PAYMENT SYSTEMS IN THE NHS - AN OVERVIEW

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ABSTRACT:

Clinicians poorly understand finance within the NHS. The limited engagement of clinical leaders in finance decisions has been recognised as a common pitfall in recent inquiries such as the Francis report¹ and recent King's Fund report into financial failure². The complexity and rapidly changing landscape of financing systems in place across the NHS on a background of complex and transient organisational structure makes it challenging for the patient-focused clinician to achieve a working knowledge of finance. This article will discuss various payment mechanisms and explore their advantages and disadvantages and then discuss how they have been used on their own or in combination to fund healthcare organisations. To provide context for clinicians, we will discuss how the payment contracts influence day to day health service practice.

INTRODUCTION:

The complexity of payment within the NHS is often poorly understood by clinicians who are often responsible or involved in decision-making processes involving vast sums of money. This can lead to poor financial decisions due to a lack of understanding of the systems involved. Financial issues have been highlighted as an area requiring improvement by several reports into failing trusts, most notably in the Francis Inquiry into Mid Staffordshire NHS Trust.¹ Clinical involvement in these decisions is essential with a recent King's Fund paper entitled "Financial Failure in the NHS"² highlighting that repeated reports have "underlined how essential active clinical engagement is

in the management and oversight of an organisation. This is as true for financial good health as for quality of care." The Audit Commission has also noted that disengagement of the clinical leaders from the core management process is common and unhelpful³. In an environment with finite resources, clinicians striving to deliver the best quality of care for their patients need to understand how their services are funded to expand their services, develop their clinical pathways or write business case proposals. This article seeks to explore and explain the various payment mechanisms in use within the NHS, together with their benefits and limitations.

BACKGROUND:

Funding for the NHS in England is set by the spending review, which occurs every three to five years and is adjusted in the Budget statement. Responsibility for NHS services in the devolved nations lies with the devolved governments, and as such, funding of healthcare is also a devolved matter. The annual budget is split into revenue spending (day to day running) and capital investment (buildings and equipment).

This mechanism of trust allocation of the central NHS funding is broadly performed through the local Clinical Commissioning Groups' (CCG). However, specialist services including major trauma, complex paediatric surgery, and specialist cancer treatment are commissioned directly by NHS England. In addition to funding from central sources, NHS income can include local education and training boards (LETBs), local authorities for providing public health-related activity, research, lettings, private patients, charity donations, and parking charges, which varies significantly between trusts.

In 2015, England was divided into 44 geographical 'footprints'. NHS organisations within these areas were asked to collaborate and develop 'place-based plans' for the future of health and care services within their area; these were known as sustainability and transformation plans. In 2016, these 'footprints' developed into sustainability and transformation partnerships to encourage closer collaboration between local health and social care organisations.⁴

The aim is that partnerships that work well together will become integrated care systems where healthcare organisations and local councils take collective responsibility for managing resources. It is essential to discuss these regional systems as payment mechanisms are often cited as key barriers preventing closer collaboration between healthcare organisations. We will discuss how some of the newer payment models address this issue.

In 2013, NHS England suggested payment systems should support sustainably delivered continuous quality improvement and the appropriate allocation and management of risk.⁵ This should be done by pursuing four objectives.

- Reimburse providers for delivering specified outcomes for patients, rather than treatments or inputs

- Promote the long term, sustainable wellbeing of the whole person
- Allow for different payment approaches where people's care needs differ, with room for local flexibility bounded by a clear structure of rules
- Signal clearly to commissioners and providers the choices available to them that will promote sustainably better outcomes for patients⁵

In contrast, the current NHS payment systems can be criticised as having a multitude of objectives – many of which were unclear – and this may be contributing to a loss of focus during commissioner–provider negotiations. This is supported by a paper that attributed 12 policy objectives to the current NHS payment system contrasting against the three to five objectives pursued in other comparable European health systems.⁶ For example, it is often unclear whether innovations in a payment system are intended to control expenditure, increase transparency, improve quality, or a combination of the above (or achieve other objectives). The reality is that no single optimal payment system would be able to improve all these objectives.

