From Payment to Results: The future for tariff-setting

ippr discussion note for Foundations and Fundamentals

a seminar series addressing five key challenges for health system reform

ippr seminar series

ippr is hosting a series of seminars to address five key challenges for health system reform: regulation, commissioning, governance, vertical integration and tariff setting. The seminars will provide an opportunity for policy-makers, public bodies, stakeholder organisations, practitioners, providers and experts to tackle these important yet controversial topics under a ‘Chatham House’ agreement. Ippr will provide discussion notes in advance of the seminars and summaries will be distributed and posted online. A report of the seminar series will be published in April 2006.

We are grateful to Monitor for funding the seminar series, and for respecting the independence of the project.

The fifth Chatham House seminar, to be held at ippr on 20th March 2006, will aim to learn from this year’s experience of Payment by Results and explore the future of tariff-setting for the health service.

1. Introduction

Since April 2005 hospitals have been paid according to the number of patients they treat for each condition – or Health Resource Group (HRG) – according to a set tariff. This represents a major change in NHS financial flows. Under Payment by Results (PbR), money follows the patient to support choice and contestability between a wider range of providers. The new financial system is also conducive to the development of stronger commissioning and the devolution of health budgets to primary care practices.

The government has set out the aim for financial flows to incentivise commissioners to invest more in preventing patients from unnecessary hospital treatment, and to seek out providers who offer better quality of care. The recent White Paper also announced the intention to ‘unbundle’ tariffs to enable more care outside hospitals,
and a new direction to set tariffs according to best practice pathways, rather than average costs. With greater devolution of decision-making and more independent providers, tariff-setting will become one of the key levers for government policy in the future.

Questions remain about the transparency and accountability of the tariff-setting process, and how PbR policy will ensure efficiency, equity and quality in the future.

2. Four approaches to tariff-setting

Four main approaches predominate in current deliberations about paying providers by activity.

The most liberal approach allows prices to be negotiated locally by commissioners and providers with minimal central control. This was the approach under Fundholding, and is the policy preferred by the Conservatives. It has the advantage of minimising central interference and is based on a trust that the market will establish the optimal price. The risk – as under Fundholding – is that quality could fall as purchasers seek lowest cost providers. It could also increase the potential for local price-fixing by provider cartels, and create an incentive for purchasers (GPs and PCTs) to restrict choices to patients for financial reasons. The administrative cost of local price negotiations could also be higher than central price-fixing.

The second two approaches involve setting tariffs based on historical costs. One way would be to reimburse providers according to costs at a ‘year zero.’ This would cause minimal disruption to the system. An historical reimbursement approach has the advantage of relative simplicity and transparency. However it would create perverse incentives to inflate costs in year zero and would reward providers that were more inefficient in the past. This approach could maintain inequities in spending and quality between areas or between different specialties by reinforcing historical flows.

The other historical approach – used to set prices for the initial implementation of PbR – has been to base prices on the national average for each HRG, with a ‘Market Forces Factor’ (MFF) held centrally to subsidise geographical variations in land and salaries. This reduces the risk of rewarding inefficiency and incentivises inefficient providers to reduce costs to the national average. However, it also creates winners and losers overnight, with below-average providers (clinical departments rather than whole organisations) enjoying a windfall as they are paid more than their historical
costs, and above-average providers falling into deficit, at least in the short to medium term, as their inefficiencies are exposed.

The scope for price-setting to be used as a proactive tool is limited under all these approaches, and there is a continued risk of behaviour reinforcement as different specialties continue to be relatively under- or over-funded. Potential efficiency gains in nationally over-priced specialties will not be incentivised, and under-priced specialties will not have the finding to improve quality.

The alternative, normative approach would be to set prices at a ‘best practice’ levels to encourage providers to reconfigure and redesign care pathways. The government, as the price setting authority, can peg prices above or below the average to induce desired changes in behaviour (Appleby and Jobanputra, 2004). This opens up the scope for using tariff-setting as a policy tool, but brings with it new risks and opportunities.

