physicians; Royal College of Surgeons; Royal College of Psychiatrists; Royal College of Nursing and the Care Quality Commission. We also gathered input from clinicians, providers, commissioners, academics and industry thinkers through workshop and round table discussions held by NHSE and Monitor. These stakeholder events included the Clinical Advisory Groups; the External Advisory Group; Workshop Reviewing Incentives in the NHS; and round table discussion on the Long Run Payment System Design. The impact of incentives is dependant on both the context in which incentives are applied and on other incentives that exist. Therefore, it is important to consider the wide range of incentives that apply to actors within the NHS when we consider what the right mix of incentives may be, and the role of the payment system within that setting.

3. Research findings
3.1. Performance management is the principle method by which to incentivise changes in behaviour within the health sector. Over the past fifteen years it has been increasingly applied as a key tool in health care organisations in a number of countries. Performance management can take a number of different forms ranging from: (i) reputational incentives, that leverage professional and personal ambition and pride; and (ii) financial incentives, that link actions or performance to financial payment or penalties. However, it is possible to use these in combination and structure them to include sanctions and accountability.

3.2. Through this work we sought to evaluate the impact of different forms of incentive on the health sector and to consider what options may be most effective in an NHS context going forward. Based on an ex-ante review more evaluation is needed to definitively isolate the impact of given forms of intervention because they are often introduced in parallel with other measures. However, it is possible to make some educated suppositions based on the evidence available, our understanding of contextual factors and a review of relevant behavioural science literature.

3.3. When considering which incentives will have the greatest impact, it is important to look at the empirical evidence regarding the impact incentives have had. However, when considering the overall impact incentives are likely to have it is vital to take into account environment in which incentives will be applied, and therefore how they may be received. The cost/resources involved with introducing given measures are also an important element to consider when evaluating the overall impact and value of given policy measures.

3.4. Where financial resources are less readily available it is even more important to ensure that incentives introduced offer good value for money (and return on investment). Reputational incentives will impact clinical behaviour, and financial incentives will attract the attention of providers and commissioners’ management and leadership. Where financial incentives are replaced by incentives focused on quality/safety and reputation these factors will demand greater attention from all.
3.5. The diagram above outlines different types of incentives and noted their likely impact as well as how difficult or costly they are to implement.

A. Quality: Reporting general performance - there is a requirement to report on performance against given measures, but no sections or externally imposed accountability associated with such reporting. This approach helps organisations to focus on measures that are important, but does not hold them responsible for meeting given targets.

B. Reputational: Public ranking apportioned blame – joins reporting requirement with non-financial sanctions for organisations that fail to meet targets and/or recognition for those that meeting and exceed given requirements.

C. Financial and Reputational: Public ranking with modest financial rewards – represents a combination reporting requirements and public visibility of performance levels, but also includes a small positive financial reward (e.g. payment) for organisations that meet certain pre-determined standards.

D. Financial: Pure financial incentives for specific targets – financial benefits (or penalties) for organisations that meet (or fail to meet) given targets. In this context the targets relate to specific, well defined activities or actions.

3.6. Financial incentives:

- Good at incentivising specific, well defined actions/activities (e.g. relating to actions that are clearly defined, can be objectively measures, are time bound and are attributable)
- Over time the magnitude of their impact slows (e.g. reputational incentives have similar effects but over longer periods of time – the limited evidence available suggests this is 2-4 years)
- It is often hard to fully isolate their effect
- Financial incentives are less effective where they seek to promote actions that are harder to define/measure or where the outcomes are subjective. This can lead to gaming behaviour, where actors may not act in the spirit of the measures, but make a
case they meet needed standards. Alternatively, actors may not be incentivised to act because they feel any reward/sanction will be reliant on a subjective judgement, and therefore there is no certainty that actions will lead to the intended benefits.

