HSJ LOCAL briefing

hsj.co.uk/briefing July 2013

THE REFORM OF PAYMENT BY RESULTS

HSJ Local Briefing is our new in-depth analysis of the key issues facing the NHS's major health economies

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In brief

Issue NHS England and Monitor recently published a discussion paper that could mark the start of the biggest reform of NHS payment systems since the introduction of payment by results. The paper gave explicit sanction for local areas to experiment with moving away from nationally fixed prices and units of payment, and set out the organisations' early thoughts on the principles for long-term national reform of the system.

Context The paper acknowledges that payment by results is an often cited barrier to the integration of care services, and this is a key reason for encouraging local experimentation.

Outcome Long-term reform of the payment system would probably take more than half a decade, and is too remote to make firm predictions. However, it is plausible to imagine a future in which activity-based tariff prices are applied largely to elective services, and other areas of NHS care are paid for in very different ways. Hypothetically, that might include forms of capitation payment for those patients that require integrated care, and paying providers of urgent services such as accident and emergency departments for maintaining capacity to meet certain levels of demand.

Introduction

The past decade has seen a sea change in the way NHS hospitals in England are paid for care. The value of healthcare activities for which there are nationally set NHS "tariff" prices has gone from nothing in 2003 to nearly £30bn in 2012. According to think tank the King's Fund, the "payment by results" system has now been expanded to include nearly all elective and emergency care, covers about 60 per cent of the average hospital's activity, and comprises about 1,300 mandatory tariffs.

This continued expansion of activity based tariff prices has found supporters in both main political parties, for two reasons. First, it is seen as having been instrumental in bringing down hospital waiting times. Second, it supports the policy of increasing market competition and patient choice in the NHS: if a given procedure has the same price anywhere in the country it becomes relatively straightforward for a patient to choose where they want to go for treatment. Fixed tariffs are also seen as a means of ensuring providers compete on quality, not price.

However, in recent years payment by results has been rapidly losing credibility within the NHS. A recent study for Monitor by consultant PwC found that the poor quality of costing data upon which tariffs are set was leading to wide and apparently random fluctuation in prices, with more than 40 per cent of prices changing by 10 per cent or more each year. In the face of this, the authors concluded, it was unsurprising that commissioners and providers were "increasingly deciding to negotiate reimbursement locally", outside of the payment by results rules.

Reflecting on this work, a King's Fund report concluded: "Overall, the policy does not appear to have much bearing on reality. On the one hand, the Department of Health has remained committed to developing payment by results to include all hospital services as well as community-based services such as physiotherapy, and for it to remain a national tariff. On the other hand, the national tariff seems to have only a loose relationship to what happens on the ground."

More fundamentally, though, the key problem currently facing the NHS is not long waiting times but rising demand for healthcare in a period of prolonged austerity. A consensus has formed that meeting this challenge will require major redesign of services – particularly those for the frail elderly and people with long-term conditions – with large scale shifts of care away from hospitals and better co-ordination of acute, community and social care.

A system where hospitals, community healthcare, GPs and social services are all subject to separate payment regimes – and hospitals are paid more for more activity – seems ill designed to support these changes. It is unsurprising, therefore, that the current financial squeeze has seen many within the NHS calling on those in charge to explicitly sanction local areas to move away from payment by results.

That explicit sanction was given last month, in a discussion paper issued by the two bodies now responsible for the NHS payment system, NHS England and Monitor. The paper says: "We recognise that current payment rules are not working in patients' interests in all services.

"We want to allow more widespread local experimentation in payment approaches straight away to support patient centred redesign.

"We are aware that some localities have already started thinking about new payment approaches and this is something we want to encourage.

"However, we intend to guard against any increase in risk to patients from such experimentation by developing variation rules that take into account potential risks and the capabilities of service providers."

Evidence base

In part, the reasoning behind this approach is that while it is clear payment by results is unlikely to be the best payment system to encourage integration, there is not enough of an evidence base on what the reimbursement model should be for integrated care to allow it to be centrally mandated.

The hope, therefore, is that by encouraging experiments that support integration or reconfiguration, and requiring local areas to be open about those, the centre can collect an evidence base to inform long-term redesign of the system while clamping down on off-tariff deals that have more to do with protecting organisations' finances than promoting patients' interests.

Intriguingly, the paper also sets out NHS England and Monitor's early thoughts on that long term redesign of the system. Both organisations are clear that these thoughts are presented to stimulate discussion and no decisions have been taken about long-term strategy. However, it is fair to say that the paper describes a very different approach from the policy of continued extension of activity based tariffs outlined above by the King's Fund.

The paper says: "Activity based payment approaches such as payment by results work best in contexts where the activity has well defined start and finish points, is planned in advance and is always beneficial to the patient. It is helpful where the two priorities are enabling choice for patients and increasing productivity.

"However, since priorities will differ across contexts of care, it seems unlikely that a single payment approach will suit all contexts. Instead, the design of the payment system for the NHS may need to be sufficiently flexible to accommodate a range of approaches which can be applied to different care contexts."

