

A fair playing field for the benefit of NHS patients

Supplementary paper
March 2013

Cost distortions



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Introduction to factors relating to costs

A fair playing field for providers of health care service would imply that the costs of different types of providers do not vary systematically according to factors out of their control. Some providers may be more efficient than others – such cost variation between providers may be expected. However there are a range of factors that lead the costs of providers to vary in ways unrelated to the underlying efficiency of the provider.

The analysis of cost factors therefore investigates whether there are any significant differences in the costs that different types of providers incur. The focus is on differences in costs that arise from the provider type, i.e. public provider, private provider or voluntary and community sector (VCS) provider. The analysis of cost factors considers whether cost differences exist according to provider type and whether they are material. We have looked at a range of factors including:

- taxation, including corporate taxes and value added tax (VAT);
- access to capital, the cost of capital and payment timings;
- labour costs, including pensions, pay and other employee benefits;
- input costs, including indemnities for clinical negligence and information technology;
- case mix and the market forces factor; and
- the costs of additional activities such as education and training and research and development.

This paper looks at each of these factors in turn. The issues arising in respect of each factor have been identified, including an assessment of stakeholder views and representations. Where possible we have attempted to quantify the extent of any cost differential between providers and to assess whether there has been any impact on the delivery of services to patients.

Some factors provide an advantage to public providers. For example, the VAT rules allow public providers to reclaim VAT on purchases of contracted-out services. Other factors may benefit private and VCS providers. For example, those providers can more easily adapt pay and benefits to local labour market conditions. For some factors there may be differences between public providers because certain payments do not reflect underlying economic costs. In this category we would include the cost of capital for public providers and the cost of covering indemnity against clinical negligence. Finally, some factors that were raised with us, we looked at but they did not seem to present material cost advantages to any provider.

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1.0 Corporate Taxes

1.1 Issue

This factor examines corporate taxes, and in particular three specific taxes: Corporation Tax, stamp duty land tax (SDLT) and capital gains tax. Each of these taxes is incurred by private, voluntary and community providers but not by public sector or charitable providers.

16% of the respondents to the initial call for evidence mentioned corporate taxes as an issue. These responses largely agreed with the inclusion of Corporation Tax in the review or highlighted that public sector providers are at an advantage with regards to Corporation Tax. Two VCS providers highlighted that this is even more of an issue for social enterprises whose profits “do not go to shareholders, but are reinvested in meeting their social mission.” Another stakeholder agreed with the goal of achieving an equitable approach across providers. However, they highlighted concerns about the possibility of money leaving the health care system if Corporation Tax were to be imposed on public sector providers without an equal increase in NHS funding. 8% of respondents on the discussion paper indicated that corporate taxes were one of the most important issues their organisation faces.

The respondents that most cogently argued that they faced a disadvantage from corporate taxes were social enterprises. One social enterprise noted that, not only did it have to pay Corporation Tax, but also this was a factor that the commissioner regarded as a source of disadvantage from contracting with the social enterprise since funds were perceived as leaking from the local health economy in tax.

We have approached this issue by initially assessing the differences that exist in the corporate taxes paid by non-public sector providers relative to public sector and charitable providers. We have then estimated the difference in the value of taxes paid. We have also considered any evidence for a material effect on providers or patients as a result of the differential imposition of corporate taxes.

SDLT and capital gains tax apply only to discrete transactions, such as purchase of property or another business, rather than on-going costs. At the rates currently charged it appears unlikely that these taxes are material enough to unduly affect provider decisions to the detriment of patients.

Respondents to the review highlighted that in principle Corporation Tax could adversely impact on the prices charged by private and non-public sector providers and the ability to provide services. However, in practice, relatively few private and non-public sector providers pay Corporation Tax. Those that do, either appear to pay very small amounts or undertake a range of activities other than UK health care provision so it is not possible to attribute the amount of Corporation Tax that arises from NHS funded activity.

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As a result while in principle the differential application of corporate taxes to health care providers could in principle affect health care provision, now and in the future, we have not seen evidence to warrant any changes to tax rules at this stage.

1.2 Findings

We considered three corporate taxes that may have a differential impact:

- Corporation Tax;
- Stamp Duty Land Tax; and
- Capital Gains Tax.

Corporation Tax

A range of organisations must, by law, pay Corporation Tax on profits. The tax is levied through a fixed percentage on all profits and gains. For 2012-13, rates vary from 20% for organisations with profits up to £300,000 to 24% for organisations with profits exceeding £1,500,000.¹ Groups subject to Corporation Tax include:²

- UK resident companies;
- other UK resident bodies corporate;
- UK permanent establishments of overseas companies;
- unincorporated associations; and
- cooperative and community benefit societies.

NHS foundation trusts (FTs) are subject to Corporation Tax if they are carrying out significant commercial activities that are not part of core health care delivery, such as running a commercial laundry.

Those not subject to Corporation Tax include:

- sole traders;
- partnerships, including Limited Liability Partnerships (LLPs);
- investment clubs;
- local authorities and local authority associations;

¹ "Corporation Tax rates", HM Revenue & Customs: <http://www.hmrc.gov.uk/rates/corp.htm>

² "Who is liable for Corporation Tax?" HM Revenue & Customs: <http://www.hmrc.gov.uk/ct/getting-started/new-company/who-is-liable.htm>

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- health service bodies (noting the exception above in relation to Foundation Trusts).

In addition charities are specifically exempt from Corporation Tax provided their income arises from and is used for charitable purposes.

Stamp Duty Land Tax (SDLT)

Stamp Duty Land Tax (SDLT) must be paid on the purchase or transfer of property or land in the UK, where the amount paid is above a certain threshold. SDLT is charged as a percentage of the 'chargeable consideration' for property or land when it is bought or transferred - unless there is a relief or exemption. The chargeable consideration is the purchase price but also includes anything of economic value given in exchange for the property, e.g. transfer of an existing mortgage. Rates for commercial properties range from 0% to a maximum of 4% on any transactions above £500,000.³

Charities enjoy an exemption from SDLT where the property is to be used for charitable purposes, although that exemption can be withdrawn if the charity stops being a charity, or the property ceases to be used for charitable purposes, within three years of the transaction.⁴ There is no general relief for public bodies but there is an SDLT exemption for NHS Bodies⁵ (for example NHS trusts, NHS foundation trusts, primary care trusts and The NHS Commissioning Board and clinical commissioning groups) and for Private Finance Initiatives.

As such, charities and public sector health care providers are exempt from SLDT, while other voluntary and community enterprises and private sector providers are liable for this tax.

Capital Gains Tax

Capital Gains Tax is a tax on any gain made on the sale or other disposal of an asset. Companies do not pay Capital Gains Tax as such. Rather they pay Corporation Tax on any gains that they make on their assets.⁶

As with SLDT, charities are exempt from any tax on their capital gains as long as the proceedings are used for charitable purposes.⁷ Health Service Bodies are also specifically exempt.⁸ Private sector providers and social enterprises,

³ "Stamp Land Duty Tax: The Basics", HM Revenue & Customs:
<http://www.hmrc.gov.uk/sdlt/intro/basics.htm>

⁴ HMRC: SDLTM26005 - Reliefs: Charities relief

⁵ "Stamp Duty Land Tax and Stamp Duty: Relief for NHS Bodies", HM Revenue & Customs:
<http://www.hmrc.gov.uk/tiin/tiin740.pdf>

⁶ "Chargeable Gains and Corporation Tax", HM Revenue & Customs:
<http://www.hmrc.gov.uk/ct/managing/company-tax-return/returns/chargeable-gain.htm>

⁷ Taxation of Chargeable Gains Act 1992, Section 271

⁸ Taxation of Chargeable Gains Act 1992, Section 256

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on the other hand, would be liable to pay Corporation Tax on their capital gains.

Consequences of tax treatment

The exemption for public sector providers prevents a circular flow of funds – if public sector providers were to be charged corporate taxes, then in order to maintain the same amount of spending on health care the Government would have to provide additional funds to cover any tax liability an NHS organisation faced. Charitable health care providers and public sector providers are ordinarily expected to invest surpluses in health care provision for the benefit of patients. By contrast private sector providers have the option to use profits for other uses than health care provision.⁹

Based on the legislation set out above, private providers, community and voluntary sector enterprises (that are not registered charities) face additional costs from corporate taxes:

- if they purchase property they incur a higher cost from SDLT;
- if they earn a capital gain they must pay some of it to the Government; and
- if they earn a profit then they must pay some of it to the Government in the form of Corporation Tax.

SDLT is incurred only if private, community or voluntary organisations purchase commercial property. The maximum cost is an additional 4% on any purchases in excess of £500,000, transactions for lower amounts incur lower rates. These are one-off costs that effectively increase the purchase price of property. Given the expected useful life of property the one-off costs are likely to be minimal in relation to its amortised value. Although a difference in cost exists, the proportionate effect on costs is low. Building costs are not a large proportion of the costs of a health care provider. Stamp Duty was not raised as a particular issue in submissions.

Capital gains tax is only paid on disposal of an asset that has gained in value. It is difficult to forecast how often this will occur. However, as noted above, companies pay Corporation Tax on any relevant capital gains. We discuss Corporation Tax below.

Quantification of Corporation Tax

To provide an indication of the financial implications that may arise from Corporation Tax we took two approaches. First, we estimated the Corporation Tax liability that a range of NHS providers would face if they were not exempt.

⁹ Some social enterprises may have restrictions in their constitution restricting the use of funds to their mission, which may mean that in effect all funds will be used for healthcare purposes.

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Second we looked at the current Corporation Tax payments of private providers and social enterprises.

The estimates for the potential public sector liability for Corporation Tax were based on providers' accounting figures. The sample of providers included 10 foundation trusts and 6 NHS trusts. The use of public sector accounting data presents two problems. Firstly, as public providers are currently not liable, it is necessary to construct a measure of their taxable profits starting from their total operating surplus. The level of accuracy of this exercise is constrained by the level of detail of the accounts. We have worked with HM Revenue & Customs (HMRC) to develop these estimates. Secondly, we have adjusted the resulting figures to account for the fact that the sample on which we have data may not be fully representative of the whole range of NHS providers. In particular, our sample has a higher than average surplus so that has been adjusted downwards to reflect the real average surplus.¹⁰

There are many NHS providers that are not earning surpluses currently. These providers would not pay any Corporation Tax. Of those that may be estimated to have a Corporation Tax liability, if it were applied to public sector providers, the maximum figure we estimate would be 0.9% of operating costs, and the average figure would be 0.6% of operating costs.

However these figures represent the maximum possible cost to public providers of being treated, for Corporation Tax purposes, by the same rules that apply to private providers. In practice Corporation Tax payments would be expected to be less than this. First, an NHS provider's current surplus is only a proxy of what its taxable profits would be. Its true taxable profits would be lower because the detailed accounting rules would allow it to offset a range of costs against the surplus were they subject to Corporation Tax. Second, as providers are currently not subject to Corporation Tax, they have no incentive to take any actions that might minimise their tax liability.

After taking steps to mitigate Corporation Tax payments it would be expected that the average public sector liability would be lower than the 0.6% of operating costs cited above.

We also looked at the level of Corporation Tax paid by private sector and non-public providers. Private providers may be part of multinational and/or diversified groups. Therefore much of the corporate profit may arise from non-NHS health care activity, either because the company engages in other non-health care activities, or because it engages in health care activities

¹⁰ To adjust the resulting figures we multiplied them by an adjustment factor. This was calculated as follows:

- we obtained the average corporation tax 'costs' as a percentage of operating costs for all Foundation Trusts using Monitor's consolidated accounts;
- we then obtained the same average figure across all the service providers in our sample; and
- took the ratio between the former and the latter.

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overseas as well as in the UK.¹¹ This makes it difficult to assess the contribution of NHS health care activities to their Corporation Tax liability.

A number of private providers are also making a loss and as such do not pay Corporation Tax. Analysis of the accounts of a number of private providers (covering primary, community and acute care) suggests that, where private providers do pay Corporation Tax, the amount of Corporation Tax paid as a proportion of operating costs is low.

One group of providers, community interest companies that have often spun off from NHS provision, appear to be at most risk of being disadvantaged by Corporation Tax. These tend to be social enterprises focused on the provision of community health care services. As they are not diversified in the way many private sector providers are, they have less opportunity to mitigate the impact of Corporation Tax.

In summary, the combined impact on costs of corporate taxes appears to be very low. Corporation Tax represents no increase in costs for a number of non-public sector providers, for others it increases costs by less than 1% of total operating costs.

In light of the estimated scale of corporate costs it appears unlikely overall these have an important impact on provider decisions and patient delivery.

One provider observed that in order 'to achieve any given post-tax rate of return on an investment, a Corporation Tax paying entity would have to charge higher prices than an NHS body or charity'.

If some providers believe they would have to charge higher prices than other alternative providers because of Corporation Tax, then this implies that Corporation Tax may weaken the effectiveness of competition between rival providers. However, as has been highlighted above, many private providers do not currently earn profits and so do not pay Corporation Tax, and those that do pay relatively small sums.

1.3 Conclusion

Private sector providers including social enterprises are liable for corporate taxes that public sector and charitable providers do not face. We have not found evidence that the cost disadvantage to private sector providers from payment of these taxes is large or has led to adverse impacts on patients. In time it may be the case that such corporate taxes become a larger source of disadvantage. However, currently we do not see a need for changes to corporate taxes to ensure a fairer playing field.

¹¹ Publicly available accounts for the following organisations were examined: Circle Holdings Plc, Spire Healthcare Limited, Bupa, Virgin Care Limited, The Practice PLC, Ramsay Healthcare Limited.

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2.0 VAT

2.1 Issues

Providers of NHS-funded health care services do not charge VAT on the services they provide. However providers typically pay VAT on the inputs used in providing those services. The UK VAT rules allow some providers to reclaim part of this VAT; and to purchase some inputs at zero VAT rate. Other providers are not able to save on those VAT payments.

The VAT rules are not straightforward. The rebate scheme is in place with a clear rationale to assist efficient provision of services by the public sector. The zero rate supports charities to meet their charitable objectives without the additional burden of VAT. Both of these may be expected to benefit patients.

However, not all providers have access to these schemes and we have seen evidence of this distorting provision. We have received examples of charitable providers, and public sector providers who have entered into joint ventures that have been unable to economically offer their services to the NHS, or only with severe difficulty, as a result of the differential application of the VAT rules. Nearly one in three respondents raised VAT in the initial request for evidence and one in eight respondents ranked it as one of the most important fair playing field issues for their organisation in the discussion paper.