Within the NHS, different payment systems are in use, often referencing the figures from the national tariff as the basis for negotiation. These payment strategies have been devised to manipulate the funding process to achieve aims such as to provide stable finances despite variation in healthcare needs or drive efficiency, performance or allow for local variation.

44 regions England was split into. Available via: www.england.nhs.uk/wp-content/uploads/2016/02/stp-footprints-march-2016.pdf

BLOCK CONTRACT:

A fixed lump sum paid for delivery of a healthcare service to a population.

Block contract payments are often paid at regular intervals throughout the year in advance of the delivered service. Payments are independent of the level of activity or number of people treated. In recent years, there has been an increase in the use of block contracts for acute organisations to enable better financial planning as it is predictable and forecastable. These payment agreements are often used for items that are hard to measure, such as community services or mental health. There was a return to block contracts during the COVID-19 Pandemic to provide stability and predictable income despite a reduction in elective activity.

Advantages:

- Predictable income and expenditure
- More amenable to integration/considering pathway options and models of care
- Useful in areas where activity levels are difficult to measure
- Lower transaction costs

Disadvantages:

- Lack of transparency and accountability
- Inevitably leads to increased waiting lists as no incentive to increase work/efficiency
- Changes in cost during contract are not accounted for
- Block contracts may lead to lower responsiveness as increases in activity are discouraged

ACTIVITY BASED FUNDING:

A funding model where an agreed fee is paid for each item of work done. An increase in work done leads to an increase in funding and vice versa.

The basic formula can be expressed as provider income being the product of the amount of activity, the price, and the Market Forces Factor (MFF). MFF is an adjustment made to reflect local variations in costs.

An activity-based payment mechanism was introduced to move away from block payment systems in the NHS acute

sector in an era of long waiting lists. Initially called Payment by Results (PbR), it is now part of the National Tariff payment system.

The PbR system, accompanied by other complementary incentives such as waiting time targets, had the intended impact of increasing activity levels leading to a reduction in waiting times. Resulting resource savings were estimated to be up to 3% with no evidence of quality reduction,⁵ suggesting that the introduction of “the payment by results” system led to improved efficiency. These findings are consistent with those from other countries that have moved away from block payments to activity-based systems. Internationally, activity-based payment systems have been associated with increases in life expectancy.

RESULTS INDICATE “THE PAYMENT BY RESULTS”
SYSTEM LEADS TO **IMPROVED EFFICIENCY**

Payments, called tariffs, are made using a classification system that group hospital activity into units of currency that are clinically similar and have similar resource requirements.⁷ In England, this classification system is called Health Resource Groups (HRGs), and the latest version has 2100 different currencies.⁸ The concept is that an HRG payment represents a cost to the service for the patient journey, including the majority of aspects of care. However, some items such as palliative care and complex radiology are unbundled and have their own tariffs. Other items such as devices and high-cost drugs are excluded, and their cost is considered to ‘pass-through’ to the commissioner. This method of payment supports patient choice by allowing funding to follow the patient wherever they choose to be treated within a range of available options.

Within mental health, where healthcare is less well defined by physical interventions or time windows, clustering is utilised to attempt to classify patients and interventions to enable appropriate payment for services. Clustering is a global description of a group of people with similar characteristics identified from a holistic assessment. The clusters, like HRG’s, allow for variation in combination and severity of needs, which are underpinned by statistical processes. This clustering is reviewed periodically, from the start of the patient journey to ensure appropriate classification using the mental health clustering tool, decision tree, and rating grids.

The purpose of the national tariff was to provide a set of prices and rules to help commissioners and providers of NHS care provide the best value to their patients.⁷ More recently, the purpose of the National Tariff has evolved; it sets the default payment mechanism for acute and mental health services, where commissioners and providers cannot agree a mixed-model contract (explored in detail below). It also provides guidance on the pricing of healthcare services based on the annual cost collection (previously known as reference costs).

Every year, all NHS Trusts submit data to NHS Improvement on how much it costs them to deliver each HRG. The data is collated, and an average obtained. Further adjustments are made to factor inflation and an efficiency component before arriving at the tariff price. This cycle takes three years to complete, in which time actual costs are likely to have changed. Trusts are beginning to move towards patient-level costing systems known as 'PLICS' to improve the accuracy of costing data and improving the national tariff system.