This briefing looks at two

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questions: what might it mean to encourage local payment experimentation to enable integrated care, and what might the vision articulated by NHS England and Monitor mean for the future reform of payment systems in the NHS?

The rules governing use of the national tariff have long contained "flexibilities" giving local commissioners means of negotiating local variations to national prices and units of payment. According to the sources HSJ spoke to, there are no plans to significantly change the substance of these existing flexibilities, at least not in 2014-15. So, it might be asked, is there any real significance to Monitor and NHS England's endorsement of local experimentation?

Yes, according to Tony Whitfield, finance director of the Salford Royal Foundation Trust and president of the Healthcare Financial Management Association. "There's a big difference," he says. "I think a lot of people did [off-payment by results experiments] quietly behind the scenes, feeling that this will be alright as long as we don't get caught.

"It's a calculated risk that you would have taken that if things had gone skewy, it would have been reasonable for Monitor to say: 'Well, have they gone skewy because you've not followed what at the time was seen as the national way in which we got paid?'"

The announcement by Monitor and NHS England, he says, is "like the teacher giving you permission. I think [it] will take a lot of pressure off the minds of some finance directors." Their paper, he adds, is a "really good description of what everybody really thinks", and it is up to the health service to demonstrate "that liberalisation to be the right way in which we can make change happen".

Obstacles to experimentation

Of course, permission alone does not mean we will see a flourishing of local experimentation across the country. A recent consultation paper on local payment variations outlined a number of obstacles to local areas testing new approaches to payment. The most intractable of those are likely to be the difficulty of reaching agreement between organisations with "misaligned incentives", and the "lack of capability and capacity to implement variations".

Designing payment systems for healthcare is difficult and risky work, the commissioning system in England has just undergone massive structural upheaval, and the new commissioners are working on running cost budgets significantly tighter than those of their predecessors. It is plausible these limitations will curtail ambitions in some areas.

However, as Monitor and NHS England note, there is appetite in a number of health economies to experiment with greater integration of care, and for the reform of payment systems that could make this possible. So, what might these experiments look like?

Conceptually, the problem with activity-based payments is that many people are living with conditions for which more activity by healthcare providers does not necessarily mean better care. For a frail elderly person, or someone living with diabetes, a series of expensive hospital admissions may represent a failure of the health and social care system. The goal, therefore, is to design a payment that gives all providers involved in that person's care the same incentive to help them live independently, and to eliminate unnecessary healthcare interventions.

The two types of payment commonly cited as having potential in this regard are "pathway tariffs" and capitation payments. A pathway tariff is a single payment covering all activities involved in a particular episode of care, from diagnostic investigation through to rehabilitation. Capitated funding is a set payment to a provider, or group of providers, per head of a particular patient group they serve. Theoretically, it makes sense for capitation payments to be combined with close monitoring of care quality and outcomes, and potentially for some element of the payment to be tied to achievement of defined levels of service or healthcare outcomes.

Alliance contract

The payment also needs to be tied to a contracting model that defines how risk and benefits are divided between the commissioner and providers involved. One option, which Cumbria Clinical Commissioning Group has begun to look at, is the alliance contract. Cumbria CCG clinical chair Hugh Reeve explains that under this model you begin by establishing the current cost of caring for a particular group of patients – say, the frail elderly – across the entire healthcare system: acute and community healthcare, possibly social care. You then incentivise providers according to their current share of those costs.

For example, if a group of patients were costing £100m a year and the health economy managed reduced those costs to £90m, the commissioner might take £2m of those savings and hand the remaining £8m back to the providers. A provider with 50 per cent of the current costs would get £4m, a provider with 25 per cent would get £2m, and so on. In theory you could thereby incentivise the whole health economy to, for example, invest in improved community nursing services to keep people out of hospital.

"If we take that approach we would hope that we would be doing it next year," says Dr Reeve. A lot of the initial discussions have focused on using the approach for older people, but he says it would work "almost for anything that isn't elective care". He adds: "We don't want to have a whole series of alliance contracts set up, because that would just become incredibly complex. You start off with a pooled fund, which is effectively what an alliance contract is; you then increase the pooled fund and add more things into it."

'Prime contractor' deal

The alliance contract appeals in Cumbria because the area has three similarly sized provider organisations: two acute trusts and a community services provider. In areas with one dominant provider, or a trust which runs both acute and community services, it may be more attractive to go for a "prime contractor" deal, such as the contract currently held by Heart of England Foundation Trust. Here, the payment is made to the contracted provider, and they are responsible for contracting any care they do not provide directly.

This is the approach currently being investigated by South Warwickshire Foundation Trust, an acute trust that took on community services under the Transforming Community Services programme. Chief executive Glen Burley says: "The way we've tried to frame this to Monitor is what if this were a year of care tariff, or prime contractor tariff. You in effect would pay the FT a sum of money per annum for older frail patients, times however many there are. Then if we can change the models of care we could subcontract bits of that to the third sector; we could also, hopefully, possibly through the [NHS England local area team], subcontract bits of that to GPs. And we would be incentivised to minimise their use of

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the healthcare system, because each time they did there would be a higher cost associated with it."

