Extracontractual referrals: safety valve or administrative paperchase?

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Abstract

Objective—To describe the extracontractual referrals of residents of a health authority during a six month period in 1994, identifying the number and cost of emergency and non-emergency referrals, including the number of cases costing more than £20 000 and those cases when payment was refused.

Design—Descriptive analysis of all extracontractual referrals submitted to the health authority between 1 April and 30 September 1994.

Setting—A health authority covering a population of 614 000.

Results—Payment of £2 583 693 was made to 263 different providers for 2400 episodes of care, of which 1469 were emergencies and 931 were elective or tertiary referrals. Authorisation was granted for an additional 1376 referrals for future treatment but was refused in 713 instances, mostly for technical reasons. Sixteen extracontractual referrals together accounted for over a fifth of total expenditure during the study period.

Conclusions—Handling large numbers of episodes of care on an individual cost per case basis imposes an enormous administrative burden on both purchasers and providers, diverting money away from patient care. Extracontractual referrals also expose health authorities to considerable financial risk and may undermine commissioning strategies. Measures are proposed to limit the number of episodes handled in this way.

Introduction

Hand in hand with the introduction of contracts for health services in 1991 came the extracontractual referral. Initially a cause of considerable anxiety,^{1,2} the management of extracontractual referrals has now become a complicated but largely routine administrative process carried out for reasons of confidentiality within designated "safe havens." The number and complexity of the rules governing their management have multiplied steadily, and they have recently been "summarised" in a 100 page document.³ A separate paper, *Establishing District of Residence*, deals with bureaucratic niceties such as "hospital hoppers," "holiday homes," and "boarding school pupils from overseas."⁴

Just as doctors in their consulting rooms take a history from their patients so administrators within the sanctity of safe havens systematically examine extracontractual referrals (most of which are rendered anonymous) to establish the health authority's liability for payment. In line with published guidance, checks carried out include:

- Address and postcode, to ensure that the patient is a health authority resident
- Whether the patient's general practitioner is a fundholder and, if so, his or her liability for payment
- Whether the request is covered by a contract with that provider

- Tariff, to ensure that the correct price is being quoted on the request or invoice

- Timeliness of the request or invoice

- The reason for the extracontractual referral, to identify whether treatment could be undertaken under a contract with another provider.

These checks, which are time consuming and tedious, often entail discussions with staff in the safe haven of the provider and with the patient's general practitioner. Unusual referrals (very expensive or uncommon treatments) require input from other health authority staff such as contracts managers and doctors in the department of public health medicine,⁵ who may need to speak to business managers or clinicians in the provider unit. Finally, whenever a request for an elective extracontractual referral is refused or referred again to another provider the patient and the referring practitioner must be informed of the reason for the decision.

The seclusion of extracontractual referrals within safe havens has tended to obscure this huge administrative burden. Other equally important issues, such as the financial risk to which health authorities are exposed by extracontractual referrals and the way in which they can undermine a health authority's commissioning strategy, have also received insufficient attention.

Many of the problems associated with extracontractual referrals also occur with cost per case contracts. As with extracontractual referrals the purchaser pays a fixed price for particular treatments as and when they arise, and again each episode of care requires separate administrative processing. The existence of a contract obviates the need for prior authorisation, however, which is a necessary stage in the processing of elective extracontractual referrals.

I describe the extracontractual referrals of the residents of one health authority during the period April to September 1994 inclusive. Some background information about the health authority is included so that the number and cost of its extracontractual referrals can be seen in the context of the total contract portfolio. I have discussed the implications of these findings as purchasing increasingly moves towards cost per case contracts, in which each episode of care is separately invoiced.

Method

All extracontractual referrals received by the health authority between 1 April and 30 September 1994 have been included. They can be divided into two broad categories: emergency and non-emergency referrals. The latter includes elective referrals, for which prior authorisation must be requested, and tertiary referrals, when a patient is referred from one NHS consultant to another. Prior authorisation is not required and payment is mandatory for both emergency and tertiary extracontractual referrals. Provider units do not always identify tertiary referrals as such, however, and there

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had been no attempt to count them separately in this paper.

The number and cost of emergency and non-emergency extracontractual referrals were recorded, and the provider units from which they originated were identified. The number of extracontractual referrals for which payment was refused was also noted; the reason for refusal and the savings thus made were recorded. Finally, all extracontractual referrals costing more than £20 000 were separately identified to establish the nature and source of the referral.

Results

The health authority studied has a population of 614 000 and a recurrent cash limit of £274 million. It has contracts with more than 50 providers, of which 30 are acute hospitals, including all the London teaching hospitals and special health authorities.

