

Best Practice Tariffs

Country Background Note: United Kingdom (England)

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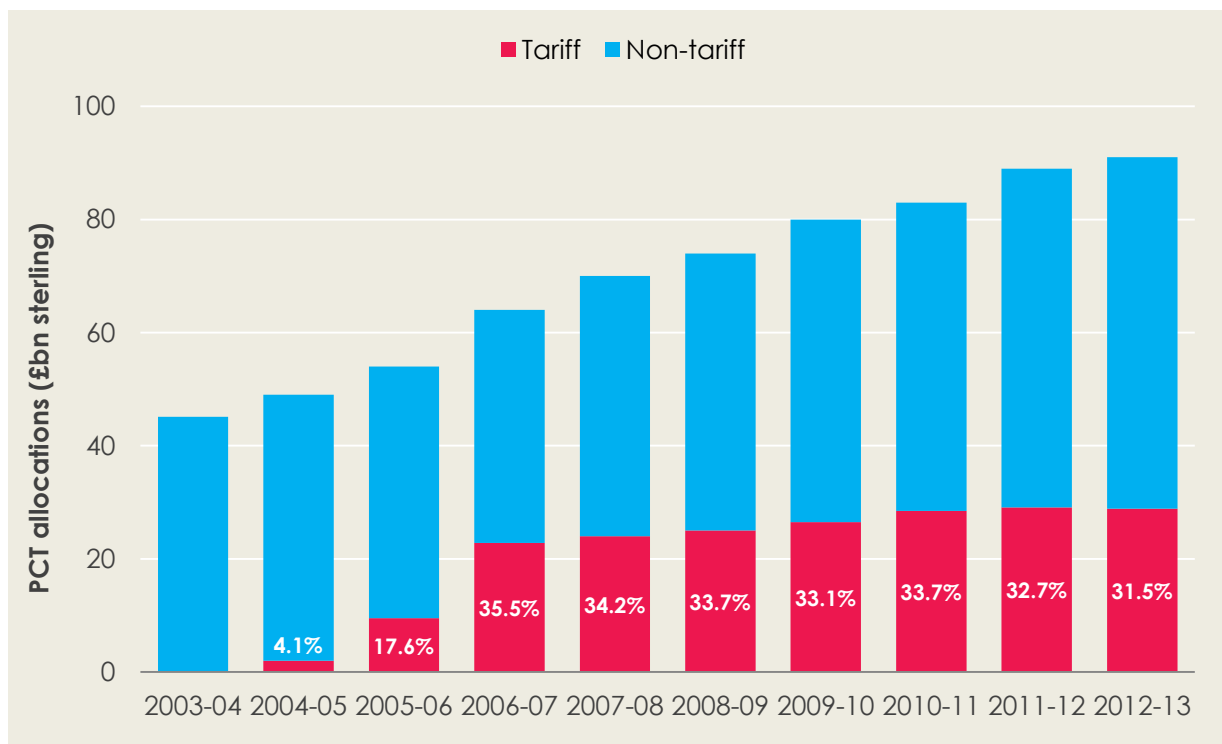
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1. Overview

The English National Health Service (NHS) operates with a purchaser/provider split, with most health care¹ commissioned by around 200 Clinical Commissioning Groups (formerly Primary Care Trusts) from providers (usually NHS trusts and foundation trusts). The main system by which providers are paid for the care they deliver is through Payment by Results (PbR). PbR accounts for around 60% of acute hospital income, and around £30bn of provider spend.

Figure 1. Percentage and value of spend on tariff vs non-tariff activity



Source: Department of Health Payment by Results (2012)

This scheme, introduced in 2002 works on a principle of nationally determined currencies (units of health care) and tariffs (the prices for these units). The currencies are healthcare resource groups (HRGs), which are clinically-meaningful groups of diagnoses and procedures that do not include much heterogeneity within a given HRG. Each covers a unit of care, and the tariff (price reimbursed) is typically based on the national average cost of treating patients in that HRG. This mechanism should incentivise providers to reduce costs, as proposed in Shleifer's theory of yardstick competition (Shleifer, 1985). This is because providers should aim to reduce costs below the price, in order to retain the difference, rather than make a loss where their cost is greater than the price they

¹ This does not include, for example, specialised and community care

are reimbursed. HRGs are not unique to England, with other countries including Australia, Canada, France, Germany and Sweden using similar clinically-meaningful groups. This incentive for providers should lead to unit cost-reductions for the system as the price adapts to the new, lower costs. There may be unpredictable impacts on volume partly due to 'cream-skimming' (a provider preferring patients where their cost of treatment is significantly lower than the price) and supplier-induced demand (a provider encouraging a patient to undertake a treatment where the cost is significantly lower than the price). These incentives are quite weak in England, and so these practices are less common than in some countries.

