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Financial and clinical risk in health care reform: a view from below

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Abstract

Objectives

This paper examines how the interaction between financial and clinical risk at two critical phases of health care reform in England has been experienced by frontline staff caring for vulnerable patients with long term conditions.

Methods

The paper draws on contracting theory and two interdisciplinary and in-depth qualitative research studies undertaken in 1995 and 2007. Methods common to both studies included documentary analysis and interviews with managers and front line professionals. The 1995 study employed action-based research and included observation of community care; the 2007 study used realistic evaluation and included engagement with service user groups.

Results

In both reform processes, financial risk was increasingly devolved to frontline practitioners and smaller organisational units such as GP commissioning groups, with payment by unit of activity, aimed at changing professionals' behaviour. This financing increased perceived clinical risk and fragmented the delivery of health and social care services requiring staff efforts to improve collaboration and integration, and created some perverse incentives and staff demoralisation.

Conclusions

Health services reform should only shift financial risk to frontline professionals to the extent that it can be efficiently borne. Where team work is required, contracts should reward collaborative multi-professional activity.

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Introduction

We are writing at a moment of sharp debate about English National Health Service (NHS) reform. Within this publicly funded health system, current proposals to devolve the commissioning of services to general practitioner (GP)-led clinical commissioning groups aim to expand market mechanisms and provider competition.^{1,2,3} These proposals build on financial and organisational reforms of the NHS begun in the 1990s, that shift financial risk 'downwards' from large public health authorities to smaller commissioning groups and frontline providers, and aim to change behaviour towards greater efficiency and effectiveness.⁴ These changes have a major impact – still under-documented - on community health professionals' experience of health and social care.

This paper presents evidence gathered in 2007 to study⁵ the professional experience of caring for people with long term chronic conditions and mental health problems within three Primary Care Trusts (PCTs) in England, in the context of the introduction of Payment by Results (PBR) (episode-based payment) for NHS acute hospitals and 'shadow' GP commissioning. We compare this with findings from 1995 research⁶ examining the interface between health and social care in the context of a 'total purchasing pilot' (TPP)⁷ with many similarities to current commissioning proposals. Each study uncovered experiences at a critical moment of organisational change with lessons for current reformers.

Our theme, the interaction between financial and clinical risk, emerged inductively from analysis of the 2007 results. We revisited the 1995 study to identify earlier resonances. We draw here on economic theory of contracting, and on fieldwork exploring the experience of

community health and social care professionals. We ask whether financial risk is being devolved to too low a level, increasing clinical risks in care for some of the most vulnerable patient groups.

Methods

The research teams in both studies included clinical, sociological and economics expertise. The 2007 study used realistic evaluation⁸ as a framework to examine commissioning within an inner London PCT, a county-wide PCT with relatively high incomes, and a non-metropolitan PCT in a unitary (single tier) local authority area with substantial deprivation.⁵ The 1995 study investigated a Total Purchasing Pilot (TPP) in outer London⁶ using action-based research.

Each study comprised two phases. Phase 1 included documentary analysis of policies and procedures, and interviews with managers (15 in 1995; 32 in 2007). Topics included financial management and the impact of organisational change on care delivery. In 1995 the focus was on the scope for total purchasing to integrate health and social care; in 2007 it was on governance and incentives.

Phase 2 in both studies comprised in-depth interviews with health and social care staff (GPs, nurses, social workers, therapists and home carers) about their experience of organisational change and the delivery of services to people with complex long term conditions (12 in 1995; 56 in 2007). Interviews were noted, taped and transcribed, then analysed systematically for emerging themes and perspectives.

Additional evidence was derived in 1995 from observation of community-based care by nurses and home carers (3 nurses, 2 home carers, 8 users and 2 informal carers), and in 2007 from discussions with three service user groups (32 users in total).

