Department of Health

Fair and transparent pricing for NHS services

A consultation on proposals for revising the objection mechanism to the pricing method

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Fair and transparent pricing for NHS services

A consultation on proposals for revising the objection mechanism to the pricing method

Department of Health

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Summary

This consultation is about proposals to revise the objection mechanism to the pricing method for NHS services in England, which applies when proposals for the national tariff are published for consultation.

The Health and Social Care Act 2012 (the Act) introduced a new independent, transparent and fair pricing system that requires Monitor and NHS England to collaborate to set prices and further develop new payment models across different services. Monitor is required to consult on proposals for the national tariff. The Act makes provision about when certain percentage levels of objection are received from commissioners or providers, when certain actions are required, and the relevant threshold levels for objections are prescribed by regulations.

This consultation is about revising the objection thresholds that were prescribed by regulations made in 2013.

The Department seeks views and comments on the proposals in this document.

How to respond

This consultation is available online at

https://consultations.dh.gov.uk/nhs-pricing/objection-mechanism-to-the-pricing-method

Please complete your response no later than 11 September 2015.

Alternative contact details:

Pricing consultation

Department of Health

Room 239

Richmond House

79 Whitehall

London

SW1A 2NS

Email: pricing.consultation@dh.gsi.gov.uk with the subject 'Pricing Consultation'.

1. Background on pricing

Rationale for pricing

1.1. The payment system for NHS funded services has been evolving since its introduction to the NHS in 2004/05. The Health and Social Care 2012 Act (the Act) introduced a new independent, transparent and fair pricing system that requires Monitor and NHS England to collaborate to set prices and further develop new payment models across different services. The intention was to create a more stable, predictable environment, allowing providers and commissioners to invest in technology and innovative service models to improve patient care. Transferring pricing from the Department, making it independent, is intended to that pricing is stable and not affected by political priorities. This is intended to help aid investment decisions and improve the quality and efficiency of care. It also needs to provide stability to enable the NHS to deliver upon the vision set out in the NHS Five Year Forward View.

Pricing and the Health and Social Care Act 2012

1.2. Sections 115-127 of Chapter 4, Part 3 of the Act give Monitor and NHS England responsibility for designing and implementing the reimbursement framework for NHS-funded healthcare services. This came into effect from 1 April 2014 as the national tariff.

1.3. The national tariff specifies:

- NHS health services that have prices set at a national level;
- The method for determining the national prices for those services;
- The national prices for each of those services;
- National variations to those prices and rules governing the agreement of local variations to those prices;
- The method to be used by Monitor for determining and deciding local modifications to those prices; and
- The rules governing local pricing arrangements for services without a national price.

1.4. Monitor has a duty to consult on and publish the national tariff but the proposals must be agreed between Monitor and NHS England. In particular, NHS England considers which health services should be priced at a national level and Monitor considers how the prices should be calculated. Both organisations are subject to a duty in section 119(1) of the Act that requires both organisations, in ensuring that prices reflect a fair level of pay for providers, to have regard to the differences in costs incurred by providers who treat different types of patients and differences between providers with respect to the services they provide.

1.5. Monitor has a duty in section 62(1) of the Act, its main duty when exercising its functions, to protect and promote the interests of patients by promoting healthcare that is

economic, effective and efficient and which maintains or improves the quality of services. Monitor is also subject to various other general duties in sections 62 to 66, relating to matters such as integration and quality of services. NHS England also has a range of duties to comply with under the NHS Act 2006, some of which are similar, such as sections 13D (effectiveness), 13E (quality of services), 13G (reducing inequalities), 13K (innovation) and 13N (integration). As a result of its duty under section 69 of the Act to carry out impact assessments, Monitor undertook and published an assessment of the likely impact on patients, commissioners and providers of NHS services or the general public in England of the proposed 2015/16 national tariff. In relation to the impact of the proposed provider efficiency factor, this was assessed as broadly neutral, with no disproportionate effect on equalities, small providers, independent providers, patient choice and competition, or NHS finances generally.

