Case study

England

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Contents

Abstract

The current English National Health Service payment system has evolved greatly over the last decade and employs a mix of different payment methods across different services and sectors. The predominance of activity-based payment in the acute sector, introduced at a time of long waiting lists, encouraged activity in hospitals. At the same time, block budgets in community services and capitated budgets in primary care offer little incentive to increase activity or enhance efficiency in these settings.

New payment models are being developed and tested in local areas. As an example, a version of capitation-based payment known as 'whole-population budgets' has recently been suggested to support new models of care delivery. However, improved arrangements for ongoing evaluation of these new payment systems and spreading of best practice must be developed.

Two key messages are reflected throughout the report:

First, that there is no such thing as an "ideal" payment mechanism (or combination thereof) per se, but that each approach has defined (and often empirically sound) advantages and disadvantages that can help policy-makers reach defined objectives. These objectives should be the guiding light that defines how prices are set in a health system, with key emphasis on making clear which objectives should be prioritized. Trade-offs are commonplace in the mechanics of incentive structures. However, if there are too many objectives, and priorities are not set, the effectiveness of a specific combination of price-setting mechanisms is muddled.

Second, that price setting is just one of many policy tools available to help reach key policy objectives. There are far too many actors at different levels of the system for the price-setting mechanism to be able to significantly incentivize every single one of them. One of the key arguments is that price setting and regulation could provide incentives to hospitals but may not have as much of an effect on individual practitioners, who may be less likely to modify their practice in the intended ways.

1
The National Health Service: payment mechanisms, budgets, and commissioning

Payment mechanisms in the National Health Service are blended across and within types of services, with the aim to optimize incentives and minimize the disadvantages of each mechanism

The National Health Service has a long history of change aimed at continuous improvement. Established in 1948 with the core idea that good quality health care should be available to all regardless of their income, it was one of the key drivers for shifting expectations (both nationally and internationally) on health care as a good – from a standard economic good to a much more complex public good that seeks to reduce inequalities. The complexity of health care as a non-standard good has been the subject of extensive research efforts and constitutes one of the main reasons why provider payment systems have evolved so rapidly, especially in the last decade. In the United Kingdom health is run separately in England, Wales, Scotland and Northern Ireland. This report only covers payment mechanisms for the National Health Service in England (henceforth referred to as the NHS), although the founding principle of free universal healthcare applies across the United Kingdom.

The NHS employs a range of payment mechanisms across its core services – primary care, acute care, community and mental health services. Each mechanism comes with advantages and disadvantages, with the optimal mix dependent on the priorities of the system. It is therefore common to not only adopt different mechanisms for different services (since objectives and incentives in each service might differ), but also to blend different payment practices within a specific service to mitigate some of the drawbacks of the main payment system in place.

The NHS incorporates block budgets, capitation, and activity- or case-based models (Wright et al., 2017). These mechanisms can be described primarily based on the extent to which they bundle payments for services:

- Block contracts bundle payments for all services provided in the sector, with a lump sum paid to providers at a specified interval (much like a salary), and may be independent of the level of activity;
- Capitated budgets bundle payments prospectively per patient enrolled in the system, often with a risk-adjustment weighting for more complex patients;
- Case-based payments made prospectively for an episode of care, which therefore involve less bundling than capitated payments since they do not involve periods where there may or may not be activity for any given patient (Marshall, Charlesworth and Hurst, 2014).

The NHS currently uses capitation as the main form of payment for primary care, block contracts for the community and mental health sectors, and case-based payments for the acute sector. The following sections detail how each of these three services has evolved in the past decade with regard to its objectives, funding and payment system, together with a general overview of the NHS as a whole and future integration plans encouraging the use of global budgets as set out in the "Five Year Forward View" (2015) and reinforced in the "Long Term Plan" (NHS England, 2019).

Funding flows in the NHS: budgets and commissioning shifts

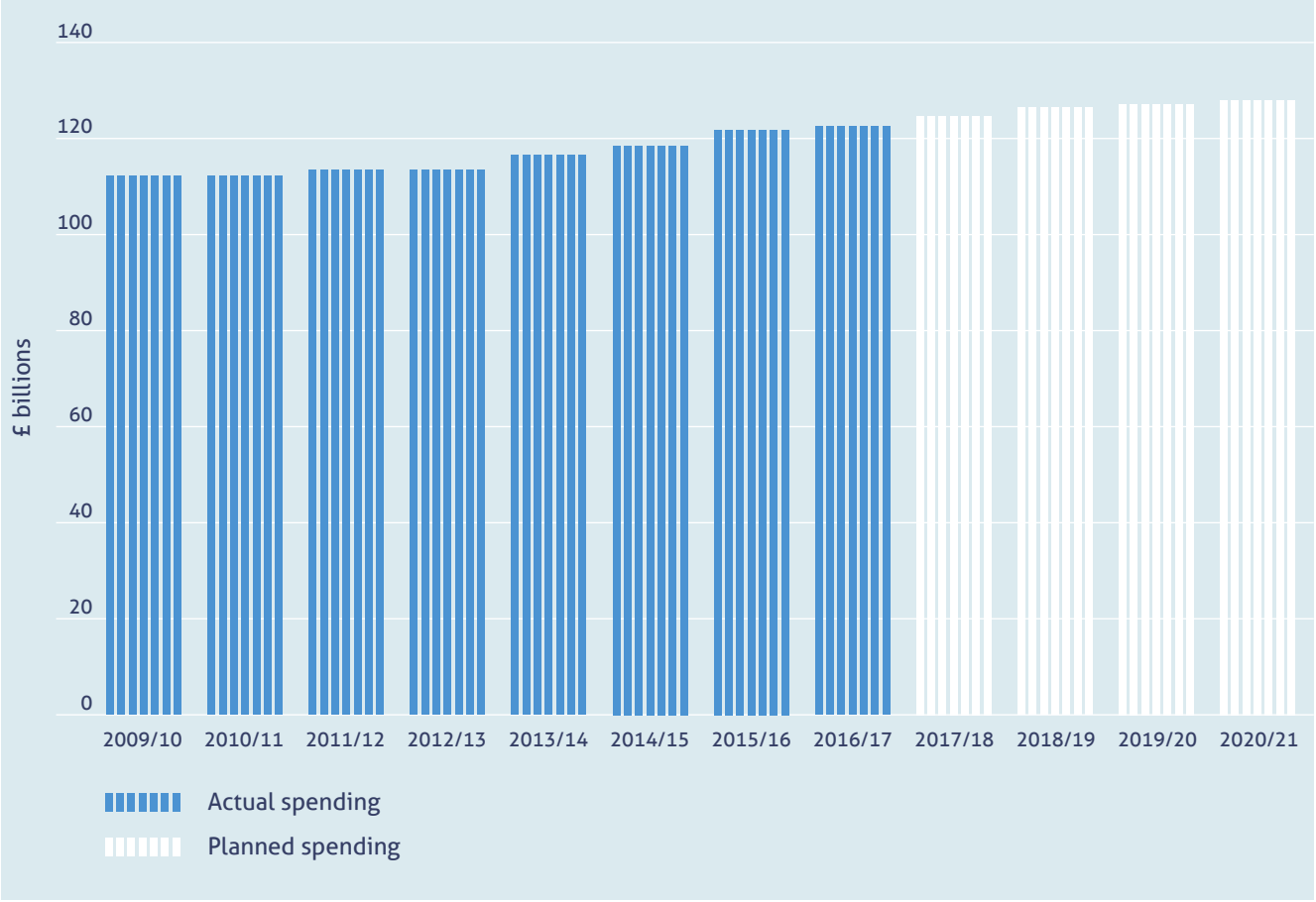
With a broadly static health budget in real terms over the five years leading to 2015-2016, the NHS was asked to make efficiency savings of 4% per year over this period, equating to a total of £15-20 billion. A key tool for incentivising higher efficiency has been the payment system through which NHS commissioning bodies purchase health care from hospitals, general practitioners (GPs) and other providers (King's Fund, 2017a).