This section sets out the VAT rules that apply to health care provision by public sector, charitable and private sector providers. We also set out estimates of the extent of the cost differential as a result of the application of the VAT rules. We also set out case studies where providers have been disadvantaged by the VAT rules.

An additional VAT-related issue that has been raised by providers, is that related to the fact that the supply of drugs, medicines and other items for personal use of patients can be zero-rated for VAT purposes if they are not “supplied for use for patients while in hospital or in a similar institution or administered, injected or applied by health professionals to their patients in the course of medical treatment”.¹² If instead, they are administered in a patient’s home then they are zero-rated for VAT purposes. This is not a fair playing field issue as such, as it is related to the setting in which the drugs, medicines and other items for personal use of patients are supplied. However, it is perceived as unfair by some stakeholders¹³. It also potentially leads to inefficient provision as a hospital may pay a third party to deliver drugs to the patient in their home, in order to avoid the VAT liability, even though this incurs the additional costs of employing a homecare provider.

¹² HMRC Notice 701/57 (November 2012)

¹³ Guild of Healthcare Pharmacists call for evidence response and Royal Pharmaceutical Society call for evidence response

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2.2 Findings

The sale of most goods and services in the UK is subject to VAT. The seller must charge VAT to the buyer, and pass this tax through to HMRC. Different categories of goods and services attract different rates of VAT. There are currently three rates of VAT, the:

- standard rate (currently 20%);
- reduced rate (currently 5%); and
- zero rate (0%).

Some goods and services are treated as exempt, or as outside the scope of VAT, so no VAT is charged by the seller. The rules on VAT are governed by both UK and EU legislation, notably the Valued Added Tax Act 1994 and Directive 2006/112/EC. There are two types of VAT that a provider must consider:

- VAT charged to the buyer of their outputs; and
- VAT paid to suppliers of their inputs.

We describe how these apply for providers of NHS services below.

VAT on providers' outputs

VAT is not charged on goods and services that are either:

- outside the scope of VAT; or
- exempt from VAT.

An entity has to be undertaking an “economic activity” in order for its supplies to fall within the scope of VAT. EU and UK VAT legislation includes provisions for public sector bodies to be outside the scope of VAT.

“States, regional and local Government authorities and other bodies governed by public law shall not be regarded as taxable persons in respect of the activities or transactions in which they engage as public authorities...” 2006/112/EC/Article 13
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The provision of medical and health care services by public sector providers is treated as not being an economic activity for VAT purposes i.e. all public sector providers do not charge VAT on the services they provide.

EU legislation provides for public sector organisations to be treated as providing an economic activity where failure so to do would lead to “significant distortions of competition”.

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“However when they engage in such activities or transactions, they shall be regarded as taxable persons in respect of those activities or transactions where their treatment as non taxable persons would lead to significant distortions of competition.” 2006/112/EC/Article 13

This is implemented in UK legislation in Section 41A(3) of the VAT Act which states that a supply by a public body, other than in respect of an activity listed Annex 1 of the VAT Directive “is to be treated for the purposes of the Act as a supply in the course or furtherance of a business if (and only if) not charging VAT on the supply would lead to a significant distortion of competition.”

As a result neither public nor non-public sector providers charge VAT on the provision of medical and health care services. However GP practices and non-public sector providers have to charge VAT on any activity that falls outside of the VAT exemption.

VAT on providers’ inputs

Providers purchase many goods and services as inputs, which are generally subject to VAT at the standard rate (currently 20%). Entities which undertake taxable economic activities, and are therefore within the scope of VAT, are entitled to recover VAT incurred on associated costs.

Public sector providers of NHS-funded care – who do not charge VAT to their purchasers – are typically not able to reclaim the VAT costs they incur on the inputs they use. In addition, entities which undertake taxable economic activities but provide an exempt supply of health care (such as GP practices and non-public sector providers of NHS-funded care), are not able to recover any of the VAT on their own expenses in relation to that exempt supply.

The UK has legislation in place that allows certain entities to reclaim some or all of the VAT incurred on the purchase of their inputs, even when they are not undertaking an economic activity, or have their purchases zero-rated for VAT purposes. In the context of providers of NHS-funded care this is in respect of:

- contracted-out services (COS) rules; and
- zero-rated inputs for purchases using charitable funds.

Contracted-out services (COS) rules

Under Section 41 of the VAT Act 1994, public sector providers are able to reclaim VAT they incur on a variety of services they “contract out” to external suppliers.

The VAT refund scheme is a UK-specific public spending measure, which sits outside the VAT rules. Only Crown bodies and specified NHS bodies benefit from it. VAT is only refundable to the extent that it is used for **non-business**

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activities. The scheme is governed by the COS rules which contains two lists:

- List 1 details the public sector bodies which can apply for VAT refunds; these include trusts and foundation trusts, but not charities, voluntary or private sector providers, or GP practices.
- List 2 gives details of the services for which VAT is recoverable. These services must be used for “non-business” purposes to be eligible. There are 75 different categories of services which are eligible for VAT refunds, including catering, laundry, cleaning, staff training, waste disposal, maintenance and repairs.

The purpose of this provision is to encourage public sector providers to contract out certain services in cases where an external supplier could provide the service more efficiently than it could be provided in-house. Without the COS rules, it might be the case that an external supplier could provide the service at a lower cost than it could be provided in-house, but because the public sector provider would have to pay VAT for this service, it would be more expensive than providing in-house. In such situations, the COS rules are intended to remove this distortion and encourage the public sector provider to choose the most efficient method of supplying services.

Zero-rated inputs for purchases using charitable funds

Certain health bodies (NHS trusts) and charitable institutions are able to purchase specified equipment - and pay for its repair or maintenance - without having to pay VAT (VAT is zero-rated). Medical, veterinary and scientific equipment and ambulance services will qualify for zero-rating if they are to be used by an eligible body mainly for medical or veterinary research, training, diagnosis or treatment.

For a provider to be eligible to purchase qualifying goods and services at the zero rate of VAT, they must purchase those goods and services using charitable or donated funds and fall into one of the following categories:

- NHS Trusts and non-profit hospital providers;
- research institutions whose activities are not carried out for profit;
- certain charitable institutions - for example those that are approved to provide institutional care, or medical or surgical treatment, where the majority of the recipients are chronically sick or disabled; or
- charities providing certain transport services, or rescue/first aid services for humans or animals;

In addition a body may buy qualifying goods or services at the zero rate if donating them to an eligible body.

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These conditions allow public sector providers and charities to purchase zero-rated medical equipment with charitable funds. It does not apply to all of the VAT costs they incur. The ability of public sector providers to take advantage of this scheme depends on their ability to raise charitable funds. The ability of charities to use their funds to purchase medical equipment for use in providing NHS funded care will depend on the object and powers of the charity as, for example, set out in its governing document.¹⁴

The scale of the impact of the VAT rules

Some stakeholders have told us that VAT is an important issue for them; others have told us that it isn't.

“If you want competition, you need to sort out VAT as private firms are hugely disadvantaged.” (Private sector provider)

“VAT is a nuisance cost. It doesn't really impact on our decisions around whether to offer a service or not.” (Private sector provider)

Cost advantage created by the COS rules

In order to assess the importance of the VAT rules we have examined evidence of the difference in VAT costs of different types of providers. The total VAT refund by public sector health care providers under COS rules is £1 billion.¹⁵ The cost saving for each provider will depend on the use of contracted-out inputs. Where contracted-out services constitute a larger proportion of input costs, the VAT rebate will be larger as a proportion of total costs and so public sector providers will have a greater cost advantage relative to other providers.

We have examined the accounts of a sample of NHS providers to estimate the cost saving to a public sector provider from COS refund as a proportion of total costs. Our estimates indicate that the saving varies from 0.9% to 3.5% of total operating expenses, depending on the structure of provider's costs.¹⁶ The impact on provider costs is at the lower end of the scale for ambulance services, which have a high proportion of labour costs and rely on relatively few inputs which can be contracted out. The impact is around 3-3.5% for hospice services, which rely on a far greater proportion of VAT-able inputs.

These estimates represent the maximum likely advantage to public sector providers. Faced with this additional VAT bill a non-public sector provider would be expected to reduce its use of contracted-out services so as to

¹⁴ Source: “CC37 –Charities and Public Service Delivery – An Introduction and Overview”. Charity Commission (<http://www.charity-commission.gov.uk/Publications/cc37.aspx#c>).

¹⁵ Evidence provided by HMR

¹⁶ The estimates here assume that the public sector providers do not have PFI funding. The unitary payments made under this type of funding are VAT-able and would therefore would lead to larger VAT-able costs, some of which could be recovered through COS rules.

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economise on VAT payments. To the extent that in house provision is more expensive than contracted-out services, these providers will still face a disadvantage but this may be smaller than the estimates above.

We have not been able to assess specifically the amounts of VAT reclaimed by providers. Therefore to estimate VAT reclaim we have looked at the proportion of a provider's operating costs that are subject to VAT.¹⁷ We have then applied an estimate of the proportion of VAT-able costs that is covered by the COS rules. These estimates are discussed in more detail below. To reach the cost advantage estimate above, we apply a 20% VAT rate to this proportion of VAT-able costs.

For example, using data for a large teaching trust, our methodology is applied as follows:

- We estimate that the trust spends 36.6% of its total operating costs on VAT-able inputs.
- If it paid VAT on all of these inputs (i.e. if it were not able to benefit from COS rules) its VAT costs would be 7.3% of its total operating costs (20% VAT on 36.6% of total costs).
- As a result of COS rules, the Large Teaching Trust can reclaim around £1 for every £8 spent on VAT-able inputs (based on 12.7% being reclaimed).¹⁸ These are the only inputs which have been contracted-out and are eligible for COS relief.
- Consequently it reduces its VAT costs from 7.3% to 6% of total operating costs.
- The large teaching trust therefore benefits from a reduction in total costs of around 1.3% due to COS relief.

This analysis of accounts shows that there is significant variation in the proportion of different providers' total costs which are spent on VAT-able inputs. In particular:

- Our analysis of a small sample of providers suggests that the proportion of VAT-able inputs on which COS relief can be reclaimed varies between 17% and 60%.

¹⁷ The proportion of a providers operating costs that are subject to VAT, is estimated by taking total operating costs and subtracting the following non-VAT-able costs:

- pay costs;
- bad debts;
- depreciation and amortisation;
- clinical negligence costs; and
- services from NHS trusts and NHS bodies.

¹⁸ KPMG (2009), Fair Playing Field Review

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- Based on evidence provided by stakeholders and data collected by KPMG as part of their 2009 report, public sector providers can recover VAT due to COS on a proportion of their VAT-able costs ranging from an average of 20.3% (for an Ambulance services provider) to 59.3% (for a mental health service provider)¹⁹.

There are some important limitations in the available evidence. We have collected data on the VAT costs incurred by providers. This gives an indication of the magnitude of any distortion created by the COS rules. However, it is limited in important ways:

- Providers do not typically report VAT costs broken down by the inputs to which they were payable. This means it is not possible to identify the precise mix of inputs used and what proportion would attract VAT under alternative rules.
- VAT costs are also not typically broken down by service. Again this means it is not possible to identify the precise VAT costs compared with an alternative provider of that service.

In addition to the information from provider accounts, private and voluntary sector providers have presented examples which suggest that even after mitigation, the impact of VAT may be as much as 2% of total costs, although this will vary between providers and particular circumstances.

- One voluntary sector provider, which spun out from the NHS under Transforming Community Services, told us that the additional VAT costs they faced (as a consequence of moving “outside the NHS”) increased their total costs by 1.7%. This figure was *after* various approaches to mitigating their VAT costs.
- Other voluntary sector providers told us that their additional VAT costs when it formed were around 1-2% of total costs²⁰.

In summary: VAT, in particular the COS rebate scheme, lowers costs for public sector providers. The review’s modelling suggests that this represents around 1-3.5% of total operating costs. The variation in this estimate depends upon the proportion of a provider’s costs which attract VAT, and the proportion of those costs which are eligible for the COS rebate scheme.

¹⁹ KPMG (2009), Fair Playing Field Review, Ernst and Young and VCS provider estimates (2012)

²⁰ Government, Public sector providers, Private sector providers, VCS providers

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Cost advantage created by the rules on zero-rated inputs for purchases using charitable funds

We have been unable to establish the overall cost impact on public sector providers and charities from the zero-rated input rules. HMRC have highlighted that a clear record of the extent of these types of purchases is not often kept by providers. To gain a full understanding would require a large accounting exercise, with a team of auditors to review the providers' invoices.

Analysis of a small number of providers (from whom data was provided directly) suggests that approximately 15-30% of a provider's spending may be on zero-rated inputs. This would indicate a saving of 3-6% compared with a scenario under which this spending was all subject to VAT. However these figures include all purchases of zero-rated inputs, not just purchases of medical equipment with charitable funds. Therefore the figures should not be used as an estimate of the magnitude of the cost advantage of an eligible provider with access to charitable funds.

Thus while public sector providers and charities are at a cost advantage over private and voluntary sector providers because of the rule on zero-rated inputs for purchases using charitable funds, we have not been able to establish whether this cost advantage is material or not as part of this review. No stakeholders raised this issue as a potential distortion.

Influence of VAT rules on provision

Impact on providers' decisions about how best to deliver a service

Any estimated cost disadvantage due to COS rules or charity relief may represent the maximum cost disadvantage faced by a provider as providers may be able to mitigate the additional VAT costs, either by switching to non-VAT-able inputs or by supplying inputs in-house, thereby influencing how a service is delivered.

Discussions with stakeholders have informed us that:

- many providers, including public sector providers, invest time and effort in finding ways to reduce their VAT costs; and
- this may involve switching between alternative sources of inputs, but is often also simply an issue of better accounting procedures and structuring contracts in alternative ways.²¹

The need to pay VAT on such inputs, in principle, can skew the choice between contracted-out services and in-house provision for these VCS and private sector providers. Provider organisations have told us that they take

²¹ Government, Public sector providers, Private sector providers, VCS providers

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active steps to minimise their VAT costs. There are a variety of mechanisms through which they can do so. VCS providers told us that they have relatively little flexibility in determining the mix of inputs they use to deliver a service. They suggested that the ability to flex between labour and equipment, for example, is very limited.

“Doing that [switching from VAT-able inputs to non-VAT-able inputs] just isn’t really an option for us.” (VCS provider)

In addition, our discussions with stakeholders have informed us that the fact that COS rules do not apply to providers outside the public sector does impact on providers’ decisions about supplying inputs in-house rather than buying them in from external providers.