NUMBER AND COST OF EXTRACONTRACTUAL REFERRALS

During the six month period (1 April to 30 September) £2 583 693 was paid for 2400 extracontractual referrals: 1469 were emergencies costing £929 514 and 931 were non-emergencies costing £1 654 179. Of the non-emergencies an unidentified number were elective referrals for which authorisation had been granted before the study period but the invoice was paid during this time. In addition, authorisation was granted for a further 1376 elective referrals (anticipated cost £1 117 053) for which invoices had not been received, and 713 requests for authorisation or payment were refused. In total, therefore, 4489 extracontractual referrals (requests for authorisation or invoices, or both) were received during the study period, with a total financial commitment of £3 700 746.

The 2400 referrals for which payment was made related to 263 different providers. Of these, 966 referrals were made to 26 providers with which the health authority has a contract. In particular, 556 were to one local, non-acute provider which excluded all highly specialist services, both inpatient and outpatient, from its contract.

REFUSAL OF PAYMENT

Authorisation or payment was refused for 713 extracontractual referrals, 16% of the total received, with a total saving to the health authority of £675 604, 18% of the total financial commitment (table I). In 584

TABLE I—Refusals of extracontractual referrals

Reason for refusal of payment	No refused	Value (£)
Covered by contract	149	221 914
Non-resident	105	154 923
General practitioner fundholder procedure	100	50 306
Retrospective request or invoice	160	80 279
Duplicate invoicing	19	24 464
Late invoicing	16	8 425
Overcharging on tariff	35	32 580
Patient referred again to block contract	113	73 501
Treatment refused	16	29 212
Total	713	675 604

TABLE II—Extracontractual referrals costing more than £20 000

Source of referral	Nature of referral	No of cases	Cost per case (£)	Total cost (£)
Emergency	Psychiatry: mother and baby unit	8	29 020	232 160
Tertiary	Bone marrow transplant (child)	2	63 491	126 982
Emergency	Neonatal intensive care	1	65 997	65 997
Emergency	Psychiatry: personality disorder	1	28 885	28 885
Emergency	Helicopter medical service	1	28 182	28 182
Emergency	Acute renal failure	1	22 997	22 997
Tertiary	Bone marrow transplant (adult)	1	22 259	22 259
Tertiary	Paraplegic patient: tissue viability	1	21 065	21 065
Total		16		548 527

instances (82% of refusals) payment was refused for "technical" reasons: referral covered by a contract with that provider; retrospective request for authorisation; late or incorrect invoicing; patient was not a health authority resident; responsibility of a general practitioner fundholder, etc.

In 113 cases, after discussion or correspondence, or both, with the patient and the general practitioner the patient was referred again for treatment under a contract. Of the 16 cases for whom treatment was refused, five were requests for treatment in private hospitals; eight did not meet agreed criteria for restricted treatments (sex change operations, assisted conception, cosmetic plastic surgery, dental implants); and in three cases the general practitioner did not support the patient's extracontractual referral for alternative medicine.

HIGH COST EXTRACONTRACTUAL REFERRALS

Sixteen extracontractual referrals, each costing more than £20 000 were paid for, of which 12 were emergency admissions and four were tertiary referrals (table II). Total expenditure on these 16 episodes of care was £548 527, 21% of total expenditure.

Discussion

I have shown the magnitude of the administrative task associated with extracontractual referrals, with nearly 4500 requests and invoices being received in a six month period by one health authority. Although the financial cost of their management was not calculated in this study, the audit commission estimated the average staff cost per extracontractual referral within the health authority alone as £20-25 in 1991-2, commenting that "the average administration cost is significant, compared to the amount being invoiced for some of the cheaper extracontractual referrals such as single outpatient consultations." Furthermore, it should be remembered that the handling charges incurred by providers are probably of at least a similar value; these become subsumed within their prices and thus become an indirect cost to purchasers.

CONTRACT EXCLUSIONS

Although most referrals in the present study originated from distant hospitals with which the health authority did not have a contract, 40% related to contracted hospitals. They occurred because of contract exclusions, which arose in two ways. Firstly, after specialty reviews or tendering, or both, the health authority identified preferred providers for certain specialties (dental specialties, otorhinolaryngology, ophthalmology) which were then excluded from contracts with other providers. Secondly, most providers now have a wide range of contract exclusions, usually for highly specialist treatments. These two factors, combined with the now almost universal practice of charging separately for each outpatient appointment, contributed greatly to the substantial workload related to extracontractual referrals and represented a major change from 1991, when contract exclusions were few and far between because of "steady state" and when outpatient appointments were rarely counted let alone charged for.