Theories of contracting and risk in NHS reforms

Current proposals to devolve commissioning to GP-led groups have financial and incentive implications similar to those facing TPPs. The TPP studied in 1995 held a budget to purchase acute physical and mental health care plus aspects of community care for its patients. This subjected GP groups to a financial risk they had not previously borne: they had to manage their budgets so that they neither ran out of money before the end of the year nor failed to provide essential services to patients, though the health authority retained ultimate financial responsibility.⁹ In 2007 PCTs held the budget for local commissioning, but GP practices were beginning once again to operate 'shadow' commissioning budgets. Payments to providers meanwhile were increasingly activity-based. In 1995 the TPP paid hospitals through cost-and-volume contracts. In 2007, PCTs commissioned hospital services using payment-by-results (PBR) contracts and a uniform national tariff, while the recently renegotiated GP contract paid GPs additional sums for meeting activity targets under the Quality and Outcomes Framework (QOF).¹⁰

These reforms seek to influence health care providers' and purchasers' behaviour by subjecting them to increased financial risk associated with opportunities for increased financial return. They aim to incentivise commissioners to save money, and to induce more efficient and effective work practices in frontline providers.¹¹

Economic theory distinguishes two types of such *incentive contracts*.^{12,13} Performance contracts such as PBR pay a provider for outputs. This is a 'high powered' contract because it effectively shifts the risk of financial failure to providers, which will make a loss if their activity drops too low to cover costs. Such a contract may be perceived as unfair if the consequences are not all under the control of the provider.

Alternatively incentive contracts can be 'low-powered': that is, structured so that the provider carries only part of the risk, leaving part with the purchaser. The economic literature suggests low powered contracts are desirable to avoid provider de-motivation where: outputs are hard to measure; the quality of service is hard to measure; and/or team working means that individual contributions to outputs are hard to identify.³¹²

These conditions characterise community health services, and we investigate the perceived implications of actual contracting patterns for clinical risk; that is, a risk of worsening health, decreasing autonomy and reductions in patient safety. Social policy research identifies risk and uncertainty as central themes in the current context. This context includes increasing institutional complexities and challenges to assumptions that human wellbeing can be improved through the state's willingness to pay for care of the most vulnerable. The result is a political agenda led by 'new patterns of risk' for both recipients and providers, driven by the requirement for cost efficient care and an increase in regulation aimed at achieving this¹⁴.

Results and discussion

Financial instability and the devolution of risk to community health services

In 1995, the TPP faced considerable financial uncertainty. Expenditure on hospital care and treatment for severe mental illness was unpredictable. One manager noted that with the (relatively new) cost-and-volume hospital contracts:

[the acute trusts] are getting better at adding up ... [finding] specious justification for demanding more money [by] identifying more activity. (Commissioning manager 1995)

This 'over-performance' (as it was then called) by hospitals was squeezing funding available for community health services. The financial risk was thus being passed 'down' to community nurses and others who were largely employed by an NHS community health services trust, some of whose services were bought by the TPP. The health authority intended that district nursing services would instead be funded via GPs. Staff were struggling to cope with financial uncertainty and administrative upheaval.

In 2007-08 the PCTs as local commissioners also faced financial uncertainty, as a long period of financial expansion in the NHS was ending. With a large proportion of GPs hitting QOF performance targets, expenditure on general practices had been larger than predicted.

Hospital services commissioning using PBR meant that rising hospital activity implied rising spending by the PCT on acute care.¹⁵

The PCT commissioners' problem was familiar from the 1990s:

You are giving the hospital an incentive to maximise income – which is the perverse incentive. (PCT finance manager 2007)

In terms of the acute contract ... with payment by results, it is governed by what actually presents at the hospital ...It's an open-access blank cheque. (PCT commissioner 2007)

PCT managers also expressed worries about conflicts of interest within planned GP budget-holding when associated with an expanding GP service provider role:

The worry I have is, how the governance arrangements should work, so that this is about benefit for patients, not benefit for GPs. (PCT Finance manager 2007)

According to finance and commissioning managers in all three PCTs, this combination of reforms had by 2007-8 produced reduction in financial flexibility and rise in financial instability:

Q. So PBR hasn't made your finances more unstable?

A. Oh yeah, it's made it much more unstable. (PCT finance manager 2007)

Two PCTs had large financial deficits, both with a temporary finance manager struggling to stabilise the situation. Only the PCT in the unitary authority had effective control of its finances. It had just two main providers: the local NHS acute hospital trust, and community and acute mental health services run by the PCT itself. The stability was thus associated with incomplete separation of the PCT's commissioning and providing functions. Financial crisis was also easier to avoid where collaboration with the single tier local authority was well established - but this collaborative financial behaviour also ran against the spirit of reforms aimed at encouraging competition.

