University Hospitals Birmingham NHS Foundation Trust

Fair and transparent pricing for NHS services: A DoH consultation on proposals for objecting to proposed pricing methodology

4th December 2012

Consultation open: 5 Oct 2012 to **21 Dec 2012**.

Response From: Large Acute Teaching Hospital Foundation Trust

Respond via e-mail: pricing.consultation@dh.gsi.gov.uk subject '*Pricing Consultation*'

Policy keynotes:

- *Monitor will publish final draft National Tariff (14/15 tariff onwards) allowing 28 days for commissioners and providers to register any objections (to NT price calculation methodology).*
- *Monitor will develop and set: price setting methodology, prices, rules for local price setting and will agree local modifications to prices.*
- *NCB will: define tariff scope, determine currencies, set rules for variations to NT.*
- *New pricing may include: local variations, different national prices or different local prices for different types of provider, rules governing pricing for specified services for which no national price.*
- *Commissioners can agree modifications to prices but only with Monitor agreement.*
- *Monitor must include in NT the method used to assess applications for modification.*
- *Monitor focus will include: quality of supporting cost data to improve accuracy, better reflection of clinical complexity, supporting the integrated care agenda and widening the scope of NT.*
- *Process for objections: if sufficient numbers Monitor must either amend or refer proposal to the Competition Commission. The CC will rules within 30 days as to whether the methodology is sound or whether requires reconsideration. CC will consider: if best available data has been used, if Monitor has had due regard to its duty to protect service users and to promotes economic, efficient and effective healthcare, if the proposal is sound in law. Unsuccessful parties must pay costs of others.*
- *All objections count towards the number of objections received, however an objection by a provider or commissioner on several grounds still counts as one objection.*
- *Commissioner objections (1) will be calculated as a straight % of all commissioners of NHS funded care.*
- *Provider objections (2):*
    - *Providers must be current at the time of the consultation to count as objectors and in the threshold denominator.*
    - *The denominator will be the sum of all providers delivering tariff services weighted by total tariff income drawn from the previous year's financial accounts.*
    - *A third objection % will take into account an objecting providers will be adjusted by each providers "share of supply" (3) to determine a proportionate weight. This is defined as: a provider's total income from tariff services exc. local adjustments divided by the national total of the entirety of tariff income.*
- *Objection % thresholds: are proposed as set at > 51% objectors i.e. the (weighted) majority. The DoH rationale is to balance tariff appropriateness with the costs of delayed publication. This threshold applies to all 3 ratios.*
- *DoH has discounted service specific "share of supply" calculations as too onerous and administrative burden.*

Responses to consultation questions

Question 1: Do you agree that providers of services in the tariff in operation at the time at which Monitor consults on the next tariff should count towards the thresholds?

Yes, we would agree that existing providers should have the opportunity to comment and where appropriate challenge the tariff construction methodology and/or pricing.

Question 2: If yes, do you agree that this should include any such providers who are exempt from the requirement to hold a licence?

No, given the proposed methodology it is important that the denominator is not distorted by providers with unrepresentative tariff portfolios.

It is important that Providers with 'voting rights' should have balance of Non Elective and Elective, specialist and non specialist workload; this would ensure that they are best placed to vote on PbR rule construction for the benefit of the majority of the NHS e.g. NEL marginal rates policy, which some exempt providers could be unaffected by. If unaffected providers were included in the denomination they would dilute the % objectors such that the threshold for challenge may not be met by a substantial number of affected providers.
Such representative providers will be, by and large, existing NHS providers subject to licensing.

Questions 3: Do you agree that the data used to calculate an objection threshold should be based on total tariff income, as reported in financial accounts? If no, please suggest an alternative source.

No, this is inequitable and would penalise small or specialist Trusts e.g. specialist cancer, paediatric, orthopaedic, women's hospitals etc. In addition, it would also disadvantage large specialised teaching hospitals with a high local price:PbR ratio due to their significant component of highly specialist work, which is more likely to be outside the scope of tariff and with a significant proportion of income from other sources e.g. Education, Training and R&D activities, where some element of cross subsidisation still exists.

Question 4: Are there any other providers who should count towards the threshold? If yes, please give details and reasons.

This should depend upon the service provided. In general, the policy is too blunt an instrument and setting thresholds for tariff challenges at organisation only level runs counter to the ethos of developing a more granular tariff to better reflect clinical case complexity.
In addition, the proposed policy leaves no place for comment and challenge by related expert groups who may have a significant contribution to make e.g. Royal Colleges and other Clinical groups.