“We’ve looked at contracting out some services, but because of the VAT we’re paying an extra 20% before we even start to consider any efficiencies. If the VAT cost wasn’t there, we’d definitely consider contracting more services.” (VCS provider)

Voluntary sector providers have also sought to benefit from the zero-rating on inputs bought with charitable funds and, more generally, taking steps to mitigate VAT costs. One voluntary sector provider told us they had set up a charity so that any donations could be invested in inputs for services in a tax-efficient way²².

Impact on decisions about service provision

As well as evidence of the cost disadvantage faced by some providers, we have found some evidence of the impact this has on decisions around whether to offer services and whether purchasers contract for services.

This evidence suggests a variable impact of VAT. Some providers suggest that VAT has been a key factor influencing their decisions (or that it could be in future), while others suggest that it is not particularly relevant.

“The additional VAT costs are small, but because the financial margins on services are so small then sometimes the VAT cost will make the difference between it being profitable and not profitable.” (VCS provider)

“The impact of VAT is managed through our ongoing efficiency programme. We target a higher percentage of efficiencies than is demanded by the commissioner”. (VCS provider)

“We believe that the disadvantages we face around our inability to reclaim VAT are offset by other tax benefits arising from the fact we are a charity.” (VCS provider)

²² Government, Public sector providers, Private sector providers, VCS providers

Figure 1. Case study on diagnostic services

A private provider explained to us that they had failed to take on a contract recently due to a HMRC ruling on VAT. After all other bidders had been eliminated this provider was the sole bidder on a contract with two foundation trusts to provide specialist diagnostic services. Once the provider had reached sole bidder status and was in the process of agreeing final contract terms, the costs included in the bid had to be revised upwards in light of an HMRC ruling to reflect the fact that they could not reclaim VAT input costs. The contract was subsequently lost. The two foundation trusts confirmed that the fundamental reason that the contract was not awarded to this private provider, and instead kept in-house, was due to the revision in costs due to VAT.

2.3 Conclusion

Based on the evidence set out in this section, we can conclude that the following cost advantages exist because of the differential application of VAT rules across providers:

- public sector providers have a cost advantage over VCS and private sector providers because of the COS rules;
- public sector providers and charities are at a cost advantage over other providers because of eligibility for zero-rated inputs for purchases using charitable funds.

Evidence from our stakeholder discussions and representations has also confirmed that these cost advantages impact on decisions on how and whether to provide health care services. There are clear examples where the application of VAT rules has led to alternative providers, which would be cheaper but for the VAT rules, not being able to win contracts for provision of services.

3.0 Cost and access to capital

3.1 Issues

All providers of health care need capital funds to finance their operations. Different types of providers have access to different types of funds to obtain capital, and they are provided on different terms and at different rates. We have received representations to the Review that there is unequal access to capital. Private providers tended to comment on their lack of access to (low cost) public funds, and public providers to their lack of access to private funds. Those most affected are social enterprises lack the access to capital who can struggle to attract either form of funding.

This section sets out the:

- different types of finance required by providers;
- evidence for differences in the access to capital between provider types;
- evidence for the differences in the cost of capital between provider types; and
- evidence that such differences represent an obstacle to providers participating fully on the playing field to the benefit of patients.

We consider two types of capital cost and funding.

- **Funding for investment – historic or prospective** – a provider may seek loans or equity funding to finance expansion of its operations. Providers may also have existing assets, for example in the form of buildings and equipment, as a result of past investments. The capital payments for those investments will usually depend on the funding source for those investments and the asset valuation.
- **Funding for working capital** – a provider that wishes to make new investments or fund its current cash flow may require additional working capital.

Providers may also require funding when in financial distress. Where the provision of a service is not currently economic for the current provider but there is no alternative provision available for patients it is necessary that funding is made available to ensure that patients continue to receive appropriate health care services. Such funding for public sector providers may come from the issuance of Government equity in the form of public dividend capital to finance restructuring to make services economic. In addition funding may be provided to allow restructuring of providers not currently in financial distress but where preventative action may be necessary.

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Capital is usually provided either in the form of debt (e.g. loans, overdraft facilities, etc) or equity (e.g. ownership of a share of the business). Grants and donations are an additional source of capital. Depending on the cost of fundraising and the cost of obtaining them, grants and donations generally do not entail ongoing financing costs.

The overall cost of capital faced by a provider includes the costs of both debt and equity finance. Both debt and equity financing require health care providers to generate a return. The cost of capital is the return that the provider has to generate to repay interest on debt or pay a return on equity.²³

The cost of debt and equity funding is influenced by a range of criteria. Commercial finance costs are generally based on base lending rate plus an adjustment for the cost of the lender and the risk that the provider will not be able to meet its repayment obligations.

The cost of Government finance in health care typically does not take into account the risk factors that commercial lenders and investors consider. This reflects two considerations. First, the Government does not seek to capture the opportunity cost of capital in its lending to public sector providers. Second, the Government chooses to bear the risk of non payment by public sector providers rather than reflect that risk in the rate it charges for the finance it provides.

3.2 Findings

Funding sources and funding costs for providers of NHS services

There are a variety of funding sources, some of which are only available to certain types of provider:

- **Public Dividend Capital (PDC)** – PDC is provided by the Department of Health (DH) and is treated by Government as an equity investment in health care assets. New PDC payments do not attract a charge directly but the assets purchased attract a capital charge of 3.5%. An NHS provider has its assets re-valued every 5 years on a modern equivalent asset valuation basis and pays the 3.5% charge on the net value of those assets.²⁴ The PDC charge is determined on the basis of the average net assets employed excluding assets that have been donated and cash held in Government accounts. As a result, when calculating the PDC charge, liabilities such as DH loans, Foundation Trust Financing Facility (FTFF) loans or commercial loans will be netted off from the total assets. DH has indicated that new PDC

²³ Taxation also plays a role but has been ignored here as it is dealt with in other factors.

²⁴ Modern Equivalent Asset valuation re-sets the value of existing assets at a level commensurate with replacing them with the modern equivalents of those assets. It reflects the cost of replacing the assets with modern equivalents.

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funding is only provided in situations of financial distress or to finance restructuring, for example in case of mergers or asset transfers between FTs and other NHS bodies.^{25 26}

Trusts do not have to repay PDC funding over any particular period, but DH can require PDC repayments in some circumstances (e.g. if a provider has more capital funds that it requires).

- **DH loans** – loans can cover capital investment or working capital. DH loans are provided to NHS trusts.
- **Foundation Trust Financing Facility (FTFF)** – the facility provides loans to NHS foundation trusts. This type of funding works in a very similar way and on the same terms as DH loans for NHS trusts.
- **Private Finance Initiative (PFI)** – this type of funding is generally used for capital investments. It is backed by Government guarantees. It usually implies that a private sector party manages and finances the design, build and operation of a new facility. The user of the facility then pays the private sector party a periodic unitary charge. The rationale for using PFI instead of direct Government funding is based on the efficiency gains from private sector delivery of capital investment and the transfer of project risk to the private sector.²⁷
- **Commercial loans** – this type of loan is provided by commercial banks and can cover capital investment or working capital. Commercial loans can be used by private providers and VCS providers. Foundation trusts are also able to borrow from the commercial lending market within certain limits.²⁸ NHS trusts cannot borrow commercially.
- **Bonds** – these are debt instruments that require payment of interest for the term of the bond and repayment of the principal at the end of the term. This type of commercial finance can be used by large private providers as it generally requires credit ratings and a minimum issuance size of around £200m to ensure liquidity.
- **Equity** – this type of capital can be used by private providers. NHS trusts and foundation trusts cannot access private equity. Most VCS providers cannot access equity because of their organisational form.

²⁵ Department of Health (2010), Public Dividend Capital 2010-11, Available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_120389.pdf

²⁶ DH, (n.d.), NHS Trust Financing Guidance

²⁷ HM Treasury, (2011), Private Finance Initiative,

<http://www.publications.parliament.uk/pa/cm201012/cmselect/cmtreasy/1146/114602.htm>

²⁸ The limits are currently set out in the *Prudential Borrowing Code for NHS Foundation Trusts*, Monitor, (2009). From April 2013 FTs will need to comply with the financial risk terms of their licence, which may contain commercial borrowing.

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- **Donations** – charitable donations can be used to fund expansions and upgrades. They are often collected by providers’ own charities and there appear to be no barriers to collecting donations (subject to setting up the appropriate structures).
- **Government grants** are also available for specific purposes and depend on Government policies and programmes.

Access to the different funding sources

The table below shows whether providers have access the different sources of funding listed above. A red cell means that a provider cannot access the source of funding. A green cell means that a provider can and does access the source of funding. Orange shading indicates that providers can access this funding source in principle but they do not make significant use this type of funding in practice.

Figure 2. Different providers’ access to funding

		NHS trust	Foundation trust	Private sector	VCS
Public capital	Grants	Green	Green	Green	Green
	PDC	Green	Green	Red	Red
	DH/FTFF loans	Green	Green	Red	Red
Private capital	PFI	Green	Green	Red	Red
	Bank loans	Red	Green	Green	Green
	Bonds	Red	Orange	Green	Orange
	Equity	Red	Red	Green	Red
	Donations	Green	Green	Green	Green

Source: Discussions with funders and review of documents²⁹

Importantly, even where one type of provider can (in principle) access the same source of funding as another type, the *extent* of access can vary. One reason for this is that providers differ in terms of their riskiness. The riskiness of a provider – that is, the likelihood that they will default – will determine whether a lender is willing to make any funding available, how much and on what terms (discussed further below).

²⁹ Such as HM Treasury, PFI statistics, http://www.hm-treasury.gov.uk/ppp_pfi_stats.htm, National Health Service and Community Care Act 1990, stakeholder consultation with private lenders, private and VCS providers, FTFF and DH

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Any differences in access caused by differences in *actual riskiness* would not advantage or disadvantage one type of provider over another, and so would not distort the playing field (because such decisions reflect the expected costs of lending). However, it is difficult to evaluate riskiness accurately and so lenders need to use imperfect credit tests for credit worthiness. A distortion to the playing field can occur when these tests make it harder for some providers to pass them than others in a way that is unrelated to their true riskiness or commercial viability.

We were told that VCS providers found it difficult to access bank loans.

“At a detailed level, social enterprises in the health care sector have been established without a financial trading history which can significantly limit their access to capital as well as leave them at a disadvantage when competing with major private sector companies.”(Representative body)

During a stakeholder interview with range of private lenders we were told that the reason for this is that credit tests tended to include criteria which VCS providers found hard to meet, including: how they long they have been trading for; whether assets are available as security; and evidence of revenue diversification.³⁰ Clearly, any new or small provider would find it as difficult to pass such credit tests including private sector providers, but we were told that it was a particular problem for VCS providers because (a) they tended to be newer and smaller than other providers and (b) they could not use equity as an alternative source of funding like private sector providers. We were also told that lenders were more reticent to lend to VCS providers than to others because they were managed in a way that puts emphasis on social impact rather than commercial viability.³¹ This implies that the organisational capability may not be geared towards generating a profit to the same extent as it would be for a purely commercial business.

This is consistent with evidence gathered by the Department for Business, Innovation and Skills (BIS) and the introduction of various Government schemes.

- Government is developing financial instruments that VCS providers can use. Social bonds and social capital investments are two examples. The market for such financing instruments is currently developing and Government is currently trying to increase social investment lending. Indeed, some large mainstream banks such as Deutsche Bank and Bank of America are ‘testing’ social investment³².

³⁰ Review team engagement with financial institutions

³¹ Review team engagement with financial institutions

³² <https://www.db.com/unitedkingdom/content/en/2147.html> and <http://about.bankofamerica.com/en-us/global-impact/supporting-businesses.html#fbid=2WYKaWrZM15>

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- Big Society Capital (BSC) is another Government initiative that has been set up to develop the market for social investment further. It is based on funding by dormant bank accounts and was established in 2012. BSC is a wholesale provider of capital for organisations with a social impact. Furthermore, some social enterprises are considering innovative forms of finance such as quasi-equity arrangements. For example, Hackney Community Transport set up a revenue participation scheme which implies that for certain revenue figures an element of return is passed over to investors³³.
- The Department of Business, Innovation and Skills found in a 2012 report on access to capital by small and medium enterprises(SME):

“Whilst the majority of firms seeking finance do get it (74% of SME employers), there are a number of structural market failures restricting some viable SMEs from accessing finance. This is due to imperfect or asymmetric information between finance providers and small businesses. This manifests itself in a debt funding gap affecting businesses that lack collateral or track record; and in the equity gap affecting SMEs seeking between £250,000 to £5m of equity finance. There are also cyclical issues relating to the supply and demand of finance (BIS, SME Access to External Finance, Jan 2012)”

However, all of these schemes are in their very early stages of development and do not yet provide a ready source of capital for the VCS.

It has not been possible as part of this review to determine the extent to which these apparent differences in access to bank loans are related to the commercial viability of VCS providers. There are a range of grants potentially available to providers to support specific areas, as set out below.

³³ <http://www.ft.com/cms/s/0/41e6c628-1f11-11df-9584-00144feab49a.html#axzz1A38Eltsw>
<http://www.bridgesventures.com/news/%C2%A33m-investment-hct-heralds-new-approach-financing-social-enterprise>

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Figure 3. Overview of grants

Type of grant	Availability of funding	Eligibility requirements	Administered by
Help the Hospices	£60m in 2012	For hospices to fund tangible physical improvements in their environments that improve care. ³⁴	DH
Social Enterprise Infrastructure Fund (SEIF)	Since 2007 the SEIF has invested £100m in the health and social care sector. £19m have been invested in 2012	To support social enterprises deliver innovative health and social care services and products as well as to invest to help social enterprises to become sustainable in the longer term	Social Investment Business Group
Investment and Contract Readiness Fund	£10m three year	Support social ventures to build their capacity to be able to receive investment and bid for public service contracts	Office for Civil society
Community Right to Challenge Support Programme	£11m	Support to social ventures to enable them to bid for and deliver local services.	Department for Communities and Local Government
Innovation, Excellence and Strategic Development Fund	£6.8m in 2012	Develop new, innovative approaches to health and care, actively share excellent practice or improve integrated care and efficiency. Incorporated non-profits and charities are eligible	DH
Children's Hospice and Hospice-at-Home Grant	£10m annual	Support to the palliative care sector in caring for children and families.	DH

³⁴ DH (2012), Capital grant programme 2012 Information and criteria, Available <http://www.helpthehospices.org.uk/our-services/grants/uk-grants/copyof-department-of-health/>

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A small number of VCS stakeholders raised concerns about potential distortions arising from the basis upon which grants are allocated, in particular those covering facilities, buildings and estates. These are particular issues in the South West of England in which social enterprises account for a higher volume of community care delivery.