3. The normative approach to tariff-setting
The aim to move towards more normative price-setting was set out in the White Paper (DH, 2006: 153). This opens up the potential to use tariffs creatively to achieve particular goals. For example, as the White Paper indicates, where care for a particular condition could be more cheaply provided in the community, the tariff could be set at a lower level so that local commissioners and providers would be incentivised to move care out of hospitals.

This opens up a means of directing policy- but the method of implementation is not apparent. The accreditation of a particular pathway as being ‘best and most cost effective practice’ implies a new stream of audit work, along the lines of NICE’s process for accrediting medicines and technologies. It also implies a level of central prescription of care pathways that may be out of tune with the direction towards devolved responsibility – a central aim of public service reform. There is a risk that innovation might be stifled as health economies wait for the centrally-prescribed best practice pathway. As Appleby and Jobanputra warn, ‘any published tariff embodies a risk of obsolescence as costs change and new procedures are developed. These may be more expensive, but also more clinically effective. A fixed tariff poses an obvious obstacle to their adoption’ (2004: 199). It is not clear from the White Paper whether cost effective but expensive care pathways would lead to increases in the tariff. Nor is it clear how changes in HRG tariffs will be tied to redesign of the relevant service, and not absorbed into organisational budgets.
Risks to equity of tariff setting

Setting tariffs for health care brings certain risks for equity. Not all patients are equally expensive to treat. Older and more frail patients, for example, may have longer recovery times or have a greater chance of complications taking up more theatre time and bed days. They may have greater risk of mortality, negatively affecting quality measures. The risk is that the necessarily simplistic tariff incentivises providers to select, or ‘cream-skim’, cheaper-to-treat patients to maximise revenue, and to ‘skimp’ or ‘dump’ more complex patients. This threatens equity if complex co-morbid patients over-represent disadvantaged groups including people from lower socio-economic backgrounds, older people or people with disabilities.

At present the scope for cream-skimming is limited by a ‘duty to treat’ placed on providers who are referred patients by commissioners, reducing their ability to select patients (Le Grand, 2006). However, restricting provider selection does not prevent skimping and more subtle forms of cream skimming. Increasing pluralism, selective marketing and unequal access to choice could lead to segmentation and carve-outs, with low-risk patients congregating at particular providers. The immediate answer is to adjust HRGs so that the payment better reflect the risks of individual patients, and to reimburse providers for the cost of treating patients who suffer complications. PbR already includes elements of risk adjustment, albeit based on a calculation of financial cost rather than reputational risk. For example, heart bypass surgery is paid a standard tariff whether one or two vessels are stenosed. The BMA has criticised this for penalising surgeons with more complex caseloads (BMA, 2005), but the tariff was set on the basis that theatre time should be roughly the same, and providers would have similar case-mixes. However, the financial incentives of the tariff, the publication of surgical mortality rates and use of quality information by commissioners and patients could encourage case-mixes to change, and more complex cases to be ‘dumped.’ PbR also provides ‘stop-loss’ insurance, so that hospitals are reimbursed for frail patients who take up more bed days. But there remain trade-offs between simplicity, risk-adjustment and cost/demand management. These issues will continue to be politically sensitive, and require debate, transparent process and accountable decision-making.

Arguments have also been made for using price setting as a positive equity tool. Le Grand’s (ibid) proposal for a positively discriminating voucher in education, with greater payments per pupil from a deprived postcode, could be applied to payment by results to incentivise more treatment for disadvantaged groups to balance out
current inequities in the NHS. Increasing the risk-weighting of payment by results could disincentivise cream skimming. But it could also risk cross-subsidising less risky but more demanding patients, or over-treating high-risk patients who have less capacity to benefit.

Certainly there is a strong argument for greater risk-weighting of capitation payments to GPs and commissioners, so that there is more incentive to move into deprived areas (Farrington-Douglas and Allen, 2005). One influential Strategic Health Authority manager has suggested PCTs pay top-ups to the tariff to encourage more providers in deprived areas (Health Service Journal, 2006) although again the problem of ecological fallacy remains: services targeted in poor areas may not reach the most deprived.

