Pricing team
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By email: pricing@improvement.nhs.uk

Dear Sir/Madam

The BMA (British Medical Association) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 170,000, which continues to grow every year.

The Association welcomes the opportunity to provide our initial comments on the proposals for the 2017-19 National Tariff Payment System.

We hope that our comments are useful – please do not hesitate to contact us for more information if required.

Yours sincerely

Raj Jethwa
Interim Policy Director
British Medical Association
Executive summary

- There are currently huge funding challenges facing the NHS which should be taken into account when setting the national tariff.
- The efficiency factor must take into account the current savings that NHS services are having to make and not result in providers having to make savings that they cannot afford.
- Although setting a two year tariff could help with stability and planning, uncertainty in economic forecasts could result in 2018/19 tariff prices being set at unsustainable rates. NHS Improvement must ensure that the tariff for this year can be revised to reflect any major changes.
- We welcome progress made in moving from HRG4 currency design to phase 3 of the HRG4+. However given the scale of change as a result of the implementation of HRG4+ and the level of economic uncertainty, NHS Improvement should consider in the autumn whether the introduction of a two year tariff should be postponed.
- We are disappointed that the marginal rate for emergency admissions has not been reviewed and is remaining in place.
- We are disappointed with the timescales that NHS Improvement has given for this informal consultation exercise – a less than one month period over the summer does not allow for meaningful engagement.

Introduction

This consultation on the new national tariff comes at a time when the funding challenges facing the NHS are significant.

At the end of 2014 the 5YFV (Five Year Forward View) estimated that the NHS in England is heading for a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21. It suggests that to close the gap, the NHS needs to achieve efficiency gains of 2% to 3% each year combined with staged funding increases close to ‘flat real per person’. This has been interpreted as a funding increase of £8 billion and annual efficiency savings of £22 billion.

The 2015 Comprehensive Spending Review however revealed that there will only be an £4.5 billion real terms increase in NHS funding by 2020/21, which is just over half the £8 billion the 5YFV said the NHS needed. This funding will be stretched even further if the additional investment will cover the NHS becoming a 7-day service.

Not only is there no credible plan for the NHS to achieve £22 billion of efficiency savings – efficiency savings worth a fifth of its current budget by 2020/21. Efficiency savings of 2%-3% per year are also unlikely to be achievable. Between 1972 and 2014 output per hour worked in the whole UK economy increased only an average 1.9% per year.

In addition to this, the funding available for the NHS is highly dependent on the strength of the national economy, which is now uncertain with events such as the UK’s decision to leave the European Union. For example, the National Institute of Economic and Social Research predicted that the UK economy would be around 2.5% smaller two years after a decision to leave the EU.

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¹ Previous governments have defined NHS spending as the totality of the Department of Health’s budget, whereas the Spending Review defined it as NHS England’s budget excluding spending on public health, education and training, capital and national bodies such as the Care Quality Commission and the National Institute for Health and Care Excellence. Using this new definition NHS funding in England will in fact increase in real terms by £4.5 billion by 2020/2.
And while the Vote Leave campaign stated that the government could choose to spend an extra £350m a week, currently sent to the EU, on the NHS – this was quickly retracted after the referendum. Economists have concluded that leaving the EU will have a negative effect on the UK economy, which in turn will impact on public spending. The Health Foundation have reported that the NHS budget could be £2.8 billion lower than currently planned in 2019/20, with the UK leaving the EU. In the longer term, the NHS funding shortfall could be at least £19 billion by 2030/31—equivalent to £365 million a week – assuming the UK is able to join the European Economic Area. If this is not the case, the shortfall will potentially be as high as £28 billion – which is £540 million a week.3

Weak tax receipts have also been reported in the UK, which will slow efforts to reduce deficits. For the financial year to date, the annual rate in growth in tax receipts is 3.1% compared with the 6% needed the Office for Budget Responsibility’s forecasts. While the government took in £1 billion more in taxes than it spent in July 2016, this surplus was £0.2 billion smaller than recorded in the same month last year.4 This provides evidence that the funding available for the NHS will be less than expected.

Efficiency factor

We note that the same method for setting the efficiency factor for the 2016/17 tariff is being used for the 2017-19 tariff. Previously Monitor set a 2% efficiency factor for the 2016/17 tariff. This was more realistic than previous higher efficiency factors, which were unsustainable. Unrealistic efficiency factors have been judged as the biggest challenge to achieving financial balance by NHS providers.5

However, this 2% efficiency factor was based on the prediction that the provider sector would meet a deficit of £1.8 billion at the end of 2015/16 and we now know that the provider deficit is much larger than predicted at £2.45 billion.

This means that providers will most likely have to continue to meet efficiency savings above 2%. The Nuffield Trust recently reported that hospitals and NHS services are being asked to make 4% cost savings this financial year – double the rate they had previously had to meet.

Therefore, we remain concerned there are insufficient funds available and an efficiency factor set at the same level as last year will make this worse. Providers cannot be required to make additional savings that they cannot afford as this can impact clinical quality and put patients at risk. The NHS is already the most efficient healthcare system in the world. For example, it has been ranked as the most efficient health system in the world by the Commonwealth Fund, and has been shown to spend considerably less on healthcare per capita than comparable countries.6

Two year tariff

We welcome the benefits that setting a two year tariff could bring. For example, this could lead to greater stability and, as a result, make planning easier as pricing will be known in advance.