Costs of different funding sources

Figure 4 below provides an overview of the typical cost of funding and the “in-principle” availability of different funding types for provision of health care services. The figure does not indicate which funds can be accessed by different providers but instead shows the general cost of different types of funding.

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Figure 4: Cost and availability of different sources of funding for provision of health care services³⁵

Funding source	Cost of funding	Availability of funding	Typical term ^(a)
Donations	Depends on cost of fundraising	Limited by willingness to donate and ability to fundraise	N/A
Grants	Depends on cost of obtaining grant	Limited by size of Government programme	N/A
PDC	3.5% ^(a)	Limited by availability of Government funds	Perpetual
FTFF	c.1-2.5% ^(b)	Limited by availability of Government funds	Up to 25 years
DH loans	c.1-2.5% (up to 4% in past 3 years)	Limited by availability of Government funds	Up to 25 years
PFI	All-in cost of c.6% based on PFI entity's blended cost of funds ^(c)	In theory unlimited but typically applied to relatively large projects that involve substantial infrastructure	>20 years
Revolving credit/ Working capital facilities	1.5-2% above short-term LIBOR	In theory unlimited but requires evidence of sustainability of Profit & Loss (for example contracts >2 years), cash flow, leverage and/or loan-to-value for a property based loan, otherwise only limited overdraft	<5 years

³⁵ LIBOR = London Inter Bank Offer Rate. Different rates are used for different length loans, 3 month LIBOR is typically used for shorter term borrowing. For a long term PFI, for example, a 20 year fixed rate might be used.

(a) Term refers to the time period of the financial instrument.

(b) DH Loans (and FTFF) are currently offered at rates of 1% and 2.5% depending on the term. Historic loans still being repaid may be at higher rates.

(c) A large proportion of PFI deals was completed when LIBOR rates were higher than today.

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		facilities likely to be available	
Commercial loans	Typically 2-3.5% above relevant LIBOR but depends on risk profile	In theory unlimited but requires evidence of sustainability of P&L (for example contracts >2 years), cash flow, leverage and/or loan-to-value for a property based loan.	5-7 years
Bonds	4-10%+ (depending on credit quality and term)	In theory unlimited but requires typically two credit ratings and substantial asset base and therefore only available to larger organisations who are raising > £100m	5-10 years
Equity	Depends but substantially higher than loans	In theory unlimited but depends on whether required rate of return can be achieved	N/A

Source: Estimates based on desktop research and interview with a small sample of providers and lenders

Cost of funding for NHS trusts

NHS trusts can access three types of funding sources: PDC, DH loans and PFI. Information received from the DH during the review indicates that DH loans currently are available at rates of 1% or 2.5% for terms of up to 10 years and up to 25 years respectively. These rates are based on the National Loans Fund (NLF) loan rates and there is no risk-pricing, as all Trusts are deemed to be equal risk. Previous DH loans currently being repaid have been made at rates of up to 4%. PDC requires a capital charge of 3.5% on net assets funded by PDC.

PFI finance is generally used for asset finance and capital projects with transaction sizes often in the order of £100million or more. Historically, this type of funding was a relatively large source of NHS trust funding and the underlying funders were either banks or bond investors. The number of transactions has declined over recent years. However, there have been some recent investments such as Alder Hey Hospital.³⁶ Margins are not typically publicly disclosed for individual transactions but HM Treasury have

³⁶ <http://www.liverpoolecho.co.uk/liverpool-news/local-news/2012/05/25/health-secretary-hails-new-alder-hey-as-an-exciting-and-inspiring-vision-video-100252-31042192/>

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indicated that margins have tended to rise in recent years from the 1.5% over LIBOR at the peak issuance through 3% over LIBOR. However as the LIBOR rate has fallen in recent years, historic PFI deals appear to have a cost of around 6.5% whereas more recent PFI deals are likely to be around 6%.

Depending on the combination of PDC charges, DH loans and PFI, the funding costs of NHS trusts will vary from 1-3.5%, where the primary source of asset funding is loans or PDC, or to 6%, where a trusts' assets have largely been funded using PFI.

Cost of funding for foundation trusts

FTs can access the same funding types as NHS trusts but also have access to the FTFF. The FTFF provides borrowing facilities for up to 10 or 25 years at a rate of 1% or 2.5% respectively, the basis for these loans is the same as for the DH loans. PFI costs for FTs are similar to those for NHS trusts.

FTs can also access commercial funding from banks but to date have made little use of this for long term funding. Bank debt financing mainly involves revolving facilities such as working capital and overdraft facilities. These facilities are used to maintain liquidity required for specific contracts. They are rarely drawn down. Conversations with lenders indicate that, although commercial banks would be willing to offer longer term funding for FTs, lenders reported that they have not been approached for this, as the long-term funding for FTs is typically sourced by other means. A small proportion of FTs also benefit from charitable income on a material scale.³⁷

The cost of funding for FTs is therefore estimated to range from 1-5% for current borrowing, although FT's with historic PFI liabilities may be paying closer to 6.5%. The Consolidated Foundation Trust Account 2011/2012 shows that 70% of historic funding was provided by PDC. Only 25% of funding is attributed to PFI and 5% to the (relatively new) FTFF.

Cost of funding sources accessed by private providers

Private providers cannot access any of the Government funds. Their funding sources are commercial loans as well as equity and bonds for larger providers. Commercial loans are typically available at 2-3.5% above LIBOR for 5-7 year terms. Commercial loans also carry the risk of re-financing after the term expires so higher rates could apply for longer term loans. However, pricing can vary substantially with the level of provider risk. Depending on the size of the organisation and their credit risk, pricing can vary between 1-1.5% above LIBOR and 10% above LIBOR. Figure 5 below provides examples of large commercial funding of private providers. The cost of funding for private providers is therefore estimated to range from 2.5% to 10%. The cost

³⁷ For example, see: <http://www.gsttcharity.org.uk/what-we-do/how-we-do-it/who-we-work-with/>

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depends strongly on the riskiness of providers and the nature of the borrowing, for example a leveraged buyout will attract the higher pricing.

It appears that private providers with the lowest risk can access short term finance at rates equivalent to the public sector, but pay a slight premium compared to equivalently risky public providers on longer term finance. Riskier private providers are likely to face a much greater premium than equivalently risky public providers.

Figure 5. Examples of commercial lending

Organisation	Amount	Term/ Type	Pricing	Date
BUPA	£800m	5 years/ revolving credit	LIBOR+1.1%	2012
	£350m	7 years/ bond	7.5%	2009
	£330m	Perpetual/ bond	6.13%	2004
The Priory	£631m	7 years/ bond	7%	2011
	£175m	8 year/ bond	8.88%	2011
Spire UK Finance	£11.8m	N/A/ term loan	LIBOR + 1.75%	2008
	£96.6m	N/A/ term loan	LIBOR + 3.00%	2008
	£50m	N/A/ capex facility	LIBOR + 1.75%	2008
Care UK	£325m	7 years/ Senior Secured Loan Notes	9.75%	2010 and 2012

Source : ThomsonOne, Loanconnector

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Cost of funding sources accessed by VCS

The key sources of funding for VCS organisations other than private donations are either Government grants or commercial finance. For Government grants the cost of capital is close to zero (depending on the cost of obtaining grants). Commercial finance is available at commercial rates comparable to those set out above, although VCS providers may be regarded as high risk (e.g. because they are new and may have few physical assets).

The cost of capital to charities is also characterised by very low rates for donations and grants. Charities with larger asset bases can access loan facilities. For example, we found a charity with property assets of £200 million that has been able to obtain term loan facilities of £50 million at fixed interest rates of between 3 and 6% depending on the facility.

The cost of funding for VCS is similar to private providers with the exception of grants and donations.

Comparing the cost of funding

Comparing the cost of funding across provider types, the evidence suggests that public providers have access to cheaper funding sources than private providers and VCS³⁸ and therefore on average incur lower costs of capital. Figure 6 summarises this result. However, the figures should be viewed with caution as they are based on a sample of private and VCS providers. As a result, the figures give an indication of the ranges of cost of capital but do not suggest that the average lies in the middle of the range.

Figure 6. Indicative cost of new capital range

	Indicative cost of new capital
Public providers	1-6%
Private providers	1.5-10%
VCS providers	0-10%

Source: Review research, Department of Health and stakeholder interviews

Capital costs are only one portion of a provider's overall cost base. For most health care providers, labour costs will be a more important part of their cost base. Consequently, these differences in capital costs have a smaller overall

³⁸ Unless VCS access a large proportion of funding via donations and grants.

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impact on a provider's total cost base. Modelling undertaken by the review based on provider accounts suggests that these differences in capital costs may translate into an overall cost advantage for public providers in the range of 1-2% of operating costs.

The assessment of the costs faced by different providers indicates that, when using commercial lending facilities, VCS and private sector providers will pay a rate that reflects at least in part the risk of the lending. The interest rate charged on DH and FTFF loans depends upon the term of the lending rather than the likelihood that the provider will be able to make repayments.

All public sector providers pay the same 3.5% charge on PDC. Therefore currently there is no difference in the cost of capital of public sector providers related to the riskiness of the provider i.e. all Government-backed entities are deemed to carry the same, Government, risk.

It is inherently difficult to compare the risk associated with a public provider and a private sector provider. In particular, the observed cost of capital for public sector providers does not vary, due to the Government-backed rates offered by DH. However these organisations are likely to present some variation in risk of repayment. This implies that the cost of capital faced by public sector providers currently does not relate to their underlying risk.

Such differences in the cost of capital could affect the ability of private and VCS providers to operate in and enter the market.

The Government has set out its view that public sector businesses should deliver returns comparable to commercial investments.

“Certain public sector businesses, notably trading funds, are set up with public dividend capital (PDC) in lieu of equity. Like equity, PDC should be serviced, though not necessarily at a constant rate. PDC is not a soft option: in view of the risk it carries, it should deliver a rate of return comparable to commercial equity investments carrying a similar level of risk. There is scope for the return to vary to reflect market conditions and investment patterns; but persistent underperformance against the agreed rate of return should not be tolerated.”³⁹

Evidence on the impact on providers

The issue of cost of capital was raised by a quarter of responses to the call for evidence. Some providers indicated that the cost of capital is seen as a “fact of life” and not as a factor that they can influence. However, 8% of respondents ranked the cost of capital as one of the most important subjects for their organisation in the responses we received to the discussion paper.

³⁹ Managing Public Money, HM Treasury, May 2012, paragraph 5.5.1

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3.3 Conclusions

Overall, it appears that the issue of access to funding is a major issue only for VCS providers. They have access to the smallest range of funding options and often have to rely on donations and Government grants. Both of these sources limit the use of the capital once it is distributed. Access to capital represents a potential fair playing field distortion as it may inhibit some providers, particularly VCS providers, from participating in the provision of NHS-funded care.

If capital is available then private providers and VCS providers where they rely on loans (rather than grants or donations) face a higher cost of capital than public providers. Furthermore, that cost of capital for private and VCS providers is likely to vary based on the risk of the provider in a way that public lending to public providers currently does not.

4.0 Pensions

4.1 Issues

Employees of public sector providers have access to the NHS pension scheme. This is a defined benefit scheme which guarantees a proportion of salary as a pension. Employees of independent sector providers typically do not have access to the NHS pension scheme.

The views of non-public sector providers were mixed on the cost implications of access to the NHS pension scheme. A number felt that, in offering terms and conditions to their employees, matching the NHS pension scheme placed additional burdens on their business. For example one provider stated:

“The considerable costs that would be incurred for the independent sector to match NHS pension arrangements place providers at a clear disadvantage and distract from what should always be the number one priority – delivering high quality patient care.” (VCS provider)

However others felt that matching the NHS pension did not affect their ability to recruit staff.

“Opening NHS pension provision would be a cost to the organisation. We have not had difficulty recruiting nurses without the NHS pension so we do not see it as a significant issue.” (VCS provider)

A number of respondents to the Review made representations about pension arrangements when bidding for tenders that would involve the transfer of staff under the “Transfer of Undertakings Protection of Employment Regulations” (TUPE).⁴⁰ The pension costs for a non-public sector provider associated with such transfers deterred some providers from bidding for such contracts.

“Pensions relating to TUPE staff deter us from tendering, especially as often insufficient information is provided to enable us to accurately cost our bid.” (Private sector provider)

We have examined these issues as part of the review, have quantified estimates of the cost implications of access to the NHS pension scheme, and looked at the impact of the Public Services Pensions Bill on the issue. These findings are set out below.

⁴⁰ Transfer of Undertakings (Protection of Employment) Regulations 2006 SI 2006/246

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4.2 Findings

Public providers' pension contributions

Public providers of health care have to enrol their eligible employees automatically in the NHS pension scheme.⁴¹ NHS providers cannot offer a different pension plan to their employees.

The NHS pension scheme is a pay-as-you go scheme which means that current employees' contributions are used to pay pensions to current retirees. The NHS pension is unfunded so the Government has to step in if contributions fall short of payments as benefits are fully guaranteed by Government.⁴² A number of reforms have been introduced to address the long-term sustainability of the system as increasing life expectancy implies that the system is not self-financing in the long-term.

The NHS pension scheme is a defined benefit scheme which guarantees a particular proportion of staff salary as a pension. It is available to the following staff:

- NHS employing authorities (NHS Trusts, Foundation Trusts, PCTs, Health Authorities);
- GP practitioners;
- Direction employers⁴³, conditional on approval by the Secretary of State; and
- Joint NHS and Social Care partnerships to provide integrated health care, conditional on approval by the Secretary of State.

The NHS employer contribution rate to the NHS pension scheme is 14% of pensionable pay.⁴⁴

Private sector providers' pension contributions

Private sector providers currently cannot offer their staff membership of the NHS pension. Pension requirements for private sector providers depend on whether their staff has been transferred from a public provider.

⁴¹ NHS Employers, Automatic and contractual enrolment, re-enrolment, opting in and opting out Available:

<http://www.nhsemployers.org/PayAndContracts/NHSPensionSchemeReview/Automatic%20enrolment%20in%20the%20NHS/Pages/Automaticandcontractualenrolment,re-enrolment,optinginandoptingout.aspx>

⁴² NHS BSA, (n.d.), Scheme Guide, NHS Pensions scheme, Available:

http://www.nhsbsa.nhs.uk/Pensions/Documents/Pensions/SD_GUIDE_COMPLETEE.pdf

⁴³ "Direction employers" are providers that are from the voluntary sector or operate on a not-for-profit basis that have been approved by the Secretary of State and therefore have access to the NHS Pension.

