

# Does productivity increase with remuneration?

Reforming the public sector occupies a central position in policy agenda. **Professor Carol Propper** argues that incentive schemes can bring about increased productivity and warns policy makers ignoring the importance of financial rewards do so at their peril.

TWO FEATURES of private market activity have attracted the attention of would-be reformers of the public sector – the role of choice and competition and the use of financial incentives. Modernisers argue that only by introducing these measures will we be able to improve our public services. Traditionalists resist such changes, arguing that choice is not appropriate when it comes to public services and that the introduction of financial rewards will drive out 'public sector' motivation.

#### Design importance

The results from studies of public sector employees show the importance of careful design. Public sector workers may respond

to incentives but in ways that the scheme designers might not always want. One of the more general themes of performance measuring literature is that of 'gaming' by those whose actions are being monitored (Propper and Wilson 2003). When a target is introduced, individuals may work harder to achieve that target. But they may also divert effort from other less well measured activities to do this.

One example doing the rounds in the UK is University lecturers monitored on their research papers may neglect their (less monitored) teaching. If the target is poorly specified, individuals may put effort into appearing to meet the target, whilst not increasing productivity. When a target

for numbers on hospital waiting lists was introduced in the UK, hospital administrators spent considerable effort removing dead individuals from these lists. This made the lists shorter, so that hospitals were more likely to hit their targets, but didn't mean the living got treated any faster.

The evidence suggests that individuals employed deep in the public sector do respond to schemes to link performance to pay and will respond quite rapidly to often small financial incentives.

#### Pay vs performance in the UK NHS

In 2001, as part of its efforts to increase productivity in health care, the UK Government introduced a rating system

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that measured the performance of NHS hospitals against a wide range of targets, including aspects of quality, volume and financial performance.

These were called the 'star' ratings. Every hospital was awarded between three (the highest rating) and zero (the lowest rating) stars. To sharpen incentives further, the government linked performance on these star ratings to the degrees of freedom to be given to hospital managers.

#### North/South divide

One striking feature of these ratings was that NHS hospitals in the North of England got more stars than those in the South. Why such a regional pattern?

It cannot be due to differences in the health of the population since, in general, this is better in the South than the North. Research undertaken by colleagues at the University of Bristol (Burgess et al 2003) suggests that differences in pay between hospitals located in high costs areas – basically the South – and those located in low cost areas – basically the North – may be a key factor driving the differences in star ratings.

Pay in the NHS is still primarily set centrally. Hospitals in London and the South East pay more than hospitals located elsewhere. All other hospitals pay the same amount to staff at a given grade and experience. But wages in the private sector are not fixed in this way. They reflect the state of the local economy. Areas of high demand for labour will have high private sector wages; areas with low demand will have low private sector wages. Since the pay differences between regions within the NHS do not fully reflect these private sector wage differentials, the differential between NHS pay and private sector pay varies considerably across the country. Hospitals in high cost areas are likely to pay less compared with the private sector than hospitals in low cost areas.

Hospitals located in high cost areas – those where wages outside the NHS are high – face more competition for staff than hospitals located in low cost areas. Low relative pay can lead to two possible shortages: staff and quality. It can cause problems in hiring and retention, that in turn affects productivity and quality.

Nurses are key NHS staff. A nursing shortage in the UK is exacerbated by widespread problems of recruitment and retention – particularly in the more prosperous South. Research has shown pay and other aspects of the work environment, such as shift work, have an impact on nurse shortages.

We examined whether the gap between what nurses are paid and what they might



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PROFESSOR CAROL PROPPER

earn outside the NHS has an impact on the star rating measure of NHS hospital quality. Unpacking the star ratings into their separate components reveals that hospitals located in areas where the outside options for nurses are good have poorer outcomes on several fronts:

- For the 2001 targets, the nurses' pay gap is associated with seven of 21 targets. Four of these are 'key' targets – the number of patients waiting for an inpatient appointment, and measures of outpatient waiting, trolley waiting and hospital cleanliness.
- For the 2002 targets, the pay gap is associated with 11 out of the 37 targets. Ten of these are performance targets, six based on inpatient surveys.
- Across the two years, more than a third of the individual targets (18 out of 53) are negatively associated with the pay gap. Many of the targets associated with the pay gap are based on patient surveys. Patient experiences depend, to a large extent, on their contact with nursing staff. The fact that these outcomes are rated as better where staff are paid relatively more points to a link between the ratings and pay.

Recent research looking at another measure of hospital quality – the number of deaths following admissions of individuals with heart attacks – supports these findings. Hospitals located in areas where the NHS pay is poor compared with the private alternatives have higher death rates, holding everything else constant.

The results imply that some of the

performance of NHS hospitals may be less related to managerial ability than to the labour market in which the hospital is located. This, in turn, suggests that allowing managers to raise pay in areas where it is relatively low may be one way to improve NHS productivity.

#### Chasing the carrot

Individuals employed in the provision of public services do respond to financial incentives. This does not mean they lack what might be called 'public sector motivation', just that they also care about financial rewards.