However, in many ways the current time is the worst time to make this change. Due to the UK’s decision to withdraw from the EU and the uncertainty over what this withdrawal will look like, economic forecasts over the next few years are incredibly uncertain. Inflation, for example, – one of the key factors in uprating tariff prices – is now expected to rise over the course of the next two years7,8, but the extent of the rise— is still highly uncertain. It will be impacted by the decisions the Bank of England makes on interest rates and the scale and pace of quantitative easing, for example.
This matters as at the same time recent fluctuations in Sterling have reduced providers’ purchasing power when making procurement decisions.

In this respect we welcome that the tariff proposal acknowledges the need to work with the service through an enhanced impact assessment to identify unplanned or undesirable effects from the proposals. We would like assurance that arrangements will be put in place for all providers who are significantly impacted by the proposed changes that allow time and resources to adapt and put plans in place to implement the changes.

Beyond that it is important that the tariff remains flexible in taking any economic uncertainties into account. The tariff must be able to respond to possible economic changes, such as significant increases in inflation, or provider deficits as a result of changes in Sterling. We therefore call on NHS Improvement to be able to revise the 2018-19 tariff to reflect any significant changes to the economy that may occur.

HRG4+

We welcome the proposal for the tariff to move from using HRG4 currency design to using phase 3 of HRG4+ due to the greater level of detail that it provides, along with better accounting for differing levels of complexity.

We were disappointed by the lack of progress that Monitor and NHS England had made on introducing HRG4+ to providers and commissioners for the 2016/17 national tariff and suggested that HRG4+ should be run through a shadow tariff alongside the main tariff.

We are pleased that a move to HRG4+ has now been made. It is however important that all reference costs, including those of independent sector providers, are included when setting prices.

As part of the changes that have been made through the switch to HRG4+, we were pleased to see increases in tariff spending for some areas such as maternity and emergency medicine, as these are areas that the BMA has called for increased investment. However, this increased tariff spending should not be at the expense of other specialties. Clinical input into the proposals is therefore crucial to ensure the tariff is set appropriately and the BMA looks forward to engaging with NHS Improvement on this over the coming months.

Given the extent of changes that come with the introduction of HRG4+ together with the economic uncertainties outlined above, we believe NHS Improvement should decide in the Autumn whether it may be worth postponing the implementation of a two year tariff.

Marginal rate for emergency admissions

We are disappointed that the marginal rate for emergency admissions has not been reviewed and is remaining in place. The principle of the rule is flawed – providers have little control over demand within emergency services and penalising them financially for closing services or redirecting patients when services have become unsafe is putting acute trusts under additional strain.

The rationale behind the rule presupposes that trusts have control over emergency admission demand. The National Audit Office concluded that there were many reasons for an increase in emergency admissions, including: A&E is seen as the default route for emergency care; the introduction of the four hour waiting time target; changing medical practices; an increasingly frail elderly population living with long term conditions and more patients with worse conditions attending A&E, with more arriving by ambulance as well as more being admitted. Although the payment system was listed as one potential additional reason, this was not evidenced.
Since its introduction, the marginal rate rule on emergency admissions has been a policy failure. It has not reduced emergency admissions\textsuperscript{\ref{11}} and has led to financial hardships within trusts\textsuperscript{\ref{12}}.

**Consultation period**

We are disappointed with the timescales that NHS Improvement and NHS England have given for this informal consultation exercise. The consultation period for this initial assessment was very short (less than one month) and set over the summer period when many BMA members are on holiday. This did not allow us to fully engage our members on the issues presented in the proposals. Our comments in this response should therefore be treated with this in mind. We hope that the full consultation that is due to be published in the autumn will provide a time period for responses that allows for meaningful engagement.

**Conclusion**

The proposals for the 2017-19 national tariff are being set at a time of huge financial challenge for the NHS and at a time of huge economic uncertainty. NHS Improvement must take this into consideration when setting tariff prices for a two year period and when setting its efficiency factor.

The BMA welcomes progress made with the implementation of the HRG4+ currency design. However, due to the major changes its implementation brings, NHS Improvement should in the autumn consider whether to postpone introduction of a two year tariff.

NHS Improvement also needs to make progress in addressing other key issues the BMA has raised time and again, such as reviewing the marginal rate for emergency admissions.

**References**

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\textsuperscript{3} Health Foundation (2016) Briefing: NHS finances outside the EU
\textsuperscript{4} Financial Times August 2016: \url{http://www.ft.com/cms/s/0/e5ccc0c-65e5-11e6-8310-ecf0b0dad227.html#axzz4Lj31V8D}
\textsuperscript{5} NHS providers (2016). Poll results – financial sustainability.
\textsuperscript{7} Bank of England (2016) Inflation report
\textsuperscript{8} HM Treasury (2016) Forecasts for the UK economy: a comparison of independent forecasts
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\textsuperscript{10} National Audit Office (2012). *Emergency admissions to hospital: managing the demand.* Department of Health.
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