The NHS is primarily funded through general taxation and National Insurance contributions from employees, employers and the self-employed. General taxation accounts for around 80% of NHS funding (£125 billion in 2017-2018). A small percentage of funding is generated through patient charges, such as prescriptions, dental care and spectacles. For the year 2015-2016, user charges amounted to £1.3 billion, corresponding to 1.1% of the budget (King's Fund, 2017a). The level of overall funding for the NHS is set through the UK Government's Spending Review process. Estimates are made of the projected income generated by the three sources. When the spending generated by user charges and National Insurance is lower than estimated, funds from general taxation are adjusted to provide the planned level of funding.

Following a period of mostly static budgets (and cuts in real terms) between 2009-2010 and 2012-2013, the budget for the Department of Health[1] is expected to grow by 1.2% between 2010 and 2021 in real terms (King's Fund, 2018). Figure 1 below details this planned budget growth, with funding pledged mainly for staff salaries and medicines, to support expansion of the number of NHS services provided seven days a week, invest in new clinical strategies for cancer and mental health, improve the integration of health and social care, and fund posts for 10 000 new nursing and other health professionals (Department of Health, 2015). In June 2018, a new long-term funding settlement was announced. The priorities for the NHS were set out in the long-term plan in January 2019 (NHS England, 2019).

1 Now renamed Department of Health and Social Care.

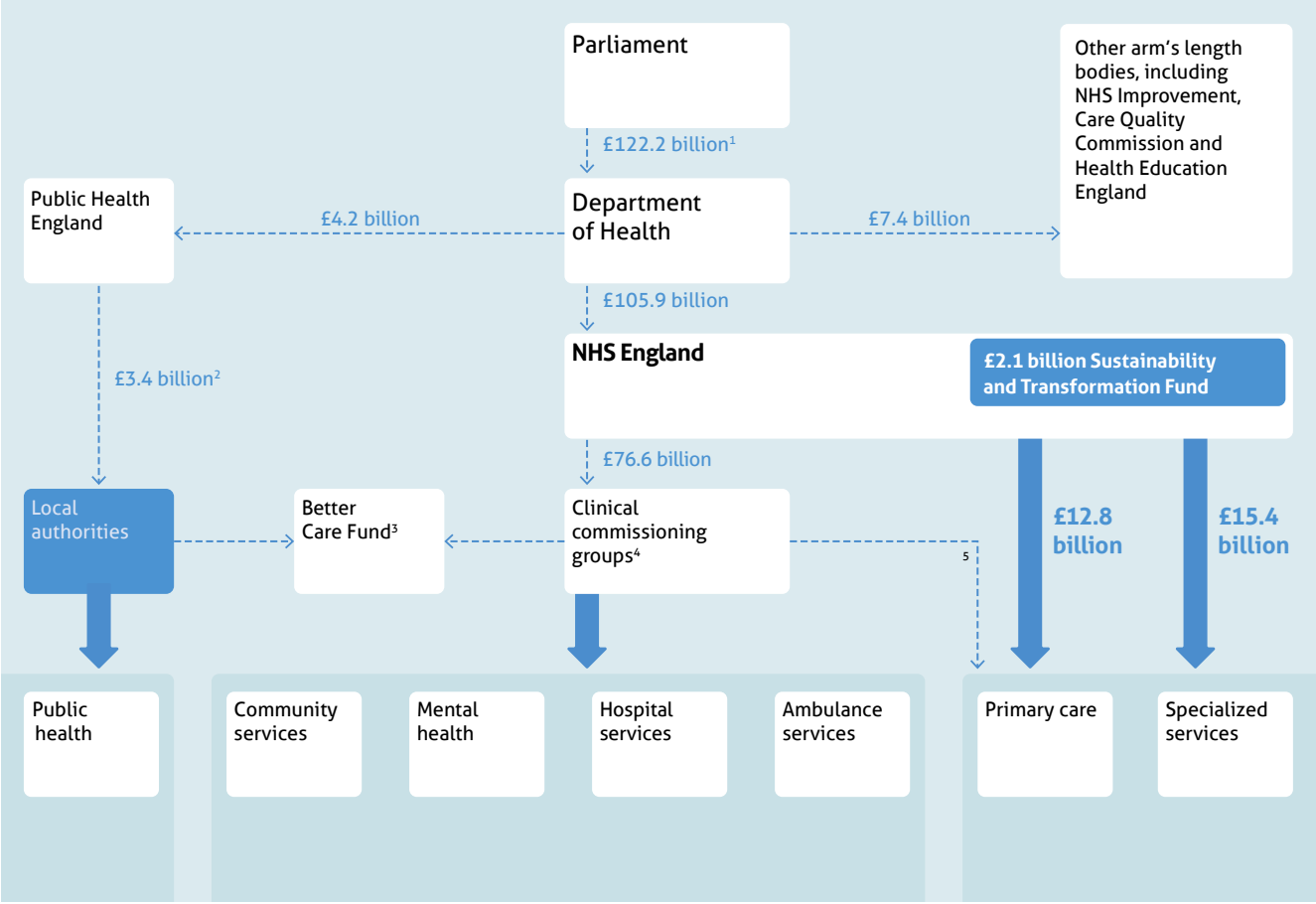
Figure 1
Department of Health total departmental expenditure limit (TDEL)



Source: King's Fund, 2018. Note: Figures are expressed in real terms at 2017-2018 prices using deflators published by the Office of Budget Responsibility in November 2017.

The commissioning structure of health services was reformed in 2013. Figure 2 below shows the reformed commissioning structure. PCTs were replaced by clinical commissioning groups (CCGs). These are clinically-led, and their governing bodies include GPs, other clinicians, patient representatives, general managers, and in some cases practice managers and local authority representatives (King's Fund, 2017b). CCGs are now responsible for the commissioning of most NHS services: acute care, mental health and community services, urgent and emergency care (including out-of-hours), rehabilitative care and, increasingly, primary care and some specialized services (NHS England, 2018a). The initial number of CCGs was 211 and was 191 on 1 April 2019. This is due to mergers and joint and integrated commissioning at the local level across a larger geographical footprint, with many areas sharing staff or structures between CCGs.

