The English NHS payment system: reforms to support efficiency and integrated care

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The NHS Payment System following the 2012 Health and Social Care Act

NHS England and 211 clinical commissioning groups (CCGs) determine:

• the volume and mix of services to purchase on behalf of NHS funded patients,
• agree contracts for those services and
• pay the providers (NHS, voluntary or independent sector organisations).

*How* and *how much* commissioners pay providers for NHS-funded services is determined by the **payment system**.

Monitor and NHS England are now responsible for overseeing the payment system. The NHS uses a wide range of different approaches to payment for difference sectors and in different area.

Health care purchased by local NHS commissioning bodies in 2012/13 (£92 billion)

- Acute care and accident and emergency (A&E): 48%
- Community health services: 11%
- Other secondary care: 5%
- Prescribing: 9%
- Other primary care: 6%
- Mental illness: 10%
- Maternity: 3%
- GP services: 8%

Source: Department of Health, 2013a.
An increasingly mixed economy of public and private providers

Source: Authors’ calculation using data from the Department of Health (2006/07 to 2011/12 financial monitoring and accounts forms for PCTs).
The payment system for secondary health care

- Secondary care services include:
  - Acute hospital spending
  - Mental health services
  - Community health services

- Payment by Results is the dominant payment system for hospital care with £29 billion of hospital activity covered by the tariff in 2012/13.

- The PbR system covers just over 40 per cent of spending on secondary care but around 60 per cent of an average acute hospital’s income.

- Secondary care services not covered by PbR are typically funded by block budget where a fixed sum is paid to the provider independent of the number of patients treated or amount and complexity of activity undertaken.

- Mental Health Services have been moving to a PbR system with a mandatory grouping system but with locally determined prices.
The evolution of Payment by Results in the NHS

Innovation increases sharply after 2009/10 with Pay for Performance (P4P), bundling, expansion beyond acute care, normative pricing and non-linear pricing.

First tariffs in HRG
15 HRGs

2003/04

550 elective tariffs cover all acute providers

2004/05

Transition funding ends
PbR extended to ISTCs* under NHS choice programme

2005/06

2006/07

2007/08

2008/09

2009/10

2010/11

2011/12

2012/13

2013/14

PbR (elective emergency, A&E & outpatient) covers all acute trusts

CQUIN introduced: 0.5% of provider income
HRG4 implemented 1,400 HRGs

No payment for emergency readmission with 30 days
Expansion of BPT
CQUIN increased to 2.5%

Expansion of BPT
Post-discharge tariff
Mental health currency
Ambulance service currency
Cystic fibrosis year of care
Maternity pathway shadow

- Mandatory introduction of maternity pathway payment system
- Unbundling: separate tariffs for diagnostic imaging (costs previously included in outpatient attendance tariffs)
- Further expansion of BPT
- Increased granularity of A&E tariff, with more separate prices
- Mental health contracts to be agreed based around identified mental health clusters, as a precursor to expanding PbR to mental health services

* Independent sector treatment centres
Evidence of the Impact of Payment by Results

The introduction of Payment by Results was associated with:

• a more rapid reduction in unit costs and length of stay in NHS hospitals.
• a faster increase in the proportion of elective care provided on a day-case basis.

There was little, if any, measurable change in the quality of care, suggesting that reductions in cost were achieved through improved productivity, rather than sacrifices in quality.

The effect sizes are comparatively small. Payment by Results was associated with a 0.5 per cent a year reduction in average length of stay and appears to have made a relatively small contribution to the NHS’s long-term reduction in length of stay and increase in day-case treatment.

This is a saving of between one to three per cent of resources to deliver the same amount of care.
Hospital activity and length of stay under diagnosis-related payments in different health systems

<table>
<thead>
<tr>
<th>Country, year of implementation of DRGs</th>
<th>Study</th>
<th>Activity</th>
<th>Average length of stay</th>
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<tr>
<td></td>
<td>Davis and Rhodes, 1988</td>
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<td>Guterman and others, 1988</td>
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<td>Kahn and others, 1990</td>
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<td>Manton and others, 1993</td>
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<td>Muller, 1993</td>
<td>▼</td>
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<td>Rosenberg and Browne, 2001</td>
<td>▼</td>
<td>▼</td>
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<td>Sweden, early 1990s</td>
<td>Anell, 2005</td>
<td>▲</td>
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<td></td>
<td>Kastberg and Siverbo, 2007</td>
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<td>Italy, 1995</td>
<td>Louis and others, 1999</td>
<td>▼</td>
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<td>Ettelt and others, 2006</td>
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<td>Spain, 1996</td>
<td>Ellis and Vidal-Fernández, 2007</td>
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<td>Norway, 1997</td>
<td>Biorn and others, 2003</td>
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<td>Kjerstad, 2003</td>
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<td>Hagen and others, 2006</td>
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<td></td>
<td>Magnusen and others, 2007</td>
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<td>Austria, 1997</td>
<td>Theurl and Winner, 2007</td>
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<td>Denmark, 2002</td>
<td>Street and others, 2007</td>
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<td>Germany, 2003</td>
<td>Böcking and others, 2005</td>
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<td>Schreyögg and others, 2005</td>
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<td>Hensen and others, 2008</td>
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<td>Audit Commission, 2008</td>
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<td>Farrar and others, 2009</td>
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<td>France, 2004/05</td>
<td>Or, 2009</td>
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Source: Euro-DRG project. For detailed data see Street and others (2011).
Evidence of the impact of Payment by Results

• Although the evaluation results for Payment by Results are positive, there is no robust evidence on either the long-term impact of Payment by Results or its impact on health system efficiency.

• The way the NHS is implementing the Payment by Results system has also changed.