Individuals located deep in the public sector do respond to targeted financial incentives, often quite small ones, and often changing their behaviour quickly. In addition, they also appear to respond (negatively) to underpayment relative to their options in the private sector.

There are caveats however. Most of the evidence comes from schemes that ran for relatively short periods or the assessments only covered short periods. Therefore we do not know whether the effect of small payments would wear off over time. We also know that schemes run over a long time period are plagued by 'ratchet type' effects – the linking of present performance to past performance means people lower their effort in order to make the initial performance as low as possible.

It is also clear that schemes have to be carefully designed. The problems of measurability and multi-tasking means that unintended consequences may easily arise, some of which may actually reduce rather than increase productivity. Financial incentives alone are also not enough to induce productivity increases. Introducing a scheme into an organisation that is confusing about its objectives and mission is very unlikely to improve matters and may well make matters worse.

The over-riding lesson here is that financial incentives are just one tool at the disposal of governments seeking to raise public sector productivity.

A blurring of the traditional distinctions between public and private sectors is important for the success of government attempts to improve our health care, our education and public sector administration.

H&H

*Professor Carol Propper is an international expert on public sector productivity and a professor with the department of economics at Bristol University, UK. This is an edited version of her address: "Is Low Pay For Nurses Bad For Your Health?" presented last month at the University of Technology Sydney for the Centre for Health Economics Research & Evaluation (CHERE). References are available on request.*

# The changing face of residential aged care

The last 18 months has witnessed a small revolution in the residential aged care sector.

**Heath Shonhan** reviews what the changes mean to the industry.



**Heath Shonhan**

THE AUSTRALIAN Government has increased its funding via a number of one-off payments and through the introduction of the Conditional Adjustment Payment (CAP). Leading the trend towards

industry consolidation, there have been a number of high profile transactions by large corporate players.

Smaller private groups have also been involved in consolidating fragmented service providers in all states. In addition, community based services are starting to turn towards larger operators to provide assistance in the shareable services areas such as human resources and project management.

At an operational level there has also been a number of interesting trends emerging. One of these is the significant increases the industry has seen in the level of accommodation bonds charged by both the 'for profit' and 'not for profit distribution' service providers.

Another trend is the level of increase in national averages for low care accommodation bonds in recent times compared with previous extended periods of low growth.

The underlying drivers behind these movements can be summarised down into a few key factors.

Firstly, for new residential aged care services, the capital inputs that go into the construction process are costing more. Land prices have risen due to scarcity in prime and central locations. Similarly, construction costs have also risen sharply in recent times, driven by rising subcontractor and raw

material costs. These two factors together have resulted in the simple necessity to levy higher accommodation bonds to offset the hike in capital costs.

Secondly, the wave of recent building certification requirements has forced service operators to recognise the importance of providing for longer term building stock capital maintenance. Service operators realise that maximising the level of accommodation bonds charged, even if they are not offsetting capital costs, can provide an important additional income source for their business operations.

By way of example – a \$300,000 accommodation bond invested in a bank term deposit at 5.25 per cent will earn an additional \$15,750 in revenue for a service. Re-investment of this income back into building stock capital improvements should assist the service provider in maintaining their buildings at a reasonable standard and in accordance with current and emerging requirements. This capital re-investment program should assist in extending the useful life of these buildings and consequently facilitate the charging of similar (and even higher) bonds in future years.

Thirdly, while property prices have increased the underlying capital cost per place, this has also supported the increases in accommodation bonds in a different way. As a general rule, the majority of incoming residents into a residential aged care facility will be selling their family home to finance the accommodation bond payable on admission into a low care or extra services facility. Put simply, significant increases in their property's value means they have an increased ability to pay a larger bond to finance their entry into a service.

Another emerging trend in recent times is the unprofitable nature of single room

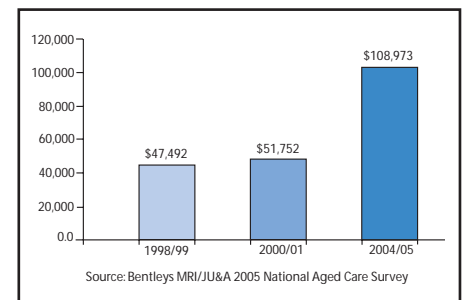
services – compared with multi resident rooms. It is a well known fact that residents (and their families) would prefer to live in a single room in a residential aged care setting. From the service provider's perspective however, this costs more, even when capital construction costs are excluded.

This obvious disparity between what is being required from the 'consumer' and what is economically profitable from the provider's perspective is further compounded by the inability to charge accommodation bonds to high care residents.

Unless the provider has approved 'extra services' status – the financing costs associated with constructing high care single resident room further increases the unprofitable nature of providing single resident rooms.

The Australian Government continues to indicate its preference towards increasing levels of community care. How will the funding streams flowing to the industry change in the coming years and change the financial 'face' of residential aged care as we know it? **H&H**

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