⁴⁴ NHS BSA, (2012), NHS Pension Scheme: 2011/12 Tiered Employee Contributions Available

http://www.nhsbsa.nhs.uk/Documents/Pensions/Tiered_contributions_2011-12.pdf

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For staff that has been transferred from a public provider TUPE applies. For TUPE-eligible staff, private providers have to provide a pension plan that is broadly comparable to the NHS pension scheme. This requirement stems from the “Fair Deal” a non-statutory policy around pension provision for public sector staff when they are compulsorily transferred to a non-public sector employer.⁴⁵ The private provider therefore has to offer staff that are transferred from the public sector a pension plan with comparable benefits but cannot offer continuing access to the NHS pension scheme.

For staff that have *not* been transferred from a public provider, non-public sector providers have some flexibility over the pension arrangements they offer their staff. However with the introduction of auto-enrolment employers over the next few years will move to a position where they will pay a minimum employer contribution of 8% of employee income.^{46 47}

VCS sector providers’ pension contributions

VCS sector providers are, for the most part, unable to offer the NHS pension scheme to their employees currently. However, providers that are from the voluntary sector or operate on a not-for-profit basis can apply to the Secretary of State to become “Direction employers”. Their application is then assessed by the Department of Health. Direction employers can offer NHS pension membership to either ex-NHS staff or all staff depending on the type of direction.⁴⁸ Providers that are eligible to become direction employers generally include:

- social enterprises;
- hospices;
- care in the community services;
- university medical schools; and
- institutes involved in research;

UNISON estimates that only 1.5% of current scheme members are members through a direction employer.⁴⁹

If a VCS provider is not classed as a direction employer, the same pension requirements apply as for private providers:

⁴⁵ HM Treasury, (2011), Consultation on the Fair Deal Policy, Available http://www.hm-treasury.gov.uk/d/consult_fair_deal_pensions.pdf

⁴⁶ The Pension Regulation, (2012), An introduction to work-based pension changes, Available <http://www.thepensionsregulator.gov.uk/docs/intro-to-work-based-pension-changes-2011.pdf>

⁴⁷ Department of Work and Pensions, (2012), <http://www.dwp.gov.uk/docs/auto-key-facts-enrolment-booklet.pdf>

⁴⁸ NHS BSA, (2012), NHS Pensions Direction Employers Guide, Available [http://www.nhsbsa.nhs.uk/Documents/Pensions/Direction_Employments_Guide_\(V5\)_10.2012.pdf](http://www.nhsbsa.nhs.uk/Documents/Pensions/Direction_Employments_Guide_(V5)_10.2012.pdf)

⁴⁹ <http://www.unison.org.uk/acrobat/20733.pdf>

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- staff that are transferred from the public sector have to be offered broadly comparable pension plans to comply with TUPE regulation; and
- the minimum statutory pension contribution rate has to be paid for all other staff.

TUPE-eligible staff

We considered the costs for a private sector provider associated with taking on staff under TUPE regulations compared to the costs associated with a public sector provider or a not for profit provider for whom staff transfer under a direction.

Public sector pension contributions

Public providers contribute 14% of wages to the NHS pension plan for every employee. This contribution rate is revised periodically to take into account the overall long-term sustainability of the NHS pension scheme. The NHS pension scheme is a defined benefit scheme. Such a scheme guarantees a specific level of pension.

Private sector and VCS pension contributions

Private sector and VCS have to provide a broadly comparable pension for TUPE eligible staff. If they are not able to offer access to the NHS pension scheme under a direction, they have to offer an equivalent alternative. The cost of providing the same level of pension benefits for TUPE-eligible staff is estimated at 22-27% of wages. These figures are based on two sources of evidence:

- Private and VCS providers that have responded to the Review have indicated that pension contributions for TUPE-eligible staff can be as high as 27%.
- By way of example we have estimated the employer contribution rate that is required to achieve the same level of defined benefit (i.e. an annuity) for a 45 year old male employee who retires at 65 with an employee contribution rate of 6.5%. In this case, the private and VCS provider would have to contribute 22%-24% of the employee's salary.⁵⁰

This estimate of the private and VCS sector contribution rate required to provide a broadly comparable pension of 22-27% is substantially higher than the contributions made by public providers (14%). There are a number of reasons for the higher cost:

⁵⁰ Review team estimate, range reflects the uncertainty around the estimate but magnitude of estimate is confirmed by stakeholder information

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1. There are economies of scale in the administration of pension schemes - this benefits the NHS pension scheme. In addition, the administration of the NHS Pension Scheme is funded by the NHS business service authority. The average administration cost of the NHS Pension Scheme of £16 per member is significantly lower than the average private sector cost of £41 to £47 per member.⁵¹
2. The NHS scheme is a defined benefit scheme that is not funded. The costs of a funded scheme on a scale sufficient to provide the same defined benefit are estimated to be significantly greater than 14 %.
3. The NHS scheme is an unfunded pension scheme backed by the Government. It is therefore not covered by the Pension Protection Fund (PPF) and so no PPF levy is payable resulting in reduced employer costs each year

In cases where non-public sector providers take over staff under TUPE, this can increase these providers' total costs by around 3.5-7.5%. This large range reflects the variation in the proportion of providers' costs which relate to staff costs. For example, capital-intensive acute providers employ relatively fewer staff, and the impact of pension costs in these services (under TUPE obligations) is around 3.5-4.5%, according to the review's modelling.

It may be especially difficult for small private and VCS sector providers to offer a comparable defined benefit pension. Defined benefit schemes imply that the employer takes on the risk of asset performance. Large providers may be able to take on such risks but for small providers the risk exposure may be too great to take on. The *Independent Public Service Pensions Commission* (2011) found that:

“By leaving almost all risks with employers, [current public service final salary pension schemes] can make it difficult to attract new providers to achieve gains in the efficiency and quality of services.[...] Smaller private and voluntary sector employers are often unwilling to take on such risks.”⁵²

Additional one-off costs from TUPE transfers

In addition to ongoing higher costs when offering a broadly comparable pension to the NHS pension scheme, a private and VCS provider also bear the risk of incurring additional one-off costs associated with the transfer.

When offering new pension arrangements to transferring employees, these employees can decide to transfer their existing NHS pension benefits to the new provider or to leave them in the NHS pension scheme.

⁵¹ Estimate for largest schemes, Independent Public Service Pensions Commission, (2011), Final Report

⁵² Independent Public Service Pensions Commission, (2011), Final Report.

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A bulk transfer is an arrangement that allows the transferring members to be able to transfer their accrued pension benefits to the new employer's scheme and receive pension benefits of equivalent value to those earned in the NHS pension scheme immediately before transfer.⁵³

The bulk transfer poses a financial risk to the private provider who takes over the service because the value of the potential bulk transfer payment is not known in advance. It depends on how many employees will choose to transfer their pensions and the size of the pension liability.

There is evidence that some providers are deterred from bidding for contracts because of possible pension obligations under TUPE, indicates that pension costs and access to the NHS pensions are significant factors that are limiting providers from offering services to NHS patients.

The risk associated with bulk transfers only applies if staff choose to leave the NHS pension scheme. In future, if independent sector providers have access to the NHS pension scheme for transferring staff, bulk transfers and their associated risks will largely disappear.

Non-TUPE eligible staff

Public sector pension contributions

As set out above, the contribution rate for public providers is 14% of pensionable pay for all staff that are members of the NHS pension scheme. Looking at a sample of public providers' annual accounts indicates that pension contributions as a proportion of overall labour costs vary between 10 per cent for some providers to 14 per cent for others. The figures are slightly lower than the 14 per cent employer contributions, as total labour costs include some items other than pensionable pay and the labour costs of temporary and agency staff.

Private sector and VCS pension contributions

For non-TUPE-eligible staff private and VCS provider must adhere to the statutory minimum contributions consistent with obligations under auto-enrolment. However, private and VCS sector providers are free to provide a higher level of pension benefits. Data from the Association of Consulting Actuaries pension trend survey, which covers all sectors and therefore is not specific to health care, indicates that the typical employer contribution for a defined contribution pension benefit ranges from 4.3% to 7%.⁵⁴ A review of

⁵³ NHS Business Services Authority, (2006), NHS Staff Compulsorily Transferred out of the NHS under PPP, PFI or other programmes: Bulk Transfer of Pension Rights. Available at: http://www.nhsbsa.nhs.uk/Pensions/Documents/Pensions/TN10_2006.pdf

⁵⁴ Association of Consulting Actuaries, (2011), Pension trends report, Available: http://www.aca.org.uk/files/2011_Pension_trends_report-3_January_2012-20111222162316.pdf

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VCS providers' contributions revealed a similar, although slightly wider range of contributions as a proportion of total wages.

In this case non-public sector providers may face a reduced burden relative to public sector providers. The review's modelling suggests their total costs may be reduced by around 2.5-6%. This depends primarily upon the proportion of a provider's costs which are attributable to staff. For capital-intensive acute services, this reduction in total costs is estimated to be around 2.5-3.5%.

Whether private sector and VCS sector providers will provide a higher level of pensions depends on the labour market conditions. During the stakeholder consultation, private providers indicated that they had to offer competitive remuneration packages to attract staff.

A number of factors were mentioned by stakeholders that imply that some non-public sector providers have to offer competitive pension levels. In general, prospective staff, will weigh up remuneration packages, including pensions, along with other factors including for some the desire to work for a not-for-profit provider, when deciding whether or not to take a job.

Location and seniority can also play a part in employee decisions. In general, the closer a private or VCS provider is located to an NHS provider, the more likely it is that they have to offer similar benefits to attract staff.

Staff at higher grades, or with long NHS service records, tend to put greater emphasis on the NHS pension scheme than those at lower grades. Pension benefits appear to matter less for career choices of young people, as a survey indicates that 35% of the 18-34 age group agree that "I'm young enough not to have to worry about this yet".⁵⁵ The Health care Financial Management Association (HFMA) also suggested that some staff want access to a lower contribution scheme so that they have more money in hand now.

Overall the NHS pension scheme appears to be an important factor in attracting employees. For instance, it is associated with a higher ratio of benefits payments to cumulative contributions by members.⁵⁶ The Independent Public Service Pensions Commissions found that final salary pension schemes have a strong retention power on senior staff.

Where the pension is an important factor, non-public sector providers will face the cost of offering equivalent pensions to the NHS scheme, but at higher contribution rates, as in the case of TUPE-eligible staff.

For example, one stakeholder stated that:

⁵⁵ Future Foundation, (2011), Survey commissioned by life assurance company Friends life

⁵⁶ Office of Health Economics, (2009), How fair?

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“The advantage for public sector providers derived from the NHS pension scheme [...takes] two forms: firstly, the adverse impact on non-NHS providers of the cost of matching the scheme, which NHS providers themselves do not bear the full cost of; and second, the extent to which the attractiveness of the scheme creates a barrier to workforce flexibility and transfers. The estimated average magnitude of this is that it adds between 6% and 7% to independent providers’ costs.” (Representative body)

A number of VCS providers also expressed concerns around offering sufficient pension contributions:

“The advantageous terms of the NHS Pension Scheme are not, therefore, available to all staff working within local hospices. Many hospices have to offer differential pension entitlements as they cannot match the generous employer contribution rates for staff not entitled to participate in the NHS Pension scheme. Hospices have expressed concern that they could face potential challenge on equality grounds by offering different pension benefits to different staff undertaking similar roles within the same organisation.” (VCS provider)

Nevertheless we also found instances where non-public sector providers felt they were able to recruit staff without matching the terms of the NHS pension and instances where public sector providers felt disadvantaged because of the cost of the NHS pension scheme. Overall staff recruitment depends on the overall terms and conditions as well as pension entitlements. This is considered in the section of pay and other benefits.

4.3 Conclusions

We have seen evidence to suggest that the cost of taking on staff under TUPE obligations, without those staff being able to remain in the NHS pension scheme, places a significant potential cost burden on non-public sector providers. We have also received submissions that this cost burden deters some providers from tendering for services.

We have also seen evidence that on average private and VCS providers tend to pay lower employer contributions to pension schemes than public providers to the NHS pension scheme. However in tight labour markets private and VCS providers may have to match the NHS pension. In these cases, the inability to access the NHS pension scheme is a disadvantage to non-public sector providers. They must pay more for an equivalent pension.

5.0 Pay and employee benefits

5.1 Issues

Most public sector providers use national collective bargaining to determine the terms and conditions of employment including pay for the staff they employ. Private sector and VCS providers can negotiate their own pay and employee benefits.

We examine whether non-public sector providers have a cost advantage compared to public providers arising from the different ways of determining pay and conditions.

We first provide a description of the framework for setting pay and benefits, we then review the evidence for a cost difference.

5.2 Findings

Pay and employee benefits are negotiated in different ways for public, private and VCS providers. This section provides an overview of the different processes.

Public providers

Employee pay and other benefits (such as annual leave or sick pay) for many NHS providers are negotiated centrally and agreed in the “Agenda for Change (AfC)”. The AfC is negotiated by unions, employers and Government. The AfC pay system comprises:

- basic pay;
- Knowledge and Skills Framework – describing the knowledge and skills that staff in particular posts need to demonstrate;
- High Cost Area supplements (HCAs) – wage premia covering Inner London, Outer London, and London Fringe areas; and
- Recruitment and Retention Premia (RRP).

In general, all public providers offer the same standard of pay and benefits. Pay bands include an uplift for inner, outer and fringe London to account for the higher cost of living. According to the NHS Pay Review Body’s research, local RRP are rarely used. Only 0.11% of FTE staff in the NHS received a

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general RRP in September 2010. The usage of RRP by NHS employers also does not show a distinct geographical pattern.⁵⁷

There are no statutory restraints on FTs or other NHS trusts that prevent them from moving away from the AfC. For example, Southend University Hospitals NHS Foundation Trust has opted out of the AfC.⁵⁸ The South West Pay Terms and Conditions Consortium was set up in June 2012 to re-consider the pay and conditions for NHS staff in south west England. 19 trusts are participants of the consortium, providing a range of services.⁵⁹ However, many NHS trusts and FTs may choose not to re-negotiate pay and conditions. Trusts would require employee consent (as would any private provider in the same circumstances). In practice, employee consent would likely be negotiated by the key unions (such as Unison, RCN, RMN, Unite, GMB and USDAW) and the professional bodies as part of a collective bargaining process. As a result, any move away from the AfC pay bands would incur substantial transaction costs and industrial relations risks.

