The BMA has endeavoured to print all material relating to ARM 2019 using recycled or FSC-certified paper. We have done this to uphold BMA policy (see below) and the Representative Body’s wish to look after the environment.

*That this meeting calls for all papers relating to BMA ARM and AGM to be printed on either 100% recycled paper or 100% FSC-certified paper from sustainable sources. (2016)*
Pre-ARM briefing paper 2019: Pay and Productivity

This briefing paper summarises the main challenges associated with defining and measuring productivity in the NHS and the further issues that arise by linking it to pay. It is intended as a background paper for members to inform discussion at the BMA’s 2019 Annual Representative Meeting.

Introduction

Across the UK, the NHS faces significant financial difficulties and the gap between NHS resources and demand is rapidly increasing, causing services to deteriorate and creating an urgent challenge. To cope with this funding shortfall the UK Government and devolved administrations have been focusing on efficiency savings and productivity improvements, but often without specifying how these will be achieved and measured. Furthermore, it is sometimes challenging to see in practice the difference between efficiency saving targets and budget cuts. Even though the BMA subscribes to the principle that resources should be spent efficiently, ensuring that tax payers are getting the best value for their money, there are inherent difficulties in defining what productivity in the NHS is and how to measure it appropriately. An important prerequisite of setting effective policy objectives is robust measurement and a precise definition of the concept to be measured.

Productivity and methods of measuring it

Productivity is traditionally considered to be the rate at which any organisation can transform its inputs into outputs: if more output can be obtained from a given level of existing inputs then productivity has been improved.¹ Like other organisations, the NHS uses inputs (eg staff, beds) to create outputs (eg GP consultations, heart transplants). Unlike other organisations, however, the output of the NHS is multi-dimensional, often unobservable and difficult to measure accurately in its entirety.

Many of the methodologies suggested for measuring productivity in the NHS focus on targets. Methodologies that focus only on one input and one output of a more complicated process often provide perverse incentives. However, as NHS outputs are numerous and interconnected, attempting to simplify these can lead to resources being diverted from unmeasured to measured activities and tasks, or focused solely on specific activities. These behaviours can hinder productivity improvements and reward poor performance, as they do not take into account changes in patient outcomes, quality of care and satisfaction. Focusing merely on targets also ignores other significant variables, such as the level of resource being used or the level of demand for healthcare in each particular area. Finally, it fails to address the fact that innovative structural solutions and improving the funding position of the health service in the long run requires major system-wide reconfiguration and increased investment across the board.

On the other hand, attempts to calculate a weighted series of inputs and outputs, such as the one adopted by the ONS (Office of National Statistics) and DHSC (Department of Health and Social Care) in England, are equally problematic as the resulting measures of productivity are dependent on the weights employed, which might not be consistent across the NHS and can often be hard to measure in themselves.

A key limitation of trying to measure productivity in the NHS is the lack of adequate, reliable and comparable information on the outcomes of care. For most forms of health care, outcome data are not collected routinely and, where they are, data collection is limited to mortality. Secondly, we have no accurate data on patients’ valuations of the improvements in health they gain from treatment. Given these two limitations, estimates of productivity can only rely on assumptions about the benefits that result from different types of treatment.²
Furthermore, it is hard to identify productivity for individual staff groups as each unit of output is generated by a combination of different staff groups, from consultants and nurses, to management and support staff. It is, therefore, difficult to disaggregate the productivity of these groups when they are contributing to the same unit of output.  

Finally, it is very challenging to design a methodology that would be applicable across all four nations as the data currently kept by each system are not comparable, therefore making it impossible to rank the performance of each system definitively.

**Factors that affect productivity**

**Investment**

Workforce productivity improvements in almost all sectors of the economy are usually preceded by capital investments. The NHS needs more money to make the transition to a more sustainable footing. By increasing investment in the UK health economy, innovating and making new effective treatments available, the NHS can drive up the quality of care for patients.

**Workforce, morale and wellbeing**

Research shows that the health and welfare of staff influences their productivity. However, as a result of insufficient funding, doctors are working increasingly longer hours and more intensely than ever. Understaffed rotas, vacancies and long hours are leaving doctors at risk of illness and burnout, impacting on patient care and the sustainability of the NHS. The effect of excessive workload has been made worse by high levels of stress and a feeling of disempowerment and disengagement. We know that this can be directly linked to a fall in productivity; the NHS lost 15.7 million days due to sickness absence in 2015 in England alone.