While the national tariff covers 60% of payments to acute care providers⁷, various areas are outside the scope of the national tariff, including public health, sexual health services, primary care, and personalised healthcare budgets (PHB's). Commissioners can negotiate locally for payment for some services that do not have a national tariff, such as critical care and HIV.

The activity-based system worked very well during the period of funding growth. However, it has proved less satisfactory in today's environment of flat-line funding and year-on-year increases in demand. 'Demand management schemes' are a key element of commissioners' plans, but there is little incentive for providers to reduce capacity.

This payment mechanism has meant that commissioners and providers are pitted against each other, with data constantly being challenged. Overall, integration and collaborative working are disincentivised.

Advantages:

- Increase activity and can reduce waiting lists
- Encourages efficiency as the tariffs are calculated using average costs, which encourages those hospitals with higher than average costs to become more efficient

Disadvantages:

- The funding regime works to skew commissioners' spending towards acute services because mental health and community services are not included in the tariff system
- Difficult to budget for both sides (Final cost/payment depends on activity)
- A barrier to integration – as organisations need numbers to generate income, so may be less willing to consider options whether their activity would be reduced i.e. (community-based options)
- Organisations are less willing to stop income generating work (mainly elective) work, despite other pressures
- There is a risk that providers are less focused on quality in exchange for volume

CAPITATION:

Finances are divided between healthcare services according to the population and often their demographics by a proportionate calculation.

Like a block contract, it is predictable and often paid in advance but is fundamentally based on the population rather than the provision of a service. Commissioners provide finances to the healthcare provider in a regular lump sum per person in a specified group. This payment will be adjusted to consider likely resource-intensive patients or those who may require more costly services by adjusted calculations. Capitated

payment may be made to a single provider (a capitated budget-holder) who arranges several providers to deliver the full scope of services specified by commissioners. Capitation could be implemented for the whole population in a given area or only cover a specific sub-segment of the population. There is a broad agreement on what the money is to be used for but provides the health service provider with a significant degree of flexibility to provide care to the defined population. General practice provides an example of capitated payment systems receiving an income-based on practice registration and is explored in more detail below.

Advantages:

- Allow clear planning as finance is dependent on a predictable figure rather than diagnosis or treatment

Disadvantages:

- Can be a disincentive as providers are paid irrespective of care given
- Does not factor in changes in demand
- Does not encourage integrated services
- Can be open to manipulation to maximise profit as has been seen with online GP services

FEE FOR PERFORMANCE:

Income is based on particular definable aims, outcomes, or targets. Meeting the target results in payment and vice-versa.

This is often part of another contract to incentivise quality improvement financially.

CCG's are incentivised by QIPPs (Quality, Innovation, Productivity, and Prevention), which is a programme developed by the Department of Health to drive quality improvement throughout the NHS. This originated out of a focus on efficiency savings and sought to reward CCG's for innovative and efficient use of resources. They are applied as a reward for a specific detailed plan that meets certain criteria.

NHS Provider contracts utilise CQUIN payments (Commissioning for quality and improvement). These are established by the Commissioning for Quality and Innovation (CQUIN) framework, which aims to support improvements in the quality of services and the creation of new, improved patterns of care. CQUIN

targets are set externally by commissioning bodies based on best practice guidelines provided by bodies such as NICE. They provide a set of standards to drive towards and reward if met. When CQUINs were introduced, they were worth 2.5% of the provider contract; in the guidance for 2020/21, they were due to contribute 1.25%. (CQUIN requirements are suspended until the 2021/22 financial year due to the Coronavirus pandemic.)

GP's are incentivised by payments under the Quality and Outcome Framework (QOF), which provide additional funding for meeting specific targets. The GP targets are fully available online⁹ and aim to drive quality care focused around guidelines published by institutions such as NICE. Each point is worth currently £194.84 to the GPs, and there are currently 567 available points¹⁰. The QOF criteria are frequently changed with the expectation that established practices continue despite the funding cessation.

Best practice tariffs are usually a proportion of the budget, which is considered a reward for meeting specific criteria in a particular pathway of care (often as a package), i.e. Trauma Care. These standards are seen to define quality care. All these additional funding mechanisms aim to reward quality care; however, at times, it can be interpreted as a penalty if they are not achieved.