Within the AfC, the “NHS terms and conditions of service handbook⁶⁰” provides the standard employee benefits such as annual leave, sick leave, unsocial hours payments, etc. The handbook states that within the framework of the AfC, FTs have freedom over a number of employee benefits, within certain limits, as they have:

- the ability to offer alternative packages of benefits of equivalent value to the standard benefits set out in the handbook, among which the employee can make a personal choice (e.g. greater leave entitlements but longer hours);
- the ability to negotiate local arrangements for compensatory benefits such as expenses and subsistence, which differ from those set out in the handbook;
- the ability to award recruitment and retention premia above 30% of basic pay where that is justified, without prior clearance by the NHS Staff Council or strategic health authority;
- the establishment of new team bonus schemes and other incentive schemes;
- the establishment of schemes offering additional non-pay benefits above the minimum specified elsewhere in this agreement; and

⁵⁷ NHS Pay Review Body (2012), “Market-Facing Pay. How Agenda for Change pay can be made more appropriate to local labour markets”

⁵⁸ National Audit Office (2009) *NHS Pay Modernisation in England: Agenda for Change*

⁵⁹ <http://meetingthechallenge.info/>

⁶⁰ NHS Staff Council, (2012), NHS terms and conditions of service handbook, Available http://www.nhsemployers.org/SiteCollectionDocuments/afc_tc_of_service_handbook_fb.pdf

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- accelerated development and progression schemes.

However, foundation trusts generally state that they are not likely to amend employee benefits since they believe that this will disadvantage them compared to neighbouring NHS organisations.

Private and VCS providers

In contrast to public providers, private sector and VCS providers tend to have more flexibility in setting pay and benefits as long as they comply with legal standards. Non-public sector organisations, as with public sector providers, can negotiate wages and employee benefits directly with their staff or through trade unions. The main requirement placed on the terms and conditions arises when staff are transferred from a public to a private or VCS provider under TUPE regulations. The new employer is then required to provide the transferred employee with the same terms and conditions (including pay and benefits) as the ones applying before the transfer took place, except in certain limited circumstances under which changes are permitted.

Research suggests that the systems that private and public providers use to manage pay are relatively similar. Large, multi-site, national organisations are considered to be the closest comparator to the NHS within the private sector. It appears from research by the NHS Pay Review Body, and evidence presented by HM Treasury, NHS employers, and several staff bodies that private sector organisations favour central control over local pay differentiation. They do use centrally-determined forms of geographical differentiation, typically using a limited number (about four) of location-specific pay bands. Overall this may suggest that the pay and benefit negotiations for large private providers may be similar to the public providers.⁶¹

Comparison of pay and conditions

There are no statutory restraints on FTs or other NHS trusts that prevent them from moving away from the AfC differences in pay and conditions. However the different industrial relations context within which public and private sector providers operate may lead to differing levels of pay and benefits and differing speeds with which pay and conditions adjust to market conditions. The Competition Commission, in its ongoing investigation into the private health care market, has noted that the ability of private sector providers to attract clinical staff depends on a number of conditions with the labour market. Their early findings suggest that some providers find this easier than others, and that this can vary between different types of staff.⁶²

⁶¹ NHS Pay Review Body (2012), "Market-Facing Pay. How Agenda for Change pay can be made more appropriate to local labour markets"

⁶² Competition Commission (2013), "Private healthcare market investigation: Annotated issues statement"

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We looked for evidence on the pay differential between providers. However robust information on the pay differential between public and private health care providers is relatively scarce. The Office of National Statistics (ONS) used data from the Annual Survey of Hours and an annual survey of employers to estimate the general public-private sector pay differential,⁶³ while the Institute for Fiscal Studies (IFS)⁶⁴ uses the Labour Force Survey. Both studies use regression analysis to obtain an estimate of the pay differential after controlling for the characteristics of workers in both sectors, including gender, age, occupation, and qualifications. The ONS estimates a that public sector pay is on average 8.2% higher than private sector pay while the IFS estimates the differential at 8.3%. The differential does not account for differences in annual leave but appears to account for differences in sick pay and unsocial hours payments, as the surveys used collect information on both of these latter two elements of pay. However there are a number caveats to these estimates:

- the estimates are not specific to health care but compares public and private sector pay and benefits across a range of sectors;
- the estimates are an average across all types of worker. The estimate for more senior staff is close to zero – evidence from the IFS suggests that the differential is largest at the lowest end of the wage distribution and gradually declines to zero at the upper end;
- there may be geographic variations in the wage differential which these average estimates do not capture;
- the estimate is taken at one point in the business cycle – if private sector pay is more flexible than public sector pay we would expect that relative public sector pay will be higher in a recession and lower in an economic boom.

These caveats suggest that the estimated 8% pay differential should be viewed with caution.

Figure 7 provides an overview of the NHS standard and the legally enforced standard for a number of other benefits. It shows that the NHS standards are more generous than the legal minimum. It should not be construed that private sector providers are offering the legal minimum – the legal minimum is merely a point of comparison.

⁶³ Office for National Statistics (2012), "Estimating Differences in Public and Private Sector Pay – 2012"

⁶⁴ Institute for Fiscal Studies (2012), "The IFS Green Budget. Chapter 5 – Public Sector Pensions and Pay"

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Figure 7. Overview of NHS benefits and legally enforceable benefits

	NHS benefits	Legally enforceable benefits
Hours	37 ½ hour week	EU Working time directive- 48 hour week but employees can opt out
Holiday	27+8, (up to 33+8 after 10 years' service)	20 + 8
Redundancy	1 month pay for each year of service (up to 24 years and after 2 years of service).	1 week's pay for each full year between age 22 and 41; and 1 and half week's pay for each full year at age 41 or older
Minimum wage	£7.24/hr	£6.19 (for employees aged 21 and over)
Sick Pay	Full pay for up to 1 month for each year of service and half pay for up to 2 months for each year of service	£85.85 per week for sick leave of 4+ days
Unsocial hours pay	Up to 25% uplift on hours worked between 7am and 7pm Mon-Friday and on bank holidays.	N/A

Sources: NHS benefits: NHS Staff Council, Terms and conditions of service handbook, Section 10, Section 13, Section 14, Section 16, Annex E, http://www.nhsemployers.org/SiteCollectionDocuments/AfC_tc_of_service_handbook_fb.pdf;

NHS minimum wage: NHS Pay Review Body, Review for 2013, <https://www.wp.dh.gov.uk/publications/files/2012/10/NHSPRB-evidence-v.30.pdf>

EU Working Time Directive: <https://www.gov.uk/maximum-weekly-working-hours>

Statutory holiday: <https://www.gov.uk/holiday-entitlement-rights/entitlement>

Statutory redundancy pay: <https://www.gov.uk/redundant-your-rights/redundancy-pay>

Statutory minimum wage: <https://www.gov.uk/national-minimum-wage-rates>

Statutory sick pay: <https://www.gov.uk/statutory-sick-pay>

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We have looked at potential variations to quantify the potential cost implications of providers offering different conditions. One area where variations in conditions may occur is in offering different levels of annual leave. NHS providers offer between 27 and 33 days leave depending on length of service. The amount of annual leave offered by non public providers depends on local labour market conditions. It is likely that the differential is higher for staff at the lower end of the wage distribution and lower at the upper end of the wage distribution.

As information on actual number of days of leave for private providers is not available, we have made an assumption for the purposes of illustration that non-public providers may offer 4 fewer days of annual leave than public providers. This assumption implies that non-public providers would offer between 23 and 29 days leave depending on the length of NHS service. A cost differential can be derived by considering that a public provider therefore has to pay for an additional 4 out of 252 working days which implies additional costs of 1.6% of total wage costs ($4/252$).

Combining the available evidence on the wage differential and the assumed annual leave differential, the impact on pay and other benefits could be 9.6% ($8\%+1.6\%$).

We have quantified the impact of this on operating costs for different types of services by considering a sample of different providers. In our sample we estimated that the potential cost advantage to a private sector provider ranges from 2.8% to 6.8%.

The main driver of the range of impacts on providers is the extent to which a service is labour-intensive. The smallest impact identified by the modelling was for capital-intensive acute services, such as diagnostics. For these services a non-public sector provider's costs would be around 2.8% lower if it paid lower wages and offered less annual leave. By contrast, integrated physical and mental health services, and social care services are much more labour intensive. For providers of these services, the impact would be 6-7%.

These estimates are derived to illustrate the potential impact of different pay and conditions on overall costs of providers. Since labour costs are a significant component on health care provision it is unsurprising that the potential for differences in pay and conditions could make a significant impact on overall costs. However, we have not compared directly the terms and conditions of private providers relative to public providers. Therefore these numbers are for illustrative purposes only.

One of key factors that influences wage differentials is the ability of providers to attract sufficient staff at lower level of benefits (and similar levels of wages). Any wage differential is likely to depend strongly on the availability of labour.

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In addition, the NHS Pay Review Body takes into account wages in the wider economy, including the private sector, when reviewing pay.⁶⁵

Discussions with stakeholders have suggested that private and VCS providers are aware of the Agenda for Change pay and benefits package and potential staff benchmark against this. Most stakeholders have indicated that they negotiate pay locally and do not have any automatic increases but rather use an annual review process. Some stakeholders have indicated that they need to match Agenda for Change pay and benefits to attract the right staff whereas others have indicated that their packages depend more on local labour market conditions (in particular supply of labour). In addition, VCS providers have indicated that some staff is attracted by the non-profit nature of their organisations. In these cases lower benefits may be acceptable to staff. Anecdotal evidence from a small non-public provider suggests that the labour market conditions require this provider to match public providers' pay and conditions.

Overall we conclude that there is some evidence to suggest there is a wage differential which results in differing labour costs between public and non-public sector providers. However, it is likely that the differential will vary between geographies and over time.

There is a range of evidence that suggests that the wage differential is largely driven by local labour market conditions. Labour market conditions include the availability of staff, quality of staff and availability of alternative options for employees.

For example, the Office of Manpower Economics (OME) (2012) found that variations in private wages between geographies are higher than the variations in public wages. In addition, leaving rates and vacancy rates are lower in those geographies that pay relatively more. The OME (2012) concludes that *"NHS recruitment, retention, motivation, earnings and patient experience across the country is indeed linked to NHS pay relative to local private sector pay"*. However, relative pay is not as important as organisation type, and many other factors influence differences in recruitment. This suggests that labour supply and quality are related to relative pay rates.

Current work by Government bodies

There is some current work to investigate the opportunity for the AfC to provide greater flexibility with respect to wage setting. A move towards more market-facing pay in the NHS was initiated by the Chancellor of the Exchequer in the Autumn 2011 Statement. In December 2012, the NHS Pay Review Body published its report on "Market-Facing Pay: How Agenda for Change pay can be made more appropriate to local labour markets". The

⁶⁵ NHS Pay Review Body, (2013), 27th report.

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report concludes that the AfC is the appropriate vehicle for moving towards a more market-facing pay system and in particular recommends using the HAC and RRP adjustments to achieve this.

5.3 Conclusion

Pay and conditions for public sector providers are negotiated centrally under agreements including Agenda for Change. Public providers are – in principle – free to depart from these terms subject to employee agreement, although in practice they do not.

Private sector and VCS providers have greater flexibility in determining terms and conditions for employees, but recognise that in order to attract equivalent quality staff, in some labour markets, they may need to benchmark their offer against the terms available in the public sector. The characteristics of local labour markets will determine whether it is public or non-public providers who benefit from existing arrangements. The extent of any benefit depends on how flexibly pay and benefits adjust over time. We conclude that pay and conditions (excluding pensions) are unlikely to be a fair playing field issue given the scope public providers have to alter their pay arrangements.

6.0 Indemnities (clinical negligence)

6.1 Issues

The NHS Litigation Authority's (NHSLA) Clinical Negligence Scheme for Trusts (CNST) is currently open to all NHS bodies. Private sector and VCS providers of NHS funded care generally must use other methods of indemnifying against their clinical negligence risks unless they are indemnified through their commissioner's membership. Members' contributions to the scheme are calculated by considering various factors including the type of Trust, clinical specialities and the number of "whole time equivalent" (WTE) clinical staff employed.

The following sections first provide a definition of the factor, then set out the available evidence before concluding.

6.2 Findings

All NHS funded providers are required by contract to make appropriate indemnity arrangements for clinical negligence. The Clinical Negligence Scheme for Trusts (CNST) is one way of indemnifying against clinical negligence claims. Private insurance is also available.⁶⁶

The CNST is a risk-pooling pay-as-you-go scheme set up in 1996 and managed by the NHS Litigation Authority. The NHSLA is a special health authority, part of the NHS, responsible for managing negligence claims against the NHS in England on behalf of its members. The CNST scheme has covered clinical negligence liabilities since April 1996. The aim is for the total costs of the scheme to be met through members' contributions. That is, the total contributions received by NHSLA should equal the expected costs of operating the scheme (both paying claims and claims handling).

CNST is currently open to all NHS bodies (commissioners and providers). Non-NHS bodies, on the other hand, must usually use other methods of indemnifying against their clinical negligence risks. However, DH has developed arrangements whereby non-NHS bodies can gain indemnity coverage through some of their contracts with commissioners, thereby benefitting from the commissioner's own membership of CNST. These "back-to-back indemnities" are used in some contracts for NHS-funded service provision by non-NHS bodies, but not all. However, the NHSLA has told us that these arrangements are not coherent, transparent or fair. They are also dependent upon existing PCT legal entities, which will cease to exist after the transition to CCGs. In terms of service provision, these indemnity arrangements are widely used by non-NHS bodies delivering acute services,

⁶⁶ The NHS strongly encourages providers to insure against clinical negligence claims, although it is not a statutory requirement. Source: The Review's meeting with NHS LA, 2012.

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i.e. through Any Qualified Provider (AQP). They are not sanctioned for use elsewhere.

The total projected claims against CNST members are estimated each year to determine the size of the risk pool (£950m for 2012-13). Providers' contributions to the risk pool are calculated by considering various factors including the type of trust, clinical specialities and the number of "whole-time equivalent" (WTE) clinical staff employed.⁶⁷ Commissioners' CNST contributions reflect the cost associated with the non-NHS bodies that they indemnify through contracts for NHS services.⁶⁸ There is currently little transparency around how this is calculated, as the NHSLA uses historic data to estimate the level of activity and risk of the non-public sector provider.

In order to assess whether CNST distorts the playing field, we look at differential access to CNST and we look at whether payments into CNST reflect the risks associated with the provider.

