Payments by results: what does it mean?

Payment By Results (PBR), first discussed in 2002 and to be fully implemented by 2008, is the most radical and fundamental restructuring of health finance that we shall see in our lifetimes. PBR offers benefits, but carries risks.

Clinicians need to know what PBR means in order to understand the new structure of financial flows, how trusts and primary care trusts' (PCTs) financial positions are affected and why clinical activity has a direct impact.

WHY INTRODUCE PBR?

PBR supports the NHS modernization agenda, and introduces a new health-care accounting system that is similar to those already established in North America and Australia. PBR means trusts being paid for what they do, and rewards efficiency and quality. In *Reforming NHS Financial Flows: Introducing Payments by Results* (Department of Health, 2002), PBR is described as replacing price disputes with discussion about the volume and mix of services that best meet population need.

WHAT WILL CHANGE?

PBR means an end to block contracts, local price negotiation and fixed budgets. Instead, PCTs will place cost and volume agreements that are based on tariffs.

HOW ARE TARIFFS WORKED OUT?

All procedures are classified by health-care resource groups (HRGs), and have a nationally set tariff or price. There are separate tariffs for elective and emergency care. The tariff is derived from the average of all hospitals' costs for each procedure, also known as reference cost data, and is always 2 years in arrears. Therefore, the tariff for 2005/06 will be based on the cost reference data supplied by trusts for 2003/04. This reference cost data is then adjusted for inflation, qualitative gain, medical advances and guidelines issued by the National Institute for Clinical Excellence.

PCTs will place cost and volume contracts with trusts and each procedure will be paid for at the tariff rate, which means that each increase or decrease in activity will be at full cost. Regional cost differences will be funded nationally.

BENEFITS OF PBR

Health-care finance will be more transparent, and payment will be fair and consistent, linking activity and case mix. Trusts will introduce sharper budgetary discipline to enable them to keep within national tariffs, and will have to take responsibility for deficits arising from a failure to do so.

For hospital trusts, increased activity means increased financial reward, encouraging activity to reduce waiting lists. For PCTs it means activity is commissioned using a single tariff for all providers which uses HRGs to adjust for case mix. PCTs are encouraged to provide care in the most appropriate settings and to avoid unnecessary hospital attendance. Patients benefit because PBR promotes and facilitates patient choice.

PATIENT CHOICE AND PBR

The introduction of patients being able to exercise choice of hospital at the point of GP referral has got off to a widely publicized poor start. But PBR is a tool which will help to promote and facilitate patient choice because it means that the cost to commissioners will not be affected. This is because the tariff to be paid will be the same regardless of provider, or whether that provider is in the NHS or the independent sector.

However, on the other hand some people have expressed worries that, just like schools, some hospitals will become oversubscribed and others under-subscribed as a result of patient choice. The reality of waiting lists may offset this consequence to some degree.

TIMETABLE

Some PCTs introduced a number of cost and volume agreements in 2003/04. In 2004/05, cost and volume agreements increased and foundation hospitals implemented PBR fully. By 2005/06 the initial target was for 70% of health-care activity to be covered by PBR arrangements, but in January 2005 this target was reduced to 30%. The date for full implementation, 2008/09, remains the same.

However, 2008/09 should not be regarded as an end point to a project, as there will be ongoing associated changes, such as new contracts for staff and the growing diversification of providers through the establishment of foundation hospitals and independent treatment centres.

DATA RISKS ASSOCIATED WITH PBR

Poor quality data on costs and activity will lead to inaccurate tariffs and invoices. Individual trusts without good financial management systems and accurate cost data will find it difficult to know whether the tariff covers their costs, and to identify areas where cost savings need to be implemented.

The Audit Commission (2004) has confirmed that 5% of the data is incorrect. This is partly a result of poor patient administration systems, lack of clinical involvement and inadequate training for coding staff. Perhaps more worryingly, 14% had not coded 3% or

more of activity, and under PBR this would mean no payment at all.

For the future greater attention needs to be given to the recruitment, training and leadership of coding staff. PBR also produces significantly higher workloads for finance functions in trusts and PCTs, and this function will require the same investment.

'UP-CODING' RISKS

Up-coding is where procedures are coded into a more complex HRG than they should be, resulting in the trust receiving a higher tariff payment for that procedure than it should.

Up-coding creates cost pressures for PCTs and to avoid this in other countries where they operate a similar system to PBR, monitoring systems backed up with stiff penalties have been introduced. It was on the basis of an audit reporting widespread up-coding that the government was prompted to reduce the PBR implementation target to 30% in 2005/06.

FINANCIAL INSTABILITY RISKS

Some trusts will have costs that are generally below the national tariff. These trusts will receive windfalls of up to £30 million without having to undertake any additional work. It is not yet clear how much influence PCTs will have over these trusts with regard to how they invest their windfalls. On the other hand, some trusts need to make cost savings of £10 million or more to bring their costs in line with the tariff rates.

RISKS FACING THE TAXPAYER AND PCTS

PBR is not by itself a mechanism to bring about greater efficiency and there is no guarantee that overall activity will increase. One could argue that a cash-limited system that encourages providers to increase activity to reap more funding will lead to unplanned service cuts as commissioners struggle to keep within budget. The Audit Commission has highlighted weaknesses in PCT financial management.

Demand for elective and emergency health-care carries a degree of uncertainty, and any additional activity has to be procured at full cost. Therefore a PCT could incur severe cost pressures if it has to satisfy a level of demand that is higher than it anticipated.

CONCLUSIONS

The implementation of PBR will give the NHS an internationally recognized form of health-care accounting that transparently reimburses providers based on activity. Financial flows will move away from historic budgets and local price negotiation. Instead, a national tariff will facilitate patient choice, promote the provision of health-care in the most appropriate setting, and require higher standards of fainancial discipline. HM

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Audit Commission (2004) Introducing Payment by Results: Getting the Balance Right for the NHS and Taxpayers. Audit Commission, London

KEY POINTS

- Fixed tariffs will replace price negotiation and procure activity at average cost
- All PCTs and providers will have to have fixed tariffs
- The introduction of the new tariffs will promote patient choice