Figure 2
Funding the NHS in England

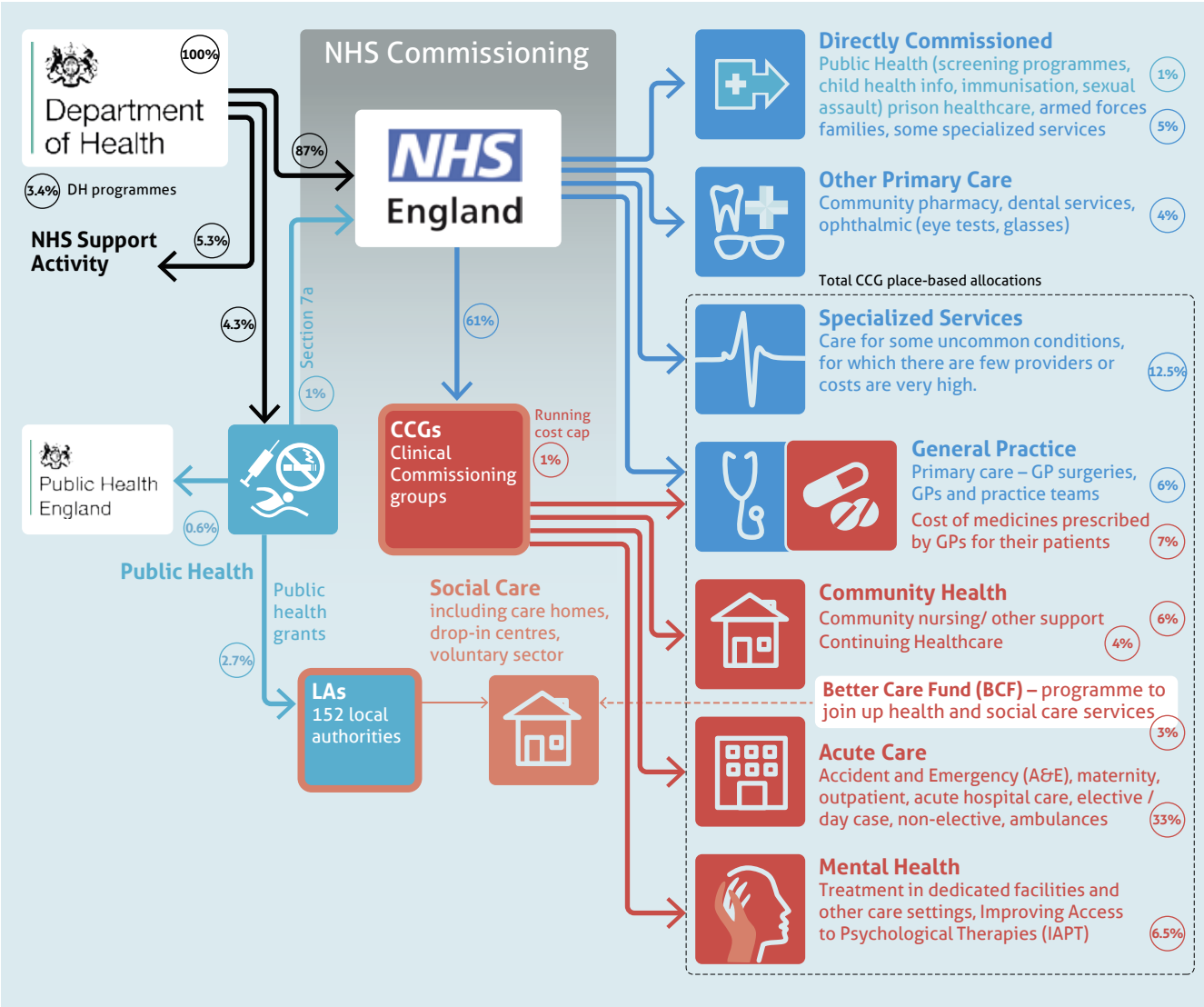


[1] All figures are for 2016/17.
[2] Public health grant.
[3] With the aim of integrating health and social care services, NHS commissioners and local authorities pool some of their annual budgets (around £5.8 billion in 2016/17) to create the Better Care Fund.
[4] From April 2017, all CCGs have assumed some responsibility for commissioning primary medical care services. Sixty-three have taken on full delegated responsibility; the rest have joint responsibility with NHS England.
[5] NHS England transfers money to those CCGs that have taken on full delegated commissioning of primary medical care services.

Source: Reproduced with permission, King's Fund, 2017c.

Figure 3 below shows the funding flows of the total NHS budget (in percentage estimated from expenditures in 2016-2017). Around 60% of the total NHS budget is managed by CCGs, and more than half of the budget managed by CCGs – which represents one third of the total NHS budget – is used to pay for acute care.

Figure 3
Distribution flow of NHS budget



Source: Reproduced with permission, NHS England, 2018b.

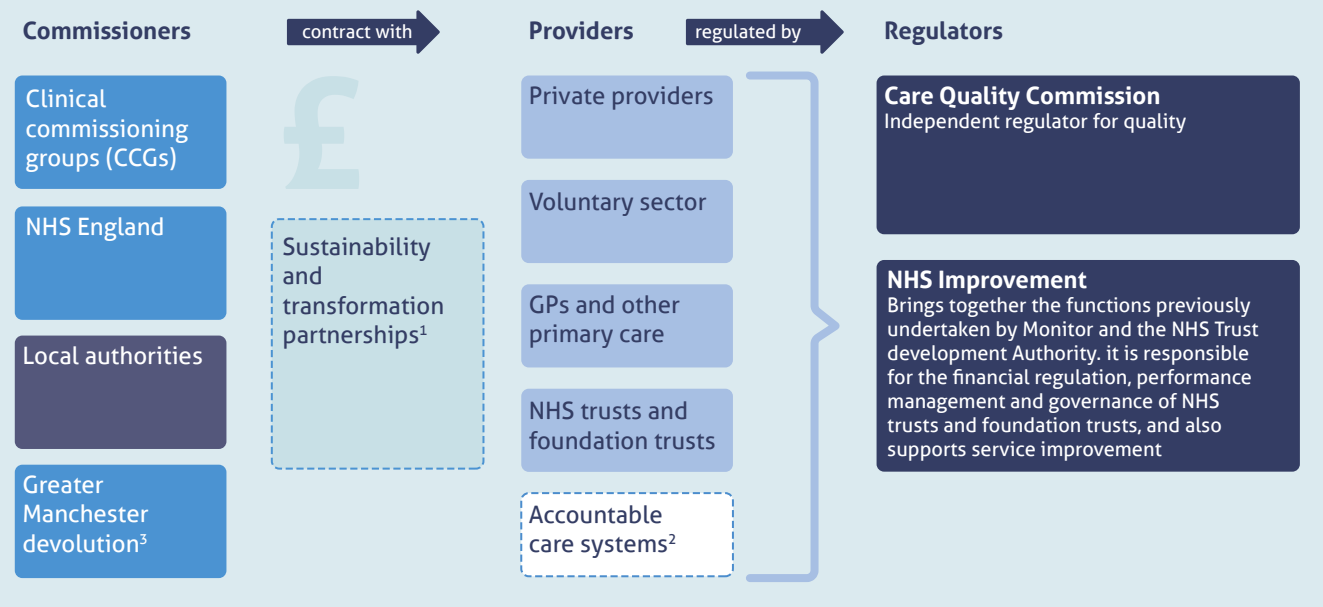
Initiatives like the Better Care Fund require CCGs to work together with local authorities by pooling budgets to deliver more integrated care. Similarly, the creation of Sustainability and Transformation Partnerships (STPs)[2] have brought together CCGs, local authorities and NHS England to plan services around long-term needs of local communities (King's Fund, 2017b). Overall, CCGs are responsible for about two thirds of the NHS commissioning budget.