**Risks to quality**

One of the aims of PbR is to improve patient care through provider competition and commissioners and patients choosing according to quality. The economic theory and empirical evidence for this in other systems are ambiguous. Competition in a fixed price system, where price is observed accurately but quality is observed poorly will lead to poor quality service; or easily observed quality may increase at the expense of less observable aspects (Burgess et al, 2005). The evidence from the USA and UK also suggests that too low tariffs or competition on price may lead to reduced quality, and that levels of competition and quality-sensitive commissioning may be significant factors for quality improvement (ibid).

The national evaluation of payment by results does not suggest that the policy is yet having a positive impact on quality, with none of the health managers interviewed in the national evaluation considering that PbR was yet stimulating Trusts to compete on quality, although this could come in due course (HERU et al, 2006). There is an increasing importance for better quality information and stronger commissioning to ensure that PbR and competition are used to increase quality and efficiency rather than to cut costs and reduce quality. Ippr has argued that, as well as competition, the process of involving patients in supported choice may have a greater benefit for quality by improving concordance, engagement and health literacy (Farrington-Douglas and Allen, op cit). However these have been lower priorities than finance and market creation.

Another approach to tariff-setting that is also reportedly being explored within the Department of Health is the idea of quality-weighting payments to providers (Harding,
The idea as reported would be for quality-accredited providers meeting key targets such as reduced MRSA rates or A&E waiting times would receive higher payments per patient. This builds on the perceived success of the Quality Outcomes Framework (QOF) in primary care. This could counteract the quality-lowering incentive of low fixed prices, but also carries risks. If the extra payments were carried locally there would be a perverse incentive for commissioners to choose cheaper, worse quality providers. It could lead to a segmentation of the market into high and low quality and cost providers—an ‘M&S v Kwiksave’ market—undermining the principle of equity and implying an acceptance of lower quality. The idea implies doubts within the Department that competition with fixed prices will drive quality improvement, but the introduction of a new form of central performance management may not be the answer. The cost-inflating effect of the GP QOF may also counsel caution.

Treatment Centre tariffs and the level playing field

The use of differential tariffs has been a particular criticism of Treatment Centres, niche providers of high volume routine surgery. Their patient base is lower risk than generalist providers, allowing them to treat more patients with lower costs. In the first wave of Independent Sector Treatment Centres (ISTCs), their payments were fixed at a higher rate than the national NHS tariff and guaranteed flows were mandated from local PCTs. This was in order to subsidise the costs of setting up the new providers and encourage market entry, but effectively undermined the case for plurality and reduced buy-in from the NHS, its workforce and representatives. Despite the benefits to patients of faster treatment and shorter waits, and the effectiveness of competition in improving productivity elsewhere in the system, the perception remains of an unfair playing field.

For subsequent waves of ISTCs, the guaranteed flows have been abolished and the market entry subsidy has been centralised rather than coming from local PCT budgets. However, there is still a lack of local NHS engagement in centrally-procured capacity. ISTCs are now in direct competition with existing hospitals for patients and staff, rather than being limited to providing ‘additional’ capacity. The future development of PbR needs to build on the principle of a level playing field in order to maintain the buy-in of stakeholders to system reform. Paying different types of provider—be they treatment centres or polyclinics—a different price for political reasons distorts the impact of the market and defeats the purpose of using a tariff to improve efficiency and quality.
The question of whether government should be subsidising the costs of market entry while other parts of the NHS are dealing with the costs of exit needs to be debated more thoroughly. Other forms of governance for Diagnostic and Treatment Centres should be explored, including public private partnership and social enterprise models. Central procurement has a questionable role in a devolved health system. Diagnostic and Treatment Centre policy should move into line with the White Paper agenda, with commissioners making strategic choices accountable to local communities. All providers – public and private, acute and community – need to be subject to the same regulatory, quality information and transparency standards (Maltby and Gosling, 2004).

