

# Summary of stakeholder responses to the *Evaluation of the reimbursement system for NHS-funded care* report

**5 July 2012**

Alongside the publication of the report entitled '[An evaluation of the reimbursement system for NHS-funded care](#)', we asked stakeholders for their comments and suggestions on what should be done as a matter of priority to address the issues highlighted in the report.

**This document is a summary of responses and includes the main themes and key findings we have taken from the feedback.**

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## Introduction

Under the Health and Social Care Act (2012), Monitor and the NHS Commissioning Board will have joint responsibility for pricing NHS services in England. In preparation for taking on these duties, Monitor has embarked on a thorough review of the existing system for reimbursing providers of NHS services, and of the arrangements that will need to be put in place to make sure that Monitor can fulfil its duties under the Act. As part of this process we commissioned a report, [\*An evaluation of the reimbursement system for NHS-funded care\*](#), from PwC. The PwC report was published on Monitor's website in February this year and its twelve key findings are reproduced in Annex 1.

We asked stakeholders for comments on the report and for suggestions about what should be done as a matter of priority to address the issues raised in it.

This document:

- provides a summary of the responses received; and
- a short response from Monitor on each of the key themes.

We asked three broad questions alongside the publication of the PwC Evaluation report:

1. *What are your views on the twelve key findings of this report?*
2. *Do you have any views on how the issues identified could be prioritised and taken forward in future work? We are particularly keen to understand what steps are most likely to lead to early impacts on the quality and efficiency of care.*
3. *Do you think there are any other issues, not covered by this report, which should also be considered with regard to the reimbursement of NHS services?*

We received twenty responses from a range of stakeholders covering a wide range of topics, and often in significant depth. We also held a roundtable event with a number of stakeholders on the findings of the report and their implications for pricing. Largely the discussion reaffirmed the responses we received to the above questions. Additionally, in the context of our further work on pricing, we have undertaken a large number of structured interviews with various stakeholders.

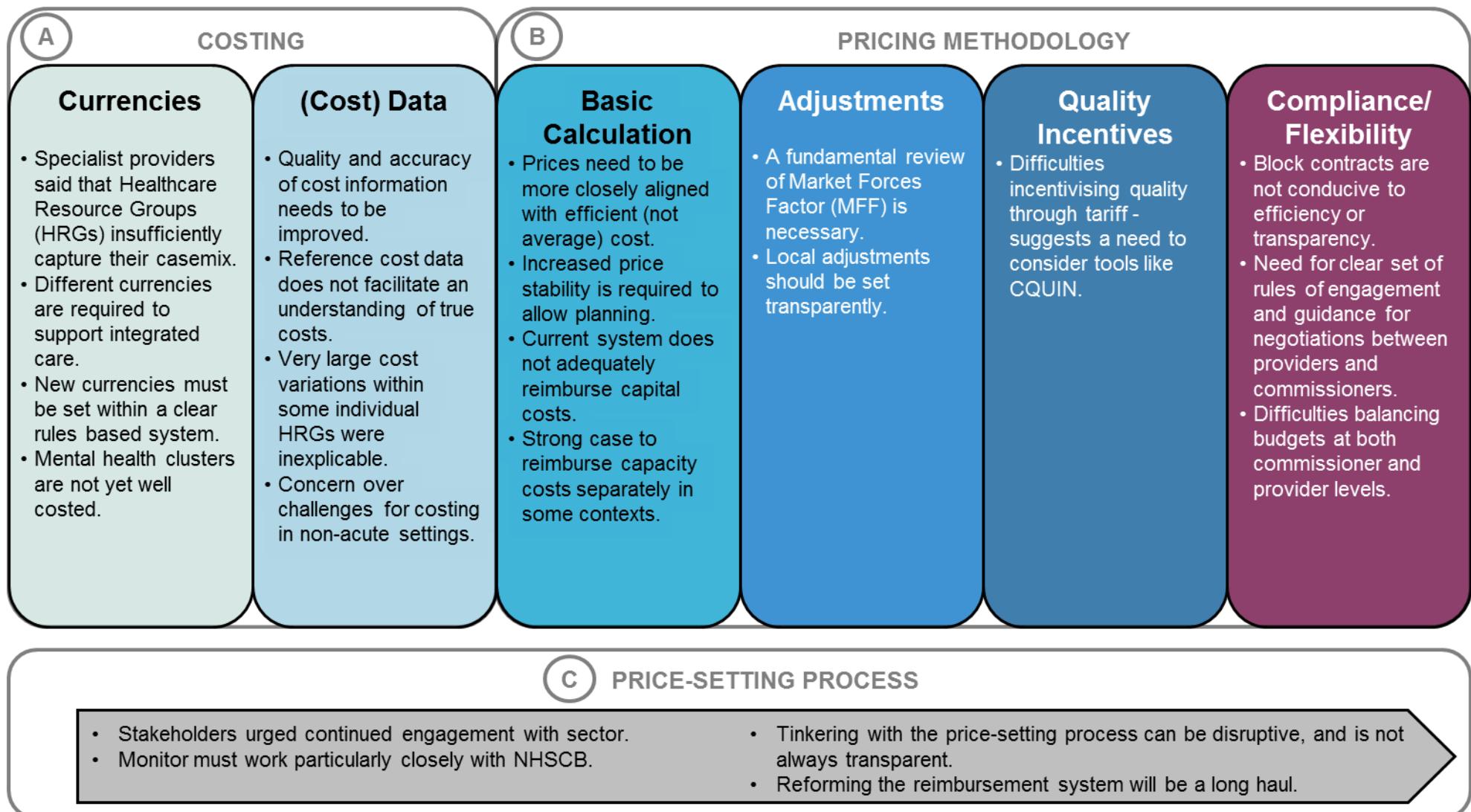
We welcome all these responses and feedback and are carefully considering stakeholders' comments.