1.6. To develop a national tariff, Monitor and NHS England engage with commissioners and providers of NHS services and other interested parties on their initial tariff proposals. This engagement has previously included the publication of a number of detailed documents setting out different aspects of the proposed tariff, which together form the Tariff Engagement Document (TED). The TED tests the underlying modelling and likely impact of the tariff proposals. Future engagement is likely to take a slightly different form with more emphasis on working directly with stakeholders, rather than publication of standalone documents.

1.7. Following this engagement, Monitor is required by section 118 of the Act to undertake a 28 day statutory consultation on the national tariff. Monitor must send a notice to all clinical commissioning groups, relevant providers of NHS services and other such persons as it considers appropriate, specifying the proposals for the national tariff.

1.8. Sections 118 to 120 of the Act specify an objection procedure, which allow commissioners and providers formally to object to the chosen method proposed for calculating national prices rather than the price itself. The method comprises a range of factors, including the historic costs of providing the service, plus cost uplifts recognising upward cost pressures since historic cost was calculated, minus system drivers such as efficiency factors which, when taken together, ensure prices reflect only efficient rather than actual costs. In relation to the objection procedure, the Secretary of State must prescribe two thresholds for the percentage by overall proportion, of objecting commissioners and providers. The Secretary of State may also prescribe a third threshold for the overall share of supply, which reflects the percentage, by proportion of providers weighted according to share of supply in England of such services as may be prescribed. These thresholds are referred to in this consultation document as objection thresholds and all three were prescribed at 51% in the NHS (Licensing and Pricing) Regulations 2013.

1.9. Following statutory consultation, Monitor is required to calculate:

- The percentage of commissioners objecting;
- The percentage of relevant providers objecting; and
- The percentage ‘share of supply’ held by objecting providers.

1.10. If the threshold in any one of the three categories is met, Monitor cannot adopt and publish the national tariff consulted on and must choose either to:

- Reconsider the proposed method itself and then publish a revised proposed national tariff for further consideration; or
- Refer the method and the objections received to the Competition and Markets Authority.

Until a new national tariff is published, an existing unexpired tariff remains in force.

1.11. The national tariff is currently updated each year to ensure that baseline prices are up to date, thereby reflecting the changing models of care in order to deliver continued, improved patient care at an affordable price. Currently, not all NHS services are included in the national tariff as some services will have local agreed prices.

2015/16 National Tariff

1.12. Engagement by NHS England and Monitor on this proposed tariff took almost seven months to complete. The outcome of the statutory consultation is explained in this section.

1.13. Monitor and NHS England formally consulted on proposals for 2015/16 national tariff from 26 November – 24 December 2014. Monitor's analysis showed the following objection rates to the proposed method for determining national prices:

- 75% of relevant providers by share of supply;
- 37% of relevant providers by number; and
- 8% of commissioners by number.

1.14. As the share of supply threshold exceeded 51%, the national tariff was not published and as a result, the existing 2014/15 tariff remained in force. The cost pressures to commissioners and providers continuing to operate on pay at 2014/15 tariff levels rather than those that would have been introduced through the 2015/16 proposals were calculated by NHS England as being approximately £1 billion.

1.15. The objection process is there to ensure that there is a mechanism for challenging the method if providers or commissioners consider that it is not fair or reasonable. In relation to the proposed 2015/16 tariff, the share of supply threshold was exceeded due to objections related largely to one aspect of the method, the efficiency factor of 3.8%, which in turn affected the level of prices. This efficiency factor was designed to reflect the cost of a reasonably efficient provider of NHS services operating at the level of quality required by commissioners. Importantly, in difficult financial circumstances, it is entirely possible, that prices may have to reduce.

1.16. However, Monitor and NHS England believe that another significant trigger for the statutory objection related to a variation to the payment of national prices for specialised

services, rather than the underlying method for the price (to which objections can be made). The largest trusts in the country are, in the main, the providers of specialised services, and they considered this variation came on top of the efficiency factor already built into the method.

