
RCN Policy Unit

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‘Payment by Results’ Update and discussion paper

ABSTRACT

This discussion paper was developed following a seminar on the development of Payment by Results (PbR). The aim is to provide an update on developments in PbR and stimulate further discussion on the issues raised by the two guest contributors, Jon Sussex (Deputy Director of Office of Health Economics) and Paul Linsey (a senior mental health practitioner and contributor to the early development of PbR in mental health). The speakers' [presentations](#) can be downloaded separately. This is the second RCN Policy Unit briefing about PbR; the [first RCN PbR briefing](#) was written in April 2005.

July 2006

Background

Payment by results is essentially a way of paying hospitals a fixed price for each individual case treated. It has several different elements but in essence uses HRGs (Healthcare Resource Groups) as a means of classifying each case or treatment. HRGs simply allow the classification of patients into a manageable number of groups of cases that are clinically similar and that require similar levels of healthcare resources for diagnosis, treatment and care.

Case mix payment systems (or activity based payments) similar to the one being developed in England have been around for some time, notably in Europe, Australia and the US, as ways of classifying patients into a manageable number of groups of cases that are clinically similar and that require similar levels of health care resources for diagnosis, treatment and care. They are all in essence an attempt to link work done to payments.

Put simply, such schemes are designed to encourage providers to increase the volume of clinical activity (e.g. increase workload and throughput) or reduce their costs (e.g. through reducing skill mix, efficiency drives, screening out costly cases, or shifting costs to other providers such as contractors, independent sector, etc).

The key issue here is that along with patient choice, PbR will be a powerful driver for service redesign. It may also have unintended consequences on commissioner and provider behaviours.

Overview of speaker presentations

Jon Sussex

Jon is currently Deputy Director for the Office of Health Economics. His areas of expertise include efficiency and incentives in the NHS, the regulation of the pharmaceutical industry, health care expenditure and the role of the private sector in the NHS (including the Private Finance Initiative). Jon is also an Honorary Visiting Fellow at the University of York Department of Economics and Related Studies.

The broad intention behind PbR is to stimulate provider efficiency (having something to show for all the money that has been invested in the NHS) but also to stimulate PCTs in more effectively managing patient demand. PbR facilitates patient choice. If PCTs want to avoid sending money to acute trusts, they will have to develop a range of services outside the hospital at or below tariff price. In terms of policy objectives, it is less certain that PbR will stimulate increased quality of care.

PbR is not payment by *results* per se. Instead it is payment per unit of hospital *activity* with a non-negotiable price, regardless of the outcome of that activity. Providers, if they deliver services below tariff price get to keep surpluses “for the benefit of their patients”.

Part of the complexity of PbR lies in the various pricing structures and detail involved in each HRG. As policy objectives shift, it is feasible that Government will vary prices to encourage either investment or disinvestment in certain activities or procedures.

To reflect the fixed costs of providing emergency inpatient services, for example, hospitals are paid 50% of the full tariff price for the expected number of non-elective patient spells in a year (defined as the historic number of non-elective episodes plus a DH-determined national expected growth percentage), but activity beyond that is only paid 50% of the tariff rate, and if activity fell below the expected level the hospital would only have to give back 50% of the tariff rate for each emergency spell below expectation.

Similarly, to compensate trusts for long-stay patients, payments for patient stays beyond pre-defined lengths of stay include per diem payments for each day beyond that threshold in addition to the basic tariff price. In this way, the hospital Trust is incentivised to keep inpatient stays as short as possible for most patients but is compensated if the patient stays for an exceptionally long period (*See attached presentation slide ‘Linear and Non-linear pricing’*).

In terms of the economic impact of PbR, it is possible that it will increase activity and encourage providers to use all their capacity. However in order to maximise surpluses, it may be tempting for providers to change the mix of activity to where margins are greater (i.e avoid complex, low volume or expensive procedures). This may lead to patient selection and skimping on quality but conversely also to the appearance of greater efficiency.

To provide for some checks and balances, the perverse incentives discussed above are restrained as follows:

More activity	restrained by cash limited budgets and practice based commissioning
Lower quality	restrained by clinical governance; good performance management; patient voice; and practice based commissioning
Patient selection	restrained by practice based commissioning and patient choice

Internationally, the evidence is mixed and the NHS operates in a different context from any other healthcare system employing a case mix approach. In the US the DRG (equivalent to England's HRGs) based payment system reduced lengths of stay and saved Medicare costs but did not appear to reduce health costs overall. There is some US evidence of patient selection and changes in focus in terms of case mix. For some conditions quality increased for less severely ill patients but fell for the more severely ill.

The Department of Health (DH) has contracted Aberdeen University, with the OHE as a sub-contractor, to perform a national evaluation of Payment by Results (PbR). Jon shared some early results from the qualitative part of that evaluation with delegates.

In terms of volume and mix of activity, the NHS managers interviewed about PbR during the summer of 2005 stated that there have been some increases in activity but this not easily attributed to PbR. There is still a sense of NHS culture or in other words, no obvious signs of aggressive competition on the basis that it would destabilise the health economy. In other words competition has yet to emerge and cooperation is still seen as desirable.

One of the other restraining factors on behaviour is the lack of trust placed on the tariff prices – it was felt that they were too volatile still and the price signals were not trusted. This will prevent trusts from rushing too far ahead in case the prices change and make their plans unaffordable or too risky. In addition, PbR was not felt to be significantly influencing efficiency at this early stage as there was already a range of efficiency incentives imposed on providers.

