Federation of Specialist Hospitals

Federation of Specialist Hospitals: Clinical leadership in developing the national tariff

The Federation of Specialist Hospitals (FSH) has been formed to provide a voice for specialist hospitals in the UK. 24 specialist hospitals carry out 250,000 procedures and 2.5 million outpatient appointments each year, mainly for patients with rare and complex conditions.

Many of these procedures fall under the national tariff. In addition to this, a 'top-up' is made to the tariff price for a range of specialised services, sometimes restricted to designated centres. This is of particular importance to the Federation's members, given the specialist nature of their activities.

As the proposed scope of the national tariff broadens to more specialised activity and responsibility for setting tariff prices transfers from DH to a combination of the NHS Commissioning Board and Monitor, the Federation sees it as important that associated governance is strengthened, incorporating clear clinical leadership. It is essential that a range of longstanding concerns, acknowledged by Ministers during passage of the Health and Social Care Bill, are addressed as part of this process. This includes the need to compensate providers according to the complexity of the work they undertake and the results they achieve.

Current arrangements for the national tariff

Payment by Results (PbR) was introduced in 2003-4 and now represents over 60% of hospital income. It was introduced to increase value for money and efficiency in secondary care, while facilitating choice and improving quality. The same tariff price is assigned to a given treatment or service, no matter who provides it: this was intended to enable competition between providers based upon quality rather than on price.

The Department of Health currently undertakes the complex process of setting tariff prices for the 1,100 services covered by PbR. Initially, their calculations are based on an average cost of services, as submitted by NHS providers. This price is subsequently modified, with consideration given to efficiency requirements, market forces, and other factors, to generate a proposed tariff price. Many specialised services receive a 'top-up' in addition to the tariff price, to compensate for the higher costs involved in providing rarer and more complex services. Tariffs are also increasingly subject to CQUIN payments, which more accurately represent a deduction from the tariff price only payable in return for meeting quality criteria defined for different areas of care. This payment has been progressively increased and now represents 2.5% of the tariff price.

Accordingly, the process for setting the tariff is a long one. The Department of Health undertakes an internal analysis of costs and considers the scope and structure of the tariff, alongside efficiency factors. It then calculates its tariff proposals for the new funding year. These are published in a 'sense check' to

selected groups: advisory bodies, a network of clinicians with experience of the PbR process, and selected NHS providers and commissioners. The sense check is intended to detect any perverse incentives generated by the tariff calculation process in its first stages, rather than to provide feedback on actual tariff values, reducing the chances of mistakes being corrected at an early stage. At this point, the wider NHS is informed about the development of the tariff, but not included in the sense checking process.

After reviewing the feedback from the sense check consultation, the Department of Health then moves the tariff to a 'road test', usually around December. This is intended to allow all organisations to familiarise themselves with the tariff, which is in its almost-final form. This presumption of finality is intended to allow providers to calculate their finances for the coming year under the tariff, and consider any strategic changes they might then need to make. The finished tariff is published in advance of the financial year to which it will apply, usually around February.

The schedule for the development of the 2012/13 tariff is:

- 6th October – 4th November 2011: Sense check
- December 2011: Road test
- February 2012: Final document published.

This process is still developing, with moves towards best practice tariffs and an ambition to develop pathway tariff pricing. The input of specialist providers could be vital as tariff refocuses its approach.

Weaknesses of the current arrangements

During debates on the Health and Social Care Bill in the House of Lords, broad agreement emerged on the flaws in the current tariff-setting procedures. Earl Howe, Under-Secretary of State for Health, highlighted the lack of transparency around tariff-setting, the unpredictability of tariff pricing from year to year, and the insufficient level of tariff to reimburse the treatment of more complex patients.

While PbR has grown to represent a majority of hospital funding, its weaknesses need to be resolved as the scope of tariff is extended further. For example, in early 2011, the Department had ignored warnings about a halving of the tariff for laser ablation of the prostate. This would have been at odds with NICE's wish to encourage more day surgery but was only changed at the road testing stage following clinical intervention with parliamentary support and even then ascribed to a typographical error.

The Federation is therefore concerned that the current process for calculating the tariff sits within the Department of Health for too long without outside input or scrutiny. The opacity of the current arrangements gives no reassurance that clinical input, where it exists, is properly considered. This lack of transparency and unresponsiveness around tariff development deters engagement and stores up problems at the road testing stage, which would be better avoided.

It follows that clinical input needs to be built in as an integral part of the process of tariff development with a formal feedback loop from year to year. If the guiding principles of NHS reform, for a clinician-led health service, are to be fulfilled, then the calculation of the national tariff – accounting for 60% of hospital funding - must engage clinicians throughout. Their insight into the actual costs and actual practice of operating services should contribute to a more accurate reimbursement system which is also more sensitive to differences in clinical practice, case-mix and innovative procedures and technologies. Further, the input of specialist clinicians in the earliest stages of tariff development would help to configure pricing for complex treatments accurately and with fewer revisions.

The Federation recognises the flexibility with which errors in the tariff are rectified under the current system. However, amending such flaws mid-year without road testing or sufficient clinical consultation can present a range of problems. Mid-year adjustments to tariff prices can be debilitating for hospital finances, and is at odds with the development of the sensible pricing arrangements required if PbR is to be a lever for efficiency and quality in the NHS.

In terms of specialised services, the Federation is concerned that the blunt instrument of specialist uplift does not reflect the true costs of providing these services. Such a crude top-up to tariff pricing, with little engagement with clinicians to define which treatment codes should trigger a specialist top-up, runs significant risks of under-compensating some providers and over-compensating others, while taking no account of the outcomes achieved. Indeed, flaws in the current arrangements have been masked by the cross-subsidising of specialist care by other procedures or departments in acute settings. As an example, knee and hip surgery has subsidised spinal surgery but, as resources diminish, this approach will cease to be viable. Working towards an accurate reimbursement system for specialised services is therefore vital given the role that they play in meeting patient need, training clinicians, and using and promoting innovation throughout the wider NHS.

While the Federation supports the principle of increasing quality through the use of fixed prices in the national tariff, the current system raises some concerns over its ability to adopt and diffuse new technologies throughout the NHS. Investing in new technologies and treatments is an established route to innovation, improved outcomes and reduced costs in the NHS. This often involves greater initial costs than tariff pricing allows. When considered alongside the existing costs involved in providing specialised care, there is some concern that an inflexible tariff might act as a barrier to the uptake of innovation in specialist hospitals.

Recommendations for improvement

Transition of responsibility for setting the national tariff, from the Department of Health to Monitor, presents a significant opportunity to improve and refine the current system of Payment by Results. The Federation seeks the opportunity to engage with the Department of Health, Monitor, and the NHS Commissioning

Board to contribute to the development of a stronger process for tariff setting in the future.

In particular, we would emphasise the need for a process that is clinically-led, open and transparent from the outset. This would engage key stakeholders and ensure expert input into tariff setting, so that national prices reflect actual costs and outcomes. This will depend on identifying compatible groupings of providers as between, for example, standard and more complex procedures. Where such grouping cannot be identified because of the nature of the provider base, the suitability of tariff may be called into question.

Monitor, in consultation with other stakeholders, should also work towards a tariff that has scope to incentivise innovation, and the prompt incorporation of new techniques and technologies. A more dynamic tariff could help secondary care providers, particularly those in specialised care, to help the NHS in its commitment to spreading and diffusing innovation at scale and pace.