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Estimated cost and payment by results (PBR) tariff reimbursement for idiopathic pulmonary fibrosis services across 14 specialist providers in England

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Background

Idiopathic Pulmonary Fibrosis (IPF) is an increasingly important respiratory illness in the UK. Rising prevalence of disease, emerging treatments, development of clinical guidelines for diagnosis and management and a NHS England service specification increase demands on healthcare providers who are required to enhance capacity or reconfigure services to manage patients.[1]

Study aim

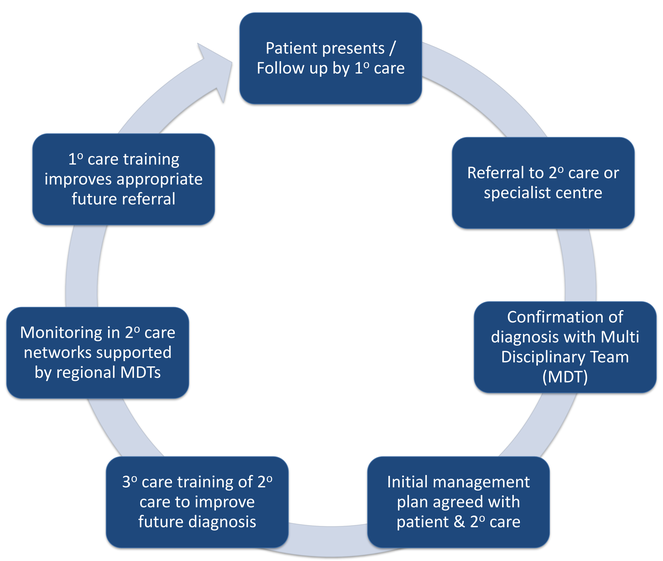
Map out the patient care pathways across service providers in England compared with pathways recommended by NICE guidelines and the NHS England Service Specification; and estimate the:

- time and cost per patient by 'diagnosis', 'management' and 'monitoring'
- levels of reimbursement to providers for current levels of care and those recommended by NICE and the draft NHS England Service Specification

Methodology

Structured interviews with clinicians and coders ascertained current levels of service provision, excluding drug costs, by 14 NHS specialist Interstitial Lung Disease (ILD) providers. Data were analysed utilising a bottom-up costing approach to estimate the total pathway costs. Comparison with services and costs as recommended by NICE guidelines and the draft NHS England Service Specification allowed estimation of NHS providers' profit or loss based on a general pathway as outlined in Figure 1.

Figure 1: The proposed model of care to achieve continuous improvement of diagnosis, management and monitoring



Results

The estimated mean cost per patient for the first episodes of diagnosis, management and monitoring was £1,384, which is approximately £408 (42%) more than is reimbursed by the PBR tariff[3]. By comparison, the equivalent cost of the NICE/service specification pathway is approximately £477 (41%) more than reimbursed by the tariff. As shown by Figure 2 below, the average costs of one diagnosis, management and monitoring episode in the NICE/service specification is £245 more than that currently incurred by centres. It was noted that significant staff time is required for MDT discussion, but that this is not reimbursed.

Figure 2: Mean cost and reimbursement for 14 providers included in this study (range as black bars), and for the cost recommended by NICE guidelines and draft NHS England Service Specification

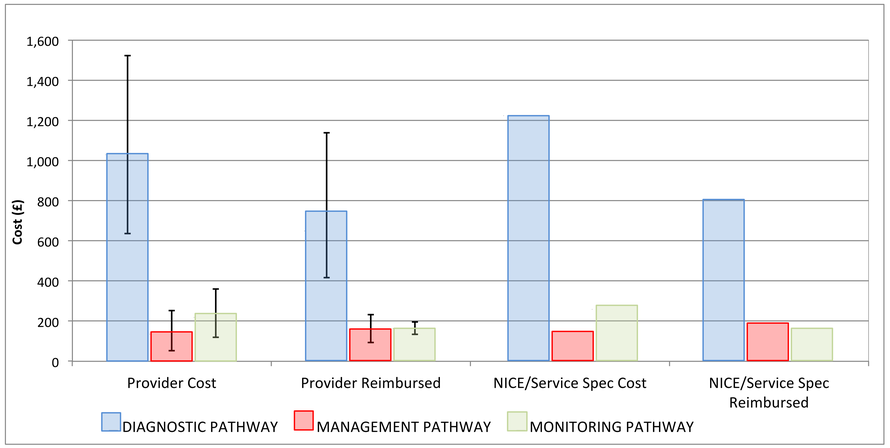


Figure 3: Timelines for Payment By Results Tariff and Lever Development

2015 – January to March	Initial scoping of proposed PBR tariff, best practice tariffs and 'levers' such as CQUIN
2015 – April to July	Development and submission of business case
2015 – August to September	Review of final case and approval of draft
2015 – October to November	Sense check – draft prices shared with PbR Clinical Advisory Panel, External Advisory Group, other partners and a selection of NHS organisations
2015/16 – December to January	Road test – tariff and draft guidance issued for comment
2016 – February	Publication of final tariff package
2016 – March	Preparation for implementation
2016 – April	Implementation

Discussion

- In the context of clinical guidelines for diagnosis and management of suspected IPF, innovative drug treatment and supportive NICE guidance, as well as the development of a new NHS Specialised Service Specification (NHS England A3D4 2013) and that NICE quality standards will be published early in 2015, an opportunity presents itself to the NHS in 2015/16 to bring world-class excellence in early diagnosis, evidence based management and monitoring to people living with IPF.
- NHS services are keen to embrace the new NHS structure, which was also introduced in 2013, and improve the services they offer to IPF patients; however, based on current tariffs of payment, many NHS providers have calculated that for every patient they diagnose, manage and monitor, they actually lose money for the trust.
- This combination of a new treatment, with a service that loses money for every patient seen, especially in an area of massive unmet clinical need, is unsustainable if patients are to expect a good standard of care. This threatens to undermine the progress made so far in IPF during 2013/14.

Conclusions

- These data show that current NHS tariffs are insufficient for service provision for IPF patients as specified by NICE guidelines.
- As recommended in NICE guidelines[2], patients with IPF should be diagnosed by MDT consensus, however there is no reimbursement of costs for MDTs.
- It became clear that several elements of care differed between specialised providers. It is important to understand why, and how it may impact future provision of care as service specifications and clinical guidelines are implemented and as quality standards measure success.
- The main differences in care provision were based on very broad and uneven variances rather than easily identifiable trends, therefore more work is required to analyse specific variances and identify if this may have a significant impact on patient care and the sustainability of services.
- The risks of failure to amend the NHS tariff are:
  - Incomplete diagnosis and management may adversely impact patient care and outcomes, at a time when services are under increasing scrutiny and disease prevalence is rising
  - Adverse impact on the financial viability of specialist ILD providers
- The process to achieve a change in the NHS tariff and associated levers is outlined in Figure 3.

References:

1. http://www.england.nhs.uk/ourwork/commissioning/spec-services/npc-crg/group-a/a14/
2. http://www.nice.org.uk/Guidance/CG163
3. https://www.gov.uk/government/publications/national-tariff-payment-system-2014-to-2015

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