Clinician involvement, which is widely recognised as vital to achieving successful and sustainable change in the NHS, is impossible under these conditions. A true commitment to increasing productivity in the NHS should start by addressing the factors that hamper clinical engagement as this would provide multiple benefits, from reducing unwarranted variations within the health service to identifying and implementing greater innovation in clinical delivery and, of course, ensuring that improving patient outcomes remains at the heart of the search for greater efficiency.

Shortages have resulted, among other reasons, from too few staff being trained, or attracted from other countries to meet present and future demands. The BMA has been calling for a realistic approach to workforce planning and in particular for a shared understanding of workforce numbers and an evidenced-based view of what will be required in the future to deliver a sustainable health service. Governments across the UK have announced plans to expand capacity and grow the workforce, but still very little has been offered in the way of detail. Given the extent of vacancies across the UK, the long-term sustainability of the NHS requires robust workforce planning that addresses the reality of the staffing crisis, which will require additional resources for training and funding.

**Technology**

Apart from ensuring that doctors have access to basic workable and interoperable IT systems, new technologies can assist with transformational improvements for the NHS. New technologies and innovative mechanisms can deliver higher productivity, safer care and substantial cost savings, by freeing up staff time, reducing bureaucracy and unwarranted variations, and enabling greater integration of services. To successfully enable this, governments not only need to provide the appropriate levels of investment, but also to adopt an approach in which doctors will play a central role in designing and delivering the transformational technological solutions.
Linking pay to productivity

The DDRB (Doctors’ and Dentists’ Remuneration Review Body) has been interested in recent years in the notion of targeting pay to support increases in productivity. The BMA has repeatedly argued against this as the performance and efficiency of the NHS relies on multiple factors beyond the performance of individual doctors: productivity of wider teams, the activities performed, the infrastructure, the technology employed, the management, the working environment, the demand, and so on. It is, therefore, the system, not the individuals, that has the biggest impact on performance variance. Doctors have effectively little control over all the variables that affect the productivity of the system they operate within and therefore linking pay to productivity improvements they cannot affect would be unfair and demoralising.

Furthermore, since the start of the last recession in 2008, doctors have experienced a prolonged pay freeze and cap. As a result, doctors have faced an unprecedented cut in their average real terms income after tax and pension deduction of up to 30 per cent. At the same time, they are being asked to work longer and harder than ever in a system which is under pressure due to chronic underfunding, workforce shortages, and rising patient demand, which has a significant impact on their morale and wellbeing. In times of generally declining morale, it is important that all doctors are valued equally in order to avoid the negative consequences that selecting a few would have on the morale and motivation of the wider workforce.

A recent GMC report found that as demand is soaring both in volume and complexity, staffing shortages put the medical workforce under undue pressure. The report recognises that doctors are delivering good care against all odds, but highlights that stress is pushing doctors to reduce the amount they work or to retire altogether. Most importantly, the GMC acknowledges that doctors are ‘reaching the limit of what can be done,’ making it clear that productivity improvements cannot be achieved by the NHS tightening its belt further and expecting more from a workforce currently pushed to its limit. Instead the NHS productivity challenge can be addressed by ensuring that the health service can recruit and retain safe levels of staffing and by creating an environment in which staff feel valued and motivated.

Key issues to consider

This briefing is intended to provide background information for members to inform debate at the BMA’s 2019 Annual Representative Meeting. In particular, the representative body may wish to:

- Call for sustained investment in the NHS to ensure the health service is efficiently providing the best quality of care.
- Support calls for developing a comprehensive workforce strategy and a positive workplace culture. Addressing the issues that lead to the deterioration of doctors’ morale and wellbeing, will have a positive effect on the productivity of the workforce.
- Work with relevant stakeholders across all four nations to identify an appropriate definition of productivity in the NHS and develop a methodology for measuring it that would capture the nuances of team working and would focus on the quality of patient care rather than activity.
- Call for the systematic collection of reliable data on quality of care, patient outcomes, and satisfaction.
- Oppose calls to target doctors’ pay to productivity improvements.
References


2. Nick Balck (2006). Health care productivity: Is politically contentious, but can it be measured accurately?


