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THE HEALTHCARE PUZZLE

integrating healthcare

Price regulation in the UK public healthcare system

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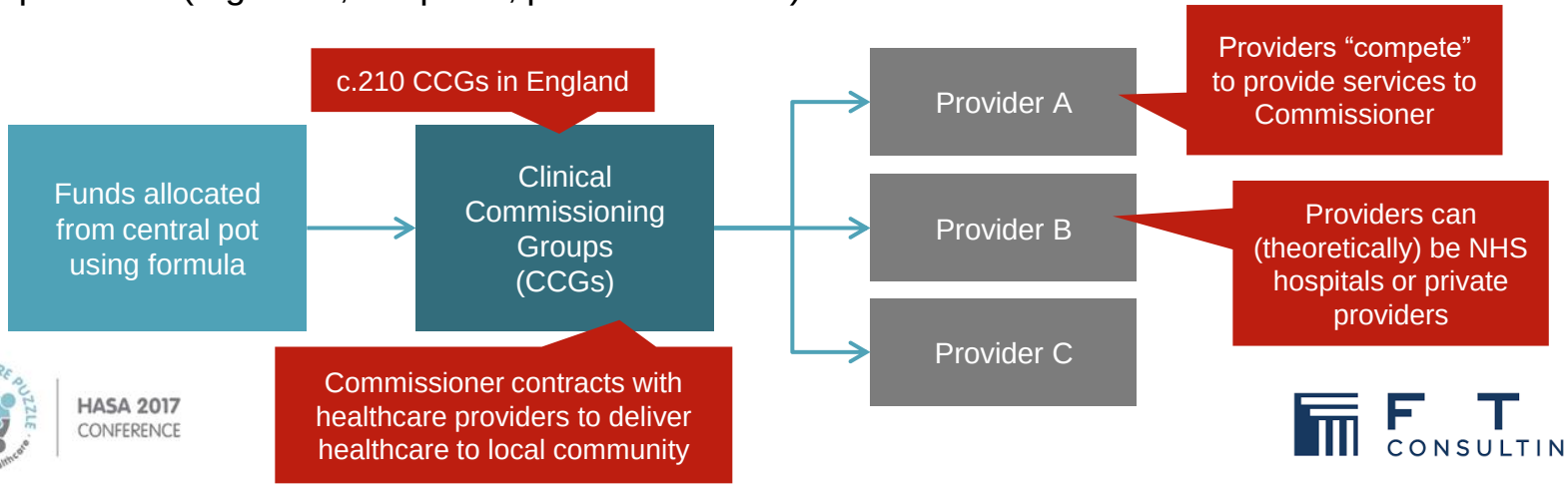
Introduction to Victoria Barr

- Economist and Senior Director at FTI Consulting
- Deputy Director of Pricing at Monitor, healthcare sector regulator in England (now NHS Improvement) – 2011-2013
  - Implemented new regulatory regime following Health and Social Care Act 2012
  - Developed 2014-15 National Tariff (payment rules for NHS services, including 1500 nationally mandated prices for hospital episodes)
- Worked with funders and providers to develop alternative reimbursement models to support the delivery of ‘value’-based healthcare – 2013-2016
- Moved to South Africa in 2016 to establish FTI’s Economic Consulting practice in Southern Africa

Quick introduction to the National Health Service (NHS)

- NHS provides healthcare free at point of use for everyone in the UK, and funded by taxpayers
- As patients do not pay to use the system, there must be some means of organising the flow of taxpayers' money to healthcare services used by patients (e.g. hospitals)
- NHS in England structured into "commissioners" (funders) and "providers" (sellers) of healthcare
- Commissioners act as agents for patients (and taxpayers) to purchase care on their behalf from providers (e.g. GPs, hospitals, pharmacies etc.)



