THE UNIVERSITY of York

PRESS RELEASE

CHE
Centre For Health Economics

18 July 2006

The administrative costs of payment by results

The NHS in England is following the USA, Australia and many countries in Europe in introducing a system of paying hospitals and other providers on the basis of the work they do. Providers receive a fixed payment – the national tariff – for each type of patient treated. Termed "Payment by Results" (PbR), the policy rewards providers for volumes of work adjusted for differences in patient characteristics.

In a study commissioned by the Department of Health, we interviewed staff in hospital trusts and primary care trusts to determine the increase in administrative costs associated with PbR. Costs were estimated to have increased by around £100k-£180k in hospital trusts and from £90k to £190k in Primary Care Trusts (PCTs). Most of the additional expenditure is due to recruitment of additional staff.

But this has brought benefits, and there was consensus among all those interviewed that the PbR system was preferable to previous contracting arrangements, partly because PbR had sharpened incentives and introduced greater clarity into the contracting process. In addition, interviewees indicated that PbR had led to improvements in the process of care delivery, by enabling resources to be shifted across settings, because of the improved specificity of information, and by highlighting where service improvements might be made.

The increase in administrative costs is to be anticipated. Although the move to PbR has entailed a reduction in some types of administrative costs, notably price negotiation, this is more than offset by increased expenditure on other things. The main cost driver has been the increased information demands of moving to a patient-based payment system.

The main changes in administrative costs are:

- higher costs of *negotiation*. While there are lower costs in negotiating prices and volumes, this is offset by difficulties PCTs have in managing activity levels, because Trusts no longer have to get approval to expand their activity, thus making it more difficult for PCTs to live within their budgets.

- higher costs of *data collection*, due to PbR's requirement for accurate patient-level data. Some of these costs are down to IT investment, but many are driven by organisations taking on staff to ensure better extraction of data directly from case notes rather than summary forms.

- higher *monitoring* costs, because the financial consequences of changes in activity are more significant and because PCTs need to verify that the type of activity – particularly the HRG allocation – is accurate.

- higher *enforcement* costs, with the sharper relationship between activity and income/expenditure increasing the potential for more disputes between Trusts and PCTs

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