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HELPING DECISION MAKERS PUT HEALTH POLICY INTO PRACTICE

This issue

Demand management and administrative costs under payment by results

Introduction

Hospitals providing care to NHS patients are receiving an increasing proportion of their income under "Payment by Results" (PbR), whereby providers are rewarded for volumes of work adjusted for differences in the type of patients they treat. The key differences to previous contracting arrangements are that prices are fixed nationally, hospital income is related to activity, and activity ceilings have been removed. After initially applying to a handful of elective services, the national tariff is being extended to most elective and non elective activity across a broad range of specialities in all NHS hospitals in England. By 2008 it is intended that 90 per cent of inpatient, day case and outpatient activity will be paid in this way.[1] Planning is also in train to extend PbR to mental health services, ambulances, community services and long-term conditions.

PbR should stimulate improved NHS performance. Facing a fixed payment – the national tariff – hospitals have an incentive to cut costs and reduce length of stay in order to free up capacity to accommodate more patients. Access should improve because hospitals have a direct financial incentive to do more work: they receive extra funds for each additional patient treated. And PCTs have the means to divert activity from hospitals because they can spend the tariff on primary and community care.

But two concerns were raised about PbR early in its implementation. First, the incentives for hospitals to do more work may be too strong, the danger being that patients who would be better treated in the community are "sucked into" hospitals.[2] To resist this, Primary Care Trusts must manage demand appropriately and effectively if they are to live within their global budgets.

Second, the Audit Commission reported that PbR might increase administrative costs[3], despite the government claiming that it would decrease the costs associated with price negotiation.[4] The shift to a patient-based payment system has introduced other costs into the contracting process, most notably because payments are driven by the Healthcare Resource Group to which each patient is allocated.

In this paper we summarise the findings from two interview-based studies that looked at each of these issues in turn.[5, 6] Details of the studies are provided in box 1.

Box 1

	Demand management study	Administrative cost study
Setting	South Yorkshire	South Yorkshire and London
Organisations	PCTs, Trusts, SHA, GPs	PCTs and Trusts
Number of interviewees	18	12
Interview dates	Aug-Oct 2005	Jan-Mar 2006

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Demand management study

PCTs are charged with commissioning care for their resident population and living within centrally determined budgets. It is now more difficult for PCTs to ensure that expenditure equates to their budget allocations. This arises for two reasons. First, under PbR they are unable to negotiate lower prices, having to pay the set national tariff for additional work. Second, they have less control over volume, with Choose and Book allowing patients greater choice about where and when they are treated.[7] This makes it difficult to specify volumes in advance with their contractual partners.

Under such circumstances, PCTs need to manage demand so as to ensure that their budget allocations are not exceeded. To be effective, PCTs will need to focus demand management on:

- GPs, who influence the level of demand by virtue of their treatment and referral decisions;
- and providers, particularly hospital consultants, who influence the extent to which demand is converted into activity by their admission and treatment decisions.

In 2005/06 the South Yorkshire health economy was one of only two areas in the country operating the full PbR regime. As such South Yorkshire can provide early lessons about the financial and behavioural impact of PbR.[8]

We found that no single set of strategies was in place in South Yorkshire to deal specifically with the potential problem of managing activity and expenditure. Instead, various strategies were highlighted as having a role in managing demand. This "patchwork" of initiatives appears to be more a reflection of each locality's situation, rather than a strategic response to an emerging problem.

Influencing GP behaviour

The approaches to influencing GP referral behaviour could be grouped under three headings:

- better collection, monitoring and review of "real-time" information;
- improved patient management;
- and development of Practice Based Commissioning (PBC).

Information provision: All PCTs in the region were attempting to collect, analyse and share information on activity and referral rates of individual practices and GPs. But we heard reports that many practices and PCTs fail to use the data routinely, lack the technical skills to interrogate these data or are defensive when identified as having above-average referral rates. That said, there were also signs that foundations were being laid that would facilitate future engagement.

The extent to which an "information strategy" can challenge and change behaviour is conditional upon at least three factors: the analytical capabilities of the PCT; the extent to which activity and referral information support performance management arrangements between the PCT and GPs; and the willingness of GPs to change their behaviour in response to the information they receive.