The PwC report, and the stakeholder responses to it, has highlighted a number of issues with the current reimbursement system. Addressing these issues will be a key priority for Monitor as we take on our pricing responsibilities. However, reform of the pricing system will be a complex process and Monitor recognises that it will take time; changes will be phased in over a number of years to minimise disruption. We are working closely with the NHS Commissioning Board to develop a long-term vision for pricing, which will inform our short- and medium-term strategy. We will publish and consult further on different aspects of our pricing duties over the coming months.

## **Key themes arising from the consultation**

Responses ranged widely over the different areas covered by the report and beyond it. The summary below gives a flavour of the breadth of issues raised. In this paper, we have drawn out three broad themes: *costing, pricing methodology and the price-setting process*. We have endeavoured to capture key messages on the following page, with more detail and some quotes under each of the key themes.

Figure 1: Summary of issues and themes from respondents



## Theme 1: Costing

### What respondents said

There was general agreement with the first four findings of the PwC Evaluation report, which focused on the quality of costing information. It was recognised that Reference Costs, which form the basis of the current Payment-by-Results (PbR) tariff, vary widely between providers and over time, and it is often unclear what drives this variation.

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*"We strongly advocate a major improvement in the system and quality of costing to underpin tariff development and are attracted by the German system described in the document. We believe the lack of costing development alongside the introduction of Payment by Results in the past was a real mistake and needs a major overhaul."*

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Most respondents agreed that in some important areas, such as specialist care, there is some doubt as to whether the current categories of health care service - Healthcare Resource Groups (HRGs) - capture the full range of variety in the seriousness of patients' conditions and the costs of their treatment. Other respondents felt that there were too many HRGs in some areas, adding unnecessarily to the complexity of the current system.

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*"The results of our work show that there is huge fluctuation in patient level costs within one HRG, and some of the major reasons for this are multiple patient co-morbidities, long lengths of stay, sometimes low age, and different levels of support from informal consultations of clinicians in other specialties, allied healthcare professionals and diagnostic activity."*

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### Monitor's response

We have already commissioned further work on costing. The first part of this has been published on our website in [Strategic Options for Costing](#) and we are currently seeking feedback on it from stakeholders until 27 July 2012. This report picks up on some of the issues highlighted in the PwC Evaluation report and also considers points raised by this stakeholder engagement exercise.