• The price paid for activity under payment by results has been falling as the NHS uses the tariff to incentivise efficiency savings.

• Some NHS organisations have agreed ‘cap and collar’ arrangements. There is limited information on the extent and impact of these arrangements but from 2014/15 such local variations to the payment system will need to be published and notified to Monitor.
The components of the annual change in Payment by Result prices

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<tr>
<th></th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
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<tbody>
<tr>
<td>Pay and prices</td>
<td>2.4%</td>
<td>2.0%</td>
<td>2.5%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Revenue cost of capital</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
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<tr>
<td>Service development</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.1%</td>
<td>0.4%</td>
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<tr>
<td>Clinical Negligence Scheme for Trusts (CNST)</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>0.1%</td>
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<tr>
<td>Efficiency factor</td>
<td>-4.0%</td>
<td>-4.0%</td>
<td>-4.0%</td>
<td>-4.0%</td>
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<tr>
<td>Net price adjustment</td>
<td>-1.5%</td>
<td>-1.8%</td>
<td>-1.3%</td>
<td>-1.5%</td>
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Source: Monitor and NHS England; Department of Health.
Pay for performance scheme in secondary care

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<tr>
<th><strong>2008 - Advancing Quality</strong></th>
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<td>24 hospitals in the North West of England, covering 28 quality measures.</td>
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<td>Top quartile quality scores rewarded with a quality payment of 4% of PbR tariff. Payments invested in improved clinical care in winning service areas.</td>
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<tr>
<th><strong>2009 - Commissioning for Quality and Innovation (CQUIN)</strong></th>
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<tr>
<td>A proportion of provider income is conditional on meeting local and national quality and innovation goals.</td>
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<tr>
<td>Covers all providers (acute, community and mental health) and all income not just PbR.</td>
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<tr>
<td>Incentive initially 0.5% of income but since 2012 increased to 2.5%.</td>
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<th><strong>2010 - Best Practice Tariffs (BPT)</strong></th>
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<tr>
<td>Specific tariffs for specified services with PbR system.</td>
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<tr>
<td>Tariff based on reimbursing high-quality care that is both clinically and cost-effective.</td>
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<tr>
<td>BPTs must be in a high impact area, have a strong evidence base and clinical consensus of best practice.</td>
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</table>
Evidence of the impact of P4P in the NHS

**Advancing Quality**
- Evaluation found a statistically significant reduction in mortality for 1 of the incentivised conditions (out of 3 evaluated).

**CQUIN**
- Helped commissioners and providers identify and prioritise local needs for quality improvement and strengthen relationships between the organisations but schemes very diverse and there was a lack of front-line clinical involvement.
- Focused on structures and process, often with weak evidence-base and data.
- No statistically significant improvement in related outcome indicators.

**Best Practice Tariffs**
- Widespread support for BPTs among clinicians – seen as evidence-based and fairer payment system
- Take-up better for stroke and hip than cataracts
- Mixed evidence on impact on outcomes – no evidence of additional improvement for stroke but improvements in process quality and outcomes for hip fracture.
Integration focused payment initiatives

Within PbR

- Maternity pathway payments
- Year of care payments for cystic fibrosis
- Emergency readmissions non-payment reinvested in support for rehabilitation and prevention
- Piloting year of care payment for Rehabilitation, Recovery and Re-ablement in 8 locations

Beyond PbR

- The Better Care Fund (£3.8 billion of pooled budgets between the NHS and Social care)
- Contracts for bundles of services such as Improving Outcomes for Older People in Cambridge and Peterborough
- COBIC initiative
Maternity Year of Care tariffs (covers £2.5 billion of maternity care services)

• Pathway is split into 3 stages, women choose their lead provider for each stage. Commissioners pay once for each stage.
• Published business rules for choice or referrals where a different provider undertakes some elements of care within a stage or if a woman changes lead pathway provider.

Antenatal care (40%)
3 categories: standard, intermediate or intensive

Delivery (50%)
2 categories: with complications or comorbidities or without complications or comorbidities. No difference in payment for vaginal births or caesarean section.

Postnatal care (10%)
3 categories: standard, intermediate or intensive
The Better Care Fund

• £3.8 billion of existing health service funding put into a formal pooled budget with local councils – governance jointly between Clinical Commissioning Groups and local council.

• Objective ‘The funding must be used to support adult social care services in each local authority which also has a health benefit’

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<tr>
<th>Plans must be agreed jointly</th>
<th>Protections for social care services</th>
<th>7-day services in health and social care to support patient discharge and prevent unnecessary admissions at the weekend</th>
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<tr>
<td>Better data sharing between health and social care, based on the NHS number</td>
<td>Ensure a joint approach to assessments and care planning and ensure that where funding is used for integrated packages of care, there will be an accountable professional</td>
<td>Agreement on the consequential impact on each acute hospital provider</td>
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</tbody>
</table>
£1 billion of the Fund is linked to compliance with national conditions and achievement of service outcomes including:

- Delayed transfer of care
- Avoidable emergency admissions
- Other locally agreed indicators

P4P money is dependent on achieving 70% of the planned performance

If performance is below threshold no financial penalty but required to produce a recovery plan.
Conclusions

• The evidence from the evaluations of payment approaches supports a role for these in improving quality and productivity.

• But the effects are often small, difficult to sustain and highly dependent on wider system changes and critically clinical engagement and support.

• There is a lack of evidence to suggest they can be confidently used to incentivise either:
  • System efficiency; or
  • Better patient outcomes.

• The NHS is experimenting with reforms to improve the integration of care:
  • Many of these changes are being implemented by developing new tariffs within the PbR system
  • But commissioners are increasingly interested in population based funding models and linking payments to outcomes.
  • The biggest experiment is the integration of health and social care through the better care fund.