Transition from Payment by Results (PbR) to Population-based funding through Integrated Care System (ICS)

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1. Introduction to the Study

The aim of this study is to explore the transition of NHS funding from payment by results (PbR) to population-based funding through an Integrated Care System (ICS). In 2014, NHS England produced a report which forecast £30 billion gap in NHS funding and to help tackle this funding gap, proposed reforms to the payment system with a move away from payment by results (PbR) to population-based funding through an integrated care system (ICS).

2. Current Funding Mechanism

PbR was introduced by the NHS to pay a fixed price for each acute patient treated. The original aims of PbR were to create a transparent link between outputs and income, to help identify and deal with inefficiency and ensure that funding follows the service user, thereby supporting their choices. For specialised services, the PbR tariff is adjusted, and a specialised service top up is added to reflect the actual costs of providing care. By its very nature, specialised commissioning relates to high cost and volume activity. In England, most acute treatments are funded using a tariff. The tariff incentivises healthcare providers to meet different objectives including improvements in efficiency, effectiveness, quality of care and patient choice. In addition, the tariff removes the need for price competition between providers. Since the publication of the National Service Framework (NSF) (Wanless, 2002), patient choice has been at the heart of the NHS and the Health and Social Act of 2012 has reinforced this. Through choice and payment by results (PbR), patient choice becomes more meaningful as it attaches payments to those choices (Self, Painter and Davis, 2008). It is worth acknowledging at this stage that not all acute treatments are funded by tariff.

PbR is a method of payment based on measurable criteria i.e., the number of patients treated. It is also worth pointing out that the underlying Health Resource Groups (HRGs) also recognise the resources consumed by the average patient in resource groups i.e., complexity/acuity. Prior to the introduction of PbR, several purchasing arrangements were used in the NHS between commissioners and providers i.e. block contracts, sophisticated block contracts, cost and volume contracts and cost per case contracts (Farrar et al., 2007). The main spur to payment reform for hospital services was provided by Tony Blair's Labour government's target for reducing waiting list times for planned hospital operations. Achieving those targets meant a reform of the payment system which would incentivise hospitals to increase their activity levels. As noted at the time, block contracts did not provide the necessary incentives to achieve the stated policy aim. Therefore, the decision was made to implement PbR in a phased manner from 2003/04.

3. Funding Gap and Reasons

In 2014, NHS England published the five year forward plan (NHS England, 2014) which forecast a £30 billion gap in funding by 2020/21 between resources and patient needs due to the effects of growing demand and flat real terms funding (Iacobucci, 2014). Therefore, to sustain a comprehensive high-quality NHS, action will be needed on all three fronts – demand, efficiency, and funding. In January 2019 "The Long Term Plan" was published which included reforms to the payment system to reduce activity-based funding and increase population-based funding (NHS Improvement, 2019) . The reason for this gap is that between 2010/11 – 2015/16, the tariff used to fund NHS Trusts for each patient treated was reduced by 1.6%. In addition, NHS-specific inflation was increasing by 2.2% making a real term cut of 3.8%. NHS Trusts in the meantime were expected to make a 4% efficiency saving in their operating costs in order to balance the books but only managed to make a 2% efficiency saving (Gainsbury, 2016). In the years after 2015/16, the tariff did increase by 1% every year however this was below the NHS-specific inflation of over 3% coupled with the fact the number of patients treated with more complications and advanced medicine has seen a continuous growth of over 3.1% for the

past decade and will continue this trend till 2020-21. It should be noted that nearly two decades after the introduction of PbR, it has not worked as originally intended. Studies, matching the researcher's experience of dealing with PbR, have shown that the downward pressure of costs imposed by the tariff has led providers to use non-tariff based income such as research grants, clinical trials, training income for doctors and nurses to finance their operational services. Furthermore, there is increasing evidence that at a local level, purchasers and providers are ignoring the tariff by entering into locally agreed block contracts for some services which by implication means that the income earned by providers from the tariff has decreased steadily over the years.