2. Best Practice Tariffs

In 'High Quality Care For All – NHS Next Stage Review' (Darzi, 2008) (also known as the Darzi Review) led by Lord Darzi, an eminent surgeon at Imperial College London, a commitment was made to 'Best Practice Tariffs'. This is a method of reimbursing providers based not on average cost, but by the cost of best practice. In the review's words:

'To support local efforts to address unexplained variation in quality and universalise best practice, we will start to pay prices that reflect the cost of best practice rather than average cost. This will be enabled through the Best Practice Tariffs programme, which we will introduce where the evidence of what is best practice is clear and compelling. We will start in 2010/11 with four high-volume areas where there is significant unexplained variation in practice: cataracts, fractured neck of femur, cholecystectomy, and stroke care. We will discuss this proposal with clinicians and give further information on these areas later this year so that providers can plan in advance of tariff changes. The Best Practice Tariffs programme will be rigorously evaluated, not least to ensure that it is working for all the partners involved in the delivery of care, and if successful, expanded in future years.'

While a large amount of variation in quality of care is very difficult for individual providers to control, there was seen to be a substantial amount of noncompliance with best practice. This meant that whilst some providers – or some clinicians, or wards – were providing care in accordance with best practice, this was not universal. Even in a relatively centralised system like the English NHS, there are fairly few tools (or 'prods') central departments can use to improve quality, but pricing is one of them (Allock et al., 2015). As a result it is a feasible way to reduce this variation, and increase the amount of care being carried out in accordance with established 'best practice'.

This method of pricing differs from the traditional pricing, which reflects average cost. The intention is to introduce a formal financial incentive for complying with known best practice. The payment is not considered a 'reward' for compliance, in that it is not paid over and above the cost itself, but rather reflects the cost. In reality, this issue is not quite so simple, as the formal pricing for some models includes a 'base price' and a 'BPT component', and likewise the 'base price' has in some cases been reduced to become punitive, in order to incentivise use of the 'best practice' guidelines. Best practice tariffs can be higher or lower than national average costs, and are paid if best practice guidelines for treatment are followed. The Department of Health make this clear:

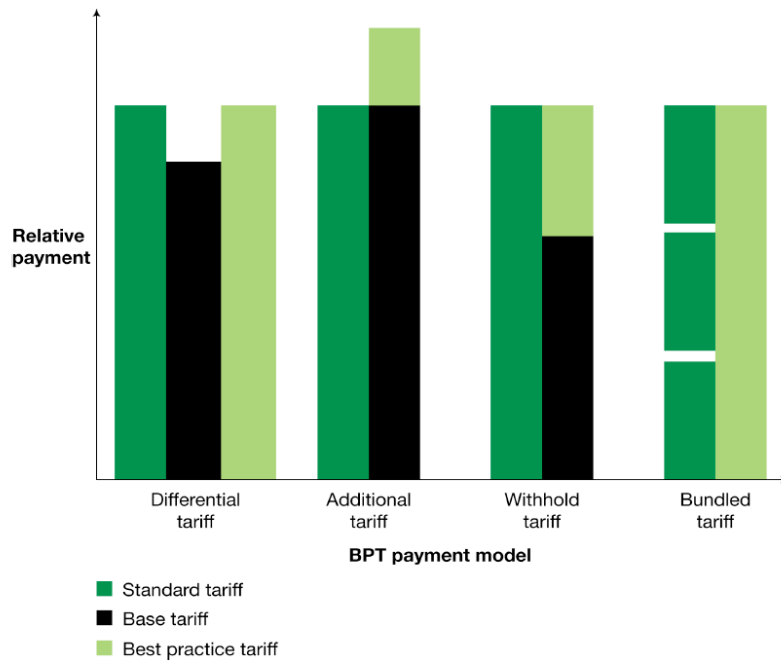
'If it is best practice for a particular procedure to treat a patient as a day case rather than an overnight inpatient, this is likely to cost less than national average costs, based on activity that includes significant levels of admitted patient care. On the other hand, best practice could involve extra steps in the treatment or the use of more expensive technology or drugs and require a tariff that is higher than national average costs.'

BPTs include a number of pricing 'models': including paying for best practice, incentivising day-case, and streamlined care pathways. As an example, the paying for best practice model consists of a base payment for all admissions, plus one or more additional payments conditional on performance (Kristensen et al., 2016). Some of the different models are shown in the chart below, grouped by their financial form. The Audit Commission identify BPTs as falling largely within four financial forms:

- differential tariffs – where the BPT is higher than the base (non-BPT) and usually (but not always) lower than the standard tariff.
- additional payments – where the BPT is higher than the standard tariff and the standard tariff is a similar value to the previous year;
- withhold payments – where the BPT payment forms a conditional part of the standard tariff; and
- bundled tariffs – where the BPT is the sum of the tariffs for a specified number of spells in the pathway and is a maximum payment.

The price differential between best practice and usual care is calculated to ensure that the anticipated costs of undertaking best practice are reimbursed, while creating an incentive for providers to shift from usual care to best practice.

