

Why is Payment by Results so difficult?

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The NHS has been planning for PbR for three years. Despite this, in 2005/6 PbR was largely abandoned; and in 2006/7 the tariff was withdrawn and revised, and financial transition caused major problems. Why is the NHS finding PbR so hard to implement?

- Counting and coding activity could be slow and inconsistent in the past, because nothing major depended on it. PbR requires improvements, but they are happening slowly.
- Fairness and simplicity rarely coincide. As a high-profile public body, the NHS tries to be fair, but that means very complicated tariffs. Anything complicated is more likely to go wrong and less likely to be understood.
- Some key decisions are political. They tend to be made late and confidentially. The “doers” in the wider NHS don’t feel involved.
- At least initially, the Department of Health did not invest enough in a large, strong team to lead PbR. Too many detailed decisions were delayed, and communication also suffered.
- Tariffs based on past average actual costs leave a lot to be desired. They are not best practice, or sometimes even current practice. It is not easy to split the tariff if you don’t know the detail of the costs within it.
- We are still not sure how far the NHS will really operate like a market, e.g. by allowing NHS hospitals to withdraw from loss-making services.
- Delays and late changes to PbR have weakened confidence and created some unforeseen financial pressures (e.g. not protecting PCTs fully from the movement to tariff).
- PbR increases financial risk in the NHS, as part of a longer-term drive to improve performance. Additional risk is rarely welcome, especially in the public sector.
- St Augustine prayed for “chastity, but not yet”. Many people in the NHS feel the same about PbR, and are always willing to find problems and reasons for delay.

Meanwhile PbR, one of the biggest changes ever to hit the NHS, is still going ahead. The onus is on the financial profession to make it work.