Report

meeting	**HEALTH SELECT COMMITTEE**	
date	**27 September 2005**	**agenda item number**

Payment by results

1 Purpose

This report has been prepared to provide Members with some background information relating to payment by results including some of the research into the likely impacts.

2 Background

Payment by results was outlined by the Department of Health (DoH) in the "NHS Plan" of 2000. Further detail followed in 2002 with the DoH publication "Reforming NHS Financial Flows: Introducing Payment by Results". The system seeks to transform the way hospitals are funded. Currently PCTs pay providers for procedures and treatment at a locally determined rate under a block contract. Payment by results will end this practice by introducing a standardised price for healthcare across the UK which will be paid to hospitals on a case by case basis.

The system is similar to payment models being used in many countries in Europe and beyond, including the US, Australia and Sweden.

The tariff is a fixed price which will be paid to a hospital for every individual case that they treat. The Department of Health has established a list of procedures and treatments and each has been given a Healthcare Resource Group (HRG) Code. The code determines the tariff that will be paid to the hospital for carrying out that procedure or treatment. The tariff has been set based upon the average cost of the treatment or procedure across the UK. For example the tariff for carrying out a hip replacement has been fixed at £4,830 because that is the average cost of carrying out the procedure. This is how much a hospital will receive for carrying out the procedure regardless of how much it actually cost that hospital to carry it out.

In some parts of the country where costs are unavoidably high (for example higher staff and capital costs in the south east) the DoH will reimburse the hospital directly.

If a hospital's costs are higher than the national tariff they will have to find ways of reducing costs as the DoH has stated that no financial assistance will be provided to hospitals in financial difficulties due to their failure to provide services at tariff level. However hospitals that are able to provide services under the tariff level will still be paid at the tariff rate and will be able to retain any the difference between the tariff and their costs and use it as they see fit.

To maximise efficiencies and therefore reduce costs it is likely that hospitals will be seeking to increase the number of patients they treat. This sits alongside the implementation of patient choice. Because the funding will follow the patient, the more patients a hospital can attract, the more income they will generate.

3 Issues

Payment by results is already in the advanced stages of implementation. Foundation Trusts have been operating the system since April 2004 and NHS Trusts began using it for elective care from April this year. The government anticipate that the scheme will be implemented in full across the NHS and independent sector by 2008/09.

Payment by results is intended to drive efficiencies in hospital provision and thereby improve productivity and, when combined with patient choice, deliver improvements in patient care. Evidence from Sweden and Australia shows respectively that hospital stays were shorter and waiting times were decreased following the introduction of a similar form of payment model.

Payment by results will also increase the transparency of NHS finances creating a clear funding route for each individual treatment or procedure.

The DoH has also stated that following the initial contract period between PCTs and Independent Sector Treatment Centres, all future payments for treatment or procedures will be subject to the same tariff as those commissioned from NHS providers.

Introducing Payment by Results, an Audit Commission report of July 2004 concluded that "Payment by Results has considerable potential to drive improvement in services, offering better incentives for both trusts and PCTs to provide efficient, effective and appropriate care than currently exists. It also offers greater fairness and transparency in funding". However the report also warned of a number of risks posed by the introduction of the system.

The Audit Commission report warned that an improvement in data quality was needed across the NHS in order that the commissioning bodies and the Trusts themselves could have faith in the data being used to determine billing. The amount a hospital receives for a case depends upon the HRG that is assigned to that case. This creates an incentive for trusts to 'upcode' a case in order to receive an increased payment.

The report goes on to state that the brunt of the risk of Payment by Results will be borne by PCTs as they will be committed to paying for work at a fixed price. Therefore if demand increases they will have no control over the prices they pay. However a significant number of hospital trusts also bear a share of that risk. Because the tariff is based upon average costs across the UK it follows that a significant proportion of Trusts will be operating above tariff. The DoH initially estimated that more that 160 trusts would face deficits of more than nine percent as a result of their historically higher costs and that almost 70 trusts would face a deficit of more than 25 percent (Harrison and Appleby 2003). Members may recall that at the Joint Health Committee meeting of 21 June the Finance Director of the City Hospital stated that the cost of treatment or procedures at Nottingham City Hospital was currently ten percent above tariff.

The Audit Report also outlined that a high degree of co-operation between PCTs and Hospital Trusts was essential if Payment by Results was to be effective. However a subsequent update report found that: "Evidence from early implementers shows that payment by results is testing relationships between acute trusts and PCTs, even in areas where relationships are historically good. …. PCTs and trusts face markedly different incentives, and where there is financial pressure within a health economy, payment by results has polarised interests and focused organisations' attention inwards."

Other researchers have outlined additional concerns about Payment by Results. The Kings Fund pointed out that "Payment by Results rewards volume, not quality" and reported that when a similar system was introduced in the United States there was some evidence that mortality rates in the time shortly following discharge from hospital increased. Nursing Management warned that providers may "Avoid providing specialist services because they are expensive and hard to code, and uncoded activity will not receive payment". The Journal also observes that the system creates opposing incentives for PCTs and acute trusts. PCTs will be seeking to reduce their costs by focussing on community care and prevention whilst acute trusts are encouraged to increase the amount of treatments and procedures they carry out in order to maximise their income.

Between now and 2007/08 providers with costs above the tariff will be expected to reduce their costs by three percent per year. Trusts with a difference of greater than nine percent will be expected to develop a

separate plan for reducing their costs in advance of the full implementation of the system in 2008/09 when 90 percent of hospital care is expected to be covered by the system.

4 Options

Nil

5 Recommendation

That Members note the report and discuss any concerns they have, to facilitate Members of this Committee taking these concerns to the Joint Health Scrutiny Committee at a later date.

Councillor James T Napier
Chair, Health Select Committee

Background papers
Nil