Payment by Results, recovery and equalities: what is happening in England?

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How should public services be commissioned?

BLOCK GRANT MODEL

- Annually contracted
- Pay a fixed sum to provider
- Expect provide to manage demand
- Usually based on adjustments to previous years activity
- Often little in the contract covering quality or outcomes

PAYMENT BY RESULTS (PbR)

- Pay for Performance (P4P)
- Identify the outcomes you want to be delivered
- Define a payment model
- Maximise incentives
- Minimise perverse incentives

Experiments in Social Policy in England in moving to PbR

Experiments in P4P models in England

- Models are being used in the NHS, Criminal Justice, Troubled Families and in Welfare to Work
- Many models and terms used, inc. Social Impact Bonds

The Tariff
The price set for each unit

The Currency:
The thing being purchased

In theory:

- Services paid for the results they achieve
- A fixed price allows a focus on improving quality & outcomes

Practical challenges to P4P

- Defining the thing being contracted for (the currency)
- How wide should the scope be across a system/pathway?
- How to define the outcomes?
- And to be able to make attributions that the service has delivered the outcomes.
- Should we specify care processes/pathways?
- What period should contracts be for?
- Defining a payment (tariff) model that provides the right incentives and rewards for risks, but also minimises perverse incentives.
- Data collection, quality and analysis.
- Balancing complexity/clarity/comprehensiveness/ practicality

PbR in Acute Physical Health Care in England

Phased introduction from 2003/4 – slow and carefully managed nationally

National tariff introduced - formula adapted almost every year to address specific challenges

The payment is actually by episodes of care (activity) (results?)

Trying to evolve to better tariffs for best practice and whole pathways

Some lessons from Acute PbR

- Early implementers generally welcomed it
- It was more complex & time consuming than anticipated
- It exposed some weaknesses, e.g. financial instability
- Coding and data were challenging
- Coding worsened in 2009/10 - new model introduced
- Wide variation in coding error rates - between 0 and 28 per cent
- Quality of costing information (to underpin the tariffs) is very variable
- Increases in capacity, with reduced waiting times
- Some evidence of increased efficiency, no sign of decreased quality in some areas of care
- But, financial pressures on commissioners – no demand management

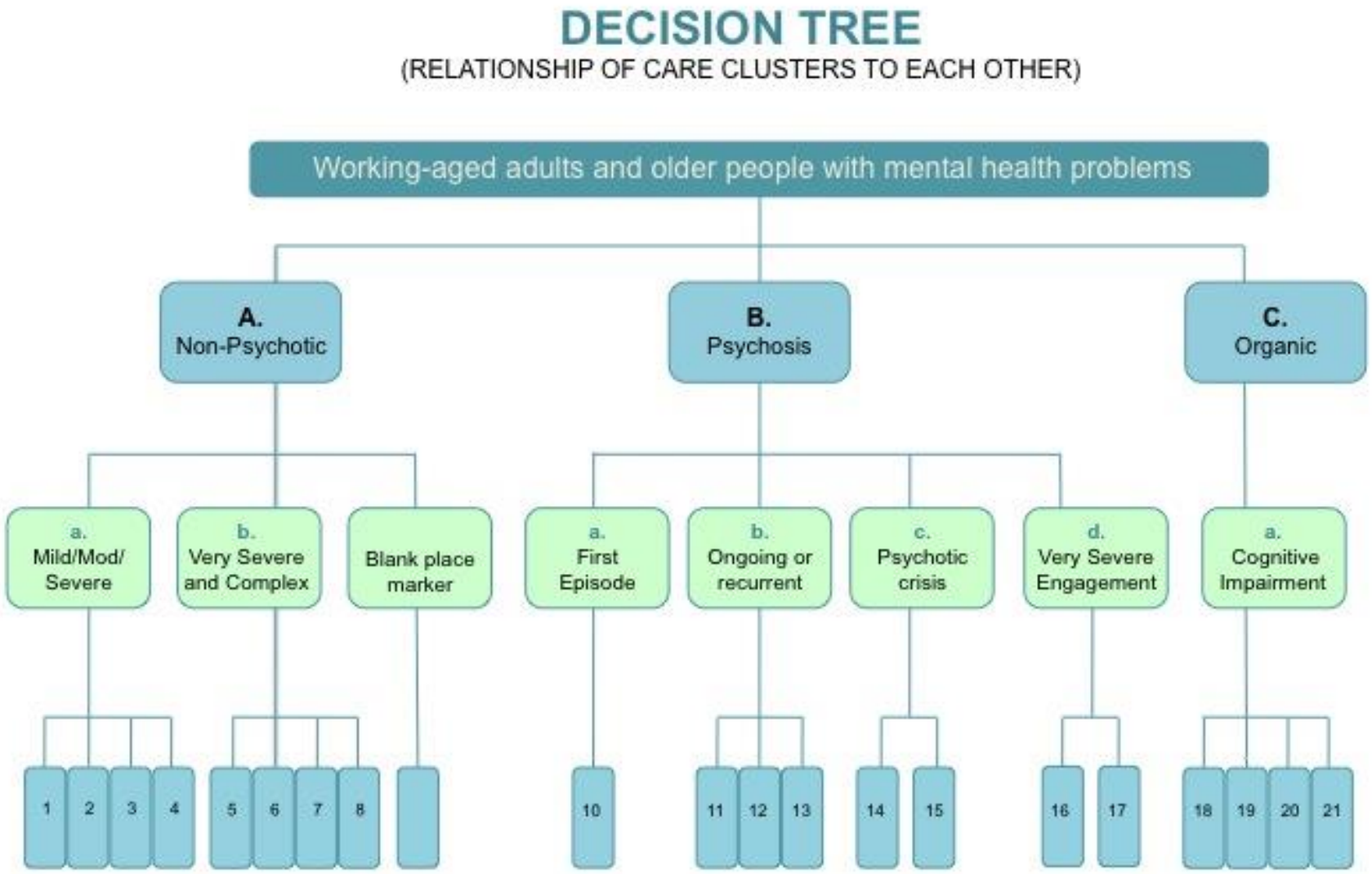
Developing PbR in Mental Health Care in England