Most of the remaining budget is managed by NHS England, which is responsible for strategic oversight for the NHS and directly commissioning most specialized services and, jointly with CCGs, primary care services, including GPs, pharmacists and dentists. NHS England is also responsible for some public health services, such as immunization and screening programmes.

2 In 2016, the NHS and local councils came together in 44 areas covering all of England to develop proposals to improve health and care. They formed new partnerships – known as STPs – to run services in a more coordinated way, to agree on system-wide priorities and to plan collectively how to improve residents' day-to-day health.

Lastly, local authorities are responsible for commissioning social care services (such as providing home and residential care), and most public health services (such as sexual health, school nursing and addiction services), with a specific ring-fenced budget since 2013 (King's Fund, 2017c) (Figure 4).

Figure 4
Commissioner-provider structure in the NHS



1 Since December 2015 NHS providers, CCGs, local authorities and other health care services have come together to form 44 STP 'footprints'. These are geographic areas that are co-ordinating health care planning and delivery, covering all areas of NHS spending on services from 2016/17 to 2020/21.
2 From mid-2017, eight areas of England are evolving into accountable care systems. This involves commissioners and providers assuming responsibility for a budget to deliver integrated services for a defined population.
3 From April 2016, leaders in Greater Manchester have taken greater control of the region's health and social care budget. This includes taking on delegated responsibility for several commissioning budgets previously controlled by NHS England. Other areas – including London and parts of Surrey – are also pursuing devolved arrangements.

Source: Reproduced with permission, King's Fund, 2017c.

Commissioners are increasingly working together across the larger STP footprints to deliver long-term plans for the NHS. In some cases, such as Greater Manchester, there are additional devolved responsibilities (Greater Manchester Health and Social Care Partnership, n.d.) for commissioning health and social care services from a range of providers – GPs and other primary care health professionals, NHS trusts and foundation trusts, private providers, and the voluntary sector. All STPs will have to evolve to form an Integrated Care System over the next two years. Alternative payment approaches are being developed, and in a few cases, commissioners have contracted to manage a single budget to deliver a range of services for the local population (King's Fund, 2017b).

Providers are regulated by two main entities: the Care Quality Commission (CQC), which is primarily responsible for quality and safety assessments for all health and social care services; and NHS Improvement, which regulates resource use, financial levers and operational performance using a shared definition of quality and efficiency with the CQC.

2
Price setting across NHS services

In this section, the current price-setting mechanisms for primary care, acute services and community and mental health services are described, with an emphasis on how these systems have changed in the past decade to better align with the objectives set out at the national level.

In this context, it is important to underline that there is a wide range of choices available to NHS patients as long as this is clinically appropriate. These are set out in the Choice Framework (Department of Health and Social Care, 2016). They include statutory rights to choose for elective acute and mental health services, where diagnostic tests will be undertaken, and the right to have a personal health budget where certain prerequisites are met. Patients should also be offered choices for maternity and community services, although these are not set out in legislation. Patients should also be offered choices for maternity and community services, although these are not set out in legislation. Patients can review the choices that are available to them for particular procedures and treatments on the NHS website, as well as the waiting times at each provider.

Primary care

GP services are primarily funded through capitation. The services are commissioned by NHS England, and increasingly by CCGs with delegated responsibility for four primary care contractor groups (medical, dental, eye health and pharmacy) (NHS England 2018). The negotiations for GP reimbursement are carried out between NHS England and the General Practitioners Committee (GPC) of the British Medical Association (BMA) on the General Medical Services (GMS) contract, under which most GPs (individuals and practices) are contracted.

GPs have traditionally worked as independent contractors under the GMS, usually in GP practices in which each GP is a partner with a stake in the financial success of the practice. Today, an increasing number of GPs are employed on a salaried basis, usually by other GPs who own the practice.

GP practices are now working together to form Primary Care Networks (PCNs) (National Health Service, 2017) covering a population of 30 000-50 000 patients, with the ambition to encourage more collaboration and delivering a more proactive and personalized approach for primary care services in each

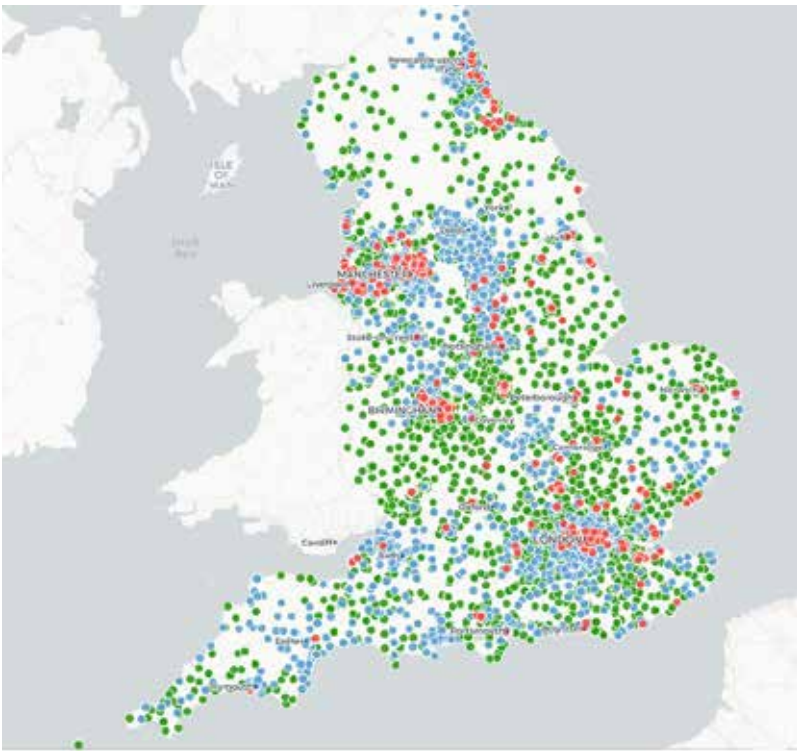
area. Additional funding for PCNs is being made available throughout 2019, and new contractual arrangements for GPs to reflect the role of GPs in PCNs start in April 2019 (National Health Service, 2019).

