

Ensuring payment by results
enables system reform

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1. Introduction

England's National Health Service is in the midst of a ten-year programme of reform. Initiated by *The NHS Plan* (2000) the government's aim is to create a 'self-improving' health service that is patient-led and delivers high-quality care to all. To achieve this, the NHS is being transformed from a service that is controlled by central government to a devolved system operating within an explicit national framework.

This paper on the national tariff is part of a series of publications focusing on areas of policy critical to the success of the reforms. The other papers can be accessed on the Monitor website, www.monitor-nhsft.gov.uk.

2. Context

Payment by results (PbR), introduced in 2004 across selected organisations and procedures, is the new pricing and payment mechanism for England's health service. By setting a fixed national tariff for each unit of activity in a healthcare resource group (HRG), PbR rewards providers for activity performed. This new payment mechanism, which replaced block contracts, is not a policy goal in and of itself, but rather a tool to support the delivery of the reform goals. It is a critical enabler for raising overall system efficiency, reducing waiting times, creating plurality of provision, enabling patient choice, as well as for introducing transparency and fairness into the system.

The critical features of the tariff are:

- it is a single per-case payment for a hospital activity, set in advance; and
- it should reflect the costs a reasonably efficient hospital incurs for the services delivered.

The English system bases the tariff on the average costs hospitals have incurred in the past (with adjustments for inflation and efficiency improvements). Other countries have used different approaches to tariff-setting.

International experience of implementing tariff-based systems shows they can successfully support reform and help system affordability. According to the OECD, tariff-based systems can save 10% or more compared with other financing methods¹. However, they can also pose a significant risk to financial performance of the system during the transition period as providers and purchasers adjust to the new incentives.

PbR requires strong leadership from the Department of Health to ensure it is implemented in a manner that delivers policy success. This includes the development of strong governance arrangements to ensure tariffs are calculated fairly and accurately and to discourage tariff manipulation or misuse by participants.

1 OECD Health Working Papers, 5 December 2003, *Health-Care Systems: Lessons from the Reform Experience*

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3. Key challenges

In order to deliver the desired policy goals, PbR must address the following five challenges:

- accuracy of tariffs;
- transparency and independence of the tariff-setting process;
- appropriate incentives for desired outcomes;
- affordability; and
- effective policy development

Accuracy of tariffs

PbR tariffs are the pricing signals for the healthcare sector, therefore, it is vital that tariffs are accurate and stable to avoid distorted resource allocation and failure of the system. Key issues that need to be addressed to improve tariff accuracy in England include:

- **Quality of cost data:** tariffs are currently derived by averaging the national cost for delivery of each unit of an HRG. The accuracy of tariffs therefore depends on the accuracy of cost data, yet little attention has been given to date to the improvement of costing systems. Large variations exist across trusts in the interpretation of costing guidelines and the robustness of cost data. These variations lead to tariff distortion and can result in high volatility in tariffs from year to year. For example, there was a large swing in the obstetrics tariff between 2004–05 and 2005–06. Such swings cast doubt on the robustness of the underlying cost data and adversely impact providers' ability to plan accurately.

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- **Setting the Market Forces Factor (MFF):** this is an adjustment to tariff to compensate for unavoidable cost pressures caused by geographical location. Currently, in some cases, large unexplained differences exist in MFFs for trusts within close proximity, e.g. University College London Hospitals NHS Foundation Trust (with an MFF of 1.26) receives approximately 9% more for a unit of activity than Guy's and St Thomas' NHS Foundation Trust (with an MFF of 1.16). Historically, there has also been significant year-on-year volatility in MFFs.
 - **Operational feasibility:** the accuracy of tariffs must be balanced against ease of use, otherwise the system risks ending up with either a very granular tariff structure which is too complex to operate, or an oversimplified tariff which does not compensate providers fairly for activity performed.

Transparency and independence of the tariff-setting process

Experience from other PbR systems shows that it is not sufficient for tariffs merely to be based on accurate costs; participants must additionally have confidence in the integrity of the tariff-setting process. Several issues exist regarding the transparency and independence of England's tariff-setting process:

- currently, tariffs are set by the payor (Department of Health). This can create perceived conflicts of interest, since providers are concerned that the payor could manipulate tariffs to wipe-away provider surpluses;
- there is a lack of consultation on the possible impact of tariff decisions resulting in little 'buy-in' from users in the final tariff decision; and
- there is no long-term visibility (i.e. beyond one year) on tariff trends so purchasers and providers find it difficult to plan ahead.

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Appropriate incentives for desired outcomes

Healthcare is a very challenging area to regulate because normal market incentives are not fully effective. This is due to many factors, including: local monopoly, information asymmetries; moral hazard in a universal, needs-based health system; and the need for coordination across different types of care providers.