"If you are sitting in a PCT there's an analysis tool you could call up that allows you to look at a speciality activity for adults or children, and it gives you a range of graphs and tables that pick out the monthly activity over the last 2 years ... You can see what has happened to the patient queue, long waits, total queue etc. It's pretty real time. It's available for PCTs to look at and in theory there could be some proactive monitoring of demand going on at that level. [But] I am pretty sure it isn't." [PCT]

"As a GP I need to know what I am spending, what my referral patterns are, whether they are inside or outside the average. I'd just like to know that in order to concentrate my views on how I would commission services differently." [GP]

Patient management: We identified a variety of different models being developed in South Yorkshire to promote and enhance

primary care as an alternative to hospital admission. These include chronic disease management; a range of intermediate care services (e.g. community intervention teams); and risk-based targeted attention to specific groups of patients, for example those who make frequent use of local hospital services ("frequent flyers"). Many such initiatives pre-dated PbR, but PbR was facilitating their development because funds were being released from the hospital sector at average rather than marginal cost if hospital admission was avoided.

Practice Based Comissioning: PBC was viewed locally as the main tool that could be developed in the future to encourage GPs to consider the financial implications of their clinical decisions and to manage demand effectively. From April 2005 practices have been able to receive an "indicative budget" and take on responsibility from their PCT for commissioning services for their patients.

However, there remain serious reservations over the expansion of PBC:

- the incentives are not thought to be sufficiently high powered for GPs to take responsibility for their PBC budget
- GPs are not motivated to embrace PBC because their attention is focussed on adjusting to the new GP contract and the Quality and Outcomes Framework
- a belief that additional resources are required at the practice and locality level to fund the additional administrative burden.

"I think it [PBC] will have a limited effect in this area … because practices just aren't motivated at the moment…They've seen a huge change with the GMS contract and the Quality and Outcomes Framework and they have received big increases in income from it. They now want to bed all that down and interest in PBC is quite limited." [PCT]

"I think unless it [PBC] has incentives, then it won't work. GPs view it with some scepticism and unless there are resources put upfront to allow it to happen then GPs will not have enough time to make it work effectively." [PCT]

Influencing provider behaviour

Service substitution: A number of initiatives have developed in South Yorkshire to substitute for hospital-based care. These initiatives include GPs with Special Interests (GPwSIs), Walk in Centres, and NHS Direct. Their effectiveness as substitute services in South Yorkshire is in doubt, however, principally because much of their workload appears to stem from awakening of previously dormant demand, as has been found in other studies.[9]

Preventing admission: Under PbR, PCTs have a very strong incentive to prevent admission, because they retain the full national tariff.

"It's a mixed bag with GPwSIs. In dermatology there are something like 3 or 4 GPwSIs established locally, but we've actually seen a massive increase in dermatology referrals over the last year. What seems to be happening is that, because there is a GPwSI, GPs are sending more patients to them, but they have limited experience and if they have anything they are not sure of they are sending them to hospital." [PCT]

Some of the PCTs in the case study had developed systems to assess whether admission is appropriate and, if not, to direct patients to alternative providers. An example is to have GPs working in A&E departments, who act as a first point of contact with patients. A pilot scheme in one Foundation trust used GPs who work for the Out of Hours service to provide a primary care medical assessment of patients who present in A&E and do not require secondary care intervention. But in the pilot most of the patients selected by GPs were patients with fairly minor complaints (patients walking into A&E) which calls into question whether this is as cost-effective as it might be.

Facilitating discharge: We found examples of GPs and PCTs working closely with hospitals to facilitate earlier discharge to more appropriate settings (e.g. step-down beds; discharge liaison teams). While under PbR the financial incentives

associated with preventing admissions are obvious, they are not so clear cut with respect to better discharge planning, except with respect to individuals at risk of staying in hospital beyond the payment trimpoint, after which they attract additional per diem payments. However, for other patients, some form of cost sharing agreement or arrangement about how to "unbundle" the patient pathway is required between PCTs and hospitals in recognition of the changing boundary of responsibility. Some interviewees indicated that co-operative working between PCTs and hospitals is being discouraged by the current structure of the tariff.

"There is a view, rightly or wrongly, that we admit far too readily. That's disputed but it's very clear that at a point in time the patients in hospital don't really need to be there, and that's been validated numerous times now, which creates the view that we bring patients in inappropriately. I think the agreed position is that we admit people appropriately but we keep them inappropriately." [Trust]

Administrative costs study

In contractual terms, the main change of PbR is the shift from a system in which volumes and prices are agreed locally to a system in which hospitals are paid a fixed national price according to the number of patients they treat.

This system of patient-based payments can be expected to change contracting costs for both hospitals and PCTs. The net effect on administrative costs depends on whether reduced effort spent on negotiating prices and volumes is offset by greater attention to other aspects of the contracting process.

