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Improving health care through payment by results

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Improving health care through Payment by Results


Summary
Nursing faces new opportunities and challenges as part of the government’s initiative to introduce Payment by Results. These opportunities arise from increasing demands to work effectively in an environment of intensive customer demand and expectation. The challenge for all nurses is to continue to deliver quality health care while keeping pace with changes to services and organisational responsiveness. It is important that nurses and other health professionals ensure that the needs of patients are not compromised in the pursuit of financial reward and that systems of work are improved as part of this initiative.

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RECENT CHANGES to the financial structure of the NHS following the introduction of Payment by Results (PbR) will affect the measurement and funding of care delivery. This is part of wider public sector reform that seeks to promote greater accountability at a local level in the NHS. Instead of being commissioned through block agreements, hospitals and other healthcare providers will be paid for the activity they undertake on a case-by-case basis in line with a national tariff (Department of Health (DH) 2006a). The tariff is currently based on the average cost of inflation, changes in technology and clinical practice and assumptions about local efficiency gains (DH 2002a).

The aim of introducing the tariff is to provide a transparent, rules-based system for trusts. More importantly it seeks to ensure a fair and consistent basis for funding rather than reliance on historic budgets and the negotiating skills of individual managers. The price is the same for all, procedures will attract the same tariff irrespective of who performs them, which should ensure that purchasers focus on quality not cost. In this way the government aims to stimulate productivity and promote patient choice and plurality of provision (Audit Commission 2005).

Commissioning services
This new way of commissioning services can be traced back to the mid-1980s when trusts became more accountable for the services they delivered and district health authorities became responsible for commissioning and monitoring contracts.

In 1990 the Audit Commission was given responsibility for external evaluation of the NHS in England and Wales, examining financial accounts and use of resources for economy, efficacy and effectiveness. In the same year Total Quality Management, a process-orientated approach successful in Japanese and United States industry, was also introduced. As a consequence, nurses were asked to measure their performance and that of the organisation by completing forms.

In subsequent years hospital league tables were introduced and trusts were required to publish quantitative performance measures. The situation began to spiral out of control as concerns grew over waiting times in accident and emergency departments, bed shortages in acute care and the inadequacy of community service provision, and trusts struggled to maintain financial viability while meeting government targets.

In 1997 the Labour government was elected and pledged to 'save the NHS'. Almost immediately the white paper, The New NHS: Modern, Dependable was published (DH 1997). This outlined the replacement of the internal market with 'integrated care', sensitive to local need, with an emphasis on quality and efficacy of services.

Clinical governance embodied this new way of thinking by integrating quality and efficiency. A series of initiatives were launched in quick succession throughout 1999, including the
document Saving Lives: Our Healthier Nation (DH 1999), which emphasised social causes of ill health and the need for a coherent approach to address health inequalities. Common to all these initiatives is the need for clear national standards for services and treatments.

Successful transition to PbR should focus on maintaining good practice while seeking to develop new ways to deliver care in collaboration with stakeholders. In the past, cost-effectiveness has been linked to lowering standards or intensification of workloads, creating unease for nurses. Principles of good clinical governance will continue to apply under PbR (DH 2002b), and this should be evident through the implementation of clinical guidelines consistent with evidence-based practice, where appropriate.

While PbR could encourage providers to use all their capacity it could also tempt them to focus on areas with greatest profit margins, for example, by avoiding complex, low volume or expensive procedures or treating patients with no co-morbidities. This may lead to patient selection and lower quality but, conversely, the appearance of greater efficiency. There are some counter measures in PbR to restrict providers from pursuing such action (Sussex 2006):

- Lower quality – restrained by clinical governance, good performance management, patient voice and practice-based commissioning.
- Patient selection – restrained by practice-based commissioning and patient choice.

Managing demand

Any increase in productivity will need to be managed in a way that is sensitive to local needs and responsive to changes imposed by government. Primary care trusts (PCTs) will commission services in partnership with general practice and local government. They will also need to engage with providers to ensure that the immediate healthcare needs of the local population are met, while planning for the future.