## Theme 2: Pricing methodology

### What respondents said

Stakeholders frequently pointed out the need for greater stability in the reimbursement system. Respondents generally felt that efforts should be made to bring prices more closely into alignment with costs. Most respondents agreed that block contracts were not conducive to driving either efficiency or transparency.

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*"It is important that the significant gains that have been made are not lost and in particular that we do not revert to crude block contracts in order to ensure financial stability as this will, in the medium and longer term, weaken incentives for efficiency and quality."*

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One respondent commented that prices ought to be based on efficient cost, rather than average cost; though other commentators emphasised the importance of reflecting actual costs accurately.

A number of respondents also felt that there was a case for reimbursing capacity costs separately in some contexts. For example, reimbursing capacity costs where the provider is required to maintain a certain level of resources to treat patients, for example, with rare conditions or in emergencies. In these circumstances, providers incur a certain level of fixed costs regardless of the volume of patients they treat. Some kind of fixed capacity-based payment would allow providers to meet the cost of having resources in place to meet a peak level of demand.

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*"Our view is that the tariff should reimburse at an amount which covers the costs of a good quality provider of a reasonable size – if there is to be any subsidy for smaller, less efficient services, this should be transparent and based upon local population need rather than trying to ensure that tariff exactly covers costs in every provider."*

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One respondent commented that the current system does not adequately reimburse capital costs. If this is the case, providers may not be able to maintain or replace their more expensive pieces of equipment or buildings, which could have consequences for quality and patient safety. Failure to reimburse capital costs adequately might also mean that providers are unable to afford to make investments in new technology, which could enable better care. Difficulties in financing the initial cost could prevent these types of investments, even if the overall cost profile of the investment and its benefits were positive.

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*"The treatment of capital costs in the tariff must be changed to enable investment in modern facilities that are fit for purpose and the new patterns of service provision that will be required to achieve the level of efficiency savings needed. However, such an approach could not be allowed to simply increase the overall cost of care as this would be unaffordable."*

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A large number of respondents picked up on the interaction of the pricing system with the need to move towards greater integrated care. The view was expressed that the current system does not support integrated care and can act as a barrier to its provision.

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*"PbR as it stands does not support closer integration of services within the NHS and between the NHS and local authorities. However, some local health economies have taken the initiative and are seeking to design appropriate payment systems for their area which ignore the national tariff."*

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Finally, in relation to the Market Forces Factor (MFF) adjustment, there was a view expressed by some respondents that a fundamental review of the system was required. It was felt that there were anomalies in the price variation (largely driven by cost variation) that it produced and difficulties arising from its potential to distort choice by introducing price differentials between different providers.

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*"Without doing something on MFF the whole piece of work is meaningless. Above all else the review should encompass this and whether or not it can be validated in the way it is currently deployed."*

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### **Monitor's response**

We are undertaking work to investigate how pricing can be used to fulfil our core duty under the Health and Social Care Act: *to protect and promote the interests of people who use health care services by promoting the provision of health care services which: (a) is economic, efficient and effective, and (b) maintains or improves the quality of the services.*

This work is drawing on a variety of sources, including: engagement with a large number and broad range of stakeholders; lessons from the Evaluation Report, and responses to that report (summarised in this paper); lessons from overseas health sectors; lessons from other UK regulated sectors; investigation of existing NHS innovation and pilots in the area of pricing; and economic analysis of health services, including empirical analysis.

Each of the points raised by stakeholders through will be considered as part of our work to develop Monitor's vision for pricing.

Additionally, we commissioned and have published research on integrated care and the implications this will have for our new role. We are seeking feedback on [Enablers and barriers to integrated care and implications for Monitor](#) until 13 July 2012.

## Theme 3: Process

### What respondents said

Some respondents were critical of what was perceived as a tendency in the past to “tinker” with prices and currencies, leading to instability and confused signals. Others warned that reforming the system was likely to be a long haul.