We interviewed staff in hospital trusts and PCTs in London and South Yorkshire to determine the changes in administrative costs associated with PbR and to identify the main drivers of these changes.

Hospitals estimated that their costs had increased by around £100k-£180k, PCTs from £90k to £190k. Cost increases are driven by increases in staffing, with appointments to junior or mid-level posts usually in the information/coding and finance departments. Given that most of the additional expenditure is on staff, the increase in costs is unlikely to be transitory. A summary of the cost drivers is provided in the box.

Negotiation costs

While PbR has made the relationship between hospitals and PCTs more "business-like", more effort is now involved in reaching agreement about the volume and nature of activity. PCTs spoke of the problems associated with the providers not having to gain approval before increasing their activity while trusts offered a different perspective on the nature of the "problem", suggesting that it stemmed from a failure by PCTs either to accurately predict demand requirements or to put effective measures in

Cost drivers

The main changes in administrative costs arise from:

- 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 most is 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.

place to manage demand in other ways.

"At the moment under PbR [Trusts are] not required to give any indication of what they think they will do. Hence the issues that have gone on about people racing through the waiting lists to generate more activity and income, and then PCTs saying they don't want you to do that … So you've got those sorts of tensions in the system." [PCT]

"So they [the PCTs] were planning for significantly less than what happened and significantly less than what they ended up paying for. They always say we over-performed but we are adamant that it was them who under-estimated … PCTs tend to try to blame PbR for that. But I don't think that is fair: I think it was just the PCTs under-commissioning." [Trust]

Monitoring costs

PbR relies on accurate patient-level data. This has increased the costs of data collection for Trusts and the costs of data verification for PCTs.

Data collection: Two aspects of the data collection process appear to have improved as a result of PbR: the timeliness of coding; and coding accuracy. Hospitals have adopted four complementary strategies to improve data collection:

- Greater engagement with clinicians to ensure accurate recording of the primary data in the case notes;
- Recruitment of extra medical records staff and improvement of their training and terms and conditions;
- Move toward coding directly from case notes rather than summary discharge forms, which is costly because it necessitates a process of getting the notes from the wards to the coding department, but the quality of electronically coded information is likely to be better;
- Investment in upgrading the information system.

"More attention is paid to coding at general management meetings: coding is now on the agenda every week." [Trust]

"Missing data queries have been reduced as a result of PbR. And we have got more accurate information; we have tightened up the processes for where we have got missing data." [Trust]

"Clinicians are now interested in detailing their records more thoroughly rather than just for their own auditing purposes. So we are getting a full case mix and we are getting a richer case mix and we have done some training sessions with the directorates. But we are also planning to train junior doctors and SHOs as well." [Trust]

Data verification: PCTs need to verify the activity data they receive in two ways:

- to ensure that each unit of activity is appropriately allocated to the correct payment (HRG) category; and
- to ensure that the PCT can afford the amount of activity being undertaken.

Hospitals have incentives to "up-code" their activity in order to gain higher payment rates. There is evidence from other countries of providers engaging in "up-coding", extreme forms of which may involve falsifying procedural information or by recording complications that may not have been present.[10-12] The HRG coding process opens up the opportunity for gaming, because PCTs do not have access to the primary information source (the case notes) from which the electronic data have been extracted. The lack of access to the primary source makes it difficult for PCTs to verify that HRG allocations are appropriate. Much effort by PCTs is directed at validating the claims made by providers and this has led to an increase

"We report a lot more about our contractual relationships with individual providers than we did. There's quite a large section in the commissioning director's report that deals with all our major hospital contracts, and clearly that has been driven by PbR really. What wasn't volatile is now potentially volatile." [PCT]

"There is less certainty in the numbers when we do the monthly accounts than there would have been previously, because it is harder to predict what is going on with activity and changes in activities have a more direct relationship with costs." [PCT]

in the number of queries between PCTs and hospitals. Arrangements are being put in place for national auditing of coding practice.[13]

Enforcement costs

PCTs felt that some aspects of the current arrangements have weakened their bargaining position:

- Volume controls are not enforceable now that patients are able to exercise choice of hospital.
- PCTs have limited ability to impose (financial or other) penalties.

