HFMA introductory guide to NHS finance

Chapter 19: How NHS services are paid for

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Overview

This chapter sets out how funding is transferred from commissioners to providers of healthcare services. It considers the evolution of payment mechanisms, the legal framework surrounding them and the way in which payments can be used to influence behaviour.

This chapter considers the history of payment mechanisms in the NHS, to give context to the current approach and then describes the aligned payment and incentive approach used to transfer funds to acute, mental health, community and ambulance services. Primary care funding flows are covered in chapter 6.

19.1 What is a payment mechanism?

A payment mechanism is a system of financial flows to move money around the health service and is used to reimburse providers of NHS healthcare in England. The payment mechanism can be used to incentivise provider and healthcare system behaviour, depending upon current priorities. The payment mechanism sets out all of the elements that contribute to the payment amount, such as activity undertaken, quality of care and patient outcomes, as well as any penalty regime for under or non-achievement. The NHS standard contract described in chapter 16 plays an important role in supporting the application of the payment mechanism, through setting out the conditions that apply in a particular context.

The NHS has traditionally used a combination of different payment mechanisms across all services but, from 2022/23 the majority of secondary care services have moved on to a single payment mechanism, the aligned payment and incentive approach.

19.2 Types of payment mechanism

Activity based payment

An activity-based payment is a sum linked to either a single unit of care, such as an outpatient appointment or a spell (a continuous period of time spent as a patient within a trust), or a pathway, where a number of related units are linked together as one. Acute care and ambulance services have traditionally been paid on this basis.

Block payment

A block payment is a lump sum amount that covers all activity undertaken. Payments for all services are bundled together and it is not directly linked to activity levels. Community health and mental health services have traditionally been paid on this basis.

Blended payment

NHS England and NHS Improvement have introduced a blended payment approach for the majority of activity across all secondary and tertiary care settings from 2022/23. This is made up of a fixed

payment, similar to a block, with a variable element to address particular policy issues. More information is included later in the chapter.

19.3 Evolution of payment mechanisms

Payment by results

The first payment mechanism – payment by results (PbR) was a key element in the NHS reform agenda set out in the Labour Government's 2000 NHS Plan. The Government at the time wanted to be sure that the large increases in resources that it planned over a five-year period would be used to develop and deliver a higher volume and quality of clinical services. To achieve this aim there needed to be a financial system that contained the right balance of reward, incentive and equity – hence the introduction of PbR.

PbR was originally designed to bring about fundamental change to the way funds moved between commissioners and providers for the payment of secondary care services. PbR does not affect the way funds flow to commissioners: CCGs receive an allocation with which to purchase healthcare for the patients registered with their constituent practices. However, in simple terms, it affects the way that commissioners spend that allocation as they pay providers for each patient seen or treated in many cases, at the national pre-set rate. Therefore, if more patients are treated than originally planned, the commissioner will spend more money, causing a budgetary pressure for the commissioner.

PbR affected the income received by providers - they were paid for the actual work they did, often at a national pre-set rate, or tariff. Therefore, if more or less patients were treated than planned, the provider may have had more or less income than anticipated.

National tariff

Prior to the Health and Social Care Act 2012, national prices were set by DHSC. The Act transferred the responsibility of the NHS payment system to NHS England and NHS Improvement (Monitor, as it was at the time). The national tariff was developed and introduced in 2014 with the intention that it would support both commissioners and providers to address the challenges facing them, in three ways:

- by offering more freedom to encourage the development of new service models
- by providing greater financial certainty to underpin effective planning
- by maintaining incentives to provide care more efficiently.

The national tariff is a legal framework that covers prices for treatments and procedures, the methodology for setting them and the underpinning rules. Under the national tariff, payments made to providers of care for NHS patients, be they from the NHS, private or independent sector, are linked to the activity and services actually provided. For most secondary care activity, payment is based on a national pre-set price for a defined measure of output or activity while recognising the type, mix, complexity and severity of the treatment provided.

Prior to 2022/23, the national tariff primarily covered elective (including outpatients) and non-elective acute care (including urgent and emergency care), and ambulance services. It did not cover all healthcare services but for those services included within it, the rules of the tariff had to be followed. However, there was provision within the tariff for local variation to prices and currencies, through an agreed process. This flexibility was included to enable service transformation or to incentivise a different service mix, for example.

The national tariff also set out the national efficiency requirement which applied to all secondary healthcare services. Billing, payment and activity reporting processes were set out in the national tariff document, along with payment for NHS funded services provided by local authorities. All licensed healthcare providers were required to comply with the national tariff and provide information to support its development.

Covid-19 arrangements

The local administration of the national tariff created a significant number of transactions, reconciliations, and queries in order to ensure that the correct activity was being charged to the correct commissioner, within the agreed contract terms.

The Covid-19 pandemic completely disrupted the normal flow of activity within the NHS, forcing the cancellation of routine procedures and elective care, as well as the repurposing of facilities and the redeployment of staff to support Covid-19 patients. The national tariff could not be used in this situation as organisations had little certainty over activity and had to respond to the changing demands of the pandemic. The enforced drop in activity would have created significant deficits if tariff payments had been maintained.