The General Medical Services (GMS) contract is the main contractual form used to commission primary medical services, and it delivers core medical services at a nationally agreed price. The capitated funding received by each GP practice to deliver these services is based on each practice's registered list size with a fixed, nationally agreed price per patient, weighted by the demographic mix of patients and levels of deprivation. Personal Medical Services (PMS) contracts provide similar core services to GMS contracts but can also include extra health services 'over and above' the standard services, are issued to address specific local health needs. Funding for such contracts is agreed locally.

Lastly, Alternative Provider Medical Services (APMS) contracts enable primary care organisations (PCOs) to commission or provide other primary medical services within their area to the extent that they are necessary. They allow PCOs to contract with non-NHS bodies, such as voluntary or commercial sector providers, or other GMS/PMS practices, to provide enhanced and additional primary medical services. Around 62.5% of practices operate under GMS contracts, 34% under PMS, and 3.5% under APMS deals (Figure 5).

Where a practice opts out of delivering out-of-hours services their contract value is reduced to reflect this.

Figure 5
GP practices by contract type



Source: Bostock, 2016. Note: Snapshot from 2016 data. OpenStreetMap contributors, © CARTO. Map created by Nick Bostock.

In addition to these core contracts, a range of voluntary and additional contracts are used to cover specific needs or to incentivize prevention and quality in primary care. These include Enhanced Services (ES), which are locally contracted and cover a range of functions such as sexual health screening, smoking cessation programmes, blood pressure monitoring and weight management (Addicott and Ham, 2014); other community-based services and public health services such as screening and immunisation programmes; and, importantly, the Quality and Outcomes Framework (QOF).

Introduced in 2004, the QOF provides additional income to GP practices that deliver improved quality of care as measured by performance against a range of metrics (mainly related to patients with long-term conditions) (National Health Service, 2018a). Most practices on GMS contracts, and many on PMS contracts, take part in the QOF. For the 2013-2014 GP contract, QOF thresholds were raised to further improve performance, and new indicators were added. The National Institute for Health and Care Excellence (NICE) took a new role in the QOF context by producing a menu of evidence-based, clinically and cost-effective indicators selected on the basis of criteria such as accuracy of data, clarity of diagnosis and relevance of actions. The indicators are being updated further from April 2019.

Acute services

The last decade has seen major reforms to the payment system for acute and emergency services. Before 2003, hospitals in England were paid through block contracts for most services. These contracts specified minimum and maximum levels of provision, with activity falling above or below these thresholds triggering actions such as renegotiation or data validation (Marshall, Charlesworth and Roberts, 2014). A series of reforms in 2002 introduced the current dominant activity-based payment scheme, initially known as Payment by Results (PbR), and now called the National Tariff. It initially financed a small proportion of inpatient elective hospital care, was expanded to cover all elective care by 2006, and by 2007 covered most acute activity, including non-elective, outpatient, and accidents and emergencies (A&E) (Department of Health, 2012). By 2014-2015, PbR covered 67% of acute income and 60% of the total income received by all NHS trusts (Wright et al., 2017).

The National Tariff sets out nationally determined currencies[3] and a schedule of prices. It is the main way that commissioners pay acute health care providers for each patient seen or treated, taking into account the complexity of the patient's health care needs.

Activity based funding has meant that money 'follows' the patient and, because prices are fixed, competition for patients has been on the basis of quality rather than price. For inpatient

3 Currencies are the unit for which a payment is made. They take a number of forms covering different time periods from an outpatient attendance to a year of care for a long-term condition. They include Health Resource Groups (HRGs) for inpatient spells. Tariffs are the set prices for each currency.

stays, providers are reimbursed for 'spells' of activity. Spells, which cover the period from admission to discharge, are coded as Healthcare Resource Groups (HRG) based on the types of patient and treatments with similar cost implications (Marshall, Charlesworth and Roberts, 2014). There are currently more than 2800 HRGs included in the national tariff.

Costs are reported by all NHS providers in the annual reference cost collection. Reference costs give the most comprehensive picture available of how the 232 NHS providers in England (80 NHS trusts and 152 NHS foundation trusts) spent £68 billion delivering health care to patients during the financial year 2017-2018 (the most recent year for which data has been published) (National Health Service, 2018b). This is 62% of total NHS expenditure and includes core admitted patient care (APC) costs of £27.7 billion, mental health costs of £7.2 billion, community care costs of £5.5 billion, ambulance costs of £1.9 billion, as well as outpatient care.

It is mandatory for NHS trusts and foundation trusts to submit their cost data. These data have been collected since 1997, and since 2003 have fed into the calculations that determine the published tariffs.

The reference cost data is publicly available at the provider and aggregate levels. It is a rich data source and has many uses, from informing price setting to public accountability to Parliament. NHS trusts have a responsibility to improve their internal costing processes and systems to help them better understand the cost of delivering services, leading in turn to the submission of improved cost data. NHS Improvement has a responsibility to ensure the costs collected are fit for purpose and support this responsibility by producing comprehensive and clear guidance.

National cost collection submissions are subject to audit as part of the costing assurance audit program, and all acute NHS trusts and foundation trusts are selected for audit at least once every three years. The purpose of the audit program is to provide assurance that reference costs have been prepared in accordance with the Approved Costing Guidance.

England's NHS trusts and foundation trusts are in the process of moving to a new national approach of cost data collection based on patient-level costing (known as PLICS). This will be the mandated approach for all acute providers from the financial year 2018-2019.

The tariff (price reimbursed) is typically based on the national average cost of providing care for each currency unit as estimated on the basis of the reference cost submissions. There is a formal consultation process with providers and commissioners about each National tariff package, including the draft prices, calculation methodology, and any policy changes. Stakeholder views are taken into account in the final published tariff package.

The price actually received for an intervention or procedure by each acute provider is then multiplied by a nationally determined market forces factor (MFF), which is unique to each provider and reflects relative costs of care across the country. London providers have the largest MFF. There may also be other adjustments to the tariff for long or short stays, specialized services, and support for specific policy goals such as providing care compliant with Best Practice (Department of Health, 2012) (Figure 6). Some tariffs were also traditionally adjusted to take account of NICE guidelines on cost-effective technology. Figure 7 shows the information flow from treatment to payment.