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*“There needs to be a set of clear objectives agreed against which the tariff setting process needs to be measured. The feeling currently is that the tariff is often ‘tinkered’ with by policy staff to generate desired system changes. Often these are not thought through and can often lead to unintended consequences. One example is the introduction of the 30% marginal rate for emergency admissions growth from 2008/09 which has no rationale whatsoever behind it other than a naive belief that the tariff change would itself reduce the growth in emergency admissions.”*

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Several respondents urged continued engagement with the sector and indicated that they would be keen to remain involved. Others warned of the potential costs of change, for example, in the areas of cost collection and systems for administering prices.

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*“Addressing these flaws will be extremely challenging. In principle, switching to collecting patient-level costing information could increase pricing accuracy and reduce variance. Rolling out a patient-level data system across all providers, and particularly non-acute providers, would be very resource intensive and potentially costly. If providers are asked to collect large additional amounts of data, this will act as a burden to existing providers (with any extra costs ultimately at the expense of patient care) and as a barrier to entry for smaller providers.”*

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### Monitor’s response

We recognise that incremental changes to the pricing system can have unintended consequences and, taken as a whole, can disrupt the stability of the system. As part of our long-term pricing strategy work, we are considering ways to achieve greater stability and predictability of prices over time.

We will continue to engage with the sector as we work closely together with the NHS Commissioning Board on these issues.

## **Annex 1: The key findings of the Evaluation Report**

1. Providers report very different average costs in providing the same treatment to patients.
2. Some of the variation in average costs is due to differences in the approaches to costing and variations in the quality of cost information between providers.
3. Some cost drivers – particularly patient case mix – are not captured adequately in the current information underpinning the reimbursement system.
4. Local reimbursement negotiations (through block contracts, and local tariffs) are not based on reliable cost information.
5. PbR has enabled improvements to quality through increased patient choice, but there is little evidence to suggest that reimbursement mechanisms have driven improvements in the quality of care to patients.
6. There is some evidence that PbR has led to improvements in efficiency across certain services. However, problems with the incentives created by the reimbursement system may limit further improvements to efficiency
7. A large amount of cost variation is left unexplained by HRGs and adjustments. Whether this is due to weaknesses in the current mechanisms, the coding practices of providers or poor information is not clear.
8. Fluctuations in average costs reported by providers have affected the stability of tariff prices. Individual tariff prices fluctuate widely each year which further blunts the incentives of the reimbursement system.
9. Different economic and clinical characteristics of different care settings and services are not reflected in the current reimbursement system.
10. Lack of information and the incentives created by pricing systems in different administrative boundaries may hinder the flow of patients between different care settings.
11. Providers are not responding to signals being delivered through the pricing system at a service level.
12. Providers and commissioners are increasingly negotiating prices locally and abandoning the pricing system.

## **Annex 2: responses received to questions published alongside Evaluation report**

Twenty-one responses were received from the following stakeholders:

1. Cheshire & Wirral Partnership NHS Foundation Trust
2. Children's Healthcare Alliance
3. County Durham and Darlington NHS Foundation Trust
4. Derby Hospitals Foundation Trust
5. Foundation Trust Network (FTN)
6. Great Ormond Street Hospital for Children Foundation Trust
7. Independent Mental Health Services Alliance (IMHSA)
8. InHealth Group
9. Individual
10. NHS Confederation
11. NHS South Central SHA
12. Norfolk and Norwich University Hospitals NHS Foundation Trust
13. Sheffield Children's NHS Foundation Trust
14. Sheffield Teaching Hospitals NHS Foundation Trust
15. Shelford Group
16. The King's Fund
17. The Walton Centre NHS Foundation Trust
18. Association of UK University Hospitals
19. University Hospitals Birmingham NHS Foundation Trust
20. Wrightington, Wigan and Leigh NHS Foundation Trust
21. Audit Commission

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Publication code: IRCP(R) 09/12

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