King's Fund Consultation response

# Response to the Department of Health consultation on Options for the Future of Payment by Results: 2008/09 to 2010/11

22 June 2007

The consultation paper sets out four challenges for Payment by Results (PbR) that the Department of Health (DH) want to address:

- rewarding appropriate, high-quality care, not simply activity delivered
- creating an environment that supports partnership working
- supporting the commissioning of integrated care based on evidence-based protocols or 'care pathways'
- developing a sustainable funding system for urgent and emergency care.

The King's Fund supports these goals. Two key question for the consultation are as follows.

- Are these goals likely to conflict in practice? That is, is it possible to devise a system that promotes all these simultaneously without detriment to any one of them or to other policy objectives?

- Can PbR – a single policy lever – be expected to positively contribute to any or all of the goals above by itself and, if not, what complementary action/mechanism is required?

In our view, the consultation paper underestimates the risks of conflicts between the various elements of the first goal, and between this goal and the other policy objectives, and also the ability of PbR to promote all these aims without complementary action.

We also consider that the paper does not adequately address the likely response of providers to the tariffs and note that it ignores completely the possible response of purchasers/PCTs.

It also does not address the question of priorities for reform of PbR. The paper raises a large number of issues on which further work is required but it does not suggest which are the most important.

This response initially addresses these general issues and then considers some more detailed questions identified in the paper.

**Appropriate high-quality and effective care**

The tariff system (with prices set at average national costs) already embodies an incentive for above-tariff providers to reduce their costs. However, this may be done at the expense of quality. The consultation paper suggests that the free

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pricing regime of the 1990s led to cuts in quality – although it presents no evidence to justify this assertion – but does not acknowledge that the same risk applies in a fixed-price regime, at least as far as above-tariff providers are concerned. A question for the situation facing below-tariff providers is how (or indeed whether) current rules (such as they are) regarding the use of surpluses go far enough in encouraging investment into improving the quality of services.

Similarly, a fixed-price regime may be damaging to access. While the promotion of access is not a specific objective of PbR, it does feature in other government policies. Providers may simply exit from the supply of above-tariff services/HRGs. While the use of capacity-based funding is noted in section 5.21 in relation to the need to ensure the availability of urgent, critical and emergency care, the presumption seems to be that this would be unusual, and that for most services capacity/access should not be protected in this way. However, it is not at all clear that patients or the public would either understand or agree with such distinctions. The issue here is not only services characterised by high fluctuations in demand and/or low volumes of cases, but the wishes of patients and the public to fair access (in geographical terms), just as it is to emergency care etc. Equally, some purchasers may wish to pay more to have routine services delivered in a local setting.

A PbR system may promote quality through the choices patients make – if patients are able to access and assess the relevant information. But this information does not form part of the current PbR system, and, despite recent improvements in hospital-based performance data (available from the recently revamped NHS choice website), is not available from other sources. Other than referring to the possible recommendations of the DH's Information Task Force group and the possible future collection and promulgation of patient reported outcome measures – the paper makes no proposals designed to improve the availability of appropriate information to inform choice. In the absence of performance information bearing directly on quality, there is no reason to expect that PbR will promote quality through patient choice.

The paper also considers an approach to improving efficiency bearing directly on providers. However, setting a price based on a model of delivery of an HRG that is technically efficient requires much more than simply setting the price based on data on current cost structures (which includes some inefficient providers) and leaving providers to react. Providers need to know what the efficient service delivery looks like so that they can adjust their production. Otherwise the risk is that – if the price is lowered – at the margin, some providers may simply react in the 'wrong way' (eg cutting quality, exiting). If the DH is going to go down this route, it must acknowledge the need to develop service or pathway specifications which, unlike currently existing guidelines, embody economic as well as clinical and organisational elements.

On the issue of whether prices can be used actively to promote higher quality, there may be some scope for careful experimentation. However, there needs to be a much clearer view/explanation of what is meant by 'quality' and a clearer separation between quality and efficiency (which also needs a clearer definition than implied by the consultation document). Importantly, there needs to be clarity about the level at which targeted prices would work in promoting quality. Given the nature of HRGs and the tariff, for example, it would not be possible to set an appropriate tariff to directly encourage a specific type of intervention or way of delivering a particular HRG. However, as with the day case/inpatient incentive, it may be possible to encourage greater/lesser activity overall for a specific HRG given evidence that this would be to patients' benefit.

Overall, there may be some scope to promote higher quality through the pricing system – but much more thought needs to be given to what is meant by quality and what the actual effects of a price rise/cut will be, given that both providers and purchasers will react to changes in prices. On technical efficiency, the system already embodies a strong incentive for above tariff providers

to cut costs – but the risk is that this is achieved by cutting quality. This is an issue that the consultation document should, but does not, address.

*Improving quality through other/additional means*
The consultation suggests that the combination of PbR, choice and the provision of information on quality may not be enough to actually improve quality and further suggests that there is a potential to add yet more incentives to do so via 'pay for performance' (PfP) contracts – essentially rewards for meeting quality targets. We would agree that PfP is worth investigating to assess its costs and benefits.

**Supporting the commissioning of care pathways**
The issue of supporting the commissioning of care pathways for patients points up (and is an example of) the issue raised above about the need to create new HRGs (through, for example, unbundling/bundling existing HRGs) if the tariff system is to exert any impact on providers to, in this case, adhere to evidence-based care pathways.

