# Payment and the NHS Long Term Plan

## The case for changing the payment system for secondary healthcare

## Introduction

In this document we look at the current payment system for secondary healthcare in England, assessing its suitability for delivering the goals for the future payment system set out in the NHS Long Term Plan. We have drawn on research from a range of external institutions, as well as work done within NHS England and NHS Improvement.

We describe the underlying payment system largely comprising activity-based payments (the national tariff) and block contracts (widely used for non-acute care). However, it is important to note that during 2020/21, as part of the NHS's response to the COVID-19 pandemic, nationally-set block payment arrangements have been put in place. These arrangements are a significant change from the underlying payment system, but in many ways provide a new starting point for any future payment system reforms.

We consider the following potential changes to the current underlying payment system, and the reasons why they may be required to deliver the Long Term Plan objectives:

- Refocusing the core purpose of the payment system in line with the Long Term Plan objectives.
- Assessing how risk is allocated through the payment system, to support collaboration and system working.
- Ensuring the future payment system supports integrated care.
- Gathering reliable cost and activity data for both acute and non-acute settings.
- Aligning contractual arrangements to support collaboration and system working.
- Bringing together payment approaches across the wider health and social care sectors to support alignment of incentives to deliver the Long Term Plan's ambitions.

We then set out some goals for the future payment system that would address these points.

In November 2020, NHS England and NHS Improvement set out its next steps for building strong and effective integrated care systems (ICSs) across England.[1] This is a key part of the context for the case for change discussed here and establishes the principle of 'collaboration' as a core component for the future payment system.

## The current underlying payment system

The NHS Long Term Plan recognised that payment methods should act as enablers of transformation towards the delivery of integrated care and the creation of ICSs, as well as promoting prevention. To support this, the Plan set out that the payment system should move away from activity-based payments and ensure that most funding is population-based.

Under the current underlying payment system, secondary care providers are mostly on either a block contract or an activity-based payment (the national tariff, formerly known as payment by results (PbR)). PbR was first introduced in 2003 in the context of competition between NHS providers and an injection of funding into the health service. The objectives were to reduce waiting times, support patient choice, reward efficiency and quality, and focus provider and commissioner discussions on quality rather than price. While it has proved successful at delivering these objectives, the context and what the payment system needs to achieve has evolved.

Other parts of the NHS use other payment approaches such as bundled payments and capitation. Each payment system promotes different incentives, behaviours and risk allocations. In the current underlying payment system, these can come into conflict and limit the delivery of the Long Term Plan a strategy that is focused on prevention and delivering integrated care.

Local areas are increasingly varying away from national payment policy defaults and using block contracts, "aligned incentive contracts" (AIC), and other payment approaches.

In some areas, COIVD-19 has presented an opportunity to move faster towards some of the ambitions for the future payment system, as set out in the Long Term Plan, than would otherwise have been the case – for example the growth in virtual outpatient appointments. The move away from underlying payment and contracting arrangements in favour of block contracts across the whole system has provided an opportunity to shift the payment system away from the activity-based approach more quickly than was initially planned. Feedback suggests that many within the sector would support such a move.

[1] NHS England and NHS Improvement, 2020: *Integrating care: Next steps to building strong and effective integrated care systems across England*.

## Potential changes to the underlying payment system

### Refocusing on the core purpose of the payment system

The payment system has a core function – to reward providers fairly for what they do, so that they can recover their reasonable costs in providing services. This purpose remains, but over time the objectives of the payment system have expanded and become diffuse. When first conceived, PbR had a clear, overriding purpose – to reduce elective waiting times. However, over time it has been asked to fulfil an expanding role. This has potentially led to competing priorities and a risk that none of the desired objectives are fully realised.

The future payment system needs to clearly focus on delivering a core purpose – whether it's creating positive incentives for change or getting funding to the right place and supporting an environment of system working. This should be centred around the Long Term Plan's objectives for the future payment system, including promoting greater integration of care, collective management of financial resources and more proactive and preventative care.

### Assessing how risk is allocated through the payment system, to support collaboration and system working

Within the NHS, leaders will sometimes set out to minimise their own organisations' risk exposure, for understandable reasons. This can mean risk is being pushed around the system between organisations, even if it reduces efficiencies and increases costs for the system. Under the current payment models, risk allocation depends on the level of activity and the payment type – so, for block contracts, increasing activity is a financial risk for providers, while for activity-based payments, increasing activity is a risk for commissioners.

This can create perverse incentives for each organisation. In the absence of effective risk sharing mechanisms there is little incentive for organisations to work together to manage risk. The Long Term Plan's ambitions for the future payment system, such as promoting system working and integrated care, rely upon organisations working together to manage risk within their system.

