Royal College of Nursing

RCN Policy Unit

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Payment by Results (PbR): Reform of funding flows in the NHS

ABSTRACT

Payment by Results is a new funding system for care provided to NHS patients, which pays health care providers on the basis of the amount of work they do. This briefing explains how PbR works; its similarity to payment schemes in other European countries, the US and Australia; implications for the NHS and key questions related to prices for mental health and community services, loss of income and funding for new services.

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What is it?

Payment by Results (PbR) is essentially a way of paying a fixed price for each individual case treated[1]. It has several different elements but in essence uses HRG (Healthcare Re

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How will it impact the NHS?

Impact on financial stability

Previously it had been suggested that because the NHS Tariff is based on average costs, by definition some trusts will be below price and some above. Some trusts will receive more money than before generating windfalls over night[2] without any increase in activity whereas others will be faced with up to 20% gaps in funding effectively wiping out any additional funding[3]

Playing the game
In addition to systems costs arising from the above there are many who consistently raise concerns that unless HRG's are closely monitored and regularly reviewed, the system will create 'gaming' behaviours amongst providers – i.e. they become 'players' in a system. Specifically one concern is that Providers may 'up-lift' or 'up-code' recorded diagnosis to claim more than is required per patient treatment to generate income.

Whilst publicly dismissing such concerns, the DH have none the less responded to such concerns and are working with the Audit Commission to develop a framework of checks and balances to discourage 'gaming' behaviours amongst providers.

Key questions

How do we price complicated health care needs such as mental health or Community Services?
The complexity of costing mental health has been acknowledged by the Department of Health, however it is anticipated that a new Mental Health payments system will be launched in 2008. This is no simple matter as generating workable tariffs for complex long-term conditions such as depression or bi-polar disorder, which can have many competing and variable treatments, is by no means straightforward. As far as the RCN is aware, coding mental health treatments has not been managed by other countries using similar systems.

What happens if a service loses all its income as patients go elsewhere?
The DH has pointed out that if a service does not attract any patients and therefore receives funding, the reasons for this should be explored. If it is because there is no longer a need for this service (e.g. because it is poor quality or too expensive), then the service should close. In reality, this poses serious risks for many local services and closure may have little to do with whether or not they offer a quality service.

As systems are reformed over time and activity is lost, Trusts risk not only loosing those services which have lost income, but other support services which may have depended on the work generated by the lost services may gradually become financially unviable. For example, in-house pathology services or diagnostic services in a hospital which has suddenly lost its surgical department may then find their work and therefore their income cut through no fault of their own. Alternatively, a counselling service which finds its local cancer treatment centre closing may then have to find other income or risk being closed even though it might have offered an excellent service and be well supported by local patients.

This raises huge questions for the coverage of services and the issues of access for communities that lose local facilities though patient choice. The

RCN continues to engage in a debate on these issues with other organisations and continues to push for a universal national health service.

How do acute Trusts get payment for new services that have not yet been coded?
Many are concerned PbR will not encourage acute Trusts to innovate in service delivery. Reference costs as calculated are 2 years behind the modernisation agenda and relate to activity that has already been coded. One suggestion has been to develop two tariffs or a special fund for uncoded activity. Alternatively, providers could agree a special rate for developing services but this has as yet been untested.

Conclusion

Although PbR is a complex matter to understand in full, its impact upon the NHS should not be underestimated. For nurses, the challenge will be to ensure that HRG's in future reflect the added value of nursing interventions and encourage innovation in service delivery to the benefit of the quality of patient care, not just to reduce costs.

In all the technicalities of the debate the remaining outstanding and yet fundamental issue is one of staff engagement – this will be key to making PbR or whatever system succeeds it a success. This is a key opportunity for the RCN to access and influence the debate to ensure that nursing continues to have an influential voice in service redesign.

The success of PbR will depend on the following;

- More effective discussion and engagement with *all* members of the health care team, not just Doctors.
- A 'within cost' and risk assessed strategy for alternatives to admission to hospital will need to be developed by PCTs.
- Has all activity been coded effectively? As much as 5% of all acute activity was found to 'uncoded' by the Audit Commission in 2004
- Are the information systems in place adequate to allow robust checking on all data and costing information supplied?
- IF activity is above reference cost, what are they doing about it? What is the impact of the plan to address 'over cost' activity, particularly on specialist and nurse led services?
- Clarification is urgently required about how the DH will ensure universal coverage and access to a range of services if market forces decide a service should close.