Monitor
Making the health sector work for patients

Impact assessment

2016/17 national tariff proposals: Currency design and relative prices

www.gov.uk/monitor

About Monitor

As the sector regulator for health services in England, our job is to make the health sector work better for patients. As well as making sure that independent NHS foundation trusts are well led so that they can deliver quality care on a sustainable basis, we make sure: essential services are maintained if a provider gets into serious difficulties; the NHS payment system promotes quality and efficiency; and patients do not lose out through restrictions on their rights to make choices, through poor purchasing on their behalf, or through inappropriate anti-competitive behaviour by providers or commissioners.

Contents

Summary

The engagement document *2016/17 national tariff proposals: Currency design and relative prices* explains a number of policies that Monitor and NHS England are proposing for the 2016/17 national tariff, and asks for your feedback.[1] We want the national tariff to act in the best interests of patients, and feedback on our tariff proposals from our stakeholders is crucial for achieving that.

To inform your feedback, this report provides Monitor's preliminary quantitative assessment of the impact on patients, providers and commissioners of these policies.[2] It compares what the NHS would look like if we implemented these policies with what it looks like now, where around 88% of NHS providers receive payment based on the Enhanced Tariff Option (ETO), and 13% receive payment based on the Default Tariff Rollover (DTR).[3]

In preparing this report, we have taken account of your feedback on the impact assessment we published last November alongside our statutory consultation notice on the 2015/16 national tariff.[4] That's why this report gives more analysis of the direct impact on patients, repeats other tariff documents less, and does more to show the combined impact of the policy proposals. Because we have aimed to avoid repeating other tariff documents, this report only provides a very brief description of the policy proposals we are assessing. It should be read alongside *2016/17 national tariff proposals: Currency design and relative prices*, which provides a full description of all policy proposals and the reasons for them.

We will work to develop our impact assessment over the coming months. This includes developing a deeper understanding of what is causing some of the more substantial impacts we have estimated, particularly in orthopaedics. The results from any additional impact assessment work will influence the policies we choose to include in our statutory consultation notice on the proposals for the 2016/17 national tariff. Alongside the consultation notice we will also publish a full impact assessment, incorporating our additional work.

---

[1] Available at: www.gov.uk/government/publications/201617-national-tariff-proposals-currency-design-and-relative-prices

[2] Because this report was prepared solely by Monitor, the use of 'we' throughout refers to Monitor alone, not to Monitor and NHS England.

[3] See press release from Monitor and NHS England *Most NHS providers opt for 'Enhanced Tariff' for 2015/16*, 10 March 2015.

[4] Monitor and NHS England (2014) *2015/16 National Tariff Payment System: A consultation notice*

Findings

We are proposing to set new relative prices (our 'draft prices') based on the HRG4+ currency design and updated cost data.[5] We assessed the impact of these changes by applying both draft prices and current prices (ETO or DTR, depending on provider choice) to the most recent available activity data. To focus our analysis on the effect of changes to **relative** prices, we scaled prices so that total spending was the same in both cases. We also analysed how draft prices would affect different care categories. The care categories we analysed were mostly HRG subchapters, but we also looked at maternity and unbundled currencies.[6,7]

Finding 1: For 90% of NHS providers, draft prices would change operating revenue by less than +/-2.5%. The providers who see the biggest falls in revenue are orthopaedic specialists; draft prices would reduce the operating revenue of three specialist orthopaedic providers by more than 7%. This is driven by the reduction in orthopaedics prices discussed in **Finding 4**.

Finding 2: Draft prices would change the spending of all clinical commissioning groups by less than +/-1.3% of their funding allocation. They would also increase NHS England's spend on services inside the scope of the national tariff by around 0.3%.

Finding 3: Draft prices would reduce the nationally priced revenue of independent sector providers by around 7%. This is largely caused by the fall in orthopaedics prices discussed in **Finding 4.** Around 40% of independent provider revenue from nationally priced services (compared with 12% for NHS providers) comes from orthopaedic services where prices have fallen by more than 10%.

Finding 4: Draft prices change the weighted average price for 23 care categories by less than +/- 5% from ETO prices. Prices for a further 10 care categories increase or decrease by 5-10%. These price changes are driven by a combination of changes in reported costs and changes in how both patient complexity and care are classified in the HRG4+ currency design. In addition, prices for four categories of care change by more than 10%. Three of these categories are in orthopaedics: Orthopaedic Trauma (+14%), Orthopaedic Non-Trauma (-10%) and Orthopaedic Reconstruction (-31%); and the other is Maternity (+11%). The price changes in orthopaedics are similar to what we observed in last year's draft prices,

---

[5] See Chapter 5 of *2016/17 national tariff proposals: Currency design and relative prices* for a full description of how we calculated draft prices. A full list of the draft prices is published alongside that report.

[6] The HRG4+ currency design is divided into 'subchapters', each of which is a group of currencies relating to a type of care for a particular body area or body system.

[7] Unbundled currencies cover a small number of services that have been split off ('unbundled') from a currency covering a whole pathway of care, to enable different parts of the pathway to be provided by different providers. The current unbundled currencies cover some types of scan, as well as chemotherapy and radiotherapy.

but eventually decided not to implement due to stakeholder concerns. We are working to understand whether orthopaedics price changes are appropriate. We also expect these price changes may influence our approach to price smoothing.

Finding 5: Draft prices change the weighted average price for 22 care categories by less than +/-5% from DTR prices. Prices for a further eight care categories increase or decrease by 5-10%. As in the comparison with ETO prices, these price changes are driven by changes in reported costs and in how both patient complexity and care are classified. However, changes in reported costs are likely to play a larger role, as DTR prices are based on older cost data than ETO prices. Six care categories change price by more than 10%; four of these are in orthopaedic care (similar to ETO). The others are A&E (+17%) and Maternity (+14%). As A&E currency design has not changed, its price rise primarily reflects increases in reported costs.[8]

Finding 6: Draft prices do not change significantly the weighted average price for 'admitted patient care' (care for patients admitted to hospital). On average, these draft prices are 2% higher than ETO prices and 1% higher than DTR prices. The weighted average price for 'outpatient attendances' (outpatient appointments that do not result in a nationally-priced procedure) changes by less than 3%. However, weighted average prices for outpatient procedures change considerably – draft prices are 13% lower than ETO and 21% lower than DTR. We are doing further work to understand what drives this change.

Finding 7: Draft prices would change the price paid for 60% of patient activity (42 million) by less than +/-10%, but for 2.8 million (4.1%) they would change the price by more than +/-50%.[9] Price changes greater than +/-50% are spread across a number of care categories, but the three with the most are radiotherapy, chemotherapy, and multiple trauma. All have similar numbers of patients with >50% increases and >50% reductions.

Finding 8: The impact of draft prices on patients does not vary substantially by ethnicity, age or gender.[10] No ethnic group experiences a weighted average price change greater than 0.9%. Weighted average prices for care provided to men and women, and for all age groups, change by less than 0.1%.

---

[8] It is also partly caused by a change in our price-setting methodology. This change in methodology and its impact are described in the impact assessment report on the 2015/16 national tariff proposals. See: Monitor (2014) *Impact assessment for the proposals set out in the '2015/16 National Tariff Payment System: A consultation notice'*, p. 19.

[9] 'Activity' in this case refers collectively to admitted patient spells (in total c.13 million), outpatient procedures (in total c.10 million) and outpatient attendances (in total c. 44 million). It excludes A&E attendances.

[10] This analysis is based on the activity data described above in Footnote 9.

1. Introduction

The engagement document *2016/17 national tariff proposals: Currency design and relative prices* explains a number of policies that Monitor and NHS England are proposing for the 2016/17 national tariff, and asks for your feedback. We want the national tariff to act in the best interests of patients, and feedback on our tariff proposals from our stakeholders is crucial for achieving that.