Advantages:

- Encourages quality improvement
- Ability for NHS England and CCGs to target specific areas for improvement

Disadvantages:

- Budgets are often calculated on the assumption that CQUIN payment will be received, can be seen as a penalty if not achieved
- CQUINs change every 1-2 years, and providers will need to invest each year to obtain CQUIN payment, whilst often also funding the ongoing costs from previous CQUINs

FEE FOR PERFORMANCE AIMS TO REWARD QUALITY CARE, WHEREAS FEE FOR SERVICE MAKES PAYMENTS BASED ON THE QUANTITY OF ACTIVITY UNDERTAKEN

FEE FOR SERVICE:

Providers are paid retrospectively per unit of activity undertaken.

This is rarely used in the NHS but is widely used within other healthcare systems. This depends on an accurate patient-level costing system and supportive infrastructure to detail costs for each treatment for each individual.

Advantages:

- Providers are paid for all treatment they choose to provide
- Supports quality and comprehensive care as the provider has no incentive to withhold or skimp on care
- Once new treatments and technologies are on the reimbursement list can be rapidly rolled out as they are paid for

Disadvantages:

- Difficult to financially control and plan for
- No incentive for efficiency
- Commissioners pay for increasing costs
- No incentive for prevention or collaboration
- Costly to implement and administer

PATHWAYS OF CARES:

A calculated fee is paid per person based on the anticipated cost of providing care across a pathway for a particular condition.

This was implemented to recognize organizational interdependence and the benefits of system-wide improvement. This was used within the maternity setting, with the lead organization spreading the funding across the involved bodies at their discretion. It is currently being suggested for some elective pathways such as hip replacement, encouraging interdependence of care across the system.

Advantages:

- Recognizes interdependence of care across Community and secondary services
- Paid in advance so predictable rather than outcome dependent

Disadvantages:

- Payments were stratified by how resource heavy the anticipated care (rather than actual care) was. Underpayment was common as when complications or unanticipated complexities were encountered this was more resource intensive than initially anticipated. The healthcare provider bears this cost.

MIXED MECHANISM SYSTEMS:

Mixed mechanism systems have the potential to more carefully craft a payment model to make the most effective and efficient use of resources by adapting the contracts to certain aims. It can focus commissioners and providers towards system-wide action to reduce growth in activity by adapting the elements of fixed and variable payments. Most mixed mechanism systems are comprised of a fixed payment (based on a block or capitated approach) and variable payment (based on a unit of activity or performance fees). The choice of these elements should consider the objectives of the blended payment and make a judgement about feasibility.

Included in this mechanism is an element of risk-sharing across the commissioner and service provider or integrated care network. With traditional block contracts, the risk is mainly held within the CCG as the payment is given to the service provider irrespective of activity and outcomes. In contrast, in traditional payment by activity, this risk is held primarily with the individual trusts. Mixed contracts, whereby elements of fixed and variable payments are incorporated, allow sharing of both financial and activity risk. Terms are agreed so that if activity levels are above or below expected, the changes in payments are pre-agreed to limit the excessive risk to one party. Risk-sharing mechanisms have the potential to encourage partners to work collaboratively across organisational boundaries and to collectively manage risk across the system. Mixed payment systems and appropriate risk-sharing models should align financial incentives to support each system's healthcare goals and aims. As noted previously, the Integrated care systems are champions of the mixed contract as this drives the integration of services by complex financial arrangements across primary and secondary care. This is likely to represent the short to medium term future of healthcare financing.

GP FUNDING:

GP contracts are another example of a mixed mechanisms contract consisting mainly of a capitation style based on the geographical or population area of the practice. Although there are three types of GP contract arrangements in use, the General Medical Services (GMS), Personal Medical Services (PMS), and Alternative Provider Medical Services (APMS), a similar payment system is in use. The GMS is negotiated each year nationally and approximately 70% of GP practices use this model. In contrast, the PMS contract is negotiated locally to offer flexibility and is being phased out of use. GMS and PMS contracts are awarded to individual GPs. The APMS contract allows fixed-term contracts to be awarded to organizations to provide primary care. Initially, contracts were for 5-10 years, but more recently, more extended contracts up to 15 years have been awarded.

