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Reply

Payment by results: qualified ambition?

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The commentaries on our original paper are interesting and informative. That of Malcomson illustrates nicely the costing and case-mix issues that are critical to the successful design of activity-based funding arrangements. The second commentary describes some more general issues and the scope for reformers to learn from international experience.

The policy documents put out by the English Department of Health (DoH) relating to Payment by Results list an array of 'key' objectives that the funding reform is designed to achieve (Miraldo *et al.*, 2006), which are listed in Table 1 together with some qualifying statements. Of course, if activity-based funding was easily able to achieve all of these objectives, no country would be slow in adopting it – yet England is fully 20 years behind the United States in introducing these payment arrangements. It is also notable that many other policy initiatives cite a similar list of desirable objectives. Rarely are these objectives ranked by priority and often insufficient consideration is given to the possibility that policies that advance some objectives may frustrate others.

Activity-based funding does have advantages over the alternatives of cost-based reimbursement and global budgets, notably in linking hospital revenue much more closely to activity and in allowing greater transparency in funding arrangements.

But the extent to which these advantages improve efficiency depends on the specific form that activity-based funding takes, and how prices are set. Prices (tariffs) could simply reflect the (average) costs of existing practice, as they do in England. In this case, activity-based funding would encourage hospitals to ensure that their costs were below average. As we have argued, this pricing rule would take the existing mix of services as given and appropriate.

But tariffs could play a more extensive role, so that they are analogous to prices in most markets. Usually (market) prices provide important signals to producers about the demand for particular services – if there is under-provision,

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Table 1. Stated aims of activity-based funding – with qualifications

DoH Aims	Qualification
Increase efficiency in the provision of existing levels of activity	Prices based on average costs may dampen incentives for low cost providers to improve. High cost providers may skimp on quality to mitigate revenue losses Possible adverse consequences include selection of patients with low expected costs and up-coding – so ongoing review of the casemix classification system and audits of coding are necessary.
Where needed, encourage expansion of activity	Cost-based prices provide neutral signals about what is needed. Additional incentives are required to indicate what is most desirable.
Enhance patient choice	Yes, compared to global budgets, as no need for price negotiation.
Increase patient satisfaction	No obvious reason why satisfaction should be higher under ABF than alternative funding mechanisms
Reduce waiting lists	Yes, if incentives are structured so that activity increases are focused on waiting list conditions as in Victoria. In England, the target-setting regime has probably been more important than ABF in successfully reducing conditions with long waiting times.
Improve quality	Quality in danger of being compromised, especially if hospitals engage in risk selection, quality skimping or cost-shifting. Better measurement and monitoring of quality – in particular of patient outcomes – is required, together with enhanced regulatory safeguards and incentives.
Keep costs under control	Not compared to global budgeting. Additional mechanisms have been introduced in England to control overall expenditure such as activity ceilings, two-part tariffs and demand management mechanisms.
Channel funding where it is needed	Within the acute sector, cost-based prices provide neutral signals. Ability to channel funding away from acute sector depends on relative bargaining power of hospitals and commissioners, and mechanisms such as practice based budgeting to influence GP referral behaviour.
Shift patterns of service provision away from historical patterns	Ability of commissioners to redirect funding away from hospitals may be counteracted by hospitals trying to attract activity into the acute sector which is better undertaken in other settings. Risk that treatment centres and independent sector providers will 'cream skim' less complex activity, thereby undermining economies of scale in NHS hospitals, with consequent inflation in unit costs.

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Table 1. Continued

DoH Aims	Qualification
Encourage the development of new, cost-effective treatment pathways	Yes, in the acute sector – exemplified by the structure of the elective tariff to encourage day case provision and by the development of treatment centres. For pathways spanning different providers, ABF might frustrate co-operative working practices unless the pathway can be 'unbundled' to ensure fair reimbursement between providers.
Introduce fairness and transparency in funding providers	Yes, essentially ABF is perceived to be fair (equal pay for equal work) and transparent. Need to take account of influences on costs that providers cannot control, such as differential input prices (corrected for in England using the Market Forces Factor). May be a case for accounting for (dis)economies of scale and scope. Need to ensure sufficiently refined casemix classification system so that hospitals are not penalised for systematically attracting high cost patients within a HRG.
Encourage providers to be responsive to patients and purchasers	Yes, to patients, if hospitals are more active in seeking 'business' now that they are paid on the basis of activity. But commissioners may clash with hospitals if they want to redirect activity to non-hospital settings.

prices rise, thereby encouraging providers to expand provision. Prices in the health system could be regulated in a similar way if there is evidence that some treatments are being under-supplied. Prices, therefore, can be used as a policy instrument to signal what the health system should be doing and to sharpen incentives so that good practice is rewarded and emulated. Use of such normative pricing requires careful piloting and evaluation.

Activity-based funding can lead to unintended consequences if case-mix descriptors and payment arrangements are not sufficiently well defined. For instance, activity-based funding may compromise quality by encouraging hospitals to be overly cost conscious, leading them to cut corners or shift costs on to other contributors to the care process, such as GPs. It might also lead to cost inflation, particularly in comparison to global budgeting arrangements. To guard against such behaviour, activity-based funding has to be supplemented by additional regulatory mechanisms, such as activity ceilings, marginal pricing, data audit, monitoring of care processes, and measurement of patient satisfaction and health outcomes.

The English form of activity-based funding needs a much clearer definition of the priority objectives it is intended to achieve. Clearly the many aims listed in Table 1 cannot be met by a single policy instrument. Payment by Results also

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needs to be integrated much more coherently with the many other regulatory interventions that have been subjected upon the NHS over the last decade under a banner of 'System Reform'. Reformers have to demonstrate that these various policies improve efficiency in terms of their impact, particularly on patient outcomes, and cost. Fixing prices is relatively straightforward. But as the articles in this debate suggest, the true challenges are in defining a fixed price payment regime that is fair, rewards desired behaviour, and complements other policies. A further challenge is to refine this regime as evidence emerges about its intended and unintended effects.

Reference

Miraldo, M., Goddard, M. and Smith, P. C. (2006), 'The incentive effects of payment by results', *Centre For Health Economics Research Paper 19*, University Of York, York.

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