1.17. The result was that a relatively small number of large trusts were able to use the share of supply element of the objection process to object to a number of issues, not all of which fell within the objection process. The result was significant disruption to the financial planning of the whole sector.

1.18. In order to reduce the unaffordable cost pressure that the objection caused, in February Monitor and NHS England offered providers the option of agreeing local variations to the 2014/15 tariff (the Enhanced Tariff Option or ETO) or remaining on the 2014/15 tariff prices (Default Tariff Rollover or DTR).

1.19. The ETO variation is slightly more generous than the original 2015/16 offer and NHS England has had to compensate commissioners for the additional costs. Those organisations remaining on the DTR however, are still benefitting from the even more generous prices that are contained in the 2014/15 tariff and so, in order to make this affordable for commissioners, organisations opting for the DTR had the potential for earning Commissioning for Quality and Innovation (CQUIN) payments worth a maximum of 2.5% of contract values removed from them.

1.20. The Department is of the view that in order to avoid future potential for disruption and consequential cost to the system, which is unsustainable, the objection thresholds need to be revisited to provide a process that is as fair and stable as possible for all NHS providers and commissioners. It is critical for commissioners and providers to have certainty on prices for services as soon as is practically possible. This is to enable them to plan and contract for services that meet their identified need well in advance of the new financial year. Stability is also needed to enable commissioners and providers to understand where to make crucial investments to enable them to implement the view set in the Five Year Forward View, as well as enable them to address any forecast deficits as soon as possible. It is crucial that the tariff development process operates more efficiently and effectively than has been the case for 2015/16, while being mindful of the views of stakeholders. The proposals in this consultation do not remove the requirement for a statutory consultation on the proposed national tariff, and should thus preserve the opportunity for commissioners and providers to provide their views to Monitor and NHS England, which must be considered by those bodies before decisions are taken, whether or not any threshold is met.

1.21. Given the current financial challenges that face commissioners and providers and the need to establish financial certainty without undue delay, we are consulting on a number of proposed changes to the objection thresholds. The statutory objection process envisages that objections can be made to method not price, but at a time of straitened financial circumstances, the link between the two is obviously close. Importantly, when efficiencies have to be made across the system in different ways, the objection process

was designed to allow providers to object to the underlying method, rather than other elements of the tariff such as the eventual price or payment terms

1.22. In particular, the threshold for objections from providers by share of supply gives a specific voice to providers of a larger percentage of NHS services. However, the Department thinks that a fairer balance will be maintained in the system as a whole if those larger providers have the opportunity to object to proposals as part of the overall provider response, rather than as a separate voice. They will in any event, continue to form an important part of the stakeholder engagement by Monitor and NHS England as part of the tariff evolution process, where they can bring forward any considerations that apply more particularly to the larger providers, such as considerations around specialist services that this type of provider is most likely to provide.

1.23. The Department considers the options put forward in this consultation represent a range of proportionate responses to this problem. They would retain the ability of commissioners and providers to object to the chosen method, but balance it in favour of the whole sector rather than a relatively small number of objectors, and require levels of objection to be significant enough to warrant a pause to and revisiting of the introduction of the proposed tariff. Nevertheless, it is fully recognised as imperative that Monitor and NHS England continue to consult and engage with all stakeholders to improve the tariff setting process and bring stakeholders along with the tough decisions that need to be taken going forward.

2. The consultation

The tariff setting and objections process

2.1. The tariff setting consultation and objections process explained in the previous section ensures that Monitor takes due account of the views of commissioners and providers when delivering the national tariff.