As a consequence, all organisations were moved to a block payment based upon their month 9 agreement of balances process from 2019/20, which was the most recent agreed position at the time. This simplification of the financial regime allowed the NHS to focus on the immediate needs of the pandemic. It freed up staff normally employed in transactional finance roles to support their clinical colleagues and it allowed organisations to work freely together without the normal financial barriers to cooperation.

While it was accepted that the simplified financial regime was not sustainable and may be causing wastage, many welcomed the reduction in transactional processing that freed up staff to focus on more transformational work. In addition, the positive outcomes of effectively removing financial barriers were something that the NHS wished to retain, driving the next, and most recent, change to the payment system.

Aligned payment and incentive approach

The 2019/20 national tariff introduced blended payments for emergency care and some mental health services, with the intention that the approach would be gradually expanded to other services in future years. However, with the move away from an activity-based approach due to Covid-19, an opportunity has arisen to move quicker.

The *2022/23 national tariff payment system*[253] moves almost all secondary healthcare services, including acute, community, ambulance and mental health onto an aligned payments and incentive approach which builds on the blended payments introduced in 2019/20. The approach covers all contracts between providers and commissioners in the same system, as well as all contracts over £30m where providers and commissioners are in different systems. The £30m threshold is based upon ICB level contracts, requiring CCGs to work together in their ICB footprints. All specialised commissioning activity will be covered by these arrangements.

A blended payment is made up of a fixed and variable element. The fixed payment is to be locally determined and does not need to be built from individual prices/tariffs. This element of the payment makes up the majority of the value. Ultimately, it is expected to be based on the costs of delivering a level of activity that conforms to the ICS system plan. However, in 2022/23, it is expected that the fixed element will be based upon the amounts paid in the second half of 2021/22 for simplicity and stability of NHS organisations. The payment value is expected to evolve over time to become more reflective of the actual costs of delivering the defined activity.

[253] NHS, *2022/23 national tariff payment system,* March 2022

Prices have still been published, as in previous tariffs, but they are mostly to be used for guidance rather than mandated for use. These prices could also be used where blended payments do not apply, for example, contracts below the threshold value.

The variable element can be used to incentivise specified activity or quality objectives. In 2022/23, the variable element is being used to support national efforts around elective recovery.

There will still need to be some national prices due to the conditions of the *Health and Social Care Act 2012*. These are considered to be appropriate for diagnostic imaging services.

Any independent sector activity commissioned through a national framework, or subcontracted by NHS providers, would be based on published tariff prices.

The aligned payment and incentive approach is designed to support:

- more efficient allocation of resources, including a focus on health maintenance and prevention activities
- collaborative system behaviours and collective management of system financial resources
- a focus on patient value, high quality care and good patient outcomes
- transparency and accountability to provide assurance that resources are being put to best use.

However, there is a danger that moving to fixed payments could reduce accountability and visibility of how resources are spent locally. The aligned payment and incentive approach will continue to evolve after implementation, to ensure that it meets the objectives set out.

19.4 Importance of currency

For the payment mechanism to work, it is important to decide what is being paid for – what is the unit of healthcare or 'currency'? Different parts of the NHS use different currencies to best reflect the way that patients are treated, and care delivered. The healthcare resource group (HRG) is the currency used for admitted patient care (covering a spell of care from admission to discharge), procedures undertaken in outpatients and accident and emergency attendances.

HRGs group services that are clinically similar and require similar resources for treatment and care. The HRG applies to a procedure or treatment regardless of where it takes place and supports the provision of components of healthcare outside of hospitals through the use of 'unbundled tariffs' whereby the payment or tariff can be shared between different providers. It provides the ability to differentiate between procedures and treatments, recognising the different costs associated with treating patients of different ages, those with multiple co-morbidities (related chronic illnesses) or where there are additional complications.

The currency for outpatient attendances is the attendance itself, split between first and follow-up attendances, the broad medical area (defined by a treatment function code) and whether the attendance relates to a single professional or a multi-professional team.

The currency used for adult mental health and learning disability services is the 'care cluster'. It describes the common needs of a group of patients/ service users over a period of time. Each of the 21 clusters includes a number of different diagnostic codes; the 'mental health clustering tool' enables service users to be matched with the appropriate cluster. However, clustering has not been

universally adopted across the sector. NHS England and NHS Improvement are currently working to develop a new mental health currency model.

NHS community health services do not yet have a defined currency model. Work is ongoing to develop currencies that reflect the way in which care is delivered in this sector, recognising that care tends to be over a longer period with multiple interventions as people manage long term conditions. This is similar to mental health services and currencies for the two sectors are being developed to complement each other.

For ambulance services, four broad activities are used as the currency here:

1. urgent and emergency care calls answered
2. hear and treat/ refer
3. see and treat/ refer
4. see, treat and convey.

Prices per call (1), per patient (2) and per incident (3 and 4) are locally agreed.

