Now more than ever pharmacists must think beyond the clinical appropriateness of medicines to the financial implications of therapeutic choices. This month we take a look at Payment by Results

Trends in NHS funding payment by results

By Catherine Hughes, DipClinPharm, MRPharmS, and Helen Thorp, DipClinPharm, MRPharmS

Pharmacists are regularly called on to support prescribers and commissioners to make the most cost-effective medicine choices. It is therefore crucial that pharmacists understand how medicines are funded and what efficiencies they (and others) are expected to make, particularly in the current financial climate.

This article — the first in a series on NHS funding mechanisms — discusses how hospitals in England are funded through Payment by Results and how the PbR system has been changing to meet the requirements of the quality and efficiency agenda. It should be borne in mind that with the recent change in government there is uncertainty about how the NHS and PbR will develop in the future. Nevertheless we can be clear at this point that there is an expectation that the NHS will be required to make at least the £20bn of efficiency savings that were forecast by the previous government.

Payment by Results

Introduced in 2003, PbR is the national funding system by which primary care trusts (which are allocated about 80% of the NHS budget) pay hospitals to deliver services, including the provision of medicines, to their patients.

Under PbR, hospitals receive money from PCTs for each episode of care (from admission to discharge) they undertake, rather than receiving a set amount of money under the block contracts that were previously in place. The idea of PbR is to reward hospitals for efficiency and to facilitate the introduction of patient choice by allowing money to follow the patient. Block contracts were thought to rely too heavily on previous budgets and the skills of local contract negotiators.

Within PbR, patient care episodes are grouped together on the basis of a diagnosis or procedure type. These groupings are called healthcare resource groups (HRGs), of which there are currently around 1,400. Each patient has an HRG assigned for each episode of care they receive (ie, from admission to discharge) based on their diagnosis or treatments recorded and coded. These codes are entered onto a database, which generates a core HRG payment for each patient’s episode of care.

Each core HRG has assigned to it a nationally set price for PbR services, which is listed in a tariff. Until now, these tariff prices have all been based on the national average price to provide that service (see later for the move towards “best price tariffs”). Tariff prices are revised each year and are displayed on the Department of Health website. In most cases, the payment made for PbR services is to cover the cost to provide the whole service, including infrastructure costs, staffing, tests and medicines. Unbundled HRGs do not currently have nationally set prices.

Excluded services and medicines

There are various specialist services that do not have a national tariff price and are therefore excluded from PbR. These services currently include those relating to mental health, critical care, transplantation, renal dialysis, chemotherapy, cystic fibrosis and in vitro fertilisation. Local arrangements need to be in place to set the prices that hospitals will be paid to provide these services, including the cost of any medicines.

There is also a list of high-cost drugs (HCDs) that are not included in PbR. These are often referred to as “non-tariff medicines” or “PbR-excluded medicines”. HCDs are specialist medicines, use of which is concentrated in a relatively small number of centres, rather than evenly across all hospitals. When a medicine is on the HCD list, it generally means that its use is excluded from PbR for all indications, regardless of licensing status.

When a hospital uses an HCD it does not automatically receive funding to cover the medicine cost, even though it might receive an HRG payment for the service the patient has used. There are many funding mechanisms in place around the country for HCDs, including service-level agreements, local increases (or uplifts) to national HRG prices and charging on an individual patient basis per dispensing episode. It is not expected that HCDs will ever have nationally set prices, so robust commissioning, funding and charging processes need to be in place.
The NHS has seen years of increased investment to improve the quality of patient services, for example by reducing waiting times. In 2010–11, the overall budget for the NHS in England is £102bn. Now that the recession is taking its toll on public finances, the NHS has been tasked with finding £20bn in efficiency savings by the end of 2013–14. While doing so, it is to remain focused on quality and to continue to improve services, despite the increasing demands that result from an ageing population and from the development of new technologies, including high-cost medicines.

“Quality, innovation, productivity and prevention” (QIPP) is the NHS plan designed to help staff meet this challenge. It is likely that, in the coming months and years, pharmacists will see changes in decision-making processes and in the funding of some medicines by the NHS as choices regarding cost effectiveness and affordability are made.

**CQUIN** Another element of recent change is the implementation of the “Commissioning for quality and innovation” (CQUIN) payment framework, which makes a proportion of a hospital’s income conditional on quality and innovation. In 2010–11, primary care trusts are required to make 1.5% of each hospital’s contract value dependent on achieving nationally and locally agreed quality goals. The two national goals in 2010–11 are to reduce avoidable death, disability and chronic ill heath from venous-thromboembolism and to increase responsiveness to the personal needs of patients. Both of these goals have medicine components. One of the measures for the personal needs goal is whether a member of staff has told patients about medication side effects to watch for when they go home; and as part of the VTE risk assessment goal hospitals need to meet targets for assessing patients’ VTE risk. It is expected that the proportion of hospital funding incorporating CQUIN payments will increase in future years.

### References