A common finding in both studies was the 'residual' financial position of the community health services. Uncapped demand on funds by acute hospital services shifted financial risk

onto community services. These services are also part-financed by local government, making coordination hard. In 2007, GP contract payments were also squeezing funds for mental health and other community services in two PCTs; only in the financially stable PCT did mental health funds appear well protected.

Financial and clinical risk, and the 'view from below'

The impetus to understand the interaction between financial and clinical risk emerged inductively from our 2007 data, leading a GP member of the research team to ask:

So what is the relationship between financial and clinical risk?

This question remains largely unanswered within the research literature.¹¹ Our clinical interviewees generally agreed that financial incentives were powerful in driving behaviour:

Care managers are financial administrators. (Care manager 1995)

[Integrated care] is all about purse strings and budgets. (Community nursing director 1995)

Furthermore, as one GP explained, institutional structure and ownership affect response to incentives:

If you have a system in which primary care are self-employed entrepreneurs....then financial incentives are going to be a key way of doing it....and love and care and doing a good job and ... and peer review is important ... and thinking about the best thing for the patients is essential, and we are not just mercenaries, but it's not as powerful an incentive, I'm afraid, as financial ones, in my view. (GP 2007)

So how do the incentives resulting from taking on financial risk feed down into clinical risk? In both studies, professionals delivering community health services faced overlapping issues characterised variously as joint working, team working, working across professional boundaries, inter-professional collaboration and 'seamless services'. Both studies explored the ways in which a contracting model of finance interacted with – or struggled with – the collaborative provision that is central to supporting people with long term chronic conditions and mental health problems.

In 2007, two overarching policy drivers were apparent in the interviews: care closer to home (and thus out of hospital); and multidisciplinary working to promote co-ordinated care and social inclusion, requiring new teams and emphasising independent living. These drivers challenged traditional ways of working and brought the issue of clinical risk to the forefront of practitioners' thinking, particularly where services were undergoing considerable change. Staff had to react to, and perform within, these changed systems in professional-patient interactions, within and across inter-professional groups and in interdisciplinary teams. They were working in new teams and roles, and faced pressure to keep people 'safe' through 'good' decision-making. Fears were expressed that these changes not only compromised patient safety, but were also 'risky' for staff because of potential litigation.

In 1995, similar themes were apparent. Observation of, and interviews with, community nurses demonstrated the importance for patients of informal communication, flexibility and shared responsibility among home carers and district nurses. There was increasing fragmentation of financing and provision, and professionals were worried about increasing risk. Nursing auxiliaries who previously worked with the district nurses providing personal care had largely disappeared, and experienced home carers who had managed domestic provision had also lost their jobs. A tightening of criteria for referrals to local government-funded home care services, and introduction of a requirement for many patients to pay privately and to arrange their own care, were associated with a perception among patients of disjointed and inaccessible provision.

1995: flexible working vs. increasing fragmentation

In 1995, GPs identified a lack of integration with local authority social services as causing risks to patients:

We need to know how to work more closely with Social Services.... the buck stops with the GP, for example the patient is admitted to hospital and her partner is found wandering the streets four times 'cos he has dementia, so the GP gets rung and has to sort it out – Social Services say, 'It's not their problem'. (GP 1995)

Observation of a district nurse attached to a GP practice illustrated the potential for flexible working across professional boundaries to make the connections the GPs found difficult, reduce patient risk and manage complex problems. She did this through a combination of assessment, teaching, and taking a range of interdisciplinary and lay referrals. For example, during visits to patients in a residential home, she treated a pressure ulcer, took routine blood samples and assessed a resident who had become 'very quiet'. Only two of the interventions had been planned and she described her visits as 'popping in' to support staff rather than something more official.

During another visit to a housebound older woman, the district nurse overlapped with the home carer employed by local government Social Services. The district nurse had no direct control over the content or quality of the carer's work, but they collaborated informally, consulted each other's records and exchanged verbal and written messages.

Not all these activities were officially sanctioned; some contravened the formal rules; and gaps in funded provision were apparent through which patients' needs could disappear. This was illustrated during a visit to a man recovering from a stroke following two months of 'good' crisis care and physiotherapy from the NHS stroke rehabilitation team. He was waiting for domestic home care (shopping and cleaning) which required a lengthy financial assessment to establish eligibility for services that had been subject to funding cuts. A social worker advised him to contact a private agency to arrange and pay for help, rather than wait for Social Services. The man expressed his frustration:

I can pay but I still can't get the services.