Figure 2. Audit Commission categorisation of different forms of tariff



Source: Audit Commission (2012)

An example of 'withhold tariff' is fragility hip fracture, where providers were paid an incremental payment of £445 over the base tariff for treating a hip fracture.² This was conditional to fulfilling all of six defined criteria; with no payment if they did not do so. Since being introduced the criteria have expanded and the differential has increased relative to the base tariff: from £445 to £890 for 2011–2012, and then to £1,335 in 2012–2013 and £1,353 proposed for 2016/17.

An example of differential tariffs is the selected day case procedures BPT. In this case there is a different price paid for a procedure depending on whether it is done as a day case or ordinary elective admission. In 2016/17 the ordinary elective payment is between 71% and 92% of the price of the day case payment.

An example of bundled tariffs is the cataracts BPT. This is a 'pathway tariff', meaning the price applies to the entire elective cataract pathway. This is the sum of the costs of the individual outpatient attendances and the surgical event. This is a non-mandatory BPT.

An example of additional payments tariffs is the paediatric diabetes BPT. This is quite unique in that it is an annual payment (of £2,925 in 2016/17) covering outpatient care meeting a set of criteria

² Further information on these different BPTs can be found in Monitor's 2016/17 national tariff technical guidance, which the examples are based on.

across multiple providers, from the date of discharge from hospital after the initial diagnosis of diabetes is made, until the young person is transferred to adult services at the age of 19.

The BPT pricing structures are mandatory, and so allow relatively little local flexibility and price-setting between the commissioners and the providers. They are applied to all providers of NHS-funded care: both NHS and independent providers. As with all payment within the NHS, providers are expected to be able to fund the cost of providing care within the confines of their level of reimbursement across the organisation. Where this is not the case, providers will (theoretically) find themselves in deficit. Of course, due to the many factors which affect providers' ability to cover costs, often providers are able to negotiate with their commissioner or the Department of Health to discuss times when they are likely to be in deficit. With the majority of providers now in deficit, this is a more important issue than ever (Monitor, 2016).

Of course, a challenging element is working out which areas are appropriate for having a BPT, and then establishing what best-practice looks like, how to measure it, and how to price it. The King's Fund use the example of the Cataracts BPT (Appleby et al., 2012):

For cataracts – a very high-volume operation – best practice guidelines had already been developed and published by the NHS Institute in its Focus on Cataracts (NHS Institute for Innovation and Improvement 2008) report. In addition, the Royal College of Ophthalmologists had also produced guidelines on best practice. As the 2010/11 guidance for Payment by Results summarised this guidance: In cataract treatment, an important element of best practice is to treat patients in a joined-up and efficient way, by carrying out all assessments before surgery at the same time, operating as a day case procedure in all but exceptional cases, and then carrying out all follow-up assessments on one day around two weeks later. (Department of Health 2010b) Establishing the value of the national tariff first involved breaking down the new, streamlined cataract pathway into existing HRG units – from initial assessment in outpatients through to surgery (as a day patient) in hospital and then follow-up in outpatients. The overall tariff for this new pathway was essentially the sum of the average national costs for each element of the pathway (Department of Health 2010b).

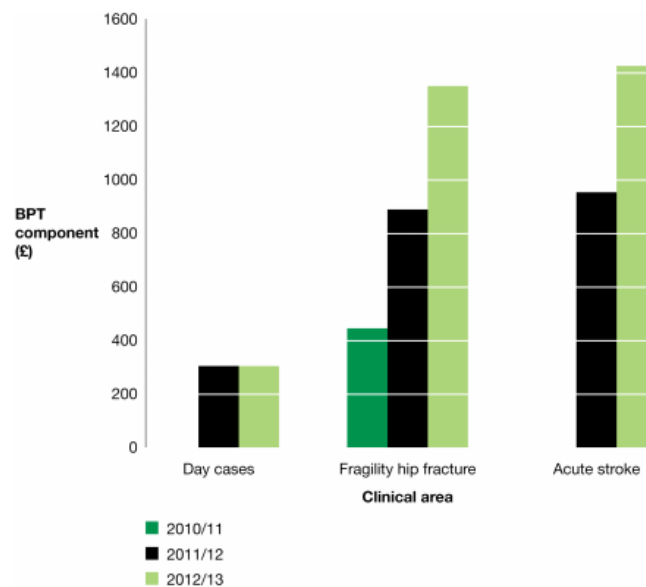
Likewise, for stroke there is good clinical consensus on what constitutes high quality care for emergency stroke patients. In England, National Clinical Guidelines for Stroke were first published in 2000. The Department of Health published a National Stroke Strategy in 2007. The National Institute for Health and Care Excellence published a guideline for interventions in the acute stage of stroke and transient ischaemic attack (TIA) in 2008 based on clinical and economic evidence and expert opinion, backed up by publication of a quality standard in 2010 and a NICE pathway. In addition, the verifiability of stroke care quality is high and increasing. The Sentinel Stroke National Audit Programme (SSNAP), for which data collection started in 2012, will provide a minimum dataset with process and outcome data for all stroke patients in England, Wales and Northern Ireland which include the indicators on the NICE quality standard and the NHS Outcomes Framework.