To inform your feedback, this report provides Monitor's preliminary quantitative assessment of the impact on patients, providers and commissioners of these policies.[11] It compares what the NHS would look like if we implemented these policies with what it looks like now, where 88% of NHS providers receive payment based on the Enhanced Tariff Option (ETO), and 13% receive payment based on the Default Tariff Rollover (DTR). It does this by applying both draft and current prices to the most recent available activity data and looking at the difference between the two, as measured by changes in spending on different types of care and different types of patient, provider revenue, and commissioner spending. To focus our analysis on the effect of changes to **relative** prices, rather than overall price levels, we scaled prices so that total spending was the same in both cases.

We have conducted our preliminary impact assessment adopting the principles we set out in our Impact Assessment Framework last year.[12] That is to say, we have aimed to make our assessment **proportionate, transparent, evidence-based, policy-specific, compared to an appropriate baseline,** and **robust to key assumptions.** We have also assessed the impact of our proposals on certain aspects of equality in order to address the principles that guide how a public authority should comply with the public sector equality duty.[13]

In preparing this report, we have taken account of your feedback on the impact assessment we published last November alongside our statutory consultation notice on the 2015/16 national tariff.[14] That's why this report gives more analysis of the impact on patients, repeats other tariff documents less, and does more to show the combined impact of the policy proposals. Because we have aimed to avoid repeating other tariff documents, this report only provides a very brief description of the policy proposals we are assessing. It should be read alongside *2016/17 national tariff proposals: Currency design and relative prices*, which provides a full description of all policy proposals and the reasons for them.

[11] Because this report was prepared solely by Monitor, the use of 'we' throughout refers to Monitor alone, not to Monitor and NHS England.
[12] Monitor (2014), 2015/16 National Tariff Payment System: Impact Assessment Framework
[13] Under s149 of the Equality Act 2010
[14] Monitor and NHS England (2014) *2015/16 National Tariff Payment System: A consultation notice*

We can better show the combined impact of policy proposals because we have improved how we model their impact on providers. We have developed a single model that covers most proposed tariff policies, and takes a more sophisticated approach to predicting impacts.

This report is more comprehensive than the preliminary impact assessment we provided for last year's engagement document, though it does still have some limitations. In particular, it shows the impact of our policy proposals if the mixture of care offered by every provider, and commissioned by every commissioner, stays the same. It will be for providers and commissioners to respectively decide whether they wish to provide or commission care differently in response to tariff policies, and the impact of our policies will ultimately be determined by their decisions.

We would like to improve our impact assessment further during the year, with your help. We encourage you to provide feedback on this report and the analysis provided in it through the online survey used to collect feedback on the engagement document, in particular on any aspect of the equality analysis.[15] Alongside this report, the Health and Social Care Information Centre is publishing an Engagement Grouper; we would encourage you to use this to help formulate your response.[16,17] We are also doing in-depth work to validate our impact modelling with a representative sample of trusts. Any improvements we make to our impact assessment over the coming months will inform the decisions we and NHS England make about which policies to propose in the statutory consultation notice on the 2016/17 national tariff. Alongside the consultation notice we will also publish a full statutory impact assessment.[18]

[15] The online survey can be found at: www.research.net/r/BWVF6CH
[16] The Engagement Grouper is a tool that enables commissioners and providers to estimate the impact on their organisation of our proposed new relative prices.
[17] Due to the timing of the release of this tool, the analysis in this report is partly supported by an earlier version of it, known as the 'Reference Costs Grouper'. The two tools are similar, and our preliminary analysis indicates that the choice of tool makes limited difference to our impact assessment. However, we will use the more up-to-date Engagement Grouper in our future work.
[18] See section 69 of the Health and Social Care Act 2012.

2. Draft prices

This year we are proposing to move to new relative prices (our 'draft prices').[19] These are mostly based on the HRG4+ currency design and updated cost data, and also reflect a small number of other currency changes. HRG4+ contains around 2,000 currencies, and is designed to better reflect patient complexity than the current HRG4 design (which has around 1,300 currencies). The new cost data we propose to use are from 2013/14; current prices are based on cost data from either 2011/12 (ETO) or 2010/11(DTR). Most of the other currency changes (such as five new national tariff prices) are changes we proposed in our statutory consultation notice on the 2015/16 national tariff and are, therefore, already in effect for ETO providers.[20] We have assessed the impact of all these changes together.[21] We assess the impact of policy changes relating to best practice tariffs separately, in the next section.

In this section, we:

- illustrate how the draft prices **differ** from current prices
- assess the impact of draft prices on **patients**
- assess the impact of draft prices on **NHS organisations** (including independent providers).

2.1. Changes to relative prices

In this subsection we illustrate how the draft prices differ from current ETO and DTR prices. We do this by showing how much would be spent in a year on different care categories under each of the three sets of prices, based on the most recent available activity data.[22] A percentage change in spend on a category of care can be interpreted as the weighted average price change. To focus our comparison on the effect of **relative** price differences we have artificially scaled prices to make total spending the same in all three scenarios.[23]

The care categories we use when describing price changes are mostly 'HRG subchapters'. In the HRG system currencies are split into 'chapters', with each chapter relating to care for a particular body area or body system: for example,

---

[19] See Chapter 5 of *2016/17 national tariff proposals: Currency design and relative prices* for a full description of how we calculated draft prices. A full list of the draft prices is published alongside that report.

[20] NHS England (2015) *Guide to the Enhanced Tariff Option for 2015/16*

[21] We have excluded from our analysis changes to the 19 'other mandatory prices'. For 15 of them, the price we are proposing is the same as the ETO price. For the remaining four, we do not hold the activity data necessary to analyse impact.

[22] The most recent available activity data are 'Hospital Episode Statistics' from 2013/14.

[23] We scaled draft prices and DTR prices to make total spend in those scenarios the same as in the ETO scenario.

‘Chapter C’ is ‘Mouth, Head, Neck and Ears’ and ‘Chapter K’ is ‘Endocrine and Metabolic System’. Chapters are further divided into subchapters, which cover different categories of care for the body area or body system.[24] For example, Chapter K is further divided into subchapters KA (Endocrine System Disorders), KB (Diabetic Medicine) and KC (Metabolic Disorders).

Each subchapter is further divided into ‘HRG roots’. An ‘HRG root’ is a set of currencies that all relate to treatment for the same intervention or diagnosis, but for patients with needs of different levels of complexity. A patient might have more complex needs if, for example, they have another illness alongside the one they are being treated for. Currencies for higher levels of complexity generally have higher prices. Some HRG roots only have one currency; for these procedures, the same price is paid regardless of the complexity of patient need.[25]

We also look at two care categories (‘maternity’ and ‘unbundled’) which are not subchapters. ‘Maternity’ covers births, antenatal and postnatal care.[26] ‘Unbundled’ covers a small number of services that have been split off (‘unbundled’) from a currency covering a whole pathway of care, to enable different parts of the pathway to be provided by different providers. The current unbundled currencies cover some types of scan, as well as chemotherapy and radiotherapy.[27]

In the analysis which follows we first show weighted average price changes for each care category, and then explain (to the extent possible) what causes them. We cannot completely explain care category price changes because they are caused by two separate effects that cannot be fully disentangled. One is a change in which currency activity is classified to; for example, in HRG4+ all activity in the paediatrics subchapter PA is classified to new currencies, which may have different prices. The other is changes in the reported cost for a currency, which will feed through into prices. We cannot fully separate these effects because many currencies in HRG4+ are new; we, therefore, cannot always identify how much of the price change in activity allocated to these currencies is due to a change in reported cost of the currency from year to year. We can, however, partially separate them as below:

---

[24] Some chapters (such as Chapter C) only have one subchapter; in these cases the chapter and subchapter are the same.

[25] All HRG system currencies are identified by a five character-code, where the first two characters indicate chapter and subchapter, the next two characters indicate the intervention or diagnosis, and the final character indicates complexity of patient need.

[26] The HRG4+ currency design does include a subchapter labelled ‘maternity’, which covers births (though not antenatal or postnatal care). However, we do not set prices for these currencies. Instead, providers are given a single payment for each ‘phase’ of a patient’s pregnancy (antenatal, birth and postnatal), to provide all the care they need during that phase. The phases are not HRG4+ currencies.