It is good practice for commissioners and providers to specify trigger points in the monitoring of activity as part of a strategy for managing demand and capacity. Where activity levels exceed these trigger points, commissioners and providers should work together to identify the causes of excess demand and revise their forecasts accordingly (DH 2006b). Where activity levels exceed these trigger points, commissioners and providers should work together to prioritise patients on the basis of clinical need. This may include changes to referral and treatment protocols to ensure that limited resources are targeted effectively. However, it should not extend to withholding payment for activity that has been delivered.

Initially, there will be much risk for PCTs, which will be committed to pay for all work done at full cost but with uncertain demand. Accurate forecasting and monitoring of demand will be critical to maintaining financial stability. Costs will need to be kept within tariff income and expenditure carefully monitored. Forecasting income accurately will be important and those trusts that incur costs above the national tariff will need rigorous cost improvement programmes. In theory, imposing a standard tariff will encourage high-cost providers to leave the market and presumes low-cost providers will seize the opportunity to offer more to compensate. However, there is no guarantee that this will happen. Trusts may not adopt this option if it will damage the local health economy and does not fit in with their strategic plan or costing, although they will have to justify any deviation based on local need.

Data accuracy

The success of PbR at a local and national level relies on the collection of accurate data. Patient activity needs to be properly recorded to ensure that PCTs are charged fairly for the work done and that income is not lost. Performance information and monitoring are vital for effective management of local services, while allowing national priorities to be set. Information is also needed for regulation, quality assurance, education and training and health research. The aim should be to deliver the information and knowledge vital to health and social care to assist service delivery, while reducing the burden of data collection on local organisations, trusts and councils responsible for social services. However, the proposed systems to support PbR have not only been delayed but have also incurred significant financial cost (Audit Commission 2005). Much of their development has been focused on data collection and financial regulation, with little emphasis on the needs of staff.

Perhaps more significant is the concern expressed by commissioners and providers of services about the accuracy of tariff prices, because the information on which these figures is based can be two years old. This should improve with time as clinical dialogue and collaboration between PCTs and providers becomes more cogent and clinical data reflect the activity undertaken more accurately.
There is evidence that acute hospitals are responding to the tariff-based funding system by increasing their levels of inpatient activity and then demanding extra payment by coding patient care in such a way that it appears that they have had treatment in advance of what they might actually receive (Audit Commission 2005). In some ways this is a reasonable response to the financial prompts of the new funding system, which are often reinforced by government targets that attract greater financial reward. In a cash-limited system this reduces the resources available to other parts of the NHS. Similarly, some PCTs are being forced to limit their funding for non-acute care in readiness for the new system. In addition, the boundaries between primary and secondary care are not rigid. This is particularly true of care arrangements for paediatrics for paediatric patients and older patients and those with mental health problems. With acute hospitals being driven to make efficiency savings, primary care may be required to provide more services but without a transfer of funding.

PbR is not the all-encompassing system it is claimed to be. The programme covers England only, does not cater for those services allied to health such as opticians and dentists and those who provide health care on a private basis, and it is concerned mainly with inpatient services. The increasing complexity of modern medicine and health services means that commissioning has to become more sophisticated to meet patients’ needs. An example of this is the need to commission along the whole care pathway in mental health networks, which span primary, multiple secondary providers, tertiary providers and voluntary sector provision. Cross-border, for example, between England and Scotland, and cross-sector (between the NHS and the private sector) activity will need to be accurately measured and provided for. One of the main reasons for introducing PbR was to encourage independent sector providers who required reasonable confidence about what they might be able to earn before they would commit to long-term investment (Chartered Society of Physiotherapy 2005).