The BPTs are designed as a base tariff paid for all stroke patients irrespective of performance, and extra performance payments for a) rapid brain imaging, b) treating the patient in an acute stroke unit, and c) alteplase.

When it introduced the stroke BPT the Department of Health attempted to set prices “to better reflect the costs of delivering best practice,” with a built-in financial incentive “to encourage uptake of best practice in the early stages.” The financial incentive was expected to be removed in the future and “align[ed] ... with the actual cost of best practice” (Department of Health, 2010) While the initial BPT prices were calculated close to the costs of providing the service, the subsequent adjustments were justified by a desire to increase the incentive for delivering best practice (Kristensen et al., 2016). Kristensen et al. (2016) report that, based on their economic modelling, the cost used by the Department of Health was (i) lower than optimal, or (ii) based on high levels of altruism, or (iii) a reflection of a very high opportunity cost of public funds.

Empirically, BPTs seem to be originally set below optimal levels, and are adjusted upwards in response to how they perform with respect to reflecting the costs of delivering best practice. Of course, these increases in reimbursement level also reflect some underlying changes in the structure of the BPTs.

Figure 3. Audit Commission analysis of change in value of Best Practice Tariff component over time



Source: Audit Commission (2012)

Views amongst commissioners are split on these increases, with some thinking this reflected a shift in cost pressure from providers to commissioners, and others believing that BPTs provide sufficient additional income in order to deliver best practice care (Marshall et al., 2014). Providers on the other hand saw BPTs not as an attempt to accurately reflect the costs of best practice care, but rather

recognition for ‘doing the right thing’, and as such were captured by neither the ‘reimbursement’ model, nor the ‘reward’ model. The Audit Commission’s analysis shows that over time the base (non-BPT) tariff for hip fracture has decreased (and so has become punitive, in order to incentivise BPT uptake), whilst the BPT component price has grown. Due to the drive for efficiency in the NHS, the BPT price (which is the base price in addition to the BPT component) is nonetheless lower in 2013/14 than in 2009/10.

2.1 Development

As set out in the Darzi Review, BPTs were started in 4 clinical areas and expanded if they were successful. Whilst there is some debate about the success, BPTs have been extended considerably. BPTs now cover more than 50 care procedures.

Monitor (the pricing authority of the NHS until 2016/17 and now under the authority of NHS Improvement) set out groups of BPTs which share similar objectives:

- avoiding unnecessary admissions;
- delivering care in appropriate settings;
- promoting provider quality accreditation; or
- improving quality of care.

Monitor also make clear the service areas are selected as being:

- high impact (i.e. high volumes, significant variation in practice, or significant impact on patient outcomes); and
- supported by a strong evidence base and clinical consensus as to what constitutes best practice.

Table 1. Development of range of Best Practice Tariffs

	Introduced	Changes	
<i>Acute stroke</i>	<i>2010/11</i>	<i>2011/12 & 2012/13</i>	<i>Increased price differential</i>
		<i>2013/14</i>	<i>Currency split to differentiate by patient complexity</i>
		<i>2016/17</i>	<i>Updated the criteria on brain imaging to be consistent with guidelines</i>
<i>Cataracts</i>	<i>2010/11</i>	<i>2013/14</i>	<i>Status changed from mandatory to</i>

			<i>non-mandatory</i>
<i>Fragility hip fracture</i>	<i>2010/11</i>	<i>2011/12</i>	<i>Increased price differential</i>
		<i>2012/13</i>	<i>Further increase in price differential + expansion of best practice characteristics</i>
<i>Day case procedures</i>	<i>2010/11 (gall bladder removal)</i>	<i>2011/12</i>	<i>12 further procedures added</i>
		<i>2012/13</i>	<i>2 further procedures added + breast surgery procedures amended and revisions to some day case rates</i>
		<i>2013/14</i>	<i>1 further procedure added + hernia and breast surgery procedures amended</i>
			<i>Recalculated BPT prices based on revised transitional targets</i>
		<i>2016/17</i>	
<i>Adult renal dialysis</i>	<i>2011/12 (vascular access for haemodialysis)</i>	<i>2012/13</i>	<i>Home therapies incentivised</i>
<i>Transient ischaemic attack</i>	<i>2011/12</i>	<i>2013/14</i>	<i>MRI payment removed in line with guidance on unbundling</i>
<i>Interventional radiology</i>	<i>2011/12 (2 procedures)</i>	<i>2012/13</i>	<i>5 further procedures introduced</i>
<i>Paediatric diabetes</i>	<i>2011/12 (activity based structure – non-mandatory)</i>	<i>2012/13</i>	<i>Year of outpatient care structure (mandatory)</i>
		<i>2014/15</i>	<i>Updated to include inpatient care</i>
<i>Outpatient procedures</i>	<i>2012/13 (3 procedures)</i>	<i>2013/14</i>	<i>Flexibility to encourage see and treat hysteroscopy</i>
		<i>2016/17</i>	<i>Recalculated price for diagnostic hysteroscopy based on an increased transitional target</i>
			<i>Updated calculation</i>