The global sum payment for each practice is based on a weighted sum for each registered patient. The 'Carr-Hill formula' is used to weight funding according to variables including age and gender, residential/nursing home residence, and rurality. For 2020-2021 this equates to a figure of £93.46 per patient.¹¹ This payment forms the bulk of the GMS contract and is for the provision of essential services. The contract also includes expected standards and key policies.

Further optional agreements for enhanced services in return for additional payment are negotiated, including out of hours services (most practices opt-out), additional services such as cervical screening and minor ops, nationally agreed enhanced services (e.g. vaccination programs), and locally commissioned services to target local issues such as rough sleeping or mental health. The funding is a complex mix of these different incomes with additional funding for performance (QOF payments) and some private services such as sick certifications and travel prescribing. GPs are also reimbursed for premise costs (lease and mortgage payments) and receive other income from training and some organisational costs (primary care organisation administered payments) for locum allowances and appraisal costs. What is not spent on items such as staff costs, consumables, maintenance, buildings, and infrastructure is received as income.

Primary care networks form a vital part of the NHS long term plan with the concept of increasing integration of general practices and community services within a local geographical footprint. Since 2019 approximately 1,300 geographical networks have been established by financially incentivizing networking to provide additional services. This is with the expectation that these networks will provide a broader range of primary care services to patients. These networks are considered the building blocks for the integrated care system. The current funding for networks comes from directed enhanced services (an optional extension of the core GP contract). Although this contract is between the commissioner and individual practices, the money is received through a single bank account directed by the network.¹²

BLENDED PAYMENT (ONE TYPE OF MIXED MECHANISM CONTRACTS):

Complex contracts with elements of block contracts, payment by results and performance-based approach.

This is now the payment method for all acute care and is mandated in maternity from the next financial year (2021/22). This contract is negotiated every year and based on previous predictions of activity and performance. It is a mixture of block, activity, performance premiums with sharing of risk,

and encouraging collaboration across trusts. This links with the development of integrated healthcare systems as it facilitates complex payments involving multiple organizations through contracts. There is an increasing focus on outcomes-based commissions, whereby an increased proportion of the blended contract is related to the performance or 'best practice tariffs'.

Advantages:

- Can be tailored to need or emphasis
- Can be highly responsive

Disadvantages:

- Complex and costly to administer
- Can change year on year
- Dependent on accurate budget and forecasting data

METRICS AND FINES:

While there is a relationship between activity and payment, all the models of contracts mentioned are subject to constant metric evaluation and open to commissioner fines for missing targets or performance. Some examples of this are the new patient to follow up ratio in outpatients, Planned Procedures with a Threshold (PPWT) / PULCE (Procedure of Limited clinical effectiveness), the ratio of day-case to outpatient activity, and excess bed days. These provide a metric as a stick to complement the carrot of best practice tariffs to limit system abuse and drive quality

LOOKING FORWARD:

Looking forward, the opportunity to reflect on the next step in the evolution of the NHS financial structure is welcome. Eight principles for future NHS payment systems have been suggested.⁴

1. Clear purpose
2. Realistic expectations about impact
3. National consistency with local flexibility
4. Appropriate, aligned incentives
5. High-quality data
6. Balance between the complexity of design and ease of use
7. Independent oversight and support
8. Time to embed and evaluate systems

Other changes have been suggested¹³ in a recent paper on pay reform proposals with an update to the now 10-year-old Market Forces Factor calculations, increasing focus on patient-level costing and blended contracts as well as encouraging the integration of services through financial models.

CONCLUSION:

Payment systems within the NHS are complicated and variable in their usefulness achieving variable results. Payment by results has achieved a drive for productivity; however, it may not be suitable for the current demands of the NHS. Blended payment contracts across the integrated system are being established, providing the tailored detail and targeted approach to drive performance and desired outcomes. Patient-level costing is integral to provide high-quality data to base the contract negotiations on to ensure sustainability, flexibility, and appropriate incentivisation.

KEY WORDS:

Finance, Clinical, Payment systems, Tariff, Blended contracts, Payment by Results, Capitation, Block Contract.

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