NHS bodies' choice of CNST over private alternatives

Non-NHS bodies have to make appropriate arrangements for indemnity cover unless they are a member of CNST through the contract with their commissioners. In practice, this means private insurance. While NHS trusts are required to use CNST, NHS foundation trusts can choose CNST or private insurance, and overwhelmingly have chosen CNST. Currently all NHS providers are members of CNST and no provider has ever left the scheme.⁶⁹

One reason that few existing members leave CNST is the cost of exit. Exit costs arise because of the difference between a risk pool and insurance. A considerable period of time may elapse between an incident of clinical negligence (when the claim is incurred) and the resulting compensation (when the claim is paid). Insurance covers liability for claims when a claim is incurred. A risk pool covers liability for claims when a claim is paid. Hence, the exit costs that a provider would face if it leaves CNST are as follows:⁷⁰

- liability for claims incurred relating to incidents prior to the trust leaving (whether reported or not), and that have not been settled within thirty days of the trust's exist from CNST, would transfer to the trust. They may not be covered by an insurer and therefore the trust may need to find its own funding for such claims.; and

⁶⁷ Source: <http://www.nhsla.com/Pages/Home.aspx>

⁶⁸ A further distortion here is that created by the fact that private or voluntary and charity sector providers who have indirect access to CNST effectively get free "run off" cover. That is, when the contract ends, any liabilities remain with the commissioner. For direct members of CNST on the other hand, they must take their claims with them.

⁶⁹ However, some providers are thinking of leaving. For example, insurance broker RK Harrison claims to be in "active discussions" with 72 NHS trusts over leaving CNST. Source:

<http://www.hsj.co.uk/news/legal/quarter-of-trusts-consider-negligence-scheme-exit/5043228.article>

⁷⁰ Marsh Risk Consulting. Comparison of the NHS Litigation Authority and the commercial insurance market: Briefing Paper.

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- a lump sum to cover the value of any outstanding payment protection orders must be paid by the trust to the NHSLA on leaving.

An added uncertainty is related to the fact that trusts currently have to provide 12 months' notice to leave the scheme, although this is being reduced to seven months.⁷¹ Trusts are currently notified of the contribution for the upcoming financial year four to six months before the financial year begins. Unless it can obtain an insurance quote that remains valid for 12 months, a trust would know neither its true costs of leaving the scheme, nor the amount of its upcoming contributions to CNST, upon handing in its notice.

Although it may be considered that there are currently significant impact costs and medium term risks associated with leaving CNST, these are not prohibitive. In fact, one trust is planning to leave as of 2013.⁷² Lancashire Care NHS Foundation Trust has handed in its 12 month notice to NHSLA after commenting that its premiums were unfairly high, effectively subsidising other, more risky providers who, they feel, contribute too little to the risk pool.

How does CNST compare with private schemes?

In order to assess whether there is a clear advantage of CNST over open market alternatives, we must look at what these alternatives are and how they compare to CNST. Figure 8 below provides a comparison of the main principles of CNST and the corresponding typical private alternative. It illustrates that an important part of CNST's strength is the cover, comprehensiveness and support offered to members. In comparison, private insurance offers more flexibility and a contractual duty for insurers to pay out on claims which fall within the scope of the contract. A direct comparison is difficult because private insurers tend not to reveal their quotes in order to preserve their competitive edge but Figure 8 illustrates some of the differences. Evidence collected through stakeholder engagement suggests that for some providers the benefits of being a member of CNST significantly outweigh the costs. For example, one provider estimates its annual cost of using an alternative to CNST would be £400k, while its annual CNST contributions are only £60k. However, given the large variation in amounts paid into CNST, this may reflect payments that are too low relative to the level of risk presented.

⁷¹ Source: Marsh Risk Consulting (2012). Comparison of the NHS Litigation Authority and the commercial insurance market: Briefing Paper

⁷² Source: <http://www.hsj.co.uk/news/legal/exclusive-mental-health-ft-is-first-to-quit-clinical-negligence-scheme/5043471.article>

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Figure 8: Comparing CNST to private alternatives

	CNST	Private Insurance
Duty to pay claims	Discretionary.	Contractual duty to pay claims which fall within the scope of the contract
Cover comprehensiveness	There is no limit on indemnity, clinical specialities covered, or on type of clinical practice. Level of cover not flexible at Trust level.	Policies may be subject to a financial limit. Insurers can also limit clinical specialities covered and may limit the types of work covered. But greater flexibility: Trusts can seek a policy that's consistent with their attitude to risk.
Excess	No excess.	Deductibles or excess levels usually apply. Typically £100,000 for general claims and £250,000 for maternity claims. May lead to some providers effectively self-insuring in relation to a significant amount of claims.
Cover for individual practitioners	Not required.	May be necessary. This would make individual practitioners liable for damages. Individual Trusts are likely to be invoiced for this. Depends on cover as agreed between provider and insurer.
Premiums	Measured relative to the risk pool. No tax on contributions.	Measured based on the provider's true risk profile. This could be lower than CNST if insurers can settle claims for a lower overall value, and also gain investment income on pre-claim premiums. However, 6% insurance premium tax levied may offset this. Insurers will also charge for profit margin and for the cost of capital.

Source: "NHS LA Meeting with NHS Trusts" 2012 and Marsh Risk Consulting. Comparison of the NHS Litigation Authority and the commercial insurance market: Briefing Paper.

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Stakeholder evidence

One social enterprise stated that insurance is beginning to create a bigger problem than it has previously. This is due to the fact that fewer insurance companies are offering what they need and where it is available, the cost of the cover is rising fast (420% increase quoted on renewal with no significant claims). This is believed to be due to the “litigation culture” that is developing in the UK. If they had the opportunity to be part of the CNST scheme, they would.

A charity explained that where they provide services which are not covered by CNST indirectly through their contract, they do not go to the private market to find insurance cover. Instead, they require consultants they hire to get insurance for themselves. This has a knock-on impact on the price that they need to pay for consultants, but they are unable to identify the magnitude of this increase as it is determined during wider negotiations around consultants' employment packages.

In addition, in the call for evidence responses, 16% highlighted insurance as a factor, making it the 14th most cited factor.

Several non-public sector providers identified the difficulty with obtaining adequate private insurance and their desire to gain access to CNST. However there were also concerns expressed by members of CNST as to whether the contributions reflect risks appropriately.

CNST contributions and risk adjustment

In 2011-12, the average CNST premium paid by trusts and FTs was £3.5m.⁷³ On average, providers' CNST contributions amount to 1.2% of total operating costs for FTs and 1.4% for trusts.⁷⁴ However, there is significant variation between providers. In particular, 10 providers made a CNST contribution exceeding £10m, while almost 40% of providers contributed less than £1m.⁷⁵ This variation would only be of concern if it did not reflect genuine differences in risks across providers, i.e. if risk adjusted CNST contributions consistently differed between providers.

In the call for evidence responses, one provider, an NHS community trust, commented: “[...] there are probably issues around the sophistication and coverage of NHSLA insurance. Does it reflect risk and limit some providers?” This suggests that providers recognise that CNST contributions could reflect

⁷³ Source: NHS Litigation Authority, Factsheet 5, <http://www.nhsla.com/Pages/Publications.aspx?library=currentactivity%7cfactsheets%7cfactsheet5trustandhealthauthorityclaimsdata>

⁷⁴ Source: 2010-11 data from DH, "NHS (England) Summarised Accounts 2010-2011", Page C27; and Monitor, "NHS Foundation Trusts: Consolidated Accounts 2011/12", Note 6.1

⁷⁵ Source: NHS Litigation Authority, Factsheet 5, <http://www.nhsla.com/Pages/Publications.aspx?library=currentactivity%7cfactsheets%7cfactsheet5trustandhealthauthorityclaimsdata>

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risk more accurately and that this would make the scheme more sophisticated.

The main driver of CNST contributions is WTE staff numbers. NHSLA acknowledges that this is not the fairest way to calculate contributions. This is evident in NHSLA's decision to change the way that contributions are calculated from 2013 onwards. As of 2013, contributions will be more activity based, with more emphasis on incentives for providers. In particular, providers will face lower premiums if actual damages are lower than expected. This should decrease the risk burden of the CNST scheme as whole, make contributions fairer by reflecting providers' risks more accurately, and also smooth individual providers' costs over time.

Limited evidence of impact of provision

Through stakeholder engagement we can see that while indemnities are an important and significant issue for some providers, no providers claimed to have been forced to reconsider expansion plans for an existing service or to provide a new service based purely on their differential indemnity arrangements. In addition, in the call for evidence, every provider who raised indemnity as an issue also raised at least four other issues. This would tend to suggest that the current indemnities regime is not a first-order factor of importance to providers.⁷⁶

Current work – NHSLA is opening up CNST to non-NHS bodies and improving the way that contributions are calculated

The Department of Health and NHSLA have been developing plans to do two things:

1. open up CNST to providers who are currently unable to access the scheme directly; and
2. improve the way that contributions are calculated so that they better reflect risk.

First, the NHSLA is seeking to extend CNST to enable all providers of NHS health care to be direct members.⁷⁷ In particular, NHSLA plan to provide indemnity for all non-NHS bodies providing NHS care, excluding services under primary care contracting arrangements. If there is any distortion this would help to remove it by ensuring non-NHS bodies and NHS bodies are treated equally. In addition, NHSLA states that the scheme needs to be clear and simple for providers to understand, while simple and effective exit

⁷⁶ Source: Monitor call for evidence responses.

⁷⁷ This includes Community Interest Companies, companies, partnerships, unincorporated associations, Social Enterprises and sub-contractors. The only excluded parties will be providers delivering NHS care outside England.

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arrangements also need to be introduced.⁷⁸ The DH has laid regulations before Parliament on 19th February, coming into force of 1st April, that support this aim.⁷⁹

Second, NHSLA is seeking to improve the way that contributions are calculated from 2012/13 to make sure that they are consistent with providers' risks, while remaining a 'pay as you go' scheme. Their goal is to smooth providers' costs over time. They aim to do this by jointly minimising the gaps between payments into and out from the CNST over multiple time periods. This would also produce a consistent risk pool over time for the NHS LA. Also, contributions would be more activity based, and more incentive based such that there will be heavier discounts (premiums) applied if claims are lower (higher) than expected.⁸⁰ All CNST members, including non-NHS bodies, would have their contributions calculated in the same way. Any differences between existing members and new members would therefore only reflect differences in true risk associated with the provider.

Outstanding issues

Opening up CNST to non-NHS bodies has prompted some special considerations for the NHSLA around particular outstanding issues, and the development of potential solutions.

One outstanding issue is the current transition costs that a provider would face if they were to leave CNST.

To reflect the outstanding issues, the NHSLA are considering appropriate solutions that could be incorporated into the new scheme. This includes the possibility of a shorter notice period (currently 12 months) as well as quicker and easier entry to the scheme to improve its flexibility and reflect the fact that service contracts do not run neatly April – March or indeed for a full financial year.⁸¹

The new notice period is expected to be around 7 months⁸² providing run-off cover⁸³ for providers exiting the scheme as well as other exit arrangements to protect patients.

⁷⁸ Source: NHS LA meeting with DH Expert Group, 23 November 2012

⁷⁹ Source: The National Health Service Litigation Authority (Establishment and Constitution) Amendment Order 2013

⁸⁰ Source: "NHS LA Meeting with NHS Trusts" 2012.

⁸¹ Source: "NHS LA Meeting with NHS Trusts" 2012.

⁸² Source: NHS Indemnity Expert Group, DH meeting, 23 November 2012.

⁸³ Run-off cover represents incremental coverage that continues to indemnify providers for a specified period after their policy expires – i.e. after they have left the scheme.

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6.3 Conclusion

We have found that there is differential access to CNST. The evidence also suggests that non-CNST members face a cost disadvantage relative to CNST members as a result of their lack of access to CNST.

Although we have not found clear evidence that contributions are not reflective of risk, there appears to be an acceptance that there is a need to move towards an alternative method of calculating contributions that better reflects risk.

We have not seen clear evidence that the lack of access to CNST has hindered provision. However we note that opening up access to non-NHS bodies will address the cost disadvantage that non-NHS bodies currently face.

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7.0 Payment timings

7.1 Issues

In 2010-11, commissioners were responsible for purchasing health care for resident populations at a total cost of £86bn⁸⁴. Commissioners contract with providers to provide NHS-funded health care. Under the terms of these contracts, providers receive payment from the commissioner.

In theory, all providers should be paid according to the terms of their contracts. The payment terms may vary from contract to contract, and provider to provider. For example, there is some variation within NHS standard contracts⁸⁵. Where the expected annual value of an NHS standard contract is agreed beforehand, small providers⁸⁶ will be paid on a quarterly basis, whereas other providers will be paid on a monthly basis. Where the expected annual value of an NHS standard contract is not agreed beforehand, providers must issue an invoice to each commissioner at the end of each month, and this must be settled within 10 operational days.

NHS standard contracts can be drawn up between commissioners and any providers. In practice, we have been informed by a private sector provider that only half of its NHS service provision is via standard contracts.

A number of issues around payment timings were identified in response to the initial call for evidence, the discussion paper and through the course of stakeholder interviews. Certain stakeholders raised concerns about the speed of payment. For example, one private provider told us the following:

“Trusts are slow to pay despite performance targets relating to payment within 30 days. Of the five pieces of work we have done, none have been paid within 30 days; average is 3 months. So access to working capital is important.” (Private sector provider)

Particular concerns were raised in relation to small providers, as illustrated by the following response in response to our initial call for evidence:

“Unfair disadvantages to small business arise because PCTs pay providers late for services, causing cash flow problems.” (Representative body)

Some providers may be at a cost disadvantage relative to others if they suffer delayed or uncertain timings of payments. At the extreme, these issues could impact upon the sustainability of service delivery by a particular

⁸⁴ Department of Health Annual Report, 2010-11.

⁸⁵ NHS Standard Contract 2013/14 – Service Conditions

⁸⁶ A “small provider” in an NHS standard contract is defined as an organisation with 50 or fewer full time equivalent employees and an aggregate income in respect of services provided to NHS commissioners for the relevant contract year that is not expected to exceed £130,000.

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provider. For example, in response to the initial request for evidence, one stakeholder put forward the following view:

The payment systems used by councils often appear to be designed to conserve council cash by delaying payments to providers. This can cause serious cash-flow problems for very small organisations and in some cases these problems have triggered bankruptcy. (VCS)

This section sets out:

- background to payment codes, requirements and contract enforcement procedures that are relevant to payment timing;
- evidence around variation in payment timings across provider type;
- evidence around the impact of slower/uncertain payments on provider costs;
- evidence on the impact of slow/uncertain payments on provider decision making; and
- conclusions.