- the *Currency* was always seen as *problematic* for mental health – too many diagnostic codes and too much uncertainty.
- model of **Care Clusters** developed in North East England
- A cluster is now the currency.

- The whole country is now in a process of adopting the model for commissioning and managing adult mental health care.

- Assessment and allocation to a cluster
- *Mental Health Clustering Tool* (MHCT) (HoNOS with additional questions) – used for assessments

Mental Health Care Clusters



Mental Health PbR Implementation

- All *service users/patients allocated* to an (initial) care cluster by the end of 2011
- Providers have submitted *2010-11 reference costs* to DH on a cluster basis for the first time
- Commissioners and providers *agree **local** tariffs for 2012-13*, based on the cost of the care clusters
- Locally refine PbR *model* in 2012-13, including refine care packages (to be in line with NICE guidance and standards)
- Earliest possible date for a *nation tariff* was 2013-4 (didn't happen)

- Steady implementation, but emphasis on local not national

Mental Health PbR, recovery & inequalities

- There is encouragement that PbR should :
  - Define and reward results in terms of recovery
  - Should address inequalities within mental health care
  - Should address inequalities between people with mental health problems and the rest of the population (e.g. physical health)

- This is ambitious
- There is ongoing work to define such **results** for PbR
- But no real testing of its impact on practice as yet
- Can such improvements rest so much on payment systems?

Challenges found so far

- Commissioners and providers reported they were not ready for local PbR
- Adjusting – language, sensemaking and communication
- Data quality for clustering
- Defining and collecting data on results/recovery
- Integrating it with social care – PbR is a health system
- Defining care packages and pathways – balancing personalised care with standardised care
- Developing consistency and addressing inequalities – is localism the answer?

- But, services are looking more closely at what teams do.

Conclusion

- Writing of plans to extend PbR beyond acute care :

  ‘It is best to decide how to pay for non-acute care by first stating what payment is designed to achieve and then evaluating the funding options. The English are making the decision back-to-front by deciding to extend PbR and then trying to make the service fit into this payment model.’ (Street & Maynard 2007)

- PbR/P4P models will continue to be experimented with in social policy in England
- Mental health has aspirations about recovery/results, but faces many challenges to make a system work
- Implementation needs evaluating

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