**Effects on clinical care**

The introduction of PbR has changed the way in which services are provided and the way in which care is delivered and measured. Much will be expected of clinical nurses in response to these changes as they take on additional tasks, not all of which will appear relevant to their practice (Clarke et al 2004). Managers need to inform employees that the changes will have beneficial results and that the collection of data for use in contracting has positive effects on practice and patient care.

The value of nursing and the work nurses undertake needs to be recognised and incorporated in any payment scheme otherwise there is a danger that we will undersell ourselves and the profession. Nurses are fundamental to the care giving process and are best placed to articulate the needs of those they care for; if nurses do not get involved in the commissioning process there is concern that the nursing agenda will be set by medical staff or trust managers. This may determine whether the nursing profession experiences the benefits or the disadvantages of PbR (Limmerick et al 2002).

Under PbR purchasers and commissioners will be able to retain and invest surpluses and savings to improve care. It is essential that nurses focus on this and play an active part in setting targets for service modernisation (Palmer 2005). Nurses need to highlight future service needs. Trusts will bear the brunt of insolvency, perhaps the most significant disadvantage of the scheme. PbR is associated with freedom and risks similar to those in a corporate culture. In this environment career progression – and even maintaining a job – will require ongoing learning and development of the highest quality specialised skills (Drucker 1994). Female staff, who often sacrifice learning opportunities to take on family or caring roles, may be disadvantaged, and their career progression interrupted. Others may experience a lack of career progression because fewer senior posts are being filled and some may find that because they have been doing the same job for so long it becomes dull or repetitive (Bardwick 1986).

**Advantages and disadvantages**

Strong leadership is required to introduce the efficiencies required under PbR, and the depth of change required by this programme will make teaching and stewardship difficult. Additionally, while the mission of providing quality care is shared throughout good health organisations, the disparity between the values of clinical nurses and managerial fiscal responsibility is a potential area for conflict. NHS trusts which have financial difficulties have downsized with job cuts and fewer opportunities for graduates. Free market responses of this kind create uncertainty and feelings of apprehension in a nursing workforce that is already feeling undervalued (BBC News Online 2006).

Conversely, free market forces could provide nurses with increased job choices and security. Under PbR non-NHS institutions offering
services of equal quality can bear the NHS logo and this will increase employment opportunities for nurses. The authors’ forecast a mobile workforce where traditional concepts of career development are challenged.

Where previously a NHS job was often viewed as a mutual lifelong commitment, the future will involve staff moving within a wider health employment market. However, given that patients will largely judge the quality of the service received on the nursing care provided, it is in the best interests of trusts to offer incentives to encourage good quality staff to stay.

Ours is a knowledge society and with knowledge and skills come the opportunity to advance (Drucker 1994). We need to refocus our thinking away from skills and knowledge based on training alone to individual nurses becoming collaborative leaders skilled in factors such as organisational development, change management, evidence-based knowledge transfer and skills development. Perhaps the main advantage in introducing PbR will be the need to address these wider training issues for the benefit of nurses and patients and hence the organisation. PbR will place nurse training in a commercial framework, thereby moving it into a more accountable and valued position in the organisational structure. Consequently, by addressing the economic advantages of more highly trained and educated nurses, PbR will have positive influences on the social and cultural aspects of the nursing profession (National Board of Employment, Education and Training 1994).

**Conclusion**

Nurses should be aware that they have a responsibility to respond to PbR. Successful implementation of any change in practice will require relevant professionals to change their behaviour. The strategies required to develop an adequate workforce response to these changes extend well beyond the narrow tradition of training.

While it is too early to reach any conclusions, there is little evidence that the new incentives have made the NHS more efficient or cost-effective. Initially, the focus will be on accurate and robust coding and data collection.

The issue of not only maintaining but also improving health quality through PbR remains a priority. Nurses need to become proactive in embracing these changes while ensuring the needs of patients are met. Clinical nurses should adopt a corporate mentality to safeguard the needs of the profession and to promote their careers by embracing the opportunities inherent in PbR NS

**References**