[27] The analysis we have done for the impact of price changes on unbundled activity uses data that do not provide granularity at patient level. We, therefore, cannot identify precisely the effect of regrouping of activity to different HRGs, so cannot separate the price change effect for activity that has been grouped differently.

- Some activity continues to be classified in the same currency. For this activity, all price change is due to changes in reported cost.
- Some activity moves currency but within the same root. For this activity, price changes are, therefore, caused by a combination of changes to reported cost and changes to categorisation of patient complexity.
- Some activity moves to a currency with a different root. Changes in total payment for this activity are due to changes in both currency and reported cost.

2.1.1. Comparison with ETO

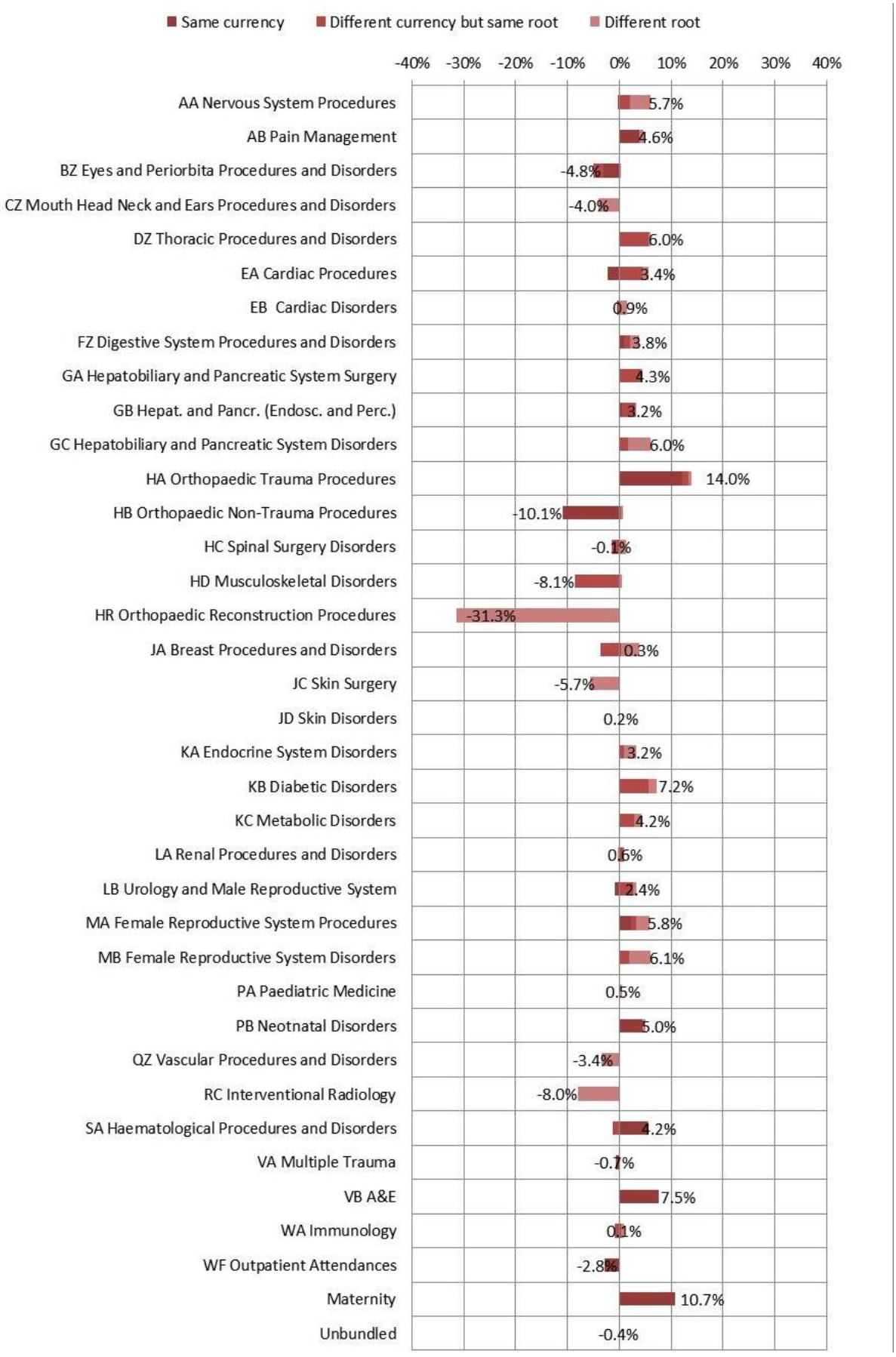
Comparing draft prices with ETO prices, and allowing for activity movements, total spending (and, therefore, weighted average price) for 23 care categories change by less than +/-5%; prices for a further 10 care categories increase or decrease by 5-10%. Prices for the following types of care change by at least 10%:[28]

- HA Orthopaedic Trauma Procedures – increase 14.0%, +£150 million
- HB Orthopaedic non-trauma procedures – decrease 10.1%, -£210 million
- HR Orthopaedic reconstruction procedures – decrease 31.3%, -£150 million
- Maternity – increase 10.7%, +£260 million.

These large price changes in orthopaedics are similar to price changes we observed in our draft prices last year, but eventually decided not to implement due to stakeholder concerns. Last year the expert working group that advises us on orthopaedics prices, and other stakeholders, did not think those draft prices accurately reflected the cost of these services. We are working to understand the underlying reasons for orthopaedics price changes, including considering whether further adjustments would be appropriate. These price changes may also influence our approach to price smoothing. We welcome your input on these price changes as part of your response to our main engagement document. **Figure 1** shows all weighted average price changes.

[28] We allow for activity movements to ensure that average price changes are not misleading. Some activity is categorised differently in our draft prices than in our ETO prices. We need to make an adjustment to correct for these activity movements, because otherwise the average price change for a care category would present a distorted picture. For example, if a very expensive procedure were moved out of a category, the average price for that category would fall even if no prices changed at all. We remove the effect of activity movements by categorising all activity in the 'draft prices' scenario using ETO categorisations. This means that, for example, the 5.7% average price increase for AA Nervous System Procedures (Figure 1) is the average price increase for all activity which is categorised as a nervous system procedure in the ETO.

Figure 1: Weighted average price change by type of care, compared with ETO



Source: Monitor analysis

There is no common explanation for other price changes that are greater than 5%, with some price changes driven by each of the possible explanations we discuss in the previous sub-section. For example, the average price change in subchapter PB (neonatal disorders, +5.0%) is mainly caused by price changes for activity that has stayed in the same currency and, therefore, is ultimately caused by changes in reported cost. The average price change in subchapter HD (musculoskeletal disorders, -8.1%), however, is mainly caused by price changes for activity that has been reclassified within the same 'root', to better reflect patient complexity. And the average price change in subchapter RC (interventional radiology, -8.0%) is mainly caused by price changes for activity that has been re-classified to new currencies.