<i>Same-day emergency care</i>	<i>2012/13 (12 clinical scenarios)</i>	<i>2013/14</i>	<i>7 new clinical scenarios</i>
<i>Major trauma care</i>	<i>2012/13</i>	<i>2014/15</i>	<i>Best practice characteristics changed</i>
Diabetic ketoacidosis and hypoglycaemia	2013/14		
Early inflammatory Arthritis	2013/14		
Endoscopy procedures	2013/14	2016/17	<i>Changed from a two tier to a three-tier payment system</i>
Paediatric epilepsy	2013/14		
Parkinson's disease	2013/14		
Pleural effusions	2013/14		
<i>Primary hip and knee replacement outcomes</i>	<i>2014/15</i>	<i>2016/17</i>	<i>National Joint Registry thresholds increased to 85%</i>
<i>Heart failure</i>	<i>2016/17</i>		
<i>NSTEMI (voluntary)</i>	<i>2016/17</i>		

Source: Adapted from: 2014/15 National Tariff Payment System. Monitor and NHS England. 2014.

Whilst compliance for most BPTs is judged by traditional measures (for example, a patient being discharged in X hours, or treatment Y rather than Z being used), the proposed 2014/15 tariff introduces a patient-reported outcome measure. Use of patient reported outcomes is not completely new to the NHS, with the introduction of PROMs (patient reported outcome measures) in 2009, a world leading initiative to try and understand the quality of health care being provided. This payment based on patient reported outcomes is innovative, and comes in the context of a wider discussion about commissioning based on outcomes.

In 2013/14, 17 mandatory best practice tariffs were included in the Department of Health's PbR guidance.

The number of day-case procedures covered by a BPT has increased from one (gall bladder removal) in 2010/11, to 16 clinical areas in 2013/14. Similarly, BPTs for same-day emergency care first introduced in 2012/13 now cover 19 clinical scenarios (Department of Health, 2012a).

Efforts have been made to introduce BPTs at achievable, non-stretching, levels. This is to let providers understand the BPT and data submission before they are increased to represent true 'best practice'. For instance the tariff document for the 2015/16 heart failure BPT states 'The threshold for specialist input has been set relatively low in 2015/16 to enable providers to make progress in meeting best practice in the first year of implementation. We anticipate this rate will be revised upwards in the future along with a review of the care processes that are incentivised in the BPT.'

2.2 Evaluation

There are (at least) two levels of possible evaluation of BPTs: uptake and cost-effectiveness. The main evaluations of BPTs are an Audit Commission³ report and a joint evaluation from the Universities of Manchester and Nottingham, commissioned by the Department of Health (Audit Commission, 2012). A summary of these, in the context of other payment systems in the NHS, can be found in Marshal et al (2014) and Charlesworth et al., (2014).

Both evaluations showed a mixed but positive picture, with BPTs clearly working better for some conditions than for others. Likewise, evaluation seems to suggest that BPTs improve outcomes in some conditions more than others. Whilst there are interesting lessons to learn from the specifics of why each individual condition's BPT has better or worse uptake and effectiveness, some general lessons can be learned. In practice, the different objectives and rollout for different BPTs makes it hard to say which have been more or less 'successful'.

Evaluations show them each to have some *general* difficulties, discussed below, as well as some *specific* difficulties. For example, the Audit Commission identified that the day cases BPT was set at below (perceived) optimal levels, the fragility hip fractures BPT suffered due to poor data quality, and the acute stroke BPT was over complex and hard to interpret. Likewise, the formal evaluation by the Universities of Manchester and Nottingham found low uptake of the cataracts BPT, and found the hip fracture BPT to produce 'significant process quality and outcome gains' compared to the stroke BPT, which had an 'absence of a beneficial effect' (McDonald et al., 2012). In reality, time, additional refinement and evaluation will be needed to understand which BPTs work better than others.

The Audit Commission report combined quantitative and qualitative analyses to assess providers' clinical and financial performance. They also looked at the quality of the data that underpins BPTs in a sample of providers and interviewed commissioners about their arrangement for BPTs.

³ An independent Audit organisation, funded at the time largely by fees from the organisations it audits and by central government grants.

The Audit Commission found that ‘the concept has strong support’ and they can ‘focus attention on an area of clinical practice’ and ‘can help bring about significant improvement’. This has supported the growth in the use of BPTs. They, however, identified three main critical themes in their findings: the BPT models were difficult to understand, local areas sometimes adapted the national rules, and providers tended not to have sufficiently detailed knowledge of their own finances to make decision about changing practice based on just minor alteration to the tariff.

Mcdonald et al. (researchers from the universities of Manchester and Nottingham) were commissioned to undertake a qualitative and quantitative evaluation. The qualitative surveys suggested ‘widespread support’ amongst clinicians in provider organisations. However, there were particular concerns about the administrative burden and assumptions behind the cataracts BPT. These frontline clinicians thought that, compared to CQUINs⁴, BPTs are more likely to be evidence based and involve fairer payment structures. Commissioners, however, had low levels of knowledge about BPTs.