He was reluctant to telephone an 'unknown' private provider, seeing the 'official' Social Services provider as a safer option.

In 1995 the erosion of public provision of services by the turn to the private sector was just beginning to create insecurity among users. This stroke survivor lacked confidence to arrange his own care, increasing his risk of being unable to manage at home. The policy challenge was

to find a way to support service integration at a time when funding and contracting was shifting to more fragmented GP and private purchasing and 'Taylorised'¹⁶ service provision that reduced holistic care to a series of technical, personal and domestic tasks.

2007: team working, fragmentation and risk

By 2007, new teams and roles had emerged. Some, such as the home treatment teams in one site, were designed, with central policy guidance, to provide alternatives for people with mental health problems. Others, such as the rapid intervention teams in a second site, aimed to prevent hospital admissions for frail older people.

Professionals noted that the disruption to existing services subject to constant redesign carries operational risks. Caseloads (defined by localities rather than GP practices) had had an impact on how district nurses worked with GPs. High caseloads, and responsibility for more than one practice, were described as having caused fragmentation of once close relationships and discontinuity in service provision with a huge impact on care:

We always had two nurses for years that were attached to us and now they are not. They no longer work from a base in the health centre.

Q. So has that affected working relationships?

Yes, it has because if the district nurses were popping in and out you'd say 'Oh, can I just ask you...' Or she'd say 'Oh, I saw Mrs so and so' and you could discuss their long term condition together. Or she'd say 'Oh, I have seen this patient and their blood sugars are up, what do you think?' You know, that sort of thing. Whereas it's much more difficult to do that now. (Diabetes practice nurse 2007)

This loss of personal relationships between GPs and district nurses was having consequences for patient care:

....things take longer to get done and things fall through the net. I can't ever remember a time when I did a referral to a district nurse and what I asked for wouldn't happen, and now I have had to write to the supervisor about two or three things in the last six months, about stuff that actually didn't happen at all. (GP 2007)

There was also a perception that continuity of care had been compromised by workforce re-designs:

Having a holistic pathway of care involves people from consultants all the way through to care assistants....we remain very fragmented and very uninvolved and I think if wehad something called co-operative commissioning, if we had a budget thatwas co-owned by primary and secondary care and ...maybe with Social Services as well, that we are all responsible for this budget... (GP 2007)

It had also seriously disrupted professional relationships making it harder to:

*Network effectively....it's just easier with people that you know very well.
(Physiotherapist 2007)*

The disruption of professional working relationships, fragmentation of the workforce and dividing of care into technical, personal and domestic tasks created particular challenges to working in inter-professional teams. The situation of frail older people, living at home alone was described as:

One of the things that has got worse in the last two years is access to Social Services, so if you are talking about this highly-ill co-morbid group at home, then this last year [2007] across the country, most local authorities have restricted even more access to home helps and ... so I think that is likely to have a serious impact on people's health and people's ability to look after themselves... (Community Matron 2007)

Different professional groups demonstrated differing attitudes to clinical risk in community services:

Many of the other disciplines are quite risk averse and say 'Oh no, you know, they can't do this, they can't do that' and we know that some discharges will fail, but, if you mitigate the risk as much as you can, patients deserve a chance. That's what I mean - the number of times we have, 'I really want to go home, I really want to go home, I really want to go home'. And we're all, like, 'Huh, she's going to be a disaster'. But you've got to let them, they're not cognitively impaired, they can make their own decisions. (Community Matron 2007)

Caring for people at home was thus considered to carry risks for both practitioners and service users, which practitioners needed to assess. This required advanced skills and new procedures for care in the community, in order to put resources and support in place to reduce clinical risk. As financial constraints tighten on community services, staff training and opportunities to create systems to support vulnerable patients at home are squeezed and the ability to reduce and monitor risk is constrained. As a result, front line practitioners are likely to become increasingly risk averse, a response which is understandable but which will inevitably have a negative effect on the quality of their clients' lives.