Figure 6
Best Practice Tariffs

A 2008 review of the NHS found a substantial amount of non-compliance with best practice for hospital services. As a result, a policy commitment was made to set some tariffs that financially incentivize providers to provide care compliant with best practice – referred to as Best Practice Tariffs (BPTs). The aim of this approach was to encourage the payment of services that followed clinical guidelines and to discourage variation in practice that did not follow best practices (Marshall et al., 2014). BPTs target hospital activities according to the following criteria: high potential impact (e.g. volume, significant unexplained variation in practice, or significant impact of best practice on outcomes), strong evidence on best practice, and clinical consensus on characteristics of best practice. In 2010, BPTs applied to all providers of NHS-funded care, including both NHS and independent providers, for hospital admissions related to hip fracture, stroke, cholecystectomy and cataract surgery. BPTs can be higher or lower than HRG tariffs based on national average costs. The price differential between best practice and "standard" care is set to ensure that the anticipated costs of undertaking best practice are reimbursed, while creating an incentive for providers to shift from standard care to best practice. Coverage of BPT has steadily increased from four in 2010 to more than 50 procedures. The tariffs are set centrally, which leaves very little room for local price negotiation between providers and commissioners, although there are some non-mandatory BPTs (OECD, 2016).

Private providers may choose to offer their services to NHS patients, in this case they are also reimbursed by commissioners using the prices published in the National tariff. For their private patients, these providers set their own prices. Around 30% of income to providers comes from NHS patients (LaingBuisson, 2018).

The development of an activity-based payment system was led by the Department of Health. Since 2014, responsibility has been shared between NHS Improvement[4] and NHS England for the tariff, currency design and price setting.

For the tariff which took effect from April 2019, England has introduced a 'blended' payment approach for emergency care taking place in acute hospitals. This comprises a fixed amount (linked to expected levels of activity) and a volume-related element that reflects actual levels of activity, as well as some

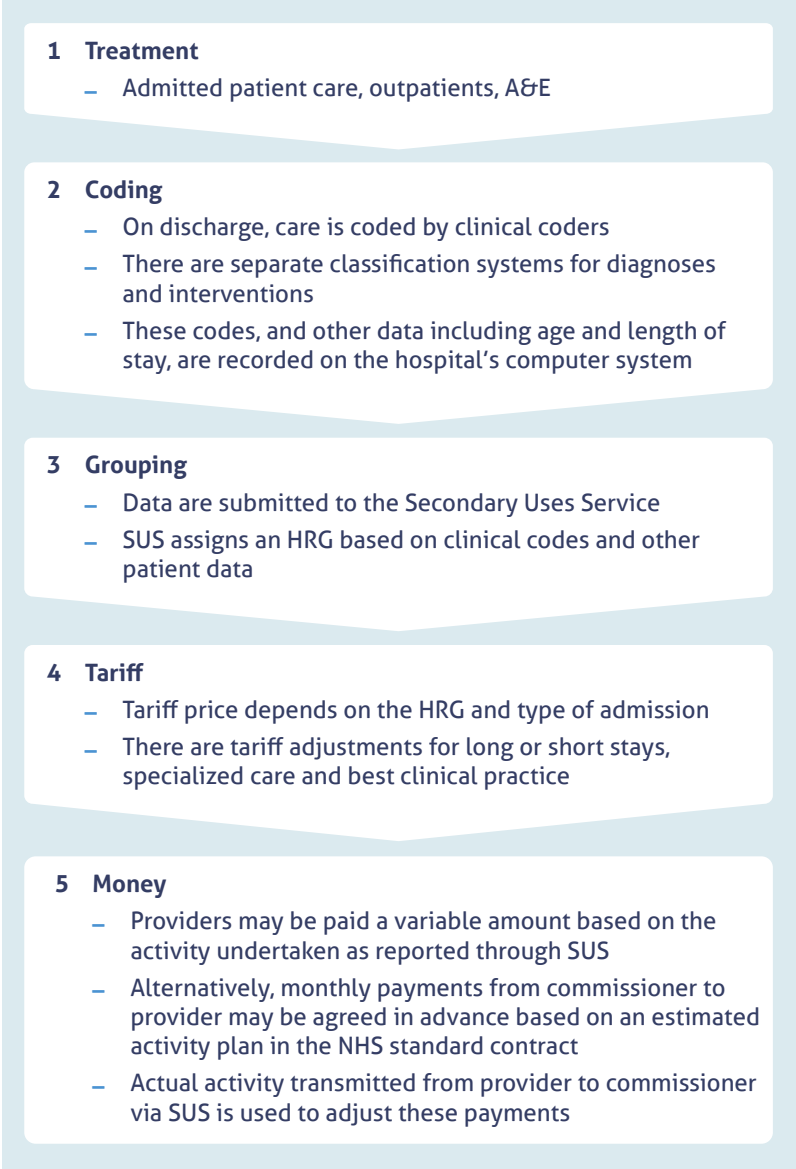
4 NHS Improvement is the organisation responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. NHS Improvement offers support to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.

sort of risk-share between provider and commissioner (National Health Service, n.d.).

The payment model covers A&E attendances, non-elective admissions (excluding maternity and transfers) and ambulatory emergency care. It is the new 'default' reimbursement model for emergency care but does not stand in the way of local systems that want to move faster towards other population-orientated payment models.

This approach is designed to provide greater stability and encourage providers and commissioners to focus on how to use resources most efficiently and effectively to improve quality of care and health outcomes. The approach shares responsibility for the resource consequences of increases in acute activity and the benefits of system-wide action to reduce growth in emergency care, and ensure that care takes place in the most appropriate setting.

Figure 7
Payment by Results (PbR) from treatment to payment



Source: Department of Health, 2012. Note: SUS: Secondary Uses Services.

Community and mental health

Putting mental health care on a level footing with physical illness has been a top priority for the NHS in England in recent years. The blueprint for improving mental health services was set out in 2016 in NHS England's Five year forward view for Mental Health, supported by an additional £1 billion investment and informed by the views and needs of thousands of patients, their families and medical professionals. The Long-Term Plan for the NHS reinforces this focus with a commitment for a further £2.3 billion increase in annual real terms investment by 2023-2024. Since 2015, spending has increased £10 979 million in 2015-2016 to £11 976 million at the end of financial year 2017-2018, around 13.7% of overall allocations to CCGs.

While almost two thirds of hospital activity are covered by activity-based payment through the national tariff, the predominant payment system for the remaining secondary care services has been through the agreement of a block contract used to reimburse around 90% of community services and two thirds of mental health care. Commissioners and providers can agree to prices and a payment approach locally for mental health and community services in line with the local pricing rules published by NHS Improvement. Pay-for-performance aspects have also been added to the payment system for mental health and community services through the Commissioning for Quality and Innovation (CQUIN) schemes.

The national currencies for mental health were introduced in 2012. These are needs-based currencies under the three broad diagnostic categories of psychotic, non-psychotic and organic presentations. However, only a small number of contracts have been agreed on the basis of such currencies. Currencies also exist for the Improved Access to Psychological Therapies (IAPT) service and are being developed by Child and Young People's Mental Health Services (CAMHS) (Marshall, Charlesworth, and Hurst, 2014).

The Mental Health Investment Standard was introduced in 2016 to try to ensure that CCGs increase spending on mental health in line with the overall increase in funding available to them. CCGs must report on their compliance with the standard.[5]

The National Tariff also proposed that blended payment would be the default payment approach for mental health services from April 2019. This combines a fixed payment with a variable element where activity exceeds planned levels, and an element linked to delivery of agreed outcomes.