The quantitative analysis was conducted using a difference-in-difference methodology. This compares the trajectories of your treatment and control cohorts before and after an intervention. From this they found that BPTs can be used to incentivise hospitals but may also produce unintended effects. Hospitals responded quickly to the increase in price for day case cholecystectomy, however they found no beneficial impact of the Stroke BPT on the available national quality and outcome indicators. The analysis suggests that providers were responding to BPTs, but that changes to pathways were taking time to be implemented, which may explain the absence of a beneficial effect. In contrast, introduction of the hip fracture BPT produced significant process quality and outcome gains. The differences in impact between the Stroke and hip fracture BPTs may be attributable to the different structures of the tariff (the BPT for hip fracture is only paid if all criteria are met), the difference in underlying quality trends, limited availability of national indicators and/or the presence of other quality improvement initiatives for Stroke, and/or the closeness of the hip fracture BPT to a new care audit.

2.3 Case Study: The Hip Fracture BPT

The King’s Fund report that since it had been introduced standards of care had rapidly improved (National Hip Fracture Database 2012). However, at least some of this could be because of the publication and audit of the standards. As an example, the eligibility requirements for the hip fracture BPT uplift are:

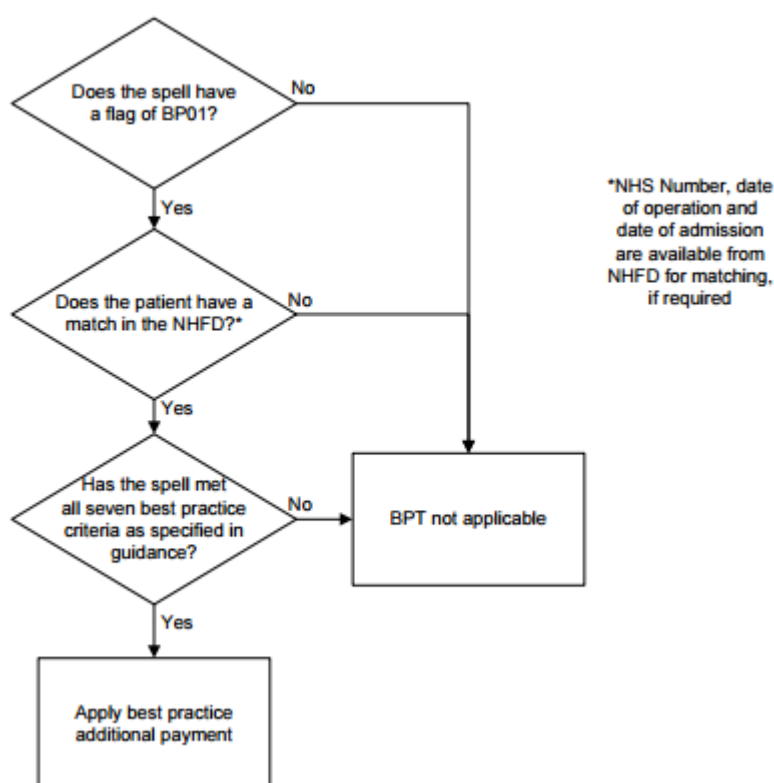
- surgery within 36 hours of admission

⁴ Commissioning for Quality and Innovation payments - another payment scheme which aims to incentivise improvements in quality

- shared care by orthopaedic surgeon and orthogeriatrician
- admission using a care protocol agreed by orthogeriatrician, orthopaedic surgeon and anaesthetist
- assessment by orthogeriatrician within 72 hours of admission
- pre- and postoperative abbreviated mental test score (AMTS) assessment
- orthogeriatrician-led multidisciplinary rehabilitation
- secondary prevention of falls
- bone health assessment.

A flow diagram for the application of the BPT can be seen in Figure 4, taken from the Department of Health's guide to Payment by Results (Department of Health Payment By Results, 2010)