In terms of some of the other negative effects of PbR, there was no evidence of patient selection going on but also little expectation of PbR impacting quality at this stage although some fears by PCTs that this could happen negatively in the interests of cost saving.

The initial OHE/Aberdeen University qualitative findings were similar to the Audit Commission's findings (published in autumn 2005) that as the NHS was only just beginning to use PbR, it was early days to assess impact. It was clear the PbR was exposing existing weaknesses in NHS finance – inadequate management, underlying financial difficulties and problems with data quality. However, there is currently little evidence that PbR has generated the positive behaviours intended.

Paul Linsey

In a review of PbR and the challenges it poses for the NHS generally, It is particularly relevant to those suffering mental ill health that PbR may offer a perverse incentive to avoid admitting those with co-morbidities but encourage the admission of chronically ill patients to

hospital. In clinical terms unplanned hospital admission often represents a breakdown of care.

Locally and nationally, the success of payment by results rests on accurate data. Patient activity needs to be properly recorded to ensure that PCTs are fairly charged for the work done and that income is not lost. Costs must be accurately allocated as not all activity will be covered by the tariff. Strong clinical engagement in the implementation of payment by results, the risks it poses and the changes which need to be made will be essential. Unfortunately, there has been a distinct lack of direct clinical input although this is improving by use of clinical teams in piloting the mental health case mix system.

Mental health HRGs are supposed to be informed by more precise and detailed data, giving more accurate analysis of treatment and costs at patient level. The mental health HRG project builds on work undertaken in the UK in 1999-2000 and draws on the example set by the New Zealand Mental Health Classification and Outcomes Study published in July 2003 and the Australian Mental Health – Classification and Service Cost Project published in August 1998.

These studies found that ‘case mix classification’ had the potential to be used in specialist mental health services to improve routine data collection and inform management and planning decisions. It could help explain the variation between providers, create a profile of the treated population and benchmark services. The studies found that case mix classification could be effective in informing funding of mental health services, although neither country has yet formally used their case mix groups for this purpose¹.

Developing case mix groups for mental health services is inevitably complex.

Data collection commenced in 2004, however this has only been effective from this year. Is this sufficient? One of the criticisms of the current PbR model is that the data upon which the acute tariff was based was in part old and in some cases inaccurate. In mental health services, there is a poor history of data collection, with systems disparate and fragmented and little success in relating interventions to outcomes.

There are also the more obvious problems of accurately recording and costing staff time spent with patients. There is an underlying assumption that NICE guidance maps to clusters and little consideration given to the impact of Mental Health Status. Collecting accurate patient level data is, therefore, the key – and the challenge to developing HRGs. In the mental health pre-pilot exercise the Case mix Service project team used the trust’s three computer systems, plus

¹ Powell, C (2004). ‘Quest for mental health tariffs’

manual data collection to test the feasibility of assembling individual patient information, such as age, gender, diagnosis, severity and legal status on admission, all derived from the Mental Health Minimum Data Sets (MH-MDS).

Involving clinicians is going to be key to the success of the new scheme so the lack of involvement by clinicians to date is worrying.

There needs to be a renewed focus on HoNOS (Health of the Nation Outcome Scales) - some suggest that it should be renamed, suggestions include, HoNOS Plus and CADET (Care Allocation Evaluation Tool).

HoNOS was not originally designed as a clinical tool and certainly not for the purposes of PbR and will need modification. In essence, HoNOS is less effective in determining resource use than diagnosis.

There are a range of questions regarding the reliability and validity of data. For example:

- What period should be used to analyse data?
- For what period is a HoNOS rating reflective?
- Is diagnosis done on discharge appropriate as a predictor for resource use?
- When does a person's care end? For example, if a discharged patient calls the service for advice, how is this activity costed? What is the audit trail?

For PbR in mental health, the 'currency' will operate using *presenting* factors – patient attributes and activities. In this sense,

Demographics + Attributes = Currency = Activity.

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There are a range of other challenges to be considered which are yet to be dealt with under the PbR in mental health but also PbR in general. They are summarised below:

- *Quality of healthcare experience*
As referred to by Jon, it is not clear that PbR is actually encouraging providers and commissioners to focus on quality. Simply relying on having a fixed price to encourage competition on quality is not sufficient.
- *Responsiveness and flexibility*
Setting the tariff is a complex process and uses data that can be up to 2 years old. This will make innovation in service design very difficult and may responses to patient demands.
- *Clinical outcomes*
There will have to be close monitoring of clinical outcomes to ensure that PbR does not result in lower standards. Clinical governance will be more important than ever.
- *Behaviours of organisations and individuals*
PbR is a complex system of payment for activity. There will need to be careful monitoring of individual and organisational behaviours within the scheme to detect any inappropriate gaming behaviours or fraud.
- *Speed of implementation*
This is a major concern. The DH is attempting to achieve in 2 years what has never been achieved in any other country. The early evidence from New Zealand is interesting but largely untested in the field and has not been used to the degree proposed in England. We should be learning lessons from the Acute Hospital PbR roll out where the pace of reform created a number of system and personnel pressures that were potentially foreseeable and avoidable.
- *Users voices*
Even though PbR is a financial system, we must ensure the users voices feed into its use, particularly where decisions are made to reconfigure or redesign services. There is no where near enough progress on this matter.

Lessons can be drawn from strategic change theory: essential steps include creating readiness for change, energising commitment, developing political support, managing the transition and sustaining momentum. Resistance to change is most likely to come from the underlying culture of the organisation – that is, values, ways of thinking, management styles and custom and practice (the way we've always done things around here). We must not underestimate the challenges for a case mix system in mental health or indeed the NHS.