2.1.2. Comparison with DTR

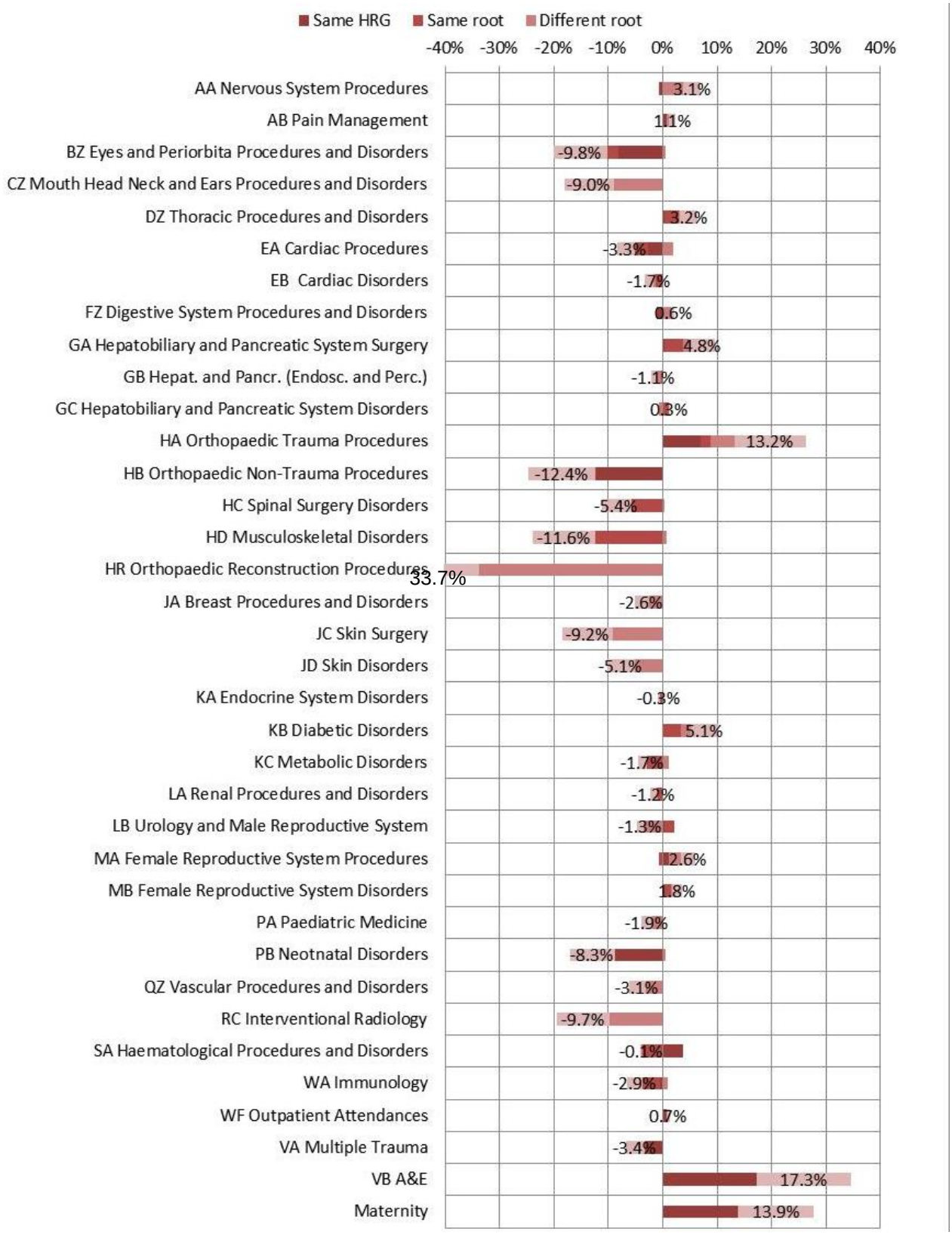
Comparing draft prices with DTR prices, and allowing for activity movements, total spending (and, therefore, weighted average price) for 22 care categories changes by less than +/-5%; prices for a further eight care categories increase or decrease by 5–10%. Prices for the following care categories change by more than 10%:[29]

- HA Orthopaedic Trauma Procedures increase 13.2%, +£135 million
- HB Orthopaedic Non-Trauma Procedures – decrease 12.4%, -£264 million
- HD Musculoskeletal Disorders – decrease 11.6%, -£29 million
- HR Orthopaedic Reconstruction Procedures – decrease 33.7%, -£159 million
- A&E – increase 17.3%, +£130 million
- Maternity – increase 13.9%, +£340 million

Figure 2 shows these price changes in more detail.

[29] Similarly to ETO prices, we have allowed for activity movements by categorising all activity in the 'draft prices' scenario using DTR categorisations.

Figure 2: Weighted average price change by type of care compared with DTR



Notes:

1. For technical reasons we have been unable to include unbundled currencies in this analysis.

Source: Monitor analysis

As in the comparison with ETO prices, there is no common explanation for the price changes that are greater than 5%. We consider that changes in reported costs are likely to play a larger role, as DTR prices are based on older cost data. In A&E (+17.3%) there have been no currency changes; these price changes are largely driven by changes in reported costs, though they are also affected by a change in our price-setting methodology.[30] By contrast, price changes for interventional radiology (subchapter RC, -9.7%) largely relate to activity that has been classified into a different currency. As in the comparison with ETO, we are working to understand the >10% average price changes in parts of orthopaedics, and would welcome your input.

2.1.3. Admitted patient care and outpatient care

Care can be either provided following hospital admission ('admitted patient care') or at an outpatient appointment. Outpatient appointments can be either an 'outpatient procedure' or an 'outpatient attendance' (where a clinician is seen but no nationally priced procedure is carried out). Outpatient attendances have their own separate subchapter (WF).[31] However, the other subchapters are a mixture of admitted patient care and outpatient procedures and, therefore, the subchapter analysis presented in the last two subsections does not separate admitted patient and outpatient procedure price changes. We do so here.

Compared with both ETO and DTR prices, our draft prices for admitted patient care have increased slightly, while for outpatient procedures they have fallen. Allowing for activity movements, the weighted average price for admitted patient care is 2% higher than ETO prices and 1% higher than DTR prices. For outpatient procedures draft prices are 13% lower than ETO and 21% lower than DTR.

We are currently working to better understand the reasons for all significant price changes. We will be engaging with relevant stakeholders on this work, which will inform our decision about which prices to propose in our statutory consultation notice later this year.

2.2. Patients

Any new draft prices potentially impact patients, but this impact is indirect. Draft prices determine the financial incentives facing providers and commissioners. It is

[30] This change in methodology and its impact are described in the impact assessment report on the 2015/16 national tariff proposals. See: Monitor (2014) *Impact assessment for the proposals set out in the '2015/16 National Tariff Payment System: A consultation notice'*, p. 19.

[31] The currencies (and, therefore, prices) for outpatient attendance are based on both the nature of the appointment (for example, whether it is a first or follow-up appointment) and the specialty of the clinician(s) who sees the patient.

how they respond to these changed incentives (by changing how they provide or commission care) that will determine how draft prices affect patients.

As a first step to estimating the impact of our draft prices, we have tried to understand how many patients, and what types of patient, would see prices for their care change substantially.[32] Substantial changes in price might affect, for example, which types of specialty are financially self-sustaining. Substantial changes in price for services used by patients with characteristics that are protected under the Equality Act might also affect how well we are fulfilling our equalities duties.[33] We assess the impact by looking at patient care in the most recent available activity data and comparing their draft price with their current price, which will be from ETO or DTR, depending on the provider who cares for them.[34] As in the previous section, to focus on the effect of changes to **relative** prices, we have scaled prices so that total spending is the same in both cases.[35]

The prices paid for around 60% of patient activity (42 million) would change by less than +/-10%. However, prices for the remaining 40% would change by more than +/-10% and, within this, prices for 2.8 million (4.1% of all patient activity) would change by more than 50%. **Figure 3** shows the full distribution of price changes.