3.7. Public ranking with modest financial rewards:

- Evidence from the US (Hospital Quality Incentives Demonstration) shows that financially penalising poor performers – which may not even be poor in absolute terms – may make their performance deteriorate further.
- This is a particular likelihood in health care settings, where the relatively poor performance is caused by external factors that strain financial or circumstances and/or reflects a more challenging population or case mix served.
- Small financial rewards do not threaten the viability of an organisation, but provide an added incentive (and therefore internal/management support) to meet given objectives.
- In contrast, financial penalties can cause organisations to become very risk as people tend to “loss aversion”. Also, financial penalties levied on organisations that are already struggling can undermine viability and undermine an organisations ability to improve their performance by removing resources from them. Further, it can lead to low morale and decreased productivity as those within organisations struggle may feel besieged, and feel they don’t have the means or power to improve.
- Similarly, significant financial rewards mean an organisation is reliant on such payment to cover core costs will lead to similar issues as those noted with financial penalties – organisation are likely to become more risk averse and less likely to improve services and innovate.

3.8. Public ranking with apportioned blame:

- This incentive leverages the concept of reference points (i.e. when people make choices they often “anchor” on something salient to them) and loss aversion (people are particularly adverse to the possibility of experiencing loss).
- People’s propensity to respond to these two triggers are among the strongest findings in the field of behavioural economics - put together these factors can act as a powerful motivator
- However, sustained use of publicising relative performance and “naming and shaming” can negatively impact morale – particularly in a resource constrained environment where organisations and/or individuals feel they have little ability to rectify the situation.
- It is important to recognise that people’s ability to identify with the organisation they work for and feel they are able identify with its objectives has been recognised as an increasingly important factor for incentivising good outcomes.
- Creating “motivated insiders” is a way to leverage the productivity and capabilities of staff (and organisations) without requiring extra pay or financial reward. This is not commonly recognised under standard economic theory, but has been shown to have an important effect

3.9. Reporting general performance:

- Looking at evidence from psychological literature and that from the field of behavioural economics it seems there may be some incentives on actors to modify their behaviour because they know they are being watched.
- This is relatively inexpensive to implement, and it may be best practice for some indicators to be accessible and monitored/assessed by an organisation or external bodies.
- However, the evidence does not indicate this approach (on its own) drives improved performance

(ii) Findings from Monitor’s mapping exercise (based on empirical evidence and sector input)

3.10. The primary concerns for commissioners and providers are financial targets, closely followed by quality and safety objectives. This creates a tension with clinicians, patients, and regulatory organisations, which are primarily focused on quality and safety. All of this is within the context of hard budget constraints.

<table>
<thead>
<tr>
<th>Actors/Incentives</th>
<th>Financial</th>
<th>Reputation</th>
<th>Quality/Safety</th>
<th>Behavioural</th>
<th>Organisational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioners of Care</td>
<td></td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Providers (senior level and financial managers)</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Clinicians</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Patients (including friends and family)</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Formal Patient Representatives (e.g. National Voices, Diabetes UK)</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

3.11. Within the health sector the majority of actors have an underlying motivation to serve the needs of patients; this is particularly strong among clinicians. However, all stakeholders commented that current incentives often encourage a focus on organisations meeting targets (e.g. financial and quality), but this does not always translate into good outcomes for patients or promote system-wide objectives (e.g. greater coordinated care and allocative efficiency).

3.12. Many clinicians are driven by basic factors linked to good performance management practices. Both better outcomes for patients and greater efficiency could be achieved by the provision of: timely feedback; praise where warranted; constructive and open dialogue about development areas for teams and individual; greater visibility of system wide-goals, increased ownership of outcomes and greater support to act in a way that meets objectives.
Table 1: Key incentives that drive behaviour of actors in the system and barriers that inhibit better outcomes for patients