Brief history of NHS hospital pricing

Global budgets (block contracts)

- Fixed annual sum based on historic funding patterns and locally negotiated annual increases

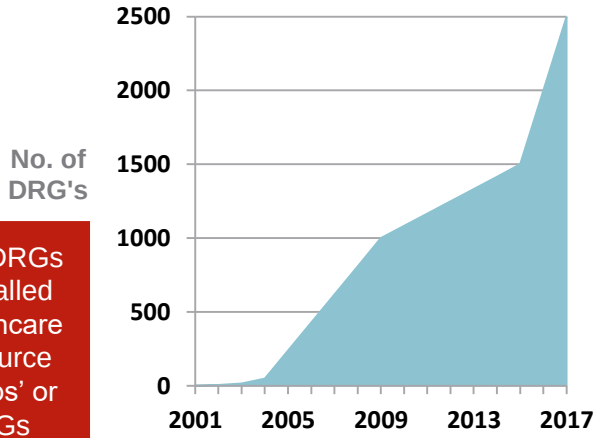
Fee for episode (Payment by Results)

- Compulsory national prices based on Diagnosis-Related Groups (DRGs)
- First introduced in 2003 with 15 DRGs
- Eventually covered almost all hospital care
- 'Market Forces Factor' for each provider adjusts prices to take account of 'unavoidable' local cost differences

DRGs group together similar types of hospital patient cases

NHS DRGs are called 'Healthcare Resource Groups' or HRGs

Number of DRGs has grown rapidly



There are many different reimbursement models, and no one approach is perfect – all have advantages and disadvantages

NHS pricing process

NHS England

'Sets currencies' – defines DRGs

Code activity – ICD and Treatment Function Codes

'Grouper' uses ICD codes and TFCs to assign DRG to each patient episode

Allocate costs to each DRG

Currently 'top-down' costing but moving to patient-level

NHS Improvement

Collect cost data for all DRGs from all NHS providers

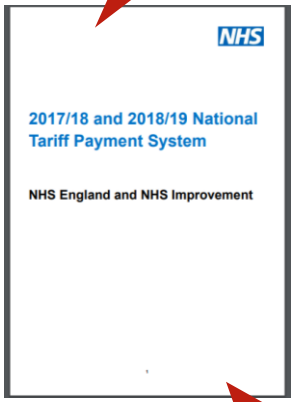
Calculates mean cost for each DRG

Cost relativities reviewed by expert clinical working groups

Macro adjustments to overall price level

Adjusts for inflation, expected efficiency, various other factors

Sets national prices for around 2,500 DRGs



Used to be set annually – now two-year cycle

Issues with NHS PbR

Poor quality cost data	▪ Quality of costing varies considerably across providers ▪ Costing at the DRG level unreliable for many hospitals
Prices not cost reflective	▪ Poor quality cost data results in prices which are not reflective of underlying costs leading to… ▪ …cross-subsidisation across services
Price volatility	▪ Poor data also results in large changes in prices between years unrelated to changes in service delivery or cost of inputs ▪ Issue slightly mitigated now by two-year tariff
Applied to all services	▪ DRG-based pricing has been applied to all hospital services, including those with large fixed costs/capacity requirements where a volume-based payment mechanism is not appropriate
Does not reward quality	▪ Depending on how currencies are defined, DRG-based payment rewards activity not quality ▪ A repeated hip replacement would be paid again at full tariff
No prevention incentive	▪ Activity-based payment for hospital services, combined with fixed budgets for community care, leads to unhelpful financial incentives in the system for care of patients with long-term conditions

'Best practice tariffs' introduced in 2010

Recent developments in NHS pricing

- Direction of NHS pricing is currently unclear
- Shortcomings of DRG pricing in addressing challenge of long-term conditions had led to development of alternative reimbursement models in some areas
- NHS now under huge financial pressure – NHS leadership have given permission for local areas to move away from national tariff
- Many areas now moving back to global budgets as a way of controlling expenditure

Lessons from the NHS experience

Accurate DRG pricing is difficult…

- DRG pricing is a labour-intensive process
  - NHS Improvement alone has around 50 full time staff working on pricing and costing
  - Plus NHS England team working on currencies
- Defining DRGs is not a once-off task
  - Currencies need to be revised to take account of changes in clinical practice and reflect improved data
- Getting the currencies and prices right is difficult
  - Accounting for case mix is challenging
  - Requires high-quality data from at least a broadly representative sample of providers

…and even if you get it right…

Trade off between greater granularity vs complexity

…DRGs are not a silver bullet

- DRG pricing is more appropriate for some hospital services than others, for example:
  - ✓ Discrete, standardised procedures for otherwise healthy people, e.g. cataract surgery, hip and knee replacements
  - ✗ Emergency services with requirement to provide certain level of capacity
- Increasingly need to consider pricing mechanisms that create right incentives across the system:
  - Incentivise investment in prevention
  - Encourage integration of care across patient pathway

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