While the tariff cannot be expected to single-handedly deliver on all the policy objectives, it is important to analyse incentives created by the tariff structure so that perverse incentives do not subvert policy goals and lead to unwanted outcomes:

- **Improved quality:** currently, tariffs reward higher activity, not necessarily higher quality of care. The risk is to incentivise “low-cost, average-quality” provision. Tariffs, combined with patient choice, effective commissioning and monitoring by the Healthcare Commission should drive improved quality. This requires availability of reliable quality data, which is currently lacking.
- **Collaboration and information sharing:** under the old NHS, hospitals did not compete with each other. While this had many downsides, it had at least one upside: providers had no incentive to hide information (e.g. on process improvements) from each other. In the new system, hospitals compete, and surpluses will come from being better than the competition. Thus, hospitals have greater incentives to innovate, but in the more competitive environment there is also an incentive to guard best practices.
- **Innovation in care delivery:** PbR incentivises innovations which lower costs relative to tariff; however, it does not necessarily incentivise innovations that improve quality while raising cost, nor does it incentivise investment in quality of the aging NHS estate. While this might be in line with a policy objective of keeping healthcare costs down, it could also limit overall quality improvements.

Affordability

PbR provides strong incentives for producers to slow unit cost growth and for purchasers to control volume growth. In the long run these incentives should have a significant and positive impact on affordability. However, the transition to PbR will create financial pressures that will need to be managed:

- For the PbR incentives to be effective poor performers should not be bailed-out. Trusts that have been unable to reduce their costs in line with the tariff quickly enough should receive technical support to do so.
- As the number of NHS foundation trusts increases more providers will be able to retain surpluses, and the Department of Health will have significantly reduced ability to transfer funds from more efficient to less efficient trusts. This could put pressure on cash availability for poor performers.
- Primary care trusts (PCTs) are currently being reorganised and lack tools to effectively manage demand i.e. to control volume and mix of services.

Effective policy development

The government has committed to developing PbR so that it covers 90% of hospital services by 2008-09. In addition, the recent Department of Health white paper, *Our Health, Our Care, Our Say* (2006), commits to ‘unbundling’ the tariff to incentivise the delivery of care closer to home. Yet, there is uncertainty about what this will mean in practice. The scope, development and pace of PbR introduction across diverse areas of care remains unclear. The lack of a clear development timetable makes it more difficult for providers and commissioners to plan ahead accurately.

One approach to improving tariff-setting could be to link prices to best clinical practice rather than average cost. This method is currently used effectively in Sweden. The tariff would be calculated from standard costs in a sample of hospitals. This method would improve the use of PbR for benchmarking relative efficiency.

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4. Recommendations

While recognising that PbR is still in its early stages, there are nonetheless clear actions which can be taken. Below we suggest four key priorities for addressing the challenges identified above.

Creating better understanding of costs through higher quality data

Obtaining reliable and accurate cost data from providers is necessary to ensure that tariffs are set at an appropriate level. Better cost data will itself create increased awareness of the importance of cost accounting. This benefit would be felt at all levels, from increased awareness of cost drivers amongst clinicians at the front line, to better cost management at the system-wide level.

To obtain better cost data, the Department of Health should support an investment in costing systems and skills across the NHS. Current costing systems and procedures are inadequate, with many trusts unable to close their books in less than four to six weeks and unable to determine their true costs for different procedures. This creates significant financial risk to them and to the system as a whole.

Ensuring independence and transparency of the tariff-setting process

In other systems using PbR, tariff-setting is generally performed by independent, streamlined bodies (e.g. CMS in the US). Similarly, in England, tariff development should be assigned to an independent body, responsible for setting tariffs within the resource envelope set by the Department of Health. Additionally, it is important to clarify how PbR will develop and operate over time. Giving stakeholders visibility to plans will enable stability and allow both providers and commissioners to plan ahead.

Creating incentives to encourage desired outcomes

Quality of care can be incentivised through use of fines for missing targets and/or bonus payments or tariff supplements for delivering superior quality. For this to work in practice, standard quality metrics must be defined, performance data on provider quality must be widely available and commissioners must insist that a tight link exist between payment and quality. As waiting times fall, patient choice could also act to drive quality improvements, but again better and comparable data on provider quality would be needed for this to be achieved.

Responding to PbR incentives to improve system affordability

It will also be important to take action to ensure overall system affordability. The financial risk can be reduced by systematically applying strong commissioning practices, such as demand management, accurate planning and claims validation, linked to a sound understanding of projected demand and clarity on providers' costs. Most importantly, providers need to respond effectively to the incentives in PbR to reduce growth in unit costs.

Equally, choices must be made regarding the speed at which the scope of PbR is expanded beyond acute care. It is better to expand the scope of PbR gradually and get tariffs "right", than to introduce flawed tariffs more rapidly. A development agenda for PbR is needed which examines the policy/financial strategy for PbR evolution in the medium to long-term.

Overall, payment by results introduces very powerful incentives into the health system. Implementing PbR effectively will require a continuous process of improvement and fine-tuning over many years.



Monitor

Independent Regulator
of NHS Foundation Trusts

4 Matthew Parker Street
London SW1H 9NL

T: 020 7340 2400

W: www.monitor-nhsft.gov.uk