Question 5: Do you agree that the objection percentage threshold should be set at 51% for commissioners? If not, what figure would you propose, and why?

No, this is set too high and the result would be that the net would be cast too wide in event of punitive tariff and could cause widespread financial instability i.e. 49% of commissioners could have a significant and material financial issue which would not count as a relevant challenge, this would cause a national problem for the NHS.

The materiality of the query and challenge needs to be taken into account i.e. what is the net effect for each provider and for the NHS as a whole?

Question 6: Do you agree that the objection percentage threshold should be set at 51% for providers? If not, what figure would you propose, and why?

No, this is set too high and the result would be that the net would be cast too wide in event of punitive tariff and could cause widespread financial instability i.e. 49% of providers could have a significant and material financial issue which would not count as a relevant challenge, this would cause a national problem for the NHS.

The materiality of the query and challenge needs to be taken into account i.e. what is the net effect for each provider and for the NHS as a whole?

Question 7: Do you agree that a provider's share of supply should be calculated across all tariff services covered by the tariff in force at the time at which the consultation takes place? If not, how should their share of supply be calculated?

No, this methodology is inherently unfair:

- Providers with a significant cohort of specialised services, which by their very nature have been difficult to encompass within national tariffs and so remain either outside the scope of PbR or are named exclusions, would be disadvantaged by this approach.
- A high proportion of objections to tariff methodology are likely to be service specific i.e. within a speciality and as such the voice of a majority provider of a particular service, could be effectively relegated to a minority vote under this "bottom line" calculation.
- This leaves no room for challenges rated to high cost/low volume procedures and could have the perverse incentive of stifling innovative clinical practice.

The DH have proposed a single definition of supply citing complexity and administrative burden, however, there are many data sources e.g. HES activity, SUS-PbR or current reference costs collection data that are readily available for all existing Providers and Commissioners.

These data sets, within a large database, can easily be grouped at: Treatment Function Code, HRG sub-chapter level or even procedure level to determine market share by organisation and hence proportional voting rights.

Hence, an alternative methodology would not seem to be an overly burdensome calculation and should be relatively quickly ascertained without recourse to any

additional data collection; this could be calculated in advance and held centrally or at the time of a specific query. Indeed a database of national market share at a granular level would be useful information for Monitor to retain for wider business purpose.

It must be recognised that for some services within PbR, a relatively small number of organisations account for a large proportion of the activity undertaken nationally e.g. Chronic Renal Dialysis and sensible discussions on relevant tariffs for such very specific services could be ignored using a voting share methodology distorted by large volumes of general medical and general surgical activity nationally. This effect would be even more marked for more highly specialised or very low volume tertiary services.

It is important to note that such services identified above could be classed as 'commissioner requested services' or 'protected services' under the proposed 'Continuity of services' and Monitor Licence conditions, and as such it is imperative that providers, with their own expert understanding of the costs of provision can be actively engaged in the process of constructing relevant tariffs. This should be by reference to specific services and cannot operate only at an organisational bottom line basis.

Question 8: Do you agree that providers should be weighted based on income received from tariff services, as stated in the previous year's financial year's accounts, minus local area adjustments? If not, on what basis should they be weighted?

As with question 3 this would seem to be inequitable and would penalise small or specialist Trusts e.g. specialist cancer, paediatric, orthopaedic, women's hospitals etc. In addition, it would also disadvantage large specialised teaching hospitals with a high local price:PbR ratio. Providers with a large tariff income base derived from e.g. general medicine and general surgery should not have a greater weight in the decision as to whether to appeal the price setting methodology for a particular service than providers with a different case-mix (including that particular service).

Question 9: Do you agree that the share of supply percentage threshold should be set at the same figure as for the objection percentage thresholds, i.e. 51% of the total supply? If not, what percentage should be set, and why?

No, this is set too high and the result would be that the net would be cast too wide in event of punitive tariff and could cause widespread financial instability i.e. 49% of providers could have a significant and material financial issue which would not count as a relevant challenge, this would cause a national problem for the NHS.

The materiality of the query and challenge needs to be taken into account i.e. what is the net effect for each provider and for the NHS as a whole?

Question 10: Do you have any evidence that the proposals in this document will impact adversely or unfairly on any protected groups?

The proposal as draft is likely to impact upon not only providers of specialised services but would also potentially impact upon the funding of patient care within the following groups: maternity services, gender reassignment, chronic disease and/or disability as their voices could easily be lost within proposals outlined.