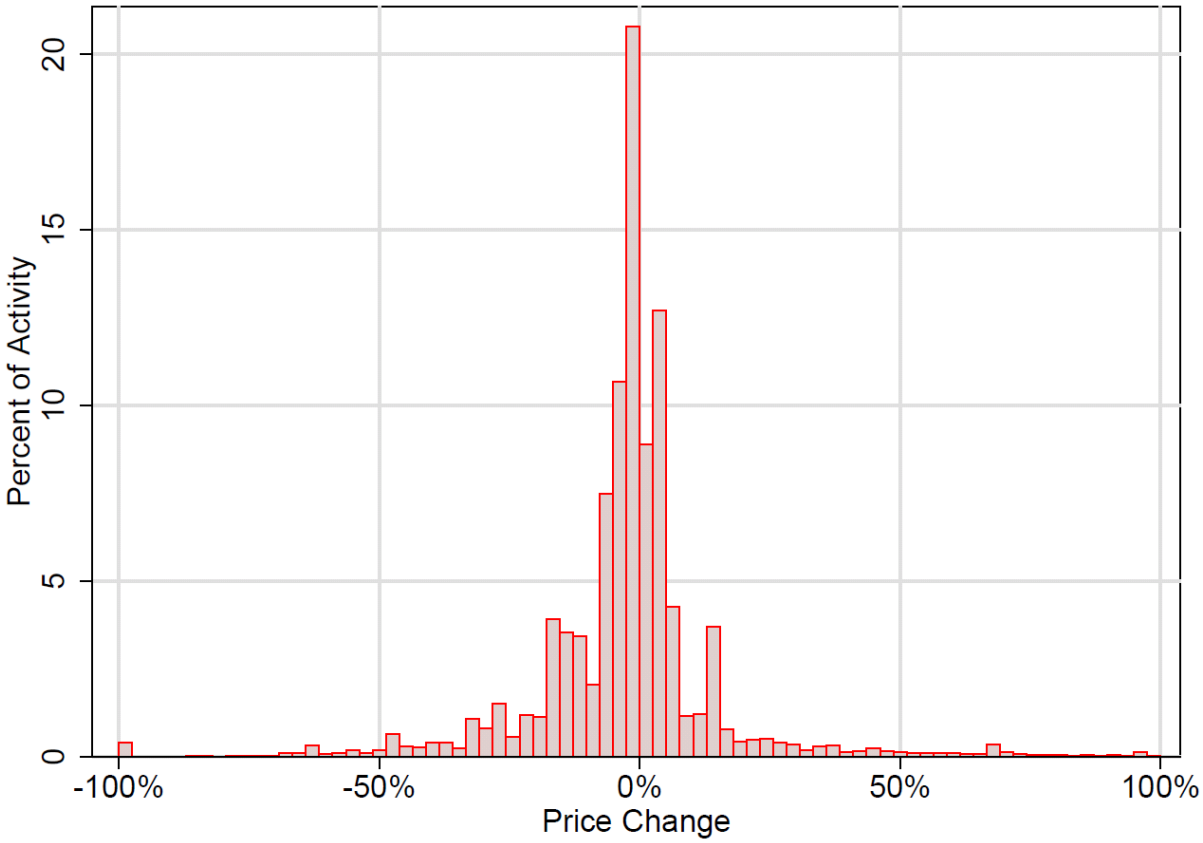
[32] We have based this analysis on the most recent available activity data (2013/14 Hospital Episode Statistics), which contains information on the age, gender and ethnicity of patients. For technical reasons, we have only been able to cover payment for admitted patient care, outpatient procedures, and outpatient attendances; together, these are around 80% of national tariff spending.

[33] Equality Act 2010 protects people from discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

[34] In this sub-section we use the word 'activity' to collectively describe admitted patient spells (in total c.13 million), outpatient procedures (in total c.10 million) and outpatient attendances (in total c. 44 million). Unless otherwise stated, analysis excludes A&E attendances as the relative prices are not changing and no attendance is coded differently under HRG4+.

[35] We scaled draft prices so that total spending from applying draft prices to 2013/14 activity equalled total spending from applying ETO and DTR prices to that activity.

Figure 3: Patient-level price changes



Notes:

1. Around 0.3% activity change price by more than +100%, and have been excluded from this figure.
2. Total activity shown in this figure is 70 million.

Source: Monitor analysis

2.2.1. Care category

Price changes that are greater than +/-50% are distributed across a number of different care categories.[36] In several, substantial numbers of patient activity have both price rises and price falls of more than 50%, suggesting that price changes are partly driven by reallocation of reported costs within care categories.[37] We will work to better understand these price movements in advance of publication of our statutory consultation notice. **Figure 4** breaks down price changes of more than +/-50% by care category.

[36] As we note above, we have based this analysis on the most recent available activity data (2013/14 Hospital Episode Statistics), which contains information on the age, gender and ethnicity of patients. For technical reasons, we have only been able to cover payment for admitted patient care, outpatient procedures, and outpatient attendances; together, these are around 80% of national tariff spending.

[37] The analysis of the impact on patients by care category considers all patient activity, including A&E attendances.

Figure 4: Number of patient activity with price changes >+/-50%

Care category	Number of patients with price rise >50% (thousands)	Number of patients with price fall >50% (thousands)
SC Radiotherapy	148	259
SB Chemotherapy	193	89
VA Multiple Trauma	110	57
PB Neonatal Disorders	108	19
HR Orthopaedic Reconstruction Procedures	55	55
GA Hepatobiliary and Pancreatic System Surgery	76	27
KC Metabolic Disorders	0	99
KA Endocrine System Disorders	51	43
KB Diabetic Disorders	71	22
RC Interventional Radiology	82	7
Other care categories	423	160
Total	**1,316**	**837**

Note: Figures are rounded

Source: Monitor analysis

2.2.2. Equalities characteristics

The impact of price changes on patients does not vary substantially by ethnicity, gender or age.[38] The ethnic group with the biggest average price increase ('Pakistani (Asian or Asian British)') gains by 0.9%, while prices for all other groups change by <0.5%. Average prices for men, women, and people aged 0-17, 17-65, and over 65 all change by <0.1%. This analysis is presented in more detail in **Annex 1**. The differences in impact between groups are caused by differences in the mix of care that they have received; for example, only children receive paediatric care.

We are very interested in further developing the way we assess the impact of price changes on patients. We would like to make some small improvements by the time we publish the statutory consultation notice on the 2016/17 national tariff. For example, we plan to analyse the distribution of price changes (as in Figure 3) for

[38] As we note above, we have based this analysis on the most recent available activity data (2013/14 Hospital Episode Statistics), which contains information on the age, gender and ethnicity of patients. For technical reasons, we have only been able to cover payment for admitted patient care, outpatient procedures, and outpatient attendances; together, these are around 80% of national tariff spending.

each different ethnicity, age and gender group. We hope to make more substantial improvements by the time we begin to engage with the sector on the 2017/18 national tariff. We welcome your views on how we could do so.