"[When a trust doesn't give us the information we need] we firstly negotiate with them and try to encourage them to improve [the data/information exchange process]. The difficulty is that, certainly, with the foundation trust contract there are no penalties in there for information data quality issues. As long as the trust produces the information in however many days it is, we struggle to withhold money from them. The contract doesn't really feel that tight from a PCT point of view. Basically the trust doesn't have the incentive of the possibility of losing money if they don't." [PCT]

"I think it took about two months to work through all those [over-performance claims] and we agreed the position with individual trusts over time but we didn't necessarily agree with what they were initially saying we should pay." [PCT]

- Externally imposed conditions on the negotiating timetable put hospitals at an advantage.

Benefits of PbR

Although PbR is associated with a net effect increase in administrative costs this has brought benefits, and there was consensus among all those interviewed that the PbR system was preferable to previous contracting arrangements, 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 and, because of the improved specificity of information, by highlighting where service improvements might be made.

The benefits derive from three sequential stages:

1. PbR has enhanced the amount and accuracy of information in the system;
2. This has led to a better understanding of what is happening to the local population and identification of where changes might be made;
3. Coupled with the financial ability that PCTs have to shift money across sectors at full average cost, this has led to changes in the provision of services and better resource allocation.

"If you'd tried to move activities previously you'd never have been able to do it at anything less than marginal cost ... [Under PbR] we have probably shifted well over £1million of foot surgery out of hospital and ... quite a lot of dermatology as well ... We've seen things move at a tariff cost ... and that is a real benefit for us - to squeeze our resources further and get better value for money for patient care." [PCT]

"The benefits locally have been quite significant. We have been able to introduce some demand management issues around non-elective care because we've got pre-admission screening, triage teams and diversion teams in place. That's been quite effective." [PCT]

Future challenges for policy and research

These findings highlight a number of key policy issues that need to be addressed as PbR is rolled out nationally as well as several important gaps in knowledge that are in need of further research.

i) Managing demand

The structure of tariffs under Payment by Results provides high powered incentives for providers to increase activity because:

- they are rewarded for hospital activity, not for co-operating in service re-configuration.

- payments for increases in activity are made at full average cost.

Although activity increases are desirable, they also need to be affordable and appropriate.

PBC is viewed as the key future demand management tool, but the effectiveness of PBC depends on how budgets are determined and the incentives GPs have to live within their budgets and to work together to manage care effectively. There are concerns that PBC will need to be supplemented by other demand management strategies, such as utilisation review and referral management centres.[2] However, there is little information on the relative effectiveness of these strategies. The challenge, therefore, is to identify "best practice" and share this more generally.

Rather than placing all the onus on PCTs and GPs to exercise expenditure control, consideration should be given to refining the incentive structure underpinning PbR. This might involve the imposition of activity thresholds, the introduction of two-part tariffs, and tariff-setting on a basis other than average reference costs.

ii) Managing administrative costs

Administrative costs are likely to increase as PbR is extended to other services. The main cost driver has been the increased informational specificity required of moving to a patient-based payment system. Providers need to focus attention on both their coding and costing activities, particularly to ensure that patients are allocated accurately to their appropriate HRG. PCTs need to put increased effort into ensuring that the volume and type of activity that is being undertaken by their providers is counted and coded accurately, and that volumes are affordable.

NHS trusts need both to improve their costing systems and also to make better use of resource data that they might already collect on a routine basis. For this to happen, trusts needs to forge closer integration between information and finance departments. In addition, the DoH needs to be more prescriptive in its requirements. There is currently too much scope for trusts to interpret activity and costing requirements differently, which then impacts on the overall usefulness of reference costs as a means for deriving tariffs.

PbR has increased the scope for disagreement between trusts and PCTs over contractual matters, if only because the financial implications are much greater than they used to be. PCTs face difficulties in controlling volumes, particularly when trusts have waiting lists and with the introduction of Choose and Book. Active engagement by GPs in Practice Based Commissioning may alleviate matters, but more attention needs to be given to demand management mechanisms in general. The merging of PCTs might help, especially if there are economies of scale involved in commissioning for larger populations.

PCTs also have problems in verifying the information they receive from trusts. PbR introduces incentives for gaming of information and, rather than placing the onus on PCTs to validate claims, greater centralisation of the auditing function might be considered.

iii) Documenting the effects of PbR

Many interviewees were positive about PbR and some cited specific examples of how PbR had enabled them to engineer changes in services. However, there is a danger that PbR could induce negative responses – such as increases in unplanned readmissions to hospital. In future, as PbR is extended, it will be important to monitor its effects and to continually refine the policy in order to stimulate appropriate behavioural responses.

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