7.2 Findings

Better Payment Practice Code and Prompt Payment Code

Under the Better Payment Practice Code (BPPC), all NHS bodies must aim to pay all invoices within 30 days, or within the agreed contract terms. To meet compliance targets at least 95% of invoices must be paid within these limits.⁸⁷

These requirements apply to all NHS bodies, including NHS trusts and foundation trusts in their treatment of suppliers.

There has been pressure to improve the payment of suppliers, beyond the targets set in the BPPC. For example, in a letter to NHS Chief Executives in October 2008, Sir David Nicholson stated:

“The NHS has already improved its supplier payment performance against the current 30-day target. However, I am now asking you to examine and review existing payment practices and payment performance – and to move as closely as possible to the ten-day payment commitment that has been set for Government Departments wherever practical.”⁸⁸

⁸⁷ Source: Primary Care Trusts Manual for Accounts 2011/12, 7 – Accounts Completion Guidance, Note 8.1

⁸⁸ Letter from Sir David Nicholson, DH Gateway Reference 10753

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In a follow-up letter in May 2009 [DH Gateway Reference 11877], Sir David Nicholson recommended adherence to the Prompt Payment Code (PPC). This letter pointed out that the code “does not include any targets but is a series of principles that we would expect all NHS organisations to follow during the normal course of business”.

The Prompt Payment Code is a payment initiative developed by Government with The Institute of Credit Management (ICM) to “tackle the crucial issue of late payment and help small businesses.” Signatories to the Code undertake to: pay suppliers on time; give clear guidance to suppliers; and encourage good practice.

Reporting requirement and enforcement

The NHS Manual for Accounts requires commissioners (and indeed all NHS bodies) to report on their performance with respect to payment timings. In particular:

1. Section 2.33 requires NHS bodies to provide a “narrative summary of” and “quantitative evidence of compliance with” the BPPC.
2. Section 2.34 requires bodies to disclose whether or not they have signed up to the Prompt Payments Code.⁸⁹

There is also provision in legislation for suppliers to demand payments which are due from commissioners, and to seek compensation in the event of late payment. The Late Payment of Commercial Debts (Interest) Act 1998 provides protection for suppliers. In particular: from 7 August 2002 all suppliers have been able to claim interest (at the Bank of England base rate +8%) on debts incurred under contracts agreed after that date; and can also claim a fixed sum of compensation for debt recovery costs. Therefore providers should not be disadvantaged by late payment by commissioners. However, apart from Foundation Trusts, NHS bodies cannot claim compensation from one another for late payment and are therefore not protected by this legislation.

Variation in payment timings across providers

Variation in payment timings across providers can take two forms:

- a difference in the terms that providers agree with their commissioner e.g. provider A is contractually entitled to payment within 14 days whereas provider B is contractually entitled to payment within 30 days; or

⁸⁹ NHS Manual for Accounts

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- a difference in whether commissioners honour the contractual agreements e.g. providers A and B are both contractually entitled to payment within 14 days, and provider A is paid within 14 days but provider B is not.

Commissioners are required to report their performance in paying NHS and non-NHS invoices. This evidence shows that non-NHS invoices are paid slightly more promptly on average, but the highest-value NHS invoices are paid more promptly than any others. This suggests that payment timings do not *systematically* favour particular types of providers, but some providers (whether public, private or VCS) are likely to be advantaged.

Performance is reported in relation to the two payment codes set out above:

- Better Payment Practice Code; and
- Prompt Payment Code.

*Better Payment Practice Code*⁹⁰

Under the Better Payment Practice Code, PCTs must aim to pay all invoices within 30 days (or agreed contract terms), and must report their performance against this target in their annual report.

Analysis of PCTs' performance shows that commissioners pay non-NHS invoices more promptly than NHS invoices:

- Around half of all PCTs (76 out of 151) paid over 95% of their invoices to non-NHS suppliers within 30 days.
- Only around one third of PCTs (51 out of 151) achieved the same 95% success rate when paying their NHS suppliers.
- Across all PCTs, 93.2% of non-NHS invoices and 87.8% of NHS invoices were paid within 30 days.

These findings suggest that any disadvantage from slow payments is likely to be suffered by NHS providers. However, the performance data also shows that commissioners pay their higher-value NHS invoices more promptly than any others:

- The majority of PCTs (129 out of 151) paid over 95% of their NHS invoices by value within 30 days. Across all PCTs, 97.8% of NHS invoices by value were paid within 30 days.

⁹⁰ NHS Summarised Accounts 2010-11

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- The weaker performance on the number of invoices paid within 30 days (described above) indicates that higher-value invoices are paid more quickly.
- For non-NHS invoices, the performance of PCTs is similar by number and by value, indicating that larger invoices are not paid more promptly.

[Source: NHS Summarised Accounts 2010-11]

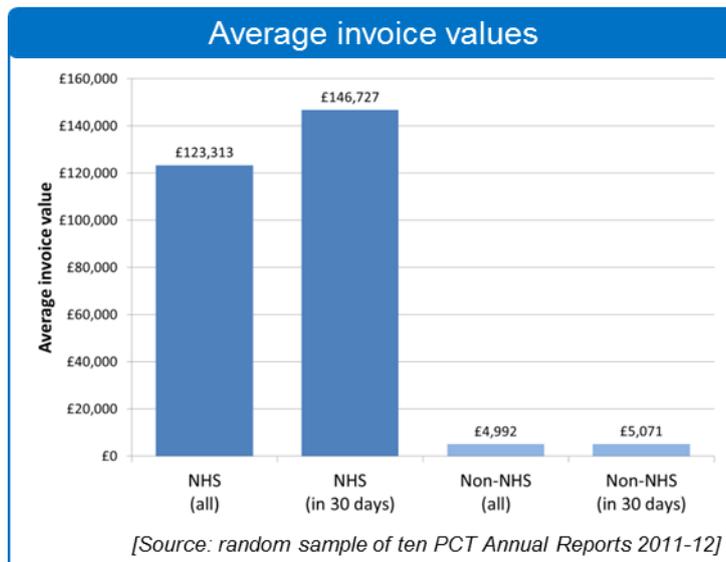
We have also tested these findings by looking at a random sample of ten PCT Annual Reports. This analysis shows that:

- The average NHS invoice value is around £120,000, compared with around £5,000 for non-NHS invoices.
- The average value of NHS invoices paid by individual PCTs ranged from £83,000 to £179,000 with an average of £123,000. The average value of non-NHS invoices ranged from £3,300 to £9,000 with an average of £5,000.
- The average value of those invoices paid within 30 days was £147,000 and £5,100 for NHS and non-NHS invoices respectively.
- Since the average value of within-target NHS invoices (£147,000) is greater than the average of all NHS invoices (£120,000), this supports the finding above that large NHS invoices are paid more promptly than other NHS invoices.
- Since the average value of within-target non-NHS invoices (£5,000) is similar to the average of all non-NHS invoices (£5,100), this supports the finding that large non-NHS invoices are not treated differently from smaller non-NHS invoices, and that they are not paid as promptly as large NHS invoices.⁹¹

⁹¹ Review analysis based on a random sample of ten PCT Annual Reports 2011-12

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Figure 9. Average NHS and non-NHS invoice values



In addition to these findings in relation to NHS and non-NHS invoices, our analysis also suggests that some commissioners are much more prompt than others in paying invoices. In particular, across our random sample of ten PCTs, the proportion of invoices being paid within 30 days varies widely:

- One PCT paid only 49.2% of its NHS invoices within 30 days, compared with 98.6% achieved by the highest-performing PCT.
- Payment of non-NHS invoices also varies, with the poorest-performing PCT in our sample paying 81.3% of its invoices within 30 days, compared with 99.4% achieved by another PCT.⁹²

These results are reproduced in Figure 10 below. They indicate that even though *on average* there may be relatively little variation in payment performance, at the level of individual commissioners the variation is more pronounced. This may lead to a disadvantage for some provider if either (a) they are paid by a “slow-paying” commissioner but compete with another provider paid by a “fast-paying” commissioner; or (b) the commissioner’s performance is better for some invoices than others.

⁹² Source: random sample of ten PCT Annual Reports 2011-12

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Figure 10. Variation in payment performance across PCTs

Variation in payment performance across PCTs			
	High	Average	Low
NHS invoices paid within 30 days (number)	98.6%	84.8%	49.2%
NHS invoices paid within 30 days (value)	99.8%	98.0%	93.9%
Non-NHS invoices paid within 30 days (number)	99.4%	93.3%	81.3%
Non-NHS invoices paid within 30 days (value)	99.5%	94.3%	83.7%

[Source: random sample of ten PCT Annual Reports 2011-12]

Impact of payment timing on provider costs

A provider's working capital requirements are determined – in part – by the speed with which their commissioners pay for services. If a provider faced slow or uncertain payments, it would need to hold additional working capital to insure itself against the possibility of being paid later rather than sooner.

These requirements are likely to be more onerous for providers which:

- operate on smaller margins (and will therefore be less able to finance additional working capital from their own finances); and/or
- have weaker access to capital or higher capital costs (which may be a particular issue for new providers without credit history).

In either of the above cases – which may be related and likely to occur in combination – higher working capital requirements may have a disproportionate impact. For example, new providers require capital to set up and to operate until they start to receive income from their commissioners, and will benefit from receiving this payment sooner rather than later. And any organisation which has less free cash, or finds it more costly to borrow, will be disproportionately impacted by higher working capital costs.

Payment timings do vary between commissioners, sometimes substantially. This means that some payments will be slow, and providers receiving those payments may be disadvantaged.

Stakeholders informed us that slow payment can be a particularly important issue for small providers. Smaller providers may be disproportionately affected either because:

- they are more likely to be paid less promptly; and/or
- the cost of managing late payments (either by insuring in advance, or managing cash flow after the event) are greater for smaller providers.

The analysis provided above suggests some evidence of the former (larger invoices tend to be paid more quickly). The latter depends on smaller

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providers having a weaker financial position, and possibly in particular a weaker ability to access working capital.

A number of responses to Monitor's initial call for evidence highlight the impact on smaller organisations of delays in payments to providers. These submissions suggest that even if the timing of payments to providers is generally good, there may be an issue in particular circumstances.

"Reimbursement for medicines and fees from the NHS Business Services Agency takes three months. Payments from PCTs for locally enhanced services are variable but usually take in excess of thirty days. Both payment systems lack transparency. [...] This lag in payment has huge implications on the business model for community pharmacy. Owners have to finance cash flow for longer periods than would be generally expected and have to pay commercial interest rates on borrowing for capital expenditure adding to costs." (Private sector provider)

Set against the evidence from commissioners' annual reports presented above, this suggests that delayed payment may be (1) more of an issue for particular providers and not widespread; and/or (2) more prevalent and more problematic for smaller providers.

The impact of payment timings is likely to be a relatively small increment to a provider's working capital requirements.

7.3 Conclusions

Payment timing has been an issue of importance for many stakeholders, as illustrated by the fact that 13% of respondents ranked it as one of the most important subject their organisation faces in their response to the discussion paper.

Stakeholder feedback indicates a general perception that non-public sector providers face delays in payment for services delivered, as compared to public sector providers. Our analysis shows that large NHS invoices tend to be paid slightly more promptly than other NHS invoices and smaller non-NHS invoices. However we did not find evidence that there were sufficient differences in payment timings to create a material distortion between providers.

8.0 Information Technology

8.1 Issues

In order to effectively provide NHS funded health care, providers' systems have to be integrated with the NHS Information Technology (IT) system. IT integration allows effective and secure information flows that are necessary for the operations of the health care sector, such as sharing confidential patient records and appointment booking. The system includes many nationwide applications such as Summary Care Record, Choose & Book, Electronic Prescription Service, GP2GP, Quality Management & Analysis System, Secondary Uses Service, and NHS Number.

The high speed connection that links health care providers is currently called "N3". It allows the following systems to be delivered:

- Choose and book
- Electronic Prescription Service
- Summary Care Records
- Picture Archiving and Communications Systems. (transfer of digital images such as x-rays and scans).⁹³

Stakeholders have raised concerns about the onerous checks and assurance process they must undergo to access the NHS IT system. This is illustrated by the following stakeholder quote, received in the response to the initial call for evidence,

"The costs associated with new IT infrastructure, new patient information systems, and with meeting the requirements of connectivity to the NHS IT system are significant and often disproportionate for small organisations such as hospices." (VCS provider)

In addition to direct financial costs associated with IT implementation, there are also concerns around the indirect costs (such as security checks and delays to access) that providers have to incur.

Overall, however, less than 5% of respondents ranked IT as the most important issue in the discussion paper. Stakeholders focused less on the IT costs and any differential between providers and more on the question of whether the NHS IT systems are fit for purpose.

⁹³ Connecting for Health, Background to N3 - The NHS National Network, Available <http://www.connectingforhealth.nhs.uk/systemsandservices/n3/background>

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“The fact that the IT asset is not owned by the social enterprise limits their ability to invest in future IT solutions which are so critical to improving care. NHS providers on the other hand own their IT assets and are able to access funding to invest in this.”

“For example where a community provider wishes for instance to work with TPP in order to develop a different mobile solution for SystemOne, they are unable to gain access to TPP through the CfH contract. NHS organisations appear to have easier access via SHAs to the contract, so can rely on this influence.”

“We have to maintain the PCTs IM&T [Information Management and Technology] infrastructure which is not fit for purpose...An IS [Independent Sector] provider would simply operate with the most effective IM&T solution.” (VCS provider)

While there may be legitimate concerns around whether the current NHS IT system is optimal, this does not directly disadvantage one provider relative to another.

This section sets out:

- evidence on the direct IT costs faced by providers;
- evidence on the indirect IT costs faced by providers; and
- conclusions.

8.2 Findings

Evidence on direct costs

This section considers the extent to which non-public sector providers have to incur direct IT costs that public providers are not faced with.

As described above, all health care providers in the UK wishing to provide NHS funded care are required to integrate with the NHS network and applications. In practice, this relies on N3, the NHS national broadband network linking hospitals, medical centres and GPs. Access is via an N3 connection.

An N3 connection can be set up on a range of broadband packages of variable broadband capacity. Since December 2012, public and private sector providers have been subject to the same minimum connection standards and therefore also incur the same minimum costs. However, there is a difference in IT costs between centrally funded providers and “self-funding” providers. Centrally funded providers are determined by