### Ensuring the future payment system supports integrated care

The payment models for acute, community, mental health and other services have evolved differently over time. This fragmentation can create confusion and prevent understanding of how resource usage in different settings leads to value for patients. It also makes it difficult to shift resources seamlessly across settings in response to patient need. To achieve an integrated care model, the payment system needs to be unified and applied consistently, across all care settings within a system. This would create a consistent set of incentives for all system partners and provide visibility over where resources need to be allocated to create best value for patients.

## Gathering reliable cost and activity data for both acute and non-acute settings

In order to make some of the ambitious allocative efficiency and transformation changes needed over the next few years, and to deliver the Long Term Plan goals, systems will need to access detailed, high quality information about the activities they are undertaking and the cost of delivering those services to the population they serve. It will therefore be more important in the future for providers to count, code and cost their activity in a rigorous way, even if there is no direct link between coding and reimbursement. Systems which have the best data will be able to build up their payment approaches in more sophisticated ways to help drive service redesign for their population.

## Aligning contractual arrangements to support collaboration and system working

The current legislation requires bilateral commissioner-provider contracts, which can limit organisations in how they manage and share risk. These contracts are often negotiated on a yearly basis, which takes away the certainty for providers with longer-term contractual arrangements. A System Collaboration and Financial Management Agreement (SCFMA) was introduced in the 2020/21 NHS Standard Contract with the intention of supporting organisations to collaborate, manage and share risk effectively.

## Bringing together payment approaches across the wider health and social care sectors to support alignment of incentives to deliver the Long Term Plan's ambitions

Having a separate payment system for secondary healthcare creates barriers to integrated care. It also limits the effectiveness of payment reform that does not encapsulate the full chain of care delivery. While changing all payment, contracting and incentives across multiple commissioning and provider contracts would be complex, it is important to recognise the benefits of aligning wider incentives across all parties in an integrated care pathway.

The payment system needs to create the right incentives (financial and non-financial) for prevention and early intervention, while not discouraging necessary healthcare activities and encouraging partners to work together within a system.

Leadership and buy in from the individuals within healthcare systems will make or break the success of any payment reform, as they are the agents who would implement any changes.

## How could the payment system change?

Each payment model, whether block contracts or activity-based approaches, has strengths and weaknesses. We want to make sure that any future payment system emphasises strengths and mitigates weaknesses. Given the issues raised above, our goals for the future payment system are as follows:

- First, to move further away from purely activity-based payment. This type of pricing rewards unilateral interest not cooperation and can make system management of healthcare activity difficult. At the same time, we want to retain its benefits, particularly: rigorous coding, counting and costing of activity; encouraging efficiency through yardstick competition and by promoting patient choice; and improving the quality of care through pay-for-performance schemes.
- Second, to align the aims and incentives of payment systems across healthcare settings. As described above, the current mix of activity-based payment and block contracts does not encourage pooling of resources or a common and shared view of system cost and value.
- Third, to establish a contracting approach that promotes collaboration between providers, while maintaining bi-lateral contracts that establish the responsibility each individual provider has to deliver healthcare services.

These goals reflect the Long Term Plan ambitions for the payment system: to take better account of the costs of delivering efficient services locally, to ensure a majority of funding is population based and to align financial incentives to the other commitments in the Long Term Plan. Achieving these goals should also enable the payment system to better support the ambitions in the Long Term Plan to change the service model of care and to improve upstream prevention.

Longer-term transformation of the payment system would need to better reflect the needs of distinct groups of patients and of different models of care. This could involve splitting the population in a local health economy into a small number of broad categories, based upon common characteristics and of the type of care provided to each. For example, chronic conditions (such as diabetes), multiple episodes of care with a defined end point (such as ophthalmology) and single episodes of care (such as having an appendix removed).

There would then be an appropriate payment approach to support that patient cohort and type of care. For example, a population-based year-of-care approach for chronic conditions, a patient-pathway approach for multiple episodes of care and activity-based payment for single episodes of care. Each approach would involve prices being built up from national and local information.

Any payment approach would rely on good quality data, and particularly costing data. The development of patient-level costs (PLICS) offers richly detailed costing information that would enable prices to better reflect the efficient costs of delivering care. The detail in patient-level costs also better supports national benchmarking such as the Getting It Right First Time programme and the Model Hospital and Model Health System. They also provide better local business information to help hospital managers and clinicians to improve care.

## Conclusion

This document outlines why we believe the current underlying payment system needs to change to support delivery of the NHS Long Term Plan objectives, particularly in light of the impact of COVID-19. It provides a foundation for our thinking on the evolving role and nature of the payment system within the NHS.

For more details on the work underpinning this document and the case studies and research that have informed it, please contact pricing@improvement.nhs.uk

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