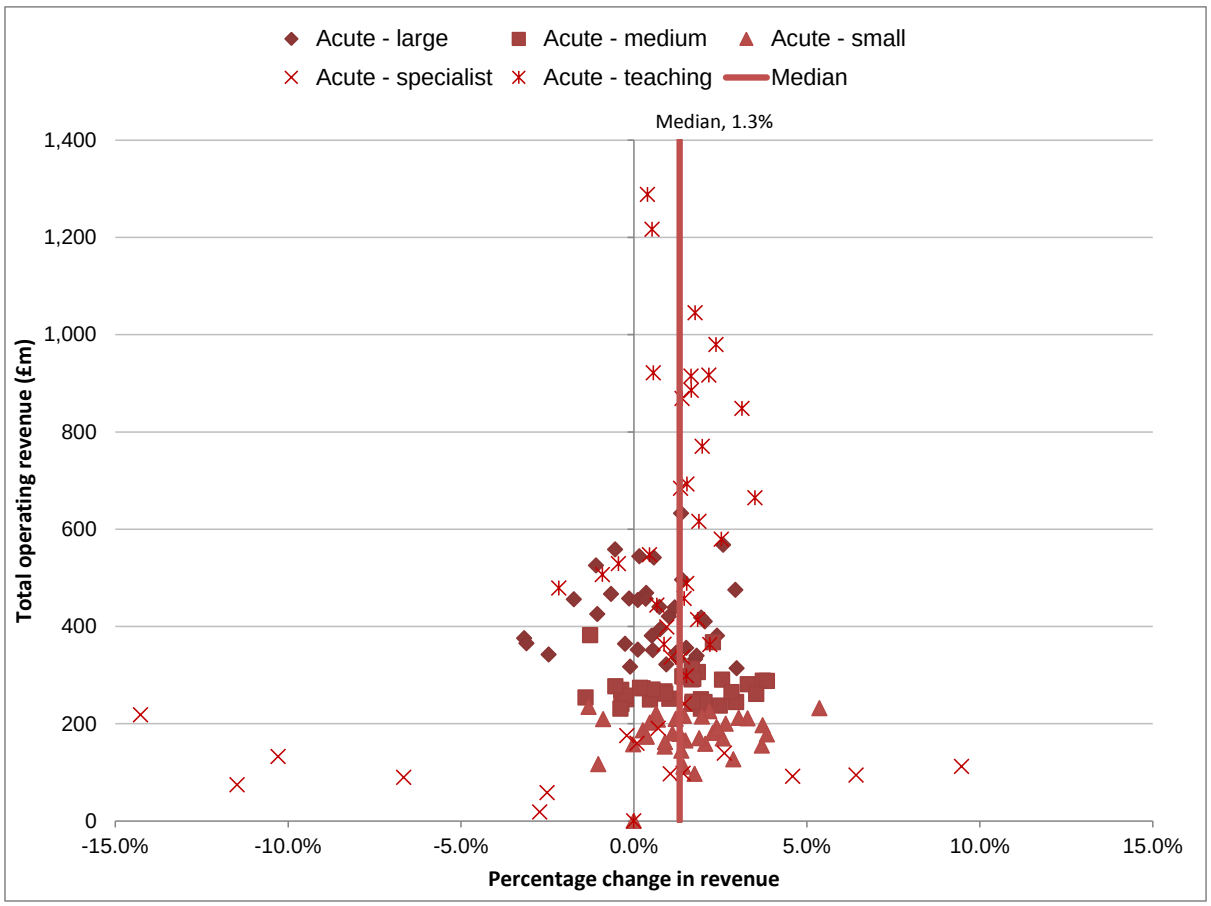
2.3. NHS organisations

In this subsection we look at the effect of new relative prices on NHS organisations; providers, clinical commissioning groups (CCGs) and NHS England. Our underlying approach is similar to the previous section. We calculate each provider's revenue and each commissioner's spending using current prices (ETO or DTR) and the most recent activity data. We then calculate how revenue or spending would change if draft prices were used instead. Prices are scaled so that total spending is the same in both scenarios.

2.3.1. Providers

For 90% of providers, draft prices would change operating revenue by less than +/- 2.5%. This is illustrated by **Figure 5**, which also shows that draft prices have relatively similar effects across different types of provider, with the exception of four outlier providers that have an impact of more than +/-7%.

Figure 5: Impact of draft prices on provider revenue



Source: Monitor analysis

Of the outliers, three (all orthopaedic specialists) would see a revenue reduction of more than 7%. This revenue reduction is driven by the price reductions for some orthopaedic services discussed above. A substantial proportion (over 75%) of the activity of the orthopaedic specialists relates to subchapters HB (non-trauma) and HR (reconstruction), whose weighted average prices fall by 10% and 31% respectively, while very little of their activity relates to Subchapter HA (trauma), whose prices rise by 14%. The other outlier would see a revenue increase of around 10%; this is driven in large part by changes in the way patient complexity is classified for a small number of currencies in subchapter EA (Cardiac Procedures).

We also investigated whether the impact of draft prices differed according to provider standardised mortality ratios. If providers with outlier mortality figures faced significant revenue shocks we would want to undertake further analysis into what was driving this trend, and what the implications were. However, our exploratory analysis did not find any clear correlation between the impact of our draft prices and provider standardised mortality ratios.

2.3.2. Independent sector providers

We found that draft prices would cause independent sector provider revenue from nationally priced services to fall by 6.8% from £917 million to £854 million, due to casemix differences between independent and NHS providers.[39] For example, around 40% of independent provider revenue from nationally priced services (compared with around 8% for NHS providers) currently comes from subchapters HB (Orthopaedic Non-Trauma Procedures) and HR (Orthopaedic Reconstruction Procedures). As we have noted above, draft prices for these subchapters are >10% smaller than both ETO and DTR prices. We also identified six subchapters where higher draft prices are expected to improve revenue for independent providers to a greater extent than for NHS providers.[40] Changes in prices for those subchapters amount to around £11 million increase in revenue for independent providers.

2.3.3. Clinical commissioning group spending

For all CCGs, draft prices would change spending by less than +/-1.3% of their funding allocation.[41,42] **Figure 6** illustrates this. In total, CCG spending would fall by

---

[39] Our analysis is restricted to independent sector providers that hold a Monitor provider licence.

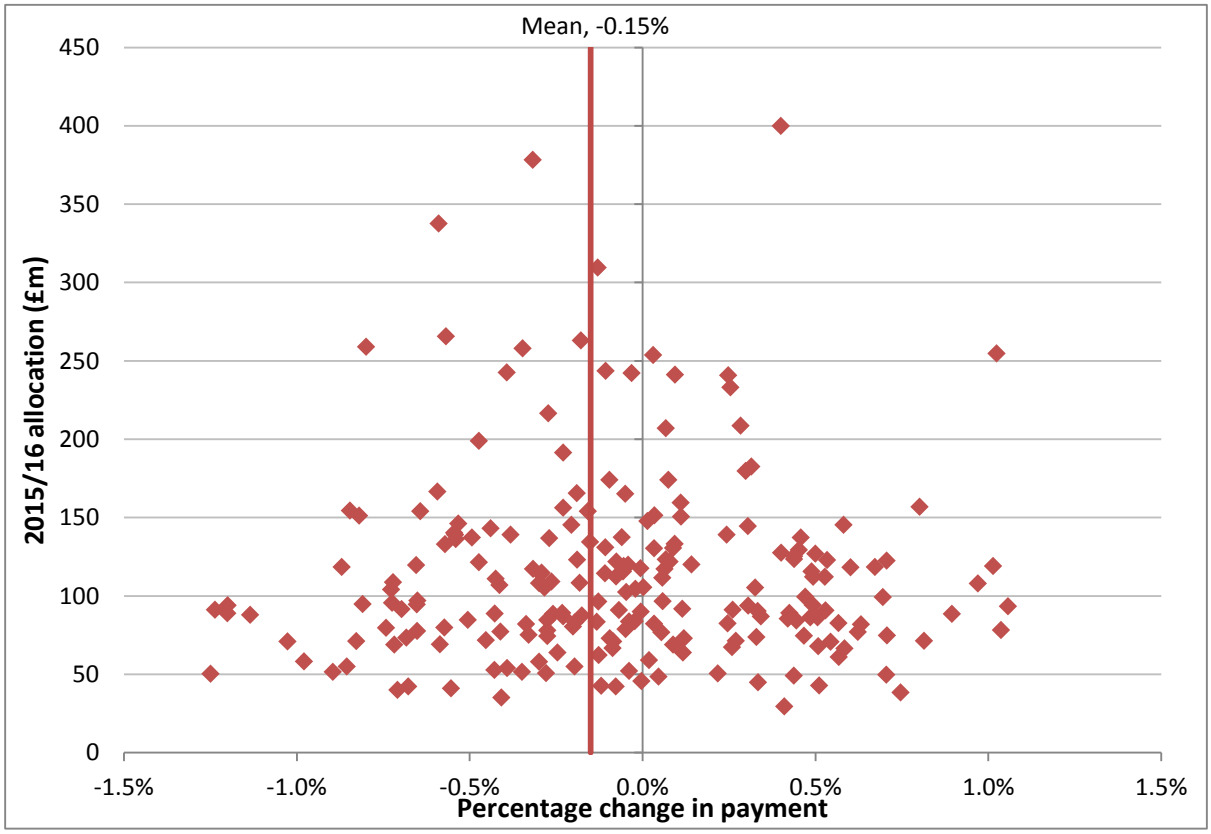
[40] The six subchapters are AA (Nervous System Procedures), AB (Pain Management), LA (Renal Procedures and Disorders), LB (Urology and Male Reproductive System), MA (Female Reproductive System Procedures) and MB (Female Reproductive System Disorders).

[41] CCG funding allocation data used in this analysis do not include the £1.1 billion of additional funding for CCGs which NHS England announced in December 2014. Our calculations, therefore, marginally overestimate the impact of draft prices on some CCGs. We will update our analysis to take account of this additional funding before we publish the statutory consultation notice on the 2016/17 national tariff.

[42] Ideally, we would have presented this impact as a percentage of CCG operating expenditure (analogous to our measurement of the impact on providers as a percentage of total operating

around £40 million (<0.1% of total CCG allocations); NHS England spending would rise by around £40 million.

