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National Tariffs in the NHS

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Managing a department of clinical radiology has never been more challenging. There has always been the risk of being reviled by both sides: by management for responding like a 'native' and by colleagues for 'going into the dark side'. It has probably always been an illusion that Clinical Directors had financial control. Although perhaps it always seemed that they were held accountable for departmental 'overspend' produced by an expanding workload of increasing complexity and generated by other clinical colleagues.

All this is due to change. The focus by the Government on diagnostic services, combined with the move to payment by results, seems likely not only to highlight clinical radiology as the central focus for patient management, but also to focus on the effectiveness and cost-effectiveness of departments of clinical radiology. The planned reduction in waiting times for diagnostic services by 2008 will stimulate the flow of resources into clinical radiology, while the development of a universal tariff will allow efficient departments to receive proper reward for the imaging services they provide. So why does not everything in the garden feel rosy?

It has been acknowledged that the financial framework for costing the services within the NHS is less than robust. Indeed, Ministers complain that no one knows where the additional money provided for improving healthcare has gone. The introduction of payment by results and National tariffs attempts to address this uncertainty and to provide a firm basis for running hospitals and departments of clinical radiology. There is, however, a lack of information relating to costs within NHS institutions. While private hospitals may bill for every last band-aid, NHS institutions have neither the IT infrastructure, the staff, nor the information to provide such sophisticated costing. Thus, the tariffs will be based on broad treatment categories or HRGs. Although these are an international tool for costing healthcare, their development has been largely based upon American systems that have always collected detailed financial data about healthcare delivery.

There are a number of concerns that National tariffs will not reflect true costs, will not promote quality service and could result in the fragmentation of departments of clinical radiology. There is a perception of a lack of understanding of the complexity of different examinations that have similar names. For the development of tariffs, any CT examination without contrast, of whatever complexity, counts as one examination, while if contrast is used, it counts as two examinations. Thus a complex staging CT for neoplasia attracts the same tariff as a standard contrast CT of the brain. Time spent in the machine may differ very little, the cost of contrast may be the same, but the number of images presented for review differ by more than 50 times. However, HRGs are developed to reflect average cost. Consequently if departments of clinical radiology have a wide case mix, then tariffs based on historical costs should allow for variations in complexity and time required to deliver the service.

It is not reassuring, however, to discover that the proposed tariffs have been reported by industry observers to be up to 20% lower than historical costs. Furthermore, a central tenet of Government policy on delivery of diagnostic services, is the development of the independent sector. It is important to acknowledge that if demand for imaging vastly outstrips supply, as is the case in the United Kingdom at present, then alternative models of service delivery need to exploit opportunities within the independent sector. This is vastly facilitated by the development of PACS and teleradiology.

Properly integrated into the existing NHS, independent sector contribution to radiology services could provide an effective short and medium term solution, and significantly reduce waiting times for diagnostic investigation. However, examination of existing independent sector procurement models reveals major potential anomalies in the provision of imaging according to a standard tariff. Many patients who have benefited from the fast track MRI service, for example, have undergone MRI screening for possible acoustic neuroma. This is a relatively simple examination and the vast majority of patients presenting for investigation in this way are, in fact, normal. While this represents pragmatic use of outsourced radiology, to suggest that it attracts the same tariff as head and neck MRI for cancer staging, is at once both laughable and disconcerting.

If, as would seem reasonable from the perspective of patient welfare, the case mix for outsourced imaging should predominantly comprise straightforward cases, then the economic viability and competitiveness of hospital departments is under severe threat. No account is made within the tariff for the role of radiologists in patient counselling, patient consent, discussion with clinical colleagues both within and outside of MDTMs,

determination of the optimum imaging pathway, as well as the development of advice on subsequent management. This significantly compromises the quality of delivery of imaging services. Departments of clinical radiology within secondary and tertiary care are already facing the challenges of modernising medical careers, the new consultant contract, extended working days, family friendly employment policies, appraisal and performance review and training of other practitioners to replace radiologists in the workplace. The new tariffs simply add to the burden of Clinical Directors.

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