The devolution of the Market Forces Factor to PCTs should be considered as part of the direction of travel towards a level playing field and incentivising care outside hospitals. Presently the MFF is held centrally and paid to acute Trusts only, effectively penalising commissioners for moving care into community services. The logic of the MFF also sends out a potentially inconsistent message from the Government that is also trying to reduce regional inequalities, only weights cost of living for London staff salaries and mandates a uniform national minimum wage. The long term simplification and reduction of the MFF may therefore also be a question for consideration.

Other risks
This note has concentrated on risks to quality and equity, and the need for a level playing field. However, there are parallel debates about the impact of tariffs on training and education, emergency and intensive care overheads and regulatory level playing fields. There are also important questions about the speed of the roll-out of PbR and, the requirement for annual budgetary balance. The suitability of PbR for emergency care, mental health and long term conditions is debatable. More widely, the impact of cost rationalisation on services that are loss making and may be closed, and the sustainability of current hospital configurations, are also related to PbR.

Tariff setting processes
As the tariff-setting policy inevitably becomes more complex, the process needs to become more transparent and accountable. If tariffs are used to achieve political goals, for example improving efficiency or moving care out of hospitals, the goal-setting needs to be democratically accountable. There will therefore remain a strong role for elected government in setting the objectives. However, the process of
calculating the levels and regulating the implementation of the tariff should be collaborative, drawing on the expertise of a range of stakeholders from regulators to providers and commissioners. As one Minister has signalled, and one regulator has argued, there may be scope for certain elements of price setting to be ‘off-shored’ to an independent body (Harding, 2006b; Monitor, 2005).

To begin the discussion, the Department should consult on the process for setting the tariff in 2006. Organisations such as the Foundation Trust Network and NHS Alliance have already begun to propose innovative ideas for improving the process (Taylor, 2005; Slipman, 2006). In order to avoid the confusion and delays experienced this year, a more open and transparent process needs to be agreed and implemented.

**The future of price incentives**

Potential proposals for tariff-setting to be used to change behaviours in the health system have been described. However, the behaviour of organisations, managers and professionals is not predictable. For example, the implementation of PbR has led to examples of gaming by both commissioners and providers (Taylor, 2005). With payments as with targets, agents do not always react in the way predicted by system reform designers. For example, some revenue-losing hospitals may resort to short-termist cost savings rather than redesigning their services according to best practice. Others will cross-subsidise loss-making areas of their business, nullifying the financial incentives of a fixed tariff.

This raises questions about motivation of decision-makers – as Appleby and Jobanputra (op cit) ask, what motivates managers, clinicians and other staff to get out of bed in the morning and go to work? At present, health economies are apparently working collaboratively rather than in competition to make the new system work (HERA, op cit). This implies an ‘altruistic’ ethos that may not be reliable in the long term to deliver what patients need, particularly as commercial incentives are tightened and commissioner-provider relations become more strained (Mannion and Street, 2005). No system will perfectly cope with knightly and knavish motivations but the challenge to create robust incentives through price setting has not yet been met. The new code of practice may help smooth the roll-out of PbR, but behaviour on the ground will remain hard to predict or regulate. In the long term, health system reformers will need to take stock of the evidence from impact of incentives and iteratively adjust the levers and mechanisms to achieve required results.
Questions for discussion
- What should be the overall goals of payment by results – reimbursement, behaviour change, encouraging market entry?
- What principles should underpin the tariff-setting process, and how should they be implemented?
- What should be the roles for different stakeholders in the process?
- How should the impacts of tariffs be measured and fed back into future versions?
- How should tariffs be implemented and what risks need to be considered on the ground?

References
- British Medical Association (2005) Memorandum to the Public Administration Select Committee inquiry: Choice, Voice and Reform in Public Services London: BMA.

ippr discussion note by Joe Farrington-Douglas March 2006

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