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## *Does Payment by Results (PbR) apply to Community Paediatrics?*

Dr Cliona Ni Bhrolchain, Dr Fawzia Rahman and Peter Howitt

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Short Answer:

**Not Yet**

# Why is PbR important?



## What is PbR?

- At its simplest, PbR is just a list of prices for acute care:

$$\text{Price} \times \text{Activity} = \text{Income}$$

HRG code	HRG name	Elective spell tariff (£)
A01	Intracranial Procedures Except Trauma - Category 1	1,127
A02	Intracranial Procedures Except Trauma - Category 2	3,287
A03	Intracranial Procedures Except Trauma - Category 3	4,174
A04	Intracranial Procedures Except Trauma - Category 4	5,645

## Before PbR introduced (2003/04):

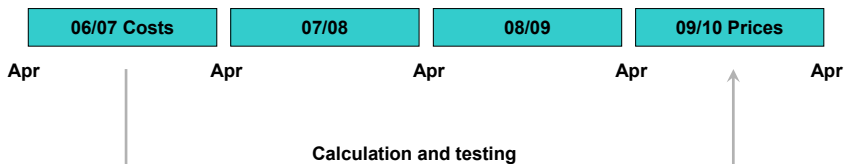
- Block contracts awarded to provide services, with prices based on historic local costs and negotiating skills
- No transparent link between outputs and cost
- Difficulty in identifying and dealing with inefficiency

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# How do we get prices?



- Annual cost collection – Every provider reports costs for services they provide. Known as “reference costs”
- ‘Average’ of reported costs determines price



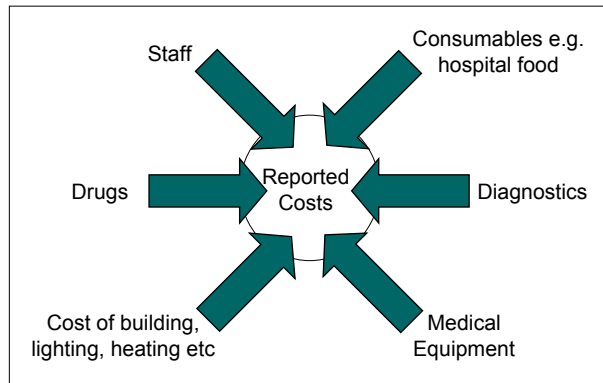
- Time lag - 2009/10 tariff based on 2006/07 reference costs  
- Tariff inflated to take account of pay and price increases

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## What should be included within reference costs?



PbR assumes full cost absorption in the cost reported :



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## BACCH a PbR Development Site



- **What does this mean?**
  - **A chance to get experts in their particular healthcare areas to be involved in developing approaches to payment.**
  - **Reflected the need to try out new currencies, or units of payment – acute hospital payment for a spell of care not going to be appropriate for all services.**
  - **In reality there is a lack of central resources so we will only make slow progress if we drive everything centrally.**
  - **Ultimately, if successful will link community paediatric funding to the care that is given.**
- **Central Questions for the Development Site:**
  - **What should be the currency (unit of payment)?**
  - **Can we get accurate costs and activity information?** <sup>6</sup>



# A Good Currency

- **Currency should support the objective of providing better patient care**
- **Currency must be clinically meaningful** - that is that as a grouping of patients/service users it is accepted by clinicians.
- **Currency should be workable** - this means that they should be supported by underlying information flows (available or attainable) and have a workable number of groups
- **Currency should have as much resource homogeneity as possible ("iso-resource")** - that is service users/patients should require a similar type and amount of resource. This avoids cherry picking and/or neglect of more serious cases.

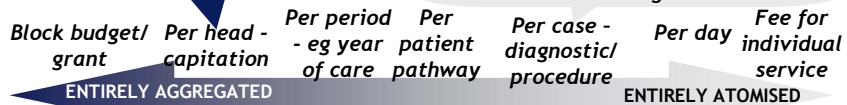
# Currency Options



GP contract increased weighted capitation & added quality adjustments

PbR has enabled choice, increased day cases, reduced LoS & helped tackle waiting

There are pros and cons to any point along this spectrum



What does it look like?

Block budget/grant	Per head - capitation	Per period - eg year of care	Per patient pathway	Per case - diagnostic/procedure	Per day	Fee for individual service
Lump sum over period of time (eg 1 yr). Sum independent of no of patients	Periodical (eg annual) lump sum <i>per patient</i> . Usually on list or enrolment system.	Lump sum per defined care service and per patient list or group over period of time	Payment for providing a defined pathways of care with multiple episodes/int erventions.	Payment based on groups of cases using similar resource & similar diagnoses and/or procedures	Used where patients have stay in hospital. Can be set to reduce over time.	All activities and/or contacts are identified and priced individually.

For what is it used?

Used for almost all community services, as well as grants in particular areas such as R&D	GP services are primarily paid for on a capitation basis	Current Diabetes project considering this	Not used at present, but lots of interest given Darzi Pathway approach	Used in hospitals for most activity (PbR)	Used for stays in hospital above the defined length of stay trim-point (PbR)	Used for some GP & private hospital services e.g. vaccination by GPs
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## “Iso-resource” requirement means good costing needed



- Cost **ACTUAL** patients using **ACTUAL** costs and recording
  - interventions
  - costs of interventions
  - any dependent variables

**SEVERAL AFFORDABLE TOOLS NOW AVAILABLE  
(PLICS)= Patient Level Information and Costing  
Systems**

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## PLICS:

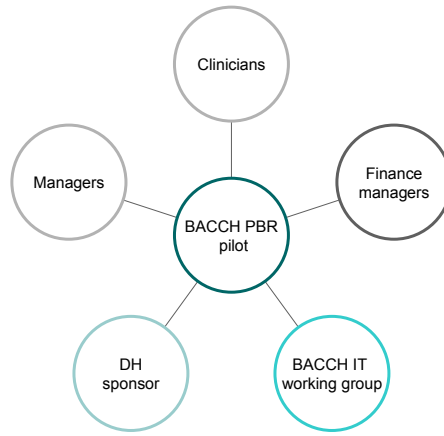
(Patient Level Information and Costing Systems )



- Records individual interactions, processes, procedures and events which take place and are connected directly with the patient's care from the time of admission until the time of discharge.
- Ascribes to the patient the direct and indirect cost of the resources used during those interactions, processes, procedures and events.
- Clinical ownership crucial:
  - Change forced on clinicians without good data /evidence is likely to be opposed and obstructed.
  - Variations in clinical practice and cost and quality outcomes must be identified in a manner which makes sense to clinicians. PLICS does this.

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## How is the pilot organised?



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## What does the pilot need to do?



- Decide what currency options to investigate
  - Pathways
- Collect activity consistently
- Establish costs in pilot Trusts
- Test it more widely
- Agree local tariff

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## BACCH Pilot Tasks (1)

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- Activity
  - Clinics/neurodisability
  - Statutory work
    - Safeguarding, LAC/Adoption, Education, public health, other
  - Immunisation programmes

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## BACCH Pilot tasks (2)

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- Finance
  - Consistent way of allocating costs
- Compare reference costs

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## What is the future?



- In future, patient-level costing?
- Tariff per case or payment by pathway?
- Payment for MDTs?
- Capitation payments for public health and designated roles?

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## Reference Costs for Community Paediatrics



	G	D	W
Pop	222,600	600,000	320,000
291 F uni		4652	5093
291 F multi	110	400	458
CP60FS	143	247	63
CP60FSS	332	372	24
CP60FSE	800	200	266
CP60FO	2333	-	-

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