Individually, these factors are eminently reasonable: the ability to move contracts to preferred providers offering higher standards of care and better value for money is the *raison d'être* of the internal market, and extracontractual referrals provide the essential safety mechanism to ensure that within this system the needs and wishes of individual patients and general practitioners are respected. The exclusion of highly specialist, high cost episodes of care also makes

sense in that the residual contract reflects more accurately what is actually provided and is easier to manage. Finally, the separate identification of extracontractual referrals for outpatients is necessary to enable purchasers to control elective authorisation at the point of referral. The combined effect of these approaches, however, has been the administrative overload I have identified in this study.

ADMINISTRATIVE PROCESSES

One approach to reducing the health authority's administrative costs associated with extracontractual referrals would be to by pass the rigorous checking processes on the grounds that the handling charge in some cases equals or exceeds the cost of the referral. This would be an unattractive option, however, because, as this study has shown, considerable savings can be made in this way—important to purchasers operating within a strictly limited budget. Nevertheless, within the broader framework of the NHS such savings are more apparent than real. There is no such thing as “free” treatment and, when providers fail to obtain their proper reimbursement because of clerical inefficiency, the incurred costs become part of their overheads, to be recouped in prices at a later date.

The fact that so many inappropriate claims for payment were made illustrates the complexity of the whole process. Each year, 1 April brings boundary changes, mergers of health authorities, mergers of providers, changes in contracts, new contract exclusions, and new general practitioner fundholders, making it difficult for providers to know to whom a request or invoice should be submitted. Furthermore, some patients, happily unaware of the problems they cause, are inconveniently involved in programmes of care that straddle the end of the financial year.

FINANCIAL RISK

The final point to emerge from this study is the financial risk to which the health authority is exposed as a result of exclusions in providers' contracts, with 0.7% (16 referrals) of extracontractual workload accounting for 21% of expenditure. All of these referrals were either tertiary or emergency admissions, for which payment is mandatory, so that no control could be exercised by the health authority over this large expenditure. This bears obvious parallels with the difficulties experienced in managing main contracts when there is an increased number of emergency

admissions and, just as elective work may have to be delayed to control contracted levels of activity, so elective extracontractual referrals may have to be deferred to the next financial year. Furthermore, in the absence of mechanisms for agreeing funding for developments in service it is common for new and expensive treatments, formerly funded from research moneys, to be introduced to the market as extracontractual referrals. By their very nature they are always likely to be accessed as tertiary rather than as general practitioner referrals so that this provider led change in health service provision has the potential to undermine health authorities' commissioning strategies, forcing them to maintain sufficient financial reserves to fund expensive extracontractual referrals for a small number of patients rather than investing in services to meet the health care needs of the population. This is illustrated by the fact that within the six month period of the study the health authority received notification of five tertiary referrals for cochlear implants at a total cost of £124 000 (treatment has not yet taken place and therefore this projected expenditure was not included in the study data).

CONCLUSIONS

The implications of this study for future health care commissioning are considerable. In addition to anxieties about managing financial risk and about purchasing strategy, the most important concern relates to the administrative paperwork after each extracontractual referral. In just one health authority a conservative projection suggests that there will be at least 4800 completed referrals in one year. This number, multiplied by an equally conservative estimate of the total handling charge (including direct and indirect costs) of £60, suggests that nearly £0.3 million will be diverted from patient care to pay for the administrative processes necessary for the management of extracontractual referrals. These processes, including computer inputting as well as letters, telephone calls, and faxes between purchasers, providers, general practitioners, and patients are, as I have shown, an inevitable consequence of the present contractual system.

They occur because large numbers of episodes of care are being handled on an individual cost per case basis. Unfortunately it seems that the problem will get worse, at least for providers. More general practitioners are becoming fundholders and because of the smaller size of their contracts are more likely to manage them as cost per case contracts, with many of the problems associated with extracontractual referrals. Furthermore, even with block contracts for outpatient appointments general practitioners require much more detailed information on individual patients than health authorities do, thus placing increasing demands on the finance and information departments of providers, which do not have systems in place to deal with this bureaucracy.

A practical response would be, firstly, a limit to be imposed on the number of extracontractual referrals or cost per case episodes permitted between any provider and purchaser; where that number is exceeded in any year a contractual arrangement covering those referrals would be mandatory the following year. Secondly, agreed and guaranteed audit procedures should be in place in all providers to reassure purchasers (health authorities and fundholders) that episodes of care are correctly coded and allocated to contracts; queries on individual sets of data should be permitted only for treatments costing more than an agreed minimum.