<table>
<thead>
<tr>
<th>Actor groups</th>
<th>Key incentives</th>
<th>Key disincentives (may prevent change/good patient outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>• Personal wellness and/or comfort</td>
<td>• Lack of information about spectrum of care options (particularly those who do not regularly need care)</td>
</tr>
<tr>
<td></td>
<td>• Social norms and awareness (e.g. healthy lifestyle, prevention and use of services)</td>
<td>• Personal/social norms</td>
</tr>
<tr>
<td></td>
<td>• Lack of information about spectrum of care options (particularly those who do not regularly need care)</td>
<td>• Underestimating or not properly valuing future risks</td>
</tr>
<tr>
<td>Clinician</td>
<td>• Patient care (quality and safety) is primary</td>
<td>• Less support for coordination and other system-wide objectives; but there is support to meet existing organisational KPIs,</td>
</tr>
<tr>
<td></td>
<td>• Reputational incentives also seen as important</td>
<td>• Culture; motivation; and morale</td>
</tr>
<tr>
<td></td>
<td>• Often driven by basic behavioural incentives and staff management has a large role in supporting staff and enabling good outcomes for patients</td>
<td></td>
</tr>
<tr>
<td>Provider (management)</td>
<td>• Meeting financial targets along with quality indicators are very important (some times both are tied together via penalties)</td>
<td>• Short term targets and financial incentives aimed at organisation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Limited incentive/scope to (i) share risk with other providers (ii) coordinate care; (iii) invest to reconfigure service offerings</td>
</tr>
<tr>
<td>Commissioner</td>
<td>• Meeting financial targets is very important</td>
<td>• Range of abilities and appetite for change, not all press for innovation - due to resource, background, knowledge</td>
</tr>
<tr>
<td></td>
<td>• Allocative decisions (e.g. models of care)</td>
<td>• Fragmented commissioning, need sophisticated approach and good professional relationships</td>
</tr>
<tr>
<td></td>
<td>• Local market or economy constituents</td>
<td></td>
</tr>
<tr>
<td>Regulator/standard setter</td>
<td>• All have a key focus on quality /safety</td>
<td>• Fragmented ownership of rules / guidance</td>
</tr>
<tr>
<td></td>
<td>• Some have direct responsibility to ensure efficient sector spending</td>
<td>• Existing system (and providers/commissioners within range of skills and abilities)</td>
</tr>
<tr>
<td></td>
<td>• All are concerned with the quality and sustainability of the sector in the long run</td>
<td>• Key focus on safety / quality can stifle innovation (via risk averse stance)</td>
</tr>
</tbody>
</table>

(iii) Differentiation within the sector
3.13. All those in the sector are aware of the challenges ahead. However, among both commissioners and providers there are a range of approaches that have been taken with regard to providing care. Some individuals or organisations have been able to innovate and thrive while others have struggled to maintain standards. Some may have taken steps to make the changes needed to provide high-quality and sustainable health services in their areas.

3.14. Outcomes can be driven by both internal and external factors. For example, structural factors relating to local health economy needs or infrastructure burdens can cause complications, and place a strain on finances. However, others may have limited means, capacity or vision to realise needed improvements or appropriately modify service delivery.

3.15. The centre has a role to play in supporting all organisations through creating the right form of incentives and regulation. It can also support all organisations through publication of data and information on how organisations may be able to improve and institute change. There could also be a requirement to share information and actively facilitate cross organisation learning. For example there is a long history of clinical peer review networks, this same principle could be applied for managers within the NHS – a two-way annual review could allow for shared learning and provision of useful peer advice.

3.16. High performing organisations should be given some additional flexibility to innovate, but should also be obligated to feel their learnings back into the system. Indeed, greater sharing of lessons learned and good practice should be instituted. Further support and oversight is needed for underperforming organisations. Organisations in the “middle” should be monitored and supported to drive continual improvement. In all cases the measures used, will clearly be an important consideration, but should be clinically driven and linked to good patient outcomes and aligned with system-wide objectives.
Underperforming
Additional help, oversight and support
Policy: lose autonomy, but support to gain it back

Good performers
Support and monitor. Framework that promotes and facilitates innovation, coordination and quality
“Standard” policies will work for this group

Highest performers
Enable innovation, support quality, promote information sharing
Policy: about reducing barriers