The other key group of services not covered by a tariff payment system is community health services. Community health

5 The Mental Health Five Year Forward View (MH FYFV) sets out the plans for improving and expanding mental health care, which continues to be central to the NHS as part of the Long-Term Plan. The MH FYFV dashboard brings together key data from across mental health services to measure the performance of the NHS. The dashboard provides transparency in assessing how NHS mental health services are performing, alongside technical details explaining how mental health services are funded and delivered. https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/

services are diverse in function and differ widely between localities across England. They include a wide range of services that are delivered at clinic or in patients' homes, including care for long-term chronic conditions, preventive services, and assessment and rehabilitation services, plus some inpatient community hospital services and hospice care. Together, these services accounted for 12% of NHS funding in 2014-2015 (Lafond, Charlesworth and Roberts, 2016).

A project is underway to test a community currency model with providers and commissioners. This work will draw upon data from the community dataset, which was introduced in October 2017, and is a nationally mandated dataset for all providers of community services. The currency model will be tested during 2019 and is focused on the changing needs of patients through their life-course.

Nursing and care home funding

The funding of places in nursing and care homes in England is a complex area. The type of care provided in such homes is often a mix of health and social care. Whilst there is no legal definition of social care, previously published NHS guidance (Davies, n.d.) defines it as a social care need "that is focused on providing assistance with activities of daily living, maintaining independence, social interaction, enabling the individual to play a fuller part in society, protecting them in vulnerable situations, helping them to manage complex relationships, and (in some circumstances) accessing a care home or other supported accommodation".

State funding for social care needs is a local authority responsibility and is means tested. Therefore, if a person needs to go into a care home or nursing home for mainly social care needs and their income and savings fall above a certain threshold, they will have to meet the costs of their care through their savings or through the sale of their home.

Where the person has some nursing needs and lives in a nursing home, they will be entitled to some NHS funding. The money is paid directly to the nursing home, and from April 2018 the standard rate is £158.16 per week. For those people whose needs are deemed to be predominantly health related, they may be entitled to NHS Continuing Health Care funding, which will pay for the entirety of their care whether at home, a care home or nursing home (National Health Service, 2018c). A multidisciplinary assessment is made of the person to decide on the entitlement.

Various governments have committed to introducing an upper cap on the requirements for an individual to contribute to their social care and have also discussed new schemes to fund social care in the future. The current UK Government has committed to publishing a Green Paper on this topic in 2019.[6]

6 This is a forthcoming green paper for which no publication date has yet been decided https://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-8002

3
Discussion

The current NHS is evolving to adapt its payment system to its stated objectives

The current NHS payment system has evolved greatly over the last decade and employs a mix of different payment methods across different services and sectors. Moves away from block budgets to activity-based payment approaches have improved provider productivity in the acute sector. However, block contracts are still the predominant payment mechanism for the community and mental health sectors. Moreover, the structure of incentives across services does little to support policy ambitions to shift care that does not need to be delivered in hospitals into a community setting, with the payment systems often giving conflicting signals. The predominance of activity-based payment in the acute sector, introduced at a time of long waiting lists, encouraged activity in hospitals; at the same time, block budgets in community services and capitated budgets in primary care offer little incentive to increase activity or enhance efficiency in these settings (Marshall, Charlesworth and Hurst, 2014).

Although a combination of methods is likely to be appropriate in most instances, the current combination of a case-based system for most acute care and block budgets in out-of-hospital services has provided a balance of incentives that are counter to the national ambition to provide more care out of hospitals and to treat mental and physical health services with parity. Equally, they do not provide incentives for prevention or early intervention.

New payment models are being developed and tested in local areas in line with the development of the various new models of delivering care. As an example, a version of capitation-based payment known as 'whole-population budgets' has recently been suggested to support these new models of care. However, arrangements for ongoing evaluation of these new payment systems and spreading of best practice are not currently clear, and must be developed and shared (Wright et al., 2017).

New models of care were proposed in the five year forward view are now in their third year and piloted by 50 vanguard areas in England. STPs published plans in 2017, and these plans will evolve into Integrated Care Systems over the next two years. The aim of these developments is to drive collaboration and more integrated care across providers to better meet the needs of local populations. These new ways of delivering care may require new ways of paying for care too. Under the current system, payments are made within organisational boundaries (Wright et al., 2017).

Policy lessons across services

Although the ultimate purpose of the health care system is to improve patient outcomes, there is currently limited evidence for the impact on outcomes of financial incentives to providers. There has, however, been only limited experimentation and even scarcer robust evaluation. This is in part due to the fact that outcomes are far more difficult to measure and attribute than the processes of care. For something to be incentivized, it must be both measurable and directly attributed to the provider. Outcomes are often difficult to measure, distant in time from the care activity, and influenced by multiple determinants, including many outside the control of the health sector, making attribution to a specific provider difficult. There are also inherent risks to incentivising outcomes which need to be managed, including the impact on equity and equality of access to care.

Conceptually, the measurement of outputs should include the quality of care as well as the volume of care. However, measuring outputs in health care is complex, and there are concerns that quality differences are not effectively captured. Measures of efficiency of health services are therefore often a simple comparison of activity and cost, rather than quality-adjusted output (Marshall, Charlesworth and Hurst, 2014).

There is still limited evidence that the increasing attempts of pay-for-performance schemes to improve quality of care are actually able to do so, both in the NHS and at the international level (Marshall, Charlesworth and Hurst, 2014). Financial incentives are more useful in influencing processes of care rather than patient outcomes.

For the QOF scheme in primary care, there is a consensus that it improved processes as well as quality of care for chronic conditions. However, there is concern that this kind of financial incentive may have a detrimental effect on the intrinsic motivation of health professionals (Glasziou et al., 2012). Glasziou et al., (2012) found that motivation was reduced due mainly to the fact that professionals disputed the evidence base for one of the quality indicators used to assess them.

For activity-based funding in acute care, there is strong evidence that the tariff system has resulted in reductions in length of stay and increases in day cases across most groups of patients, providers and HRGs (Farrar et al., 2010). These changes came with a resource saving of around 1-3% over a five-year period and an increase in the number of spells of 3-9%. Overall, this evidence is broadly consistent with international evidence of similar DRG-based payment systems introduced in place of block budgets.

Moreover, since DRG-based systems require good information on costs, quality and outcomes, there is the risk that inaccuracies in cost data will result in reimbursement levels that do not reflect true underlying costs (Marshall, Charlesworth and Hurst, 2014).

Regarding BPTs, evaluations show mixed effects. There is clear clinical support for BPTs due to their promotion of evidence-based protocols. It is, however, unclear whether the financial incentives alone are sufficiently high to change care or significantly reduce variation (Gershlick, 2016).