4. Population-Based Funding

There is recognition that health and social care go hand in hand hence the reason for ICSs. The issue that needs to be discussed and understood is how population-based funding is defined and how the component that make up population-based funding are derived. Furthermore, the growing demand for health services has been exacerbated by lifestyle choices like obesity, alcohol, smoking and other major health issues. To help reduce this funding gap (£30 billion), there need to be plans and action on health prevention and public health initiatives with funding to match. The WHO defines health *"as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"* (World Health Organisation, 1946). Health as a concept promoted by WHO considers the notion that it is a fundamental right of all people regardless of race, age, religion, political beliefs, economic or social condition to have the access to the highest standard of health. Although the WHO have stated that governments have a duty to provide health for their population, it also acknowledges that there are other factors beyond health and social care that have a major impact on health and wellbeing which can be stated as the determinants of health. In moving from PbR to population-based funding through ICS, it is important to define and assess what is meant by population health and how this affects how funds are distributed. Health systems around the world vary in their performance and coverage. For countries with universal healthcare, the healthcare coverage seems to be more extensive than those without. It should further be noted that performance of healthcare systems across countries vary even when they have universal healthcare as it depends on wealth, education, and health expenditure. It is for these reasons that a lot of countries have enacted health reforms to improve the performance of their health systems.

Kindig and Stoddart (2003) defined population health as "*the health outcomes of a group of individuals, including the distribution of such outcomes within the group"*. This means that population health can be characterised as having policies and processes in place to ensure that there is a health management system in place that caters for the need of a given population within a geographical area and that this health management system is effective and efficient. The sole aim of population health should be to improve the health of the population and the way to achieve this aim is to reduce the existing health inequalities. Therefore, the success/failure of this aim can be summarised in three strands or determinants (Murray et al., 2002) – health, responsiveness, fairness of household financial contribution.

5. Integrated Care System (ICS)

"Integrated care is a term that reflects a concern to improve patient experience and achieve greater efficiency and value from health delivery systems. The aim is to address fragmentation in patient services, and enable better coordinated and more continuous care, frequently for an ageing population which has increasing incidence of chronic disease" (Shaw, Rosen and Rumbold, 2011).

Countries around the world increasingly see integrated care as a way to reform their healthcare systems. However, there is a feeling that few countries understand what the meaning of integrated care is and judging by the different definitions around the concept of integrated care and lack of clarity of what it means, helps reduce its understanding and successful application as a concept which therefore renders any evaluation very difficult. Governments now see integrated care as a policy tool to bring together the disparate parts of the healthcare system to increase efficiency, quality of care, quality of life and save money in the long term. Examining a lot of the literature on integrated care, they contain a few drivers for change which are vital to the change process: collaboration, fragmentation, care coordination, efficient use of resources, specialisation and decentralisation, cost control, ageing, chronic

illness and disability, access, continuity, inefficient use of resources, lack of quality and shortcoming in health and social care systems. In this respect therefore, "the lack of specificity and clarity in the definition and process of integrated care hinders systematic understanding and successful, real-world application of integration" (Sutton and Long, 2014). It should further be noted that one of the major issues with understanding integrated care and how it works through the various strategies to be deployed to make it a success is mainly due to a lack of systematic analysis and coherent frameworks. Having systematic analysis and coherent frameworks in place helps to "facilitate communication, understanding, hypothesis generation, policy formulation, program development, and evaluation" (Kodner and Kyriacou, 2000).

Penno, Gauld and Audas (2013) acknowledged that there is a dearth of literature into what is within the formulae setting population-based funding or the varying options that policy makers may choose from. These funding formulae will increasingly be key to resource allocation, encompassing the different components used to determine basic healthcare. There has been a lot of research conducted in several countries with respect to PbR and population-based funding, including the ICS, which many countries have adopted for payment purposes. To the best of the researcher's knowledge, there has been no research regarding the transition from PbR to population-based funding. This is a gap this research aims to fulfil, and this will be achieved by exploring different funding mechanisms from the UK and other countries.

6. References

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