Under this model, he says, the trust would have to pay for any hospital admissions that "fall out of those care packages not working". "That," he says, "would then incentivise us to get as much care out into the community as we possibly can," because, "any failures in delivering the right levels of care would result in us having to pick up the tab for those emergency admissions". He adds that Monitor is also "really keen" on the payment having "some kind of quality premium" that would link part of the trust's reimbursement to healthcare outcomes, which he believes "seems really appropriate".

The organisation is in discussion with its commissioners and hopes to be able to take initial steps toward this model in next year's contract.

Long term reform

As complex as local experimentation could be, it is just one aspect of a move toward broader reform of the NHS payment system. That process will take a number of years, probably more than half a decade. Monitor and NHS England are keen to emphasise that they are at the start of a long and genuine period of consultation, and their early views are not set in stone. With that in mind, however, it is possible to tease out picture of what the future payment system might look like if it were based on the principles set out in their discussion paper.

The first thing to say is, while there might be nationally defined units of payment for a broader range of services than there are today, it is unlikely there would be a significantly extended range of activity based tariffs. As the passage quoted above states, it "seems unlikely that a single payment approach will suit all contexts. Instead, the design of the payment system for the NHS may need to be sufficiently flexible to accommodate a range of approaches which can be applied to different care contexts." The paper, therefore, implies a system in which different "contexts of care" are subject to qualitatively different payment regimes.

Activity-based tariffs, it suggests, would be best applied to elective services: those where patients have choice, which are planned in advance, and where there is something like a clinical consensus around their benefits. However, the tariff for those services might well be significantly less intricate than it is today. Monitor interim director of pricing Jason Mann tells HSJ: "I would say that the trajectory of travel – of starting with 60 prices in 2003 or 2004, going to over a thousand, [and] I think it's over 2,500 now – is not sustainable.

"It's not really possible to centrally set those prices and hope to get them all right. I don't know how many you're going to get right and how many you're going to get wrong, but you're not going to get them all right ever if you do that. So I think the concept of centrally setting thousands and thousands of prices is one that we need to think about carefully. It's fraught with risk at the centre, if you get it wrong in either direction that potentially places risks on one set of constituencies or one set of stakeholders, and therefore we need to think carefully about whether it's always the right approach in all cases.

"For the avoidance of doubt, I think it always has a place, but my suspicion is it may have already gone too far. It may not have done, but it may have gone too far already. We might need to think about changing that slightly as well."

There may also be scope for something more than mere simplification of the tariff. Mr Mann suggests that in the long term, if Monitor was confident there was sufficient commissioning acumen in the NHS and sufficient information available on costs and service quality, "there might be scope for relaxing how one sets prices" for those on-tariff services. He adds: "You might be able to... not worry so much about how that's done at the centre, at least, and leave that more to people on the front line."

Patient need and supply

But what might the payment regimes be for other "contexts of care"? The paper states that patterns of patient need and supply differ along three main divisions: "planned versus unscheduled", "routine versus complex and rare", and "proactive versus reactive".

Unscheduled care, it notes, needs to be "on permanent stand-by" and its provision "has to be planned to allow for uncertain patterns of demand". This might imply that providers of emergency care – for example hospital accident and emergency departments – should not be paid for activity, but for maintaining capacity to meet certain levels of demand.

Mr Mann confirms that this is a possibility. Asked how he thinks the payment system could look in six years' time, he says: "I can tell you one vision of how it might be. I don't know if it will be like that. But I could see a world where there would be some activities that are pretty well done as now, and that would be the elective, planned type of services. At the other [end], there would be a set of services, the urgent services, that... would be arguably more regulated, and Monitor would spend more of its time looking at the regulation of those... services, where there isn't much choice, if you like. And [the way those services are priced] might well have some capacity element to them, in some cases, not all cases. A&E is the obvious one."

The third dimension – proactive versus reactive – refers to the distinction between those patients who need one-off, episodic care, and those whose care needs to be actively managed on an on-going basis. Clearly, the latter group are those who might benefit from the kind of experiments in integration that NHS England and Monitor are now seeking to encourage.

The way payment systems for this type of care develop might therefore be expected to depend in part in how successful those experiments are, how successful Monitor and NHS England are at developing their evidence base, and how widely applicable the models developed prove to be. Hypothetically, that could lead to the eventual development of nationally mandated or recommended forms of capitation payment for integrated services, such as year-of-care tariffs, or to the extended use of local variation combined with improved information from the centre to aid local negotiations.

However, the distinction between "proactive" and episodic care in the discussion paper suggests that – under the framework it sets out – you would be unlikely to see a big push to develop activity based tariff prices for many of the community services currently paid for under block contracts. That's certainly South Warwickshire chief executive Glen Burley's prediction. For community services, he says: "I think they will continue to develop costing so we can understand the cost of delivering these services, but I'm convinced we will not see a national price list that has to be followed. It will just be more of a backstop to allow those local negotiations to come up with an innovative solution.

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"I don't think it would be sensible to look at a price list which could lead to a fragmentation of those services which have to be delivered together to get the best outcomes for the patient."