System objectives and other policy levers

The scale of change required in a payment system is hard to determine without clear objectives in mind. Figure 8 shows the difference in how many priorities were identified in the NHS for the tariff system compared with countries with similar DRG payment schemes.

Figure 8
Policy objectives for DRG payment in European countries

	England	Finland	France	Germany	Ireland
Increase efficiency	√		√	√	√
Expand activity	√				
Enhance patient choice	√				
Increase patient satisfaction	√				
Reduce waiting lists	√				
Improve quality	√		√	√	
Control costs	√				
Ensure the fair allocation of resources (or funding) across geographical areas and across and within health care sector	√	√	√	√	
Shift patterns of service provision away from historical patterns	√				
Encourage the development of new, cost-effective, treatment pathways	√				
Improve transparency of hospital funding, activity and management	√		√	√	√
Encourage providers to be responsible to patients and purchasers	√				
Cover costs of production		√			
Create a level playing field for payment to public and private hospitals			√		
Improve documentation of internal processes and increased managerial capacity, which would in turn improve efficiency and quality				√	
Establish link between activity and funding		√			√

Source: Reproduced with permission, O'Reilly et al., 2012.

Achieving so many objectives through the payment system will lead to an overly complex system that is ultimately unable to deliver on any of them (Wright et al., 2017).

The payment system can play an important – although limited – role in improving the quality of care and efficiency of services provision, but it cannot by itself overcome the many challenges that characterized complex care systems. Where payment mechanisms have improved quality and efficiency, the effect tends to be small. Their impact is also very dependent on the wider policy and delivery context.

A number of factors (e.g. organisational culture, relationships between organisations, and system-wide funding and demand pressures) can either undermine or enhance the impact of a payment system, and thus must be considered. Payment rules are just one lever among a range of tools that should be considered to maximize effectiveness (Wright et al., 2017).

References

Addicott R, Ham C. Commissioning and funding general practice. Making the case for family care networks. King's Fund. London; 2014.

Bostock N. Map: Find out where GPs are on APMS, PMS and GMS contracts. GPOnline; 2016. (https://www.gponline.com/map-find-gps-apms-pms-gms-contracts/article/1401067, Accessed 1 May 2019).

Davies T. What is the Difference Between Healthcare and Social Care? Compass continuing healthcare. N.d. (https://www.continuing-healthcare.co.uk/continuing-healthcare-guidance/difference-between-healthcare-and-social-care, Accessed 2 May 2019)

Department of Health. Spending Review 2015; 2015. (https://www.gov.uk/government/news/department-of-healths-settlement-at-the-spending-review-2015, Accessed 14 March 2019).

Department of Health. A simple guide to Payment by Results. NHS; 2012. (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213150/PbR-Simple-Guide-FINAL.pdf, Accessed 14 March 2019).

Department of Health and Social Care. The NHS Choice Framework: what choices are available to me in the NHS? 2016. (https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs, Accessed 2 May 2019)

Farrar S, Chalkley M, Yi D, Ma A. Payment by Results - Consequences for key outcomes measures and variations across HRGs, providers and patients: Report to the Department of Health. Health Economics Research Unit; 2010.

Gershlick B. England Case Example – Best Practice Tariffs. OECD Project on Payment Systems. OECD; 2016.

Glasziou P, Buchan H, Del Mar C, Doust J, Harris M, Knight R, et al. When financial incentives do more good than harm: a checklist. British Medical Journal 2012;345: e5047.

Greater Manchester Health and Social Care Partnership. About Devolution. N.d. (http://www.gmhsc.org.uk/about-devolution/, Accessed 2 May 2019)

King's Fund. The NHS budget. In: The NHS in a Nutshell. King's Fund; 2018. (https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/nhs-budget, Accessed 14 March 2019).

King's Fund. How the NHS is funded. King's Fund; 2017a. (https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/how-nhs-funded, Accessed 14 March 2019).

King's Fund. What is commissioning and how is it changing? King's Fund; 2017b. (https://www.kingsfund.org.uk/publications/what-commissioning-and-how-it-changing, Accessed 14 March 2019).

King's Fund. How is the NHS structured? King's Fund; 2017c. (https://www.kingsfund.org.uk/audio-video/how-new-nhs-structured, Accessed 14 March 2019).

Lafond S, Charlesworth A, Roberts A. A perfect storm: an impossible climate for NHS providers' finances? The Health Foundation. London; 2016.

LaingBuisson. Private Acute Healthcare UK Market Report. LaingBuisson; 2018.

Marshall L, Charlesworth A, Hurst J. The NHS payment system: evolving policy and emerging evidence. Research Report. Nuffield Trust; 2014.

National Health Service. 2019/20 planning prices: an explanatory note. NHS; N.d. (https://improvement.nhs.uk/documents/3613/201920_planning_prices.pdf, Accessed 2 May 2019)

National Health Service. NHS Payments to General Practice. NHS; 2017. (https://files.digital.nhs.uk/publication/4/t/nhspaymentsgp-16-17-rep.pdf, Accessed 2 May 2019)

National Health Service. Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan. NHS; 2019. (https://files.digital.nhs.uk/publication/4/t/nhspaymentsgp-16-17-rep.pdf, Accessed 2 May 2019)

National Health Service. Quality and Outcomes Framework, Achievement, prevalence and exceptions data - 2017-18 [PAS]. NHS; 2018a. (https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2017-18, Accessed 2 May 2019)

National Health Service. Reference costs 2017/18: highlights, analysis and introduction to the data. NHS; 2018b. (https://improvement.nhs.uk/documents/1972/1_-_Reference_costs_201718.pdf, Accessed 2 May 2019).

National Health Service. NHS continuing healthcare. NHS; 2018c. (https://www.nhs.uk/conditions/social-care-and-support-guide/money-work-and-benefits/nhs-continuing-healthcare, Accessed 2 May 2019)

NHS England. CCGs. NHS; 2018a. (https://www.england.nhs.uk/ccgs/, Accessed 14 March 2019).

NHS England. Fair Shares - A guide to NHS Allocations. NHS; 2018b. (https://www.england.nhs.uk/wp-content/uploads/2018/09/nhs-allocations-infographics-v1.2.pdf, Accessed 14 March 2019).

NHS England. Long Term Plan. NHS; 2019. (https://www.england.nhs.uk/long-term-plan , Accessed 2 May 2019).

OECD. Better Ways to Pay for Health Care. OECD Health Policy Studies, OECD Publishing. Paris; 2016.

O'Reilly J, Hakkinen U, Busse R, Or Z. Paying for hospital care: The experience with implementing activity-based funding in five European Countries. Health Economics Policy and Law 2012;7(1):73-101.

Wright A, Cornick E, Jones H, Marshall L, Roberts A. Towards an effective NHS payment system: eight principles. The Health Foundation; 2017.

Barber SL, Lorenzoni L, Ong P, editors. Price setting and price regulation in health care: lessons for advancing Universal Health Coverage. Case Studies. Geneva: World Health Organization, Organisation for Economic Co-operation and Development; 2019.