Figure 6: Impact of draft prices on CCG spending



Source: Monitor analysis

2.3.4. NHS England spending

As noted in the previous section, draft prices would increase NHS England spending by around £40 million, which is less than 0.3% of its spend on services within the scope of the national tariff.[43]

revenue). However, we do not currently hold the CCG financial data necessary to do so. We hope to obtain this data before we publish the statutory consultation notice.

[43] NHS England is responsible for commissioning specialised services, all of which are within the scope of the national tariff. Its budget for this in 2015/16 is around £14.6 billion. It has also budgeted £12.8 billion to commission primary care and £1.7 billion to commission public health. These services are outside the scope of the national tariff. More details of how NHS England has allocated its resources for 2015/16 can be found in *Allocation of resources to NHS England and the commissioning sector for 2015/16*, a paper for the December 2014 NHS England Board meeting.

3. Best practice tariffs

We are proposing a number of changes to best practice tariffs (BPTs).[44] BPTs are designed to encourage best practice by setting a different price for care that meets specific criteria for best practice. Examples include paying higher prices for doing certain procedures as day cases, rather than admitting patients to hospital overnight. The BPT changes we are proposing include, for example, increasing the range of procedures eligible for the day case BPT, changing the structure of the endoscopy BPT, and introducing a new BPT to encourage timely delivery of coronary angiography for people with non-ST segment elevation myocardial infarction (NSTEMI). We also propose to set as many BPT prices as possible based on the HRG4+ currency design and 2013/14 cost data and using a new, simplified modelling approach.[45]

We cannot fully evaluate the impact of these proposals at this stage, due to a lack of data. Within each currency to which a BPT applies, some activity may not be eligible for BPT prices (for example, the heart failure BPT is only applicable for heart failure patients seen by a specialist) and instead attracts a standard national price. We do not currently have the data necessary to identify the ineligible activity. This means that we can only assess the impact of BPT changes by assuming that all activity within a currency is inside the scope of the BPT. Any assessment produced in this way is likely to be an over-estimate.[46] We have therefore not been able to fully impact assess these proposals.

Instead, we present here an illustrative assessment of the impact of one proposed policy change, to the fragility hip fracture BPT. We propose to set prices for this BPT using a new modelling approach, currency design and cost data. Our assessment of this change assumes that all activity within the currency is eligible for the best practice tariff, and therefore shows the upper limit of the possible impact. We include this assessment here to illustrate the impact assessment work we have begun to do on BPTs. We plan to include a comprehensive assessment in the impact assessment we publish alongside our statutory consultation notice on 2016/17 national tariff proposals. This will, for example, use data on eligible activity (as we discuss above) and cover as many BPTs as possible.

We assessed two things:

---

[44] See Sections 4.5 to 4.13 and Section 5.4 of *2016/17 national tariff proposals: Currency design and relative prices* for a full description of our proposed changes to best practice tariffs.

[45] Section 5.4 of *2016/17 national tariff proposals: Currency design and relative prices* lists the BPTs that we are not able to base on HRG4+ and 2013/14 cost data and describes the approach taken for setting those BPTs for 2016/17.

[46] We plan to obtain the data necessary to identify ineligible activity, and to present in our consultation notice refined analysis which takes account of this.

- **Upper limit of impact on provider revenue compared with a standard national price**. If there were no BPT, all activity within the currency would be paid for at a standard national price. All BPT models incorporate 'expected' best practice success rates, and are designed so that if the national average success rate is as expected then total provider revenue will not change. Using the most recent data on provider activity and success rates, and assuming (as discussed above) that all activity within the currency is eligible for the BPT prices, we estimate the maximum potential effect on provider revenue of using the fragility hip fracture BPT instead of a standard national price.

- **Upper limit of impact on provider revenue compared with ETO BPTs (where applicable).** We will present a comparison with DTR BPTs alongside our statutory consultation notice.

We found that the fragility hip fracture BPT would increase provider revenue by a maximum of 3% (£16 million) compared with a single national price if success rates remain at 2014/15 levels. The 'expected' success rate is 48%, while in 2014/15 we estimate the achieved success rate was approximately 64%. Conversely, for tonsillectomy (19 years and over), the current 'expected' success rate is 80% while the achieved rate in 2013/14 was 52%. For more details on expected and achieved BPT success rates, see *2016/17 national tariff proposals: Currency design and relative prices.*

Our exploratory analysis also suggests that the fragility hip fracture BPT would result in slightly higher provider revenue than the BPT previously applied to ETO prices, though this result should be treated with caution.[47] It is difficult to separately identify the impact on provider revenue just of changes to BPTs, because we cannot apply both sets of BPTs to the same currencies. The ETO BPTs are designed to work with the old HRG4 currency design, while our proposed BPTs are designed to work with the HRG4+ currency design. Instead, we:

- calculated provider revenue from applying the ETO BPT to ETO prices and the most recent activity data

- calculated revenue from applying the **proposed** BPT to **draft** prices and the most recent activity data

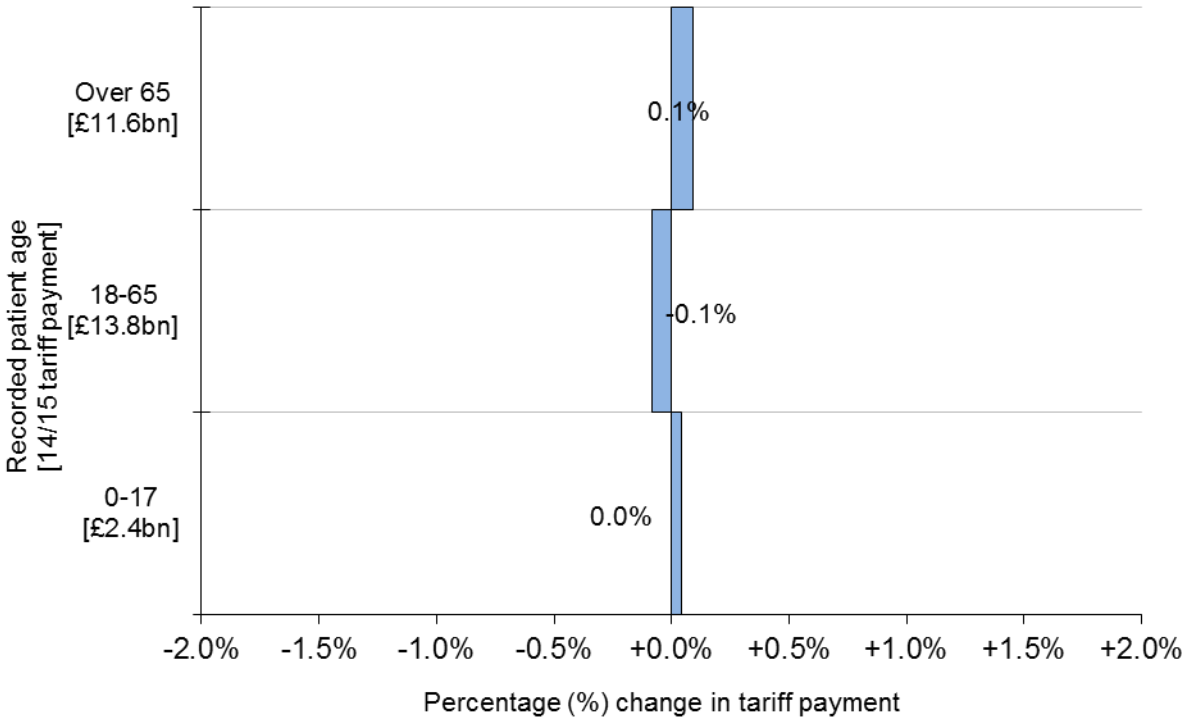
- compared provider revenue in the two scenarios, after making an adjustment to remove the effect of the difference between ETO and draft prices.[48]

[47] Within this, revenue increases for some BPTs and reduces for others.
[48] This adjustment removed the effect of price changes at the HRG subchapter level.