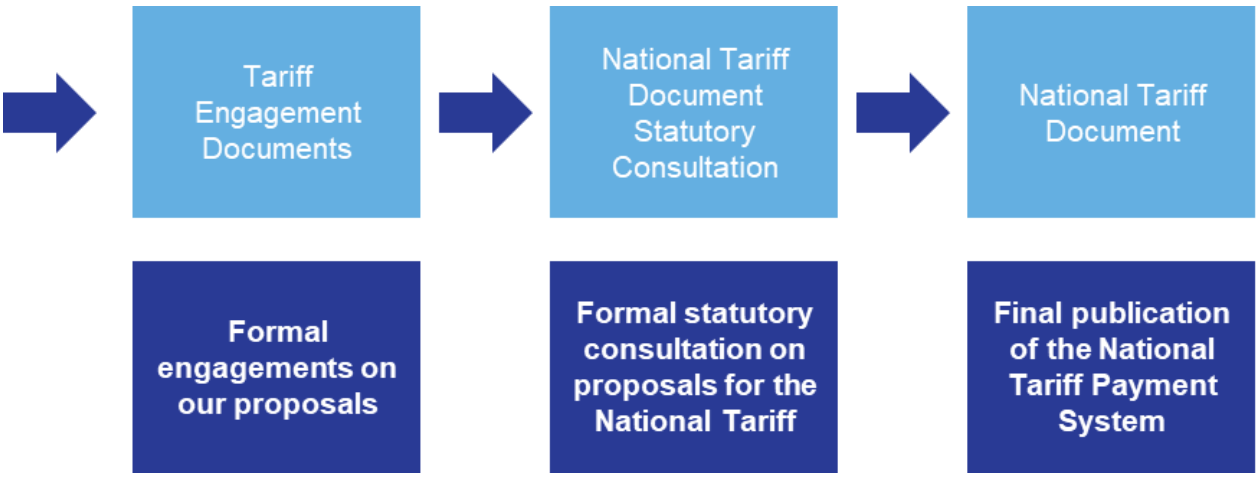
Currencies do not have to have a payment attached but they provide an agreed way to count and measure activity. They therefore underpin all payment mechanisms where it is necessary to understand activity in order to fund a service at the correct level.

19.5 Setting the national tariff

Legal framework

The *Health and Social Care Act 2012* means that the process of producing the national tariff and the associated documents is set out in law. NHS England and NHS Improvement work to a staged process for the development and publication of the *National tariff*[254] document as set out in figure 9:

Figure 9: Development of the *National tariff*



[254] The *Health and Social Care Act 2012* requires the document to be called the 'national tariff'

The stages, timing and documents and their statutory basis are set out in the table below:

Table 10: Basis for development of the *National tariff*

Stage	Documents Released	Statutory Basis
National tariff engagement	Tariff engagement documents	Not applicable
Statutory consultation	Proposed *National tariff document* for the coming year including proposed final prices	Section 119 of the *Health and Social Care Act 2012*
Publication of the *National tariff*	Final *National tariff document* for the coming financial year	Section 116 of the *Health and Social Care Act 2012*

The publication the '*National tariff document* (NTD)' is fundamental here. It details:

- the services covered by the payment mechanism and their prices where applicable
- how the prices have been calculated
- variations to nationally set prices
- how and when the local agreement of a change to a national price may be appropriate
- the underpinning rules associated with payment.

Proposed legislative changes to the national tariff payment system

The *Health and Care Act 2022*[255] sets out a number of changes to the legislation surrounding NHS payments, to support the move to system working and an aligned payment and incentive approach.

The national tariff will be replaced by the NHS payment scheme. NHS England will publish a document called the NHS payment scheme containing the rules for determining the price that is payable by a commissioner for the provision of health care services or public health functions. Both commissioners and providers must comply with the rules.

The rules may:

- specify prices
- amounts, formulae or other matters on which prices are to be determined
- provide for prices to be determined for or by reference to components or groups of services
- make different provision for different services or provision for some services and not others
- make different provision for the same service depending on different circumstances.

The rules may allow for or require local agreement of prices. NHS England will need to take into account the different costs incurred in providing services and differences between providers in order to ensure a fair level of pay.

Before publishing the rules, NHS England must undertake a consultation process (of at least 28 days) with all ICBs and provider bodies as well as any other person or body that is considered

[255] UK Parliament, *Health and Care Bill*, July 2021– the Act was not available to reference at time of publication

appropriate. There will be an objection process where more than a determined percentage of ICBs or providers object to the proposals.

The payment scheme will be able to be amended during the financial year for which it has effect unless the amendment is so significant as to require a new edition of the scheme.

Key learning points

- A payment mechanism is the way in which funding is transferred from a commissioner to a provider
- The NHS has used a number of different payment mechanisms, each of which has its own advantages and disadvantages
- The *Health and Social Care Act 2012* requires the NHS to publish a national tariff which sets out prices for most acute sector activity
- The aligned payment and incentive approach has been introduced in 2022/23 to encourage collaborative system working and more effective allocation of resources.

Additional HFMA resources

The HFMA maintains a directory of resources which provides links to other HFMA outputs such as briefings and webinars across a range of subjects. It also highlights e-learning courses that are available. The directory of resources can be found here.