Financial risk and clinical risk

The findings from these two research studies share a number of common features. First, financial decision making was being devolved to smaller, lower level groups, led by clinicians (GPs), who in the case of TPPs and 'shadow' commissioning, were also providers. Second, providers were increasingly being paid contractually according to activity. Third, financial constraints *and* the needs of patients with long term conditions and mental health problems combined to create professional incentives to keep such patients out of acute hospital care and supported in the community. Fourth, in order to achieve point three, everyone agreed that team working and frontline collaboration among different professions was key.

The devolution of budgets to PCTs or to GP commissioners was intended to provide incentives to reduce acute admissions. In 1995 and in 2007, managers were keen to strengthen community services to this end. However, in each case, the incentives for acute hospital providers to increase activity conflicted with this objective. Furthermore, GPs in each case were not necessarily effective in – and did not necessarily prioritise – supporting broader, district-based community provision in the form of cross-professional team working. In 2007, the PCT finance officers complained that they could not 'claw back' funds from GPs to support other community services. As a result, points one and two, above, often conflicted with the objectives agreed in points three and four. Financial uncertainties added to the squeeze on community care resources in each case.

An unintended consequence of the new financing and contracting structures studied was thus to shift financial risk downwards onto some of the most vulnerable patients and the community staff who worked with them. The economic principles of contracting outlined above suggest that this is not only unfair, but also inefficient.

Health care reformers thus face a difficult dilemma. Our interviewees agreed that (high powered) financial incentives work; that is, they change behaviour by subjecting people to risk¹⁷:

The fact that there's uncertainty, you know, in the past we just turned up and provided care for patients and that was it. Now we have got to think about whether we are businesslike, and have we got the contract? (Manager 2007)

The language of managers implementing reforms repeatedly refers to shaking people out of old practices:

They do get set in their ways and it's been very hard to get people to question their practice. (Manager 2007)

The snag – also widely agreed – is that it is hard to incentivise flexibility, joint working, team working, informal care for patients encountered opportunistically during community visits or working across professional boundaries. In these contexts, one does not want to pay individuals too tightly according to activity, but rather to value the outcomes of networking. The smaller the units and the tighter the contracts – and the more uncertain the employment contracts - the more people may find it hard to work collaboratively and flexibly to give a more integrated service.

In 1995, faced with this dilemma and asked for recommendations, we proposed a radical recasting of the integration problem. Instead of using yet more skilled staff as co-ordinators, we suggested that the 'view from below' was key and that the home care service should be the 'link service' between Social Services and the NHS.⁶ We proposed the integration of home care assessors into primary health care teams; that district nursing support for home carers should be further developed; and that including the home care teams would improve information sharing. This was a sharp change in thinking from a hierarchy that treated home carers as the least valued professionals in terms of status, influence and rewards,

increasingly providing short narrowly defined tasks and visits and facing disincentives to take responsibility.

In 2007, we observed that, like the district nurses and home carers in 1995, many professionals worked hard to transcend boundaries and overcome disincentives to team work. In the most integrated of the three areas – where the community and mental health services were still in the PCT – there was less instability and much more optimism about scope for collaboration on improving community-based care. In the two PCTs struggling with large deficits, repeated reorganisation and competing acute providers, it was much harder for commissioners to protect community services and there was more uncertainty and demoralisation.

Conclusion

The implications of the two studies are much easier to state than to achieve. Financial and contracting structures should shift risk downwards to providers *only* to the extent that the benefits justify the costs. In community health services contexts, where team working and shared responsibility are essential to good outcomes, contracts should be low-powered and more risk should remain with the funders. This means that community health services contracts cannot be set on the basis of tightly specified outputs, but need to allow and encourage experimentation, sharing of resources, and risk-taking when it is in the clients' interests.

If incentives are too specific, and services funded in small units on the basis of narrowly specified activities, this can create de-motivation and risk-aversion, 'box-ticking' and a 'blame culture'. In hard financial times, de-motivation will sharply worsen if community services' provision continues to be a residual after the demands for acute hospital care have been met.

This is no-one's intention, but it risks emerging as an unintended consequence of the current and planned English NHS reforms. Community services' funding needs protecting from the squeeze exerted by the response of others, such as hospitals and GPs, to high powered incentives. Current proposals furthermore appear to envisage a further fragmentation of the supply of community health services, through for example the setting up of social enterprises. It is important to ensure that this fragmentation does not undermine the collaborative behaviour essential to meet the specific needs of those with long term chronic conditions and mental health problems, many of them elderly and highly vulnerable.

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