Annex 1: Equalities analysis

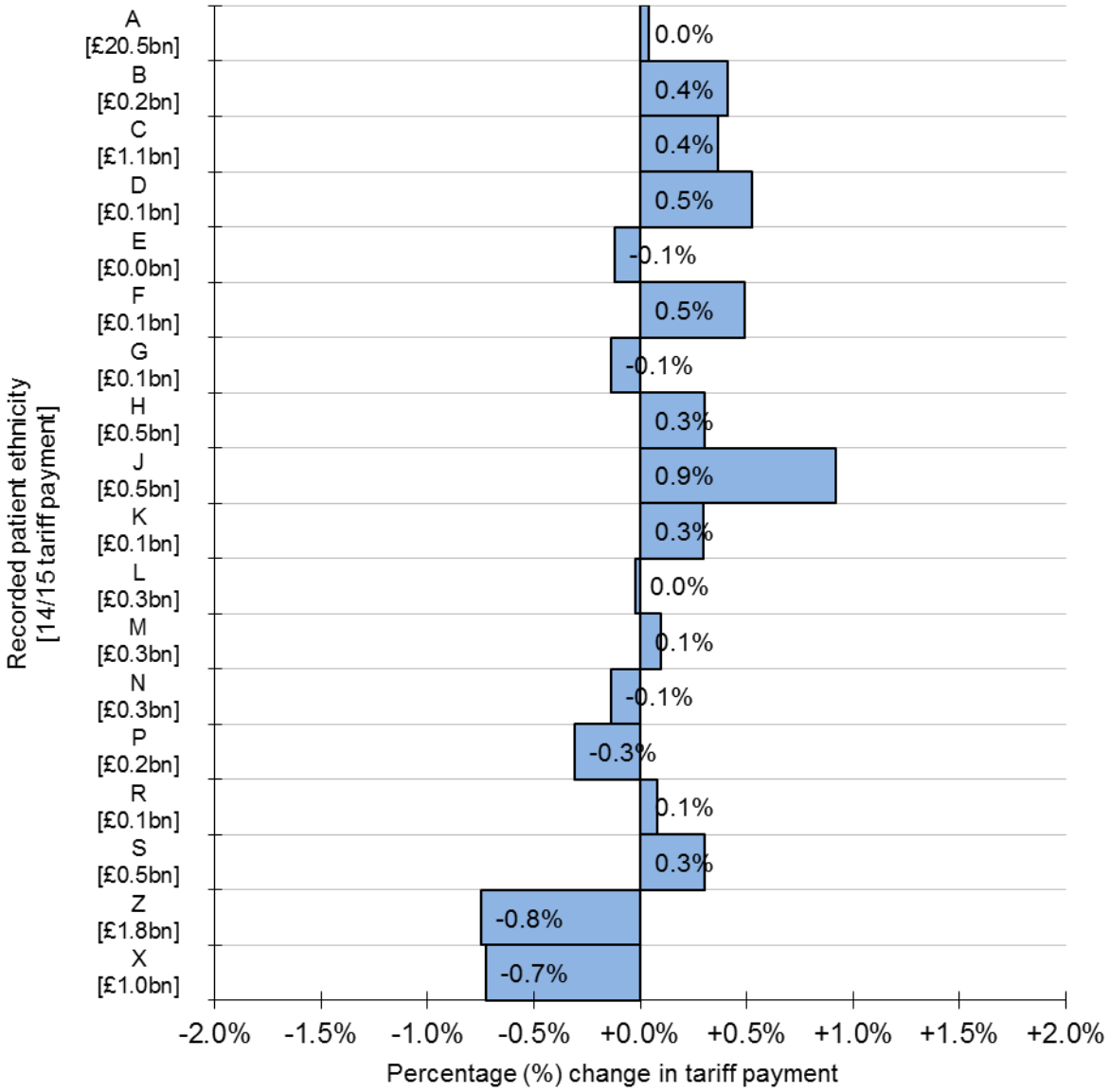
This annex provides a summary of the impact of price changes on patients by age (Figure A1), ethnicity (Figure A2) and gender (Figure A3).

Figure A1: Percentage change in tariff payment by age



Source: Monitor analysis

Figure A2: Percentage change in tariff payment by ethnicity

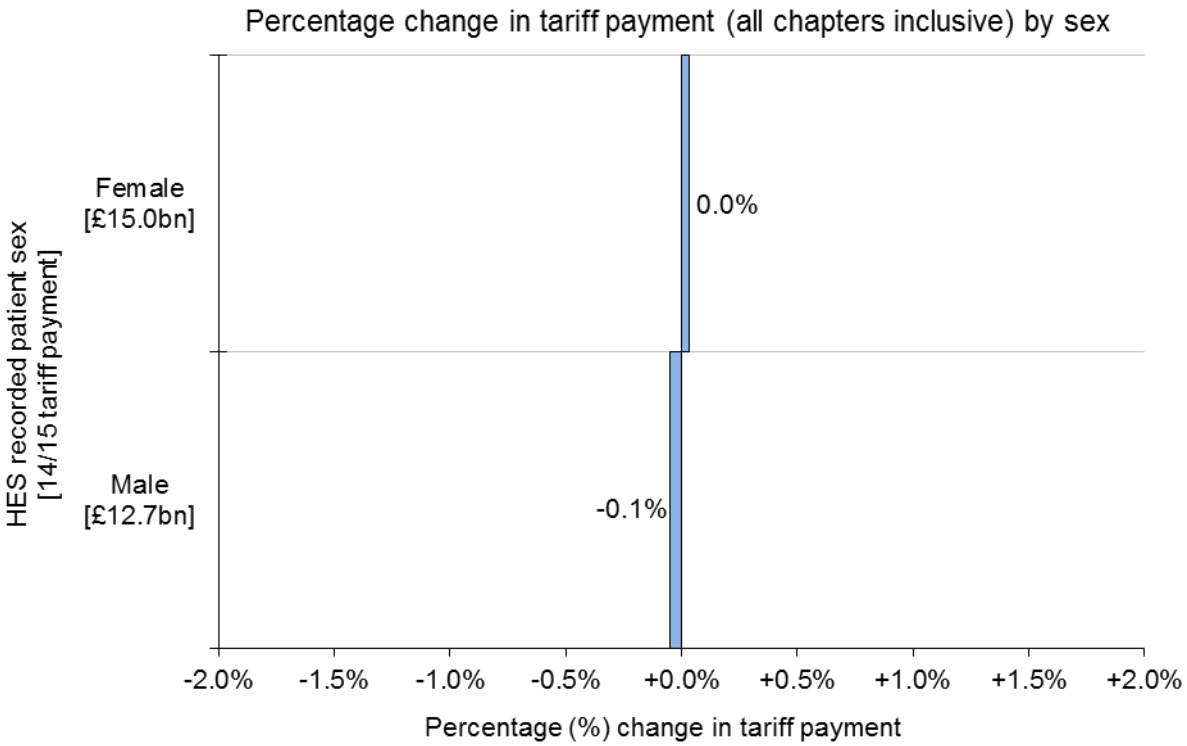


Notes:

1. Ethnicity Codes: A = British (White); B = Irish (White); C = Any other White background; D = White and Black Caribbean (Mixed); E = White and Black African (Mixed); F = White and Asian (Mixed); G = Any other Mixed background; H = Indian (Asian or Asian British); J = Pakistani (Asian or Asian British); K = Bangladeshi (Asian or Asian British); L = Any other Asian background; M = Caribbean (Black or Black British); N = African (Black or Black British); P = Any other Black background; R = Chinese (other ethnic group); S = Any other ethnic group; Z = Not stated; X = Not known.

Source: Monitor analysis

Figure A3: Percentage change in tariff payment by sex



Source: Monitor analysis

Contact us

Monitor, Wellington House,
133-155 Waterloo Road,
London, SE1 8UG

Telephone: 020 3747 0000
Email: enquiries@monitor.gov.uk
Website: www.gov.uk/monitor

 Publication code: IRCP 11/15