Figure 4. An example flow chart for application of a Best Practice Tariff

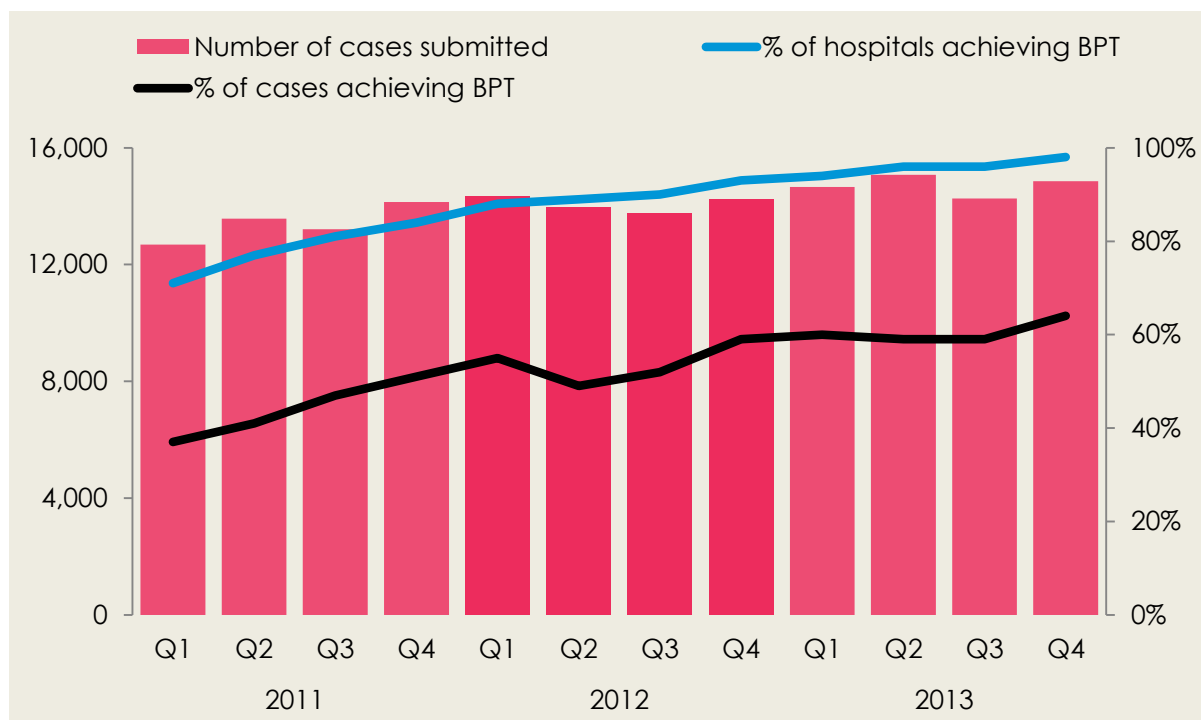


Note: 'BP01' is a 'flag' in the data which suggests the spell might be eligible for the hip fracture BPT; 'NHFD' is the national hip fracture database

Source: Department of Health Payment By Results (2010)

As data from the Falls and Fragility Fracture Audit Programme's National Hip Fracture Database extended report below shows, the amount of uptake and achievement of BPTs for hip fracture has increased considerably, although it is not clear what the causal factors for this are (Royal College of Physicians, 2015).

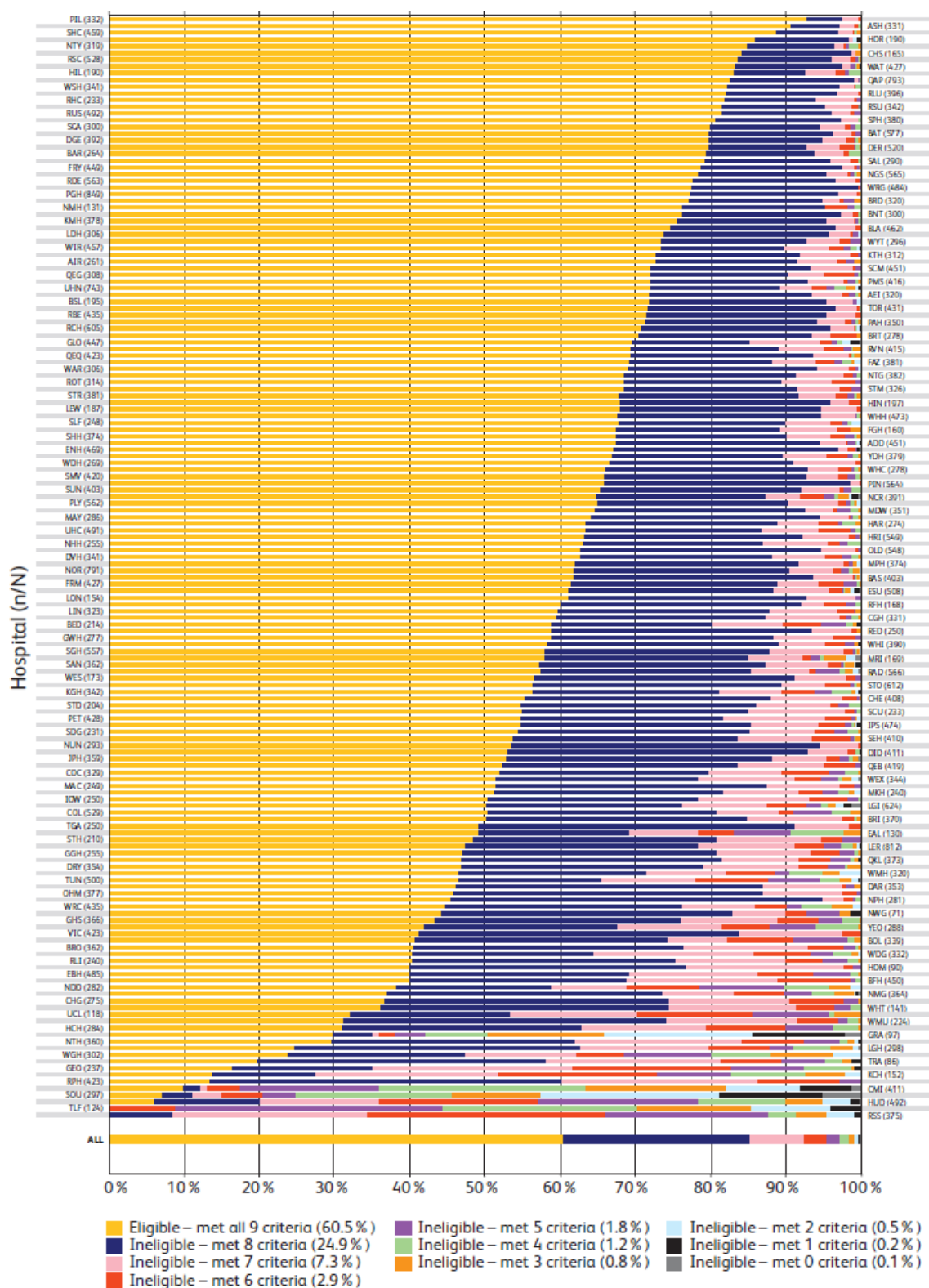
Figure 5. Best Practice Tariff by quarter of calendar year, 2011–2013