2.2. The Department considers that an efficient and fair tariff setting consultation and objection process would achieve the following:

- To drive efficiency through pricing - Monitor and NHS England need to be able to discuss with stakeholders, reach a view and propose pricing efficiencies, to ensure sustainability of NHS services.
- To increase the accuracy of pricing – to enable commissioners and providers through stakeholder engagement by Monitor and NHS England positively to influence the pricing system, to allow for any errors and/or incorrect prices to be amended, and to act as a check and balance on Monitor's role in setting national prices.
- To ensure fairness and proportionality – to ensure that all providers and commissioners have a fair opportunity to object to the pricing method.
- To protect – to protect commissioners and providers from Monitor and NHS England imposing unfair method. Also, to protect patients by balancing the interests of all parties.
- To improve quality - to ensure that commissioners and providers are incentivised to deliver better quality care and value for patients
- Easily implemented – to ensure that the objection process is uncomplicated, transparent and easy to put into practice, to ensure a minimum level of burden for providers, commissioners and for Monitor.
- Not unnecessarily delayed - by allowing reference to the Competition and Markets Authority, which results in delay to the publication of the tariff and incurs associated costs, only in exceptional circumstances.

2.3. The Department's view is that the objection threshold mechanism was intended to be a process to be triggered in exceptional circumstances, as it was felt that greater transparency and more formal engagement in the development process would reduce the likelihood of objections and of thresholds being triggered. As set out above, however, this has inadvertently allowed a route for a particular group of providers (who may not be representative of the whole sector) to frustrate the process if and when they disagree with a particular aspect of the method, or changes to the pricing system outside the method. When the thresholds were prescribed in 2013, the Department explained in the explanatory memorandum to the regulations that the mechanism would be kept under review given that there was no precedent from other industries for what an appropriate threshold should be.

Question 1: Do you agree that the objection mechanism for the NHS national tariff should be revised to provide greater certainty on prices in advance of a new financial year?

Share of supply objection threshold (for providers)

2.4. The share of supply percentage in section 120(2)(c) of the Act allows the Secretary of State the option to prescribe an additional objection threshold which takes account of a relevant provider's scale and share of market, where this is considered to be necessary. The Act included this option in case it was thought helpful to allow providers of the largest amount of NHS services greater influence in challenging the proposed pricing method. This differs from the other provider objection percentage in section 120(2)(b) of the Act which gives each relevant provider an equal vote.

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2.5. When responsibility for setting tariff was transferred from the Department to Monitor and NHS England, it was not clear what was the most appropriate method to define share of supply. We defined share of supply across all tariff services in the first instance, which would allow for a simpler and more transparent process to calculate objections and afford time for the new payment system to bed down. We rejected looking at changes to the definition of share of supply as we did not see the benefits in having a more complex definition because we moved to thinking that it is more balanced for the system to look at objections on a numerical basis.

2.6. All three objection thresholds were prescribed in 2013. Evidence indicates that exercising the power to prescribe a threshold for providers by share of supply has resulted in giving a disproportionate weight to views of a small group of providers with a large share of supply. As set out previously, the 2015/16 process was only triggered by 134 of 361 relevant providers by 'share of supply'. A number of the largest hospitals were included in the 134 and would have accounted for most of the share of supply.

2.7. We have discounted the option of raising the objection threshold for the share of supply. Because a small number of providers have a larger influence, calculating the weightings involved is in practice very difficult. Additionally, since 2013 there has been a gradual shift towards larger providers as a result of mergers between providers, which changes the impact of any threshold. Therefore, we are of the view that revising the threshold would not rebalance the system sufficiently.

2.8. We therefore propose that the objection threshold based on the provider's share of supply be removed. Large providers will be included in the pre-consultation engagement and have a voice with all other providers in the consultation and objection process. In addition, the Impact Assessment which Monitor prepares will have to consider and report on the differential impacts of tariff proposals, so Monitor will need to take into account the impact on larger providers when designing a fair tariff for consultation.

Question 2: Do you agree that the objection threshold based on providers' share of supply should be removed? If not, why should this threshold remain? If it should remain, at what level should it be set?

Objection thresholds (for commissioners and providers)

2.9. In 2013, the Department prescribed all the thresholds at 51% (the objection percentage for providers and commissioners). The intention was that the threshold should be high enough to prevent any unnecessary delay to the tariff caused by objections that were not sufficiently representative, but low enough to highlight systematic issues with the method. In 2013, the Department considered that, at 51%, the majority of providers and commissioners must be dissatisfied with the tariff method in order to prevent Monitor adopting and publishing the tariff.