The above measures offer a practical approach to controlling the burgeoning administration associated with extracontractual referrals and other cost per case contracts. They require prompt implementation to

Key messages

- During a six month period one health authority paid over £2.5 million for 2400 extracontractual referrals
- Sixteen non-elective referrals, each costing over £20 000, accounted for 21% of total expenditure
- Mandatory payment for non-elective referrals can undermine a health authority's commissioning strategy and expose it to considerable financial risk
- The high administrative costs of extracontractual referrals arise because a large number of episodes of care are handled individually
- Measures should be introduced to limit the administrative burden of extracontractual referrals and other cost per case contracts to prevent further diversion of funds away from patient care

prevent the further diversion of scarce resources into pointless clerical tasks that have nothing to do with improving health care or the management of the NHS.

I thank the extracontractual referrals manager for generous help with data collection. This work was carried out while I was a commissioning manager for acute services in a health authority.

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Hospital investigation of men and women treated for angina

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Recent studies suggest that women suffering a myocardial infarction and those discharged from hospital with a diagnosis of coronary heart disease receive poorer treatment than men.^{1,2} We looked at cases of treated angina in two general practices in Newcastle upon Tyne. We hypothesised that women with angina were less likely to be referred for hospital investigation than men.

Patients, methods, and results

All men and women aged 20 to 74 years in two general practices, who were receiving repeat prescriptions for antianginal drugs (nitrates, β blockers, or calcium antagonists) were identified. One practice is in the most affluent ward of Newcastle (list size 10 000) and the other in one of the most deprived wards (list size 11 500). Patients were sent questionnaires, which included (a) questions on personal details such as occupation, (b) the Rose angina questionnaire,³ (c) the Canadian Cardiovascular Society's functional classification of angina questionnaire,⁴ and (d) a question on whether the patient had ever been referred to hospital for chest radiography, exercise electrocardiography, isotope scanning, echocardiography, or coronary angiography. Social class was defined according to the Office of Population Censuses and Surveys' standard occupational classification. Patients were classed as having angina if they met the criteria of the Rose questionnaire.³

Questionnaires were sent to 1019 patients and responses were received from 917 (90%). Of these, 100 respondents were selected at random and their responses compared with their medical records. Ninety two records (41 on men and 51 on women) were available for examination, and there was complete agreement in 70. The tendency was to underreport—for example, three men and five women who had been referred for hospital investigation had not indicated it on the questionnaire.

Altogether 144 men and 143 women met the case definition of angina, giving a point prevalence of 2.1% and 2.0% respectively in the combined practice populations aged 20-74 years. Most of the other patients were taking drugs for hypertension. The Canadian Cardiovascular Society classification was fully completed by 125 men and 120 women; seven men and five women had grade 1 angina, 91 and 88 grade 2, 10 and eight grade 3, and 17 and 19 grade 4. The age distribution of the men and women was similar, with a median age of 66.5 (interquartile range 60-71) and 67 (60-73) years. The social class distribution of the men and women who gave an occupation was different, with

a greater proportion of the women in social classes 4 and 5 compared with the men (51/117 (44%) v 24/141 (17%); ($\chi^2=20.6$, $P<0.0001$). The table shows the numbers of men and women who reported hospital investigation. When stratified by social class the weighted odds ratio (Mantel-Haenszel test) for hospital investigation for men compared with women was 2.15 (95% confidence interval 1.22 to 3.82) ($P=0.008$).

Comparison of men and women reporting hospital investigations for angina

Investigation	Men (n=144)	Women (n=143)	Odds ratio* (95% confidence interval)
Chest radiography	88	60	2.17 (1.32 to 3.58)
Exercise electrocardiography	73	40	2.65 (1.58 to 4.46)
Echocardiography	19	14	1.40 (0.64 to 3.10)
Thallium scan	13	9	1.48 (0.57 to 3.90)
Coronary angiography	30	14	2.42 (1.17 to 3.08)
All five	85	53	2.50 (1.49 to 4.20)

*Men to women.

Comment

In this cross sectional study of two general practice populations women with treated angina were half as likely to have been referred for hospital investigation as men. On the basis of the Canadian Cardiovascular Society's classification, however, the severity of their angina was similar to that of the men. They were also of similar age and the difference remained after controlling for social class.

Coronary heart disease is more difficult to diagnose in women than men.⁵ The prevalence of angina defined by the Rose questionnaire, or diagnosed clinically, is more similar in women and men than the incidence of myocardial infarction. Women with chest pain are also more likely to have normal coronary arteries. Arguably therefore, hospital investigation in determining the correct diagnosis and management of anginal chest pain is as, if not more, important in women. Our observations suggest that the comparatively unfavourable management of women with coronary heart disease in hospitals is also found in primary care.

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