Optical Confederation
The voice of UK optics

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

The Optical Confederation represents the 12,000 optometrists, the 6,000 dispensing opticians and 7,000 optical businesses in the UK, who provide high quality and accessible eye care services to the whole population. The Confederation is a coalition of the five optical representative bodies: the Association of British Dispensing Opticians (ABDO); the Association of Contact Lens Manufacturers (ACLM); the Association of Optometrists (AOP); the Federation of Manufacturing Opticians (FMO) and the Federation of Opticians (FODO). As a Confederation, we work with others to improve eye health for the public good.

We thank you for the opportunity to comment on this consultation.

Why we are responding

We respond to this consultation from the perspectives of both existing providers and potential providers of outpatient type services delivered in the community by NHS eye care providers under the tariff.

We strongly support the decision that the national sight-testing service will be commissioned nationally by the NHS Commissioning Board (NHS CB) for the efficiency benefits this brings to the NHS, the wide distribution of services and access for patients. Furthermore, we welcome the Government's proposal that community eye health services should be exempt from Monitor licensing in that they are already appropriately regulated under parallel regimes.

Support for the Government's aims

As a sector operating in a genuine, open and highly competitive market, we fully support the Government's aims of ensuring that the traditional NHS system delivers "better health, better care and better value for money" (Introduction, paragraph 1, page 6).

We also welcome the aim to minimise any perverse incentives for providers to "cherry pick" the services they deliver or the patients they treat. (The Rationale for the New Pricing System, paragraph 6, page 6).

In the community eye care sector, NHS providers are prohibited from cherry picking or discriminating against patients and, in the rare event that they have to refuse to see a patient (e.g. because the patient is violent or abusive), this has to be recorded and – rightly - reported to the NHS CB.

Factors in setting the tariff & integration of care

In our view, the tariff should be set for traditional NHS providers at a level which takes account of

- clinical and demographic complexity
- the actual cost of providing the service
- the cost of providing high-quality clinical care, audit and training for hospital doctors and other staff.

The tariff should not provide an incentive for acute providers to suck in patients, who could be treated equally effectively and more cheaply, or conveniently in other parts of the system.

A pricing incentive in this direction (e.g. QIPP) may well be as beneficial in driving more integrated services than all the regulation in the world.

Eye Health Sector

In the eye health and eye care sector, a greater quantum of care overall is required in order to meet the growing need of an ageing population.

In our view, this should include

- sufficient capacity within hospital eye departments to cope with the level of serious pathology they now need to see, to audit care, to report back to referring clinicians and with sufficient case mix of patients to provide training for the next generation of ophthalmologists, orthoptists, ophthalmic nurses and opticians
- management in the community of all other patients with stable conditions which can be managed conveniently and accessibly for patients outside the hospital sector
- supported by improved communications between the two sectors and with GPs.

As a sector we are very keen to work with the NHS Commissioning Board, providers and clinical colleagues across the entire eye health and care spectrum, including the voluntary sector, to achieve these aims and to deliver QIPP.

Key to this, from our perspective, will be the twenty-seven new Local Eye Health Networks which will be structurally part of every NHS CB Local Area Team in the country.

It follows, in our view, (please see responses to questions 4 and 6 below) that Local Eye Health Networks (as the voice of the clinician-led, patient-centred service locally) should also have the right of objecting to the tariff, and particularly about where insufficient or inappropriate local variations are to be permitted.

It is against this background that our more detailed responses to the specific consultation questions follow.

Q1: Do you agree that providers of services in the tariff in operation at the time at which Monitor consults from the next tariff should count towards the thresholds? If not, can you suggest an alternative method to take this on?

A1: Yes, this seems sensible.

Q2: If yes, do you agree that this should include any such providers who are exempt from the requirement to hold a licence?

A2: Yes, as in the case of eye health and eye care services, providers of primary ophthalmic services in the community will be exempt from the requirement to hold a Monitor licence on the grounds that they are adequately and equally regulated under alternative systems.

Q3: Do you agree that the data used to calculate an objection threshold should be based on total tariff income, as reported in the financial accounts? If no, please suggest an alternative source.

A3: Yes.

Q4: Are there any other providers who should count towards the threshold? If so, yes please give details and reasons.

A4: It is not immediately apparent to us how alternative providers, who do not currently hold any NHS contracts, will be able to object to a tariff which may be set on the historical basis with an in-built bias towards traditional providers. This may be deliberate but, if so, should be made explicit.

In this context would it be helpful to have a duty on Monitor to take account of serious objections of potential providers who might consider the tariff and local adjustments proposals to be over-protectionist and anti-competitive?

'Serious objections' would need to be defined, but ought not to be linked to the size of the sector objecting.

Q5: Do you agree that the objection percentage threshold should be set at 51% for commissioners? If not, what figure would you propose, and why?

A5: Please see above and, yes, provided these thresholds can be reviewed in the light of experience in case they are inappropriate.

Q6: Do you agree that the objection percentage threshold should be set at 51% of providers? If not, what figure you would propose and why?

A6: Yes, provided again that the threshold can be reviewed in the light of experience in case it is inappropriate.

We refer under our response to Q4 above, to our lack of clarity as to how potential alternative providers could challenge tariff proposals. It may be that a number of small providers could actually provide services more efficiently than Foundation Trusts and NHS Trusts and by doing so have the potential significantly to increase the proportion of care they provide. However, without any way of making their voice or objection known, at least considered or taken into account, they will never be able to break into the market sufficiently to drive the improvements in efficiency and quality that they could bring.

Again, as in Q4, our solution would be to impose a duty on Monitor to take account of the reasonable views of alternative providers in setting the tariff so this could be combined with a simple and easy report back when the tariff is set about which other providers' views were considered and why they were not taken into account.

No one is seeking a right of veto or to give powers to vexatious potential providers who would never have the capacity or might even have no intention of providing the requisite services. All we are seeking to do is to highlight what appears to be an omission in the proposed regime.

Q7: Do you agree that a provider's share of supply should be calculated across all tariff services covered by the tariff enforced at the time at which the consultation takes place? Then if not, how should their share of supply be calculated?

A7: Yes.

Q8: Do you agree that providers should be weighted based on income received from tariff services, as stated in the previous year's financial accounts, minus local area adjustments? If not, on what basis should they be weighted?

A8: Yes.

Q9: Do you agree that the share of supply percentage thresholds should be set at the same figure as for the objection percentage thresholds, ie 51% of the total supply? If not, what percentage should be set and why?

A9: Yes, provided this is subject to review in the light of experience and also subject to our queries at questions 4 and 6 above.

Q10: Do you have any evidence that the proposals in this document would impact adversely or unfairly on any protected groups?

A10: No.