Source: Royal College of Physicians (2014)

As Figure 6 below shows, there is, however, substantial variation in uptake and achievement of the hip fracture BPT. For some providers, more than 90% of patient care meets all 9 criteria, but for other providers it is closer to 10%.

Figure 6. Variation in meeting Best Practice Tariff criteria



Source: Royal College of Physicians (2015)

The criterion that people with hip fracture have their cognitive status assessed, measured and recorded from admission is seen as a valuable quality measure. The proportion of patients whose care met this standard improved markedly when it became a requirement for best practice tariff (BPT) in 2012. The mean figure of 93% in 2013 has improved further in 2014, to a figure of 94.5%. (Royal College of Physicians, 2015) The hip fracture database report includes a case study (Royal College of Physicians, 2015).

Box 1. Improving BPT attainment at York District Hospital

At York District Hospital we have worked over the last few years to increase our BPT attainment and improve the care of hip fracture patients.

We identified that our main barrier to achieving BPT was a delay to patients undergoing surgery within 36 hours and a lack of senior medical review. It became apparent that the day of admission had a significant impact on the likelihood of delay to surgery.

We used this data to submit a business case, and in autumn 2014 we were successful in securing additional dedicated theatre time at weekends: a Sunday trauma list with priority given to hip fracture patients. As a consequence, the proportion of our patients receiving BPT-eligible care rose from 66.6% in 2013 to 74.2% in 2014.

Over the past 2 years, we have strengthened our team with the addition of a hip fracture specialist nurse and an advanced clinical practitioner. Our specialist nurse integrates patient care from admission in A&E, links with theatre and ward teams, ensures regular patient and family updates and coordinates discharge plans with the ward team. She also ensures completion of cognition assessments and offers counselling for future bone health treatment for all patients, in keeping with NICE guidelines.

Until 3 years ago, only around 75% of patients were admitted directly to our dedicated hip fracture ward, but this is now over 95%. Our team has introduced a daily ward round that links with the detailed multidisciplinary team meeting, which is also attended by our ward dietician. With this cohesive approach, we ensure that discharges are planned in advance and discussed with the pharmacy to ensure that discharge medications are available on time.

Regular review of NHFD data has been pivotal to developing local services and improving patient care throughout their time in hospital. We now have one of the best rates of return home from home within 30 days among NHFD sites, and our service was highly commended at the Patient Safety Awards 2015.

Source : Royal College of Physicians (2015)

This hip fracture example shows the impact a BPT can have on uptake and spread of good practice. It is hard to isolate how much of this is part of a trend towards improved quality of care, but taken in hand with the wider evaluation of BPTs is strong evidence for the use of payment incentives where there is a targeted, well evidenced example of non-compliance with best practice. Total payment to providers for hip fracture care in 2011–2012 was £532 million, of which the BPT element contributed £72 million (14%) (Khan et al., 2014).

3. Conclusion

Best Practice Tariffs (BPTs) are an innovative way of incentivising improving quality through a payment system. As this is one of the few tools national policy makers have, the success or failure of this scheme is likely to be of interest to national bodies. It works in the same framework as Payment by Results, but differs in that it pays according to the cost of (and achievement of) best practice, rather than average cost. The use of BPTs in the NHS has increased, both in terms of the number of BPTs and the amount of money being reimbursed through BPTs.

Evaluations show mixed effects. There is clear clinical support for BPTs due to their promotion of evidence-based protocols. It is, however, unclear whether the financial incentives alone are sufficiently high to change care or significantly reduce variation. Due to the complexity of the reimbursement system in England, and underwhelming costs attached to best practice, the influence of BPTs could remain marginal for the time being. This is not necessarily a bad thing, as it allows time to adjust the current BPTs (as is done each year); allows BPTs to be thoroughly thought through before being added (and so only those conditions which have well established best practice and sensible incentive structures become BPTs); and allows for innovative BPTs (such as BPTs based on patient reported outcomes).

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