Payment by Results: How can payment systems help to deliver better care?

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Payment by Results
How can payment systems help to deliver better care?
More than one way to achieve better services…
Payment by Results

“New outcomes-based payment models replace bureaucratic targets with simple outcomes that reward the long term success that the public wants to see, while giving people on the front line more freedom to get the job done.”

Home Office
http://www.homeoffice.gov.uk/crime/reducing-reoffending/pbr/

“The move follows a lengthy review of spending by the Department... that was in turn prompted by reports that huge sums of money had been wasted or simply been stolen on the ground.”

Department for International Development (reported in Daily Telegraph):
http://www.telegraph.co.uk/news/worldnews/8336022/Ministers-axe-foreign-aid-to-half-the-current-countries.html#
PbR objectives: 2002

Facilitates **achievement of national and local strategic objectives**, including the national objective of sustained reductions in waiting times, together with local objectives for service improvement agreed among PCTs and providers.

Delivers these objectives in a **decentralised way**: moving beyond reliance on central budgets for short-term initiatives.

Pays NHS Trusts and other providers on a **fair and transparent basis** for services delivered, while managing demand and risk.

Supports **patient choice** by ensuring that diverse providers can be funded according to where patients choose to be treated.

**Rewards efficiency and quality** in providing services.

Helps **match capacity to demand**.

**Reduces transaction costs and negotiating disputes over price** between PCTs and acute Trusts – focusing the role of PCTs on the volume and mix of services that meet population need, and on the pathway of care for patients and facilitating partnership working.
(Non-exhaustive) PbR timeline

2000
NHS Plan

2002
PbR consultation

2003
Tariff for 15 HRGs
‘Preparing for 2005’

2003/4
Tariff for 48 HRGs, Early implementer FTs

2004/5
All trusts: elective, non-elect, out, A+E

2005/6
Tariff covers all admitted elective pats.
Plus, FTs: non-elective, outpatient and A+E

2006/7
Incentive tariffs to support ‘unbundling’
Marginal emergency admissions: 50% of tariff

2007/8
Transition complete, Specialist top ups

2007
Consultation on development of PbR

2008/9
CQUIN. BPT. Combined day/inpat tariff

2009/10
Tariff = 1% lower than avg cost
New currency. Emerg marginal tariff stopped

2010/11
Incentive tariffs to support ‘unbundling’

2011/12
Transition complete.
Specialist top ups

2012/13
Maternity pathway. MH mandated
New rules for emerg reads. ‘Year of care’ cystic fibrosis

2008
Common tariff for some HRGs in all settings

2009
Provision for prices below tariff. More BPT introduced

2010
Combined day/inpat tariff

2011
Tariff = 1% lower than avg cost

2012
Common tariff for some HRGs in all settings

2013
Provision for prices below tariff. More BPT introduced

Development

Phased implementation
International review

• Despite recognition of the complexity, unintended adverse effects and limitations of activity-based systems, no simple alternative or new model for the design of payment methods.
## Activity-based payment systems: some problems

<table>
<thead>
<tr>
<th>Unintended effect or limitation</th>
<th>Policy responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased hospital admissions</td>
<td>Volume or budget caps; volume risk-sharing agreements with providers; discounted prices for activity above agreed targets; restriction of activity-based payment to elective admissions; referral management measures in primary care; agreed treatment criteria/thresholds</td>
</tr>
<tr>
<td>Unco-ordinated care across settings</td>
<td>Disease management programmes; payments for case co-ordination; experiments with bundled payments for pathways or year of care for patients with chronic conditions</td>
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<tr>
<td>Under treatment</td>
<td>Additional payment for outliers, high-cost inputs, new technology; case-mix tools give increased weight to procedures, complications and co-morbidities; penalties for re-admission; supplementary pay-for-performance</td>
</tr>
<tr>
<td>Cost shifting to other budgets</td>
<td>Development of costed activity-based payment tools for ambulatory care and rehabilitation; penalties for re-admission; piloting of pathway-based payments;</td>
</tr>
<tr>
<td>Cherry-picking of lower risk cases</td>
<td>Additional payment for outliers, high-cost inputs, new technology; case-mix tools give increased weight to procedures, complications and co-morbidities</td>
</tr>
<tr>
<td>‘Up-coding’ or misreporting</td>
<td>Data audit; avoiding excessive disaggregation of case-mix</td>
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International lessons

- **Different payment approaches** needed in different settings, for different conditions and patient groups.
- Increased amounts of **data and analysis** are needed if innovations in payment approaches designed to address unintended effects and limitations in activity-based payment are to be soundly based.
- Crucial to how payment methods work is the **contract structure** used, and the way this shares risk and facilities engagement between payers and providers in different care settings.
- Payment systems need to combine a **blend of different methods**. As they are only one of many forms of policy intervention designed to improve system performance, their relative effectiveness and cost-effectiveness is critical.
New challenges....

A recent analysis by The King’s Fund highlighted the main challenges facing the health and care system in the future*. These include:

- Relative neglect of prevention and the threat posed by risk factors such as obesity
- The demands created by the ageing population and the increased prevalence of long-term conditions
- Wide variations in the quality of care with evidence that lives could be saved and outcomes improved by the more systematic adoption of best practices
- Fragmentation between services that inhibits the provision of high-quality integrated care
- An overreliance on hospitals and care homes linked to the under-development of primary care and community services

...and objectives

- Reducing costs and promoting efficiency
- Promoting quality
- Supporting innovation and diffusion
- Shifting the location of care
- Promoting integration

Minor ‘tinkering’ with PbR will not produce the changes in service configuration that are increasingly being recognised as necessary. Worse, perhaps, the current payment system may actively be obstructing change.

Top-down pressure to reduce costs through the application of an across the board efficiency factor to PbR tariffs has reduced costs. However, unclear to what extent this has also damaged quality of services and the sustainability of such a policy remains questionable.
Five general lessons

Given experience of PbR, and activity-based systems used in other countries, as well as new challenges facing the NHS in a tough financial environment, we draw some general lessons:

- Payment systems cannot do everything
- One size does not fit all
- Payment systems need to be flexible
- Trade-offs between objectives are inevitable
- Data and research for payment systems must be strengthened
The future: Three scenarios...

1. Business as usual ...
   Monitor and the NHS Commissioning Board develop PbR incrementally alongside other variants such as bundled and year of care payments - In essence, a continuation of policies pursued in the last decade.

2. Centrally-driven development...
   Monitor and the NHS Commissioning Board develop a much wider range of payment systems with the aim of creating a coherent and mandatory national framework to support the implementation of a variety of policy objectives.
Third scenario...

3. Locally-driven development ...  

Monitor and the NHS Commissioning Board allow encourage local experimentation. The rationale is the difficulty faced by national policy-makers in devising a framework that is appropriate to all services and localities, especially at a time when the need for innovations in models of care is urgent.

Commissioners and providers would be required to seek approval for, and commit to evaluate the impact of, local variations.

For their part, the NHS Commissioning Board and Monitor would provide technical support where needed and keep track of the innovations adopted.