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. On average our membership this year has been around 170,000.

The Association welcomes the opportunity to provide our comments on 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
Director of Policy
British Medical Association

Chieff Executive: Keith Ward
Executive summary

- There are currently huge funding challenges facing the NHS which must be taken into account when setting the national tariff.
- Although the 2% efficiency factor is lower than in previous years it is still unachievable taking into account the current savings that NHS services are having to make. It is crucial that it does 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 can be revised to reflect any major changes and consult on any changes to the tariff before it is issued.
- We welcome progress made in moving from HRG4 currency design to phase 3 of the HRG4+.
- We are concerned that a reduction to tariff prices for follow up outpatient appointments could prevent patients from accessing the care they need and lead to an unnecessary shift in workload from secondary to primary care.
- We are disappointed that the marginal rate for emergency admissions has not been reviewed and is remaining in place.

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 was heading for a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21. It suggested that to close the gap, the NHS would need 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.

Despite the Government’s statements that the NHS budget will increase in real terms by £10 billion during this parliament, the 2015 Comprehensive Spending Review revealed that there would only be an £4.5 billion real terms increase in NHS funding by 2020/21. A number of stakeholders including the BMA have written to the UK Statistics Authority about statements made by representatives of Government that the NHS budget will increase in real terms by £10 billion during this parliament, when in reality it is only £4.5 billion. These concerns are in line with those raised by the Health Select Committee Chair, in an open letter to the Chancellor of the Exchequer, dated the 26 October. This reduced 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, but 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 ahead of the referendum that the UK economy would be around 2.5% smaller two years after a decision to leave the EU.2 And while the Vote Leave campaign stated that the government could choose to spend an extra £350m a week, which it said is currently sent to the EU, on the NHS – this was quickly retracted after the referendum.

Following the referendum, the Health Foundation estimated that the NHS budget could be £2.8 billion lower than currently planned in 2019/20 as a result of 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 in 2030/31 – which is £540 million a week.3

Since the Chancellor has announced no additional money for the NHS in the recent Autumn Statement and the Office for Budget Responsibility now forecasts a deficit of £21.9 billion in 2019/20⁴, the funding climate for the NHS will continue to be tight.

**Efficiency factor**

Setting a 2% efficiency factor for the 2016/17 tariff is 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, although this 2% efficiency factor is lower than in previous years, it is still an unrealistic achievement for providers given the local deficits that exist.

The 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 2015/16 provider deficit was 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 Kings Fund confirmed that the trend in provider deficits is set to continue through their quarterly monitoring report⁶. The report showed nearly half (47%) of trusts forecast ending the current year (2016/17) in deficit. Furthermore, 50% of providers expecting to receive Sustainability and Transformation Fund monies still forecast a deficit by the end of 2016/17.

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 may 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.⁷

**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, 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 years⁸,⁹, 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 because at the same time recent fluctuations in Sterling have reduced providers’ purchasing power when making procurement decisions.

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 revise the 2018-19 tariff to reflect any significant changes to the economy that may occur. It is vital that any changes to the tariff will be fully consulted on with all stakeholders before a new tariff is issued.

**HRG4+**

We welcome the 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. HRG4+ reflects the varying costs incurred in treating patients at different levels therefore the level of income assigned to activity should reflect the cost of the activity more accurately.

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 in which 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. It is also important that NHS Improvement and NHS England provide any assistance needed by hospital teams to implement the changes for this move.

**Follow up outpatient appointments**

Some specialities will see a reduction in tariff income for follow up outpatient appointments in 2017/18. We have concerns that this loss of income could potentially result in some trusts reducing the number of outpatient appointments. Many of the patients requiring these follow up appointments will have highly complex needs and will require regular consultant input. It is crucial that the change to tariff prices does not prevent patients accessing the care they need.

As a result of reduced outpatient follow up appointments there could be an increase in the number of patients being referred back to their GP. This will increase workload for general practice which is already overworked and underfunded unnecessarily. This would counter the work that NHS England is currently undergoing to improve the primary/secondary care interface and recent changes to the standard NHS contract. For example, ensuring hospitals make internal referrals for a related problem and not needing a GP to re-refer; and ensuring hospitals stop asking GPs to re-refer DNA (did not attend) appointments.

It is vital that changes to tariff prices do not lead to an unnecessary shift in workload from secondary to primary care and prevent patients accessing the consultant appointments they need.

**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 puts acute trusts under additional strain\textsuperscript{10}.

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 the following:

- 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\textsuperscript{11}.

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{12} and has led to financial hardships within trusts\textsuperscript{13}.

**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. NHS Improvement must make changes to the 2018/19 tariff if prices change considerably, fully consulting stakeholders an on any changes.

The BMA welcomes progress made with the implementation of the HRG4+ currency design. However, any increases to tariff prices for certain specialities should not be at the expense of others. In addition, a reduction in tariff prices for follow up outpatient appointments should not disrupt quality patient care and lead to disadvantages for other services such as primary care.

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

**References**

\textsuperscript{1} Own analysis, ONS GVA per hour statistics 1972-2014
\textsuperscript{3} Health Foundation (2016) Briefing: NHS finances outside the EU
\textsuperscript{5} NHS providers (2016). Poll results – financial sustainability.
\textsuperscript{6} The Kings Fund (2016) Quarterly monitoring report 20.
\textsuperscript{8} Bank of England (2016) Inflation report
\textsuperscript{9} HM Treasury (2016) Forecasts for the UK economy: a comparison of independent forecasts
\textsuperscript{10} Foundation Trust Network (2013). *Emergency Admissions Rate Review: Call for Evidence.*
\textsuperscript{11} National Audit Office (2012). *Emergency admissions to hospital: managing the demand.* Department of Health.