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.

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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 in-patient 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.

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.

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 effect

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

- *Quality of healthcare experience*
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