Clearly, as evidence accumulates of best practice with regard to the care and treatment of particular cases, then the definition of the 'product' – currently the HRG – will need to change in order to reflect this and to avoid any disincentive to changing service delivery.

One issue to consider here is the extent of any freedom that local purchasers could have in negotiating bespoke deals that would effectively mean the bundling/unbundling of HRGs, for example. This appears to be similar to the consultation's discussion of the third generic model of PbR where local currencies (and indeed, prices) are used for certain services for which there are no national currencies/prices.

**Urgent and emergency care**
In general, the paper does not adequately distinguish between the various kinds of service the NHS embodies. In respect of urgent or emergency care, there is little potential for competition or real patient choice as far as the most expensive facility – the accident and emergency department – is concerned. However, there is a high degree of substitutability between this and other forms of provision for care at the less serious end of the spectrum. In addition, the structure of provision is undergoing change and more is on the way. In this dynamic environment, it is important that the tariff and the rules surrounding it does not impede change and service innovation driven by other forces.

But perhaps the most important point is that in this area, less rather than more activity should be rewarded. This requires a different approach to any set out in the paper and as far as we are aware has not been given serious attention.

This is one example of a wider problem with the tariff system, which the paper acknowledges but does not deal with: how to allow for the need to 'spend to save'. This may involve capital projects but also 'double running' as services are transferred or reorganised. In the case of emergencies, the spending may be in the community setting on preventive or anticipatory services.

**Purchasers**
There is no mention of, or connection made to, the role of PCTs (over and above the tariff system) in commissioning high-quality care for their residents. What efforts could be made to encourage purchasers to 'do the right thing' by way of greater quality (if they are not already)? The standard tariff presents no direct incentive for them to do so. However, if a lower tariff was set to discourage a procedure, that would create an incentive for PCTs to use it; the paper does not take into account possible demand side effects.

There is also the question of how purchasers may wish to use the tariff. Presumably, one way to encourage providers to produce more HRGs deemed to provide higher quality would be to raise the tariff. For example, the current 18-week target for waiting times could be supported in this way. That is, the tariff (related to appropriate HRGs) could be related to proportion achieving the target. That is currently not allowed – but PCTs are able to 'fine' providers for excess performance.

**Who sets the tariff?**

Section 5 of the consultation notes three generic PbR models. The third model effectively abandons national price setting and suggests local negotiation. However, the consultation warns that 'unmanaged price competition can have an adverse impact on the quality of care.' As noted earlier, this may be true, but it is also true in a fixed-price system too. Fixing prices does not take price out of the basic equation for providers as far as quality is concerned. It is perfectly conceivable that quality may be adversely affected in a fixed-price system as a result of the incentives on above tariff providers to reduce costs – as we noted above.

So, whoever sets the tariff/price or however it is done, the important issue is how patients are protected against any adverse impact on the quality of care (and, indeed, on the availability of services in an area).

Related to this, we would agree that tariffs should be set by the DH as they are now. The issue is not so much *who* sets the tariff, but *how* it is set – that is, what criteria should be used to set prices and what should the goals be for the reimbursement system. It is appropriate for the DH to set the criteria and goals as this is a matter of policy. Having done so, it is difficult to see much if any advantage in then having, for example, an independent body simply to perform the technical job of applying the pricing rules to generate a set of tariffs. However, there may be advantage in an independent body whose job is to *advise* the DH on tariffs and who could provide the technical and research evidence to test the impact (for example, on quality, access, etc) of changes in the tariff and impact of the system overall as it develops.

**Tariff setting**

The suggestion of using a sample of trusts from which to generate a 'representative' set of costs to calculate PbR tariffs has some appeal. However, the benefits of sampling – faster and more accurate cost data – implies that most trusts do not, or will not be able to, supply accurate and timely cost data. In turn this suggests that most trusts will be in a poor position to respond to the apparent incentives of PbR due to their poor-quality and untimely cost data. This would undermine the assumptions about the incentive effects of PbR; if most trusts take production decisions based on inaccurate/untimely cost information, then no matter how accurate/timely are the prices in the system, the danger is that wrong decisions may be taken.

All providers must realise the most basic incentive of PbR – to produce accurate and timely cost information. If there are reasons – apparently implicit in the suggestion of sampling – that they do not understand this, then the DH should make efforts to rectify this, otherwise the risk is that PbR will be undermined as a tool to promote appropriate behaviour in providers – to improve quality and efficiency in the interests of patient care.

Furthermore, there is still a need to collect cost information from all providers – the National Reference Costs – and to ensure that these are as accurate and timely as possible, in order to monitor trends in costs (not least to evaluate the impact of PbR).

Rather than use a sample of trusts' costs to inform the tariff, efforts would be better spent ensuring the accuracy and timeliness of the data collected as part of the NRC database.

**Conclusions**

The consultation paper raises a wide range of possibilities for ways in which the current PbR system might be developed and, while that is to be applauded, it raises the question of which areas are it most important to improve. Our chosen candidate would be emergency care. This is probably the most important area to focus on given the scale of the resources devoted to it, the fact that information on quality is poor, that access is highly important to users, and that changes in the way that services are configured are about to be published.

Longer term, the consultation paper raises the possibility of developments in needs-based funding which could (depending on the exact design of the allocation mechanism and the appropriateness of the currency) embody the basic principles of PbR while providing a better fit with the type of care to be provided. We would support investigation and testing in this area.

Overall, as experience of similar reimbursement systems in other countries show, there will be a need for the DH to monitor and evaluate the impact of this payment system and to be prepared to change and adapt in the light of such evaluation.