2.10. In 2013, this was a new process for the national tariff. There was no existing information on what an appropriate threshold should be. When developing and setting the existing threshold levels in 2013, we considered a range of examples from across gas, electricity and water markets. We also sought the views of Monitor, NHS England and the Competition and Markets Authority. We discounted threshold levels below 50% as we believed this did not strike the fairest balance as a starting point for the new system, giving less weight to providers and commissioners who are content with the tariff over those who are dissatisfied.

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2.11. Taking into account the two tariff processes for 2014/15 and 2015/16, and engagement with key partners, we are minded to increase the objection thresholds for commissioners and providers to between 66% and 75% rather than remain on the current threshold at 51%. (We think it is fair for the levels for both providers and commissioners to be the same.) While both represent an increase over the current threshold level, we believe these are proportionate and reasonable at a time of financial constraint - when efficiency savings must be found and changes may be made to the pricing system outside the method (but which might prompt objections via the method). We consider that increasing both thresholds reflects the objective behind the removal of the share of supply objection threshold, by creating the right balance between giving commissioners and providers the opportunity to raise their concerns, and creating stability for the tariff setting process. It is important to remember that the duty on Monitor and NHS England relating to securing a fair level of pay for providers in section 119(1) of the Act remains unchanged. The Department believes that the proposed thresholds, although higher than the current threshold levels, are not set so high that they could not in practice be met. However, they will only be met if there is substantial support across the particular group for an objection to be made.

Question 3: Do you agree that the objection threshold for commissioners and providers should be raised and, if so, to what level?

Future review of the objection process and thresholds

2.12. The Department will continue to keep under review whether any further changes to the objection mechanism and the thresholds are necessary to ensure that the system operates optimally.

Business and equality impacts

2.13. The proposals set out in this consultation document for regulatory change give commissioners and providers the ability formally to challenge the consultation process on the national tariff in a balanced way. As the national tariff is only paid by NHS commissioners for NHS services, we therefore do not consider a business impact assessment needs to be published.

2.14. The Government is covered by the Equality Act 2010, and specifically the Public Sector Equality Duty. The Duty covers the following protected characteristics; age; disability; gender reassignment; pregnancy and maternity, race (includes ethnic or national origins, colour or nationality); religion and belief (includes lack of belief); sex and sexual orientation.

2.15. Following the commencement of the Health and Social Care Act, the following duties must be complied when the Secretary of State is exercising functions in relation to health services:

- A duty to exercise those functions with a view to securing continuous improvement in the quality of service provided to individuals;
- A duty to have regard to the NHS Constitution:
- A duty to have regard to the need to reduce health inequalities between the people of England;
- A duty to promote autonomy within the health service;
- A duty to promote research into health service matters and to promote the use of such research;
- A duty to secure an effective system for education and training NHS workers or people who might work in the NHS.

2.16. We do not envisage any differential impact in equality terms arising from the proposals, and the proposals are put forward with the Secretary of State's general duties in mind.

Question 4: Are you aware of any equality issues or of any particular group for whom the proposed changes could have either a detrimental or differential impact?

Question 5: Do you consider there to be any significant impact on the sector as a result of the proposed changes to the objection process?

The consultation questions

Question 1: Do you agree that the objection mechanism for the NHS national tariff should be revised to provide greater certainty on prices in advance of a new financial year?

Question 2: Do you agree that the objection threshold based on providers' share of supply should be removed? If not, why should this threshold remain? If it should remain, at what level should it be set?

Question 3: Do you agree that the objection threshold for providers and commissioners should be raised and, if so, to what level?

Question 4: Are you aware of any equality issues or of any particular group for whom the proposed changes could have either a detrimental or differential impact?

Question 5: Do you consider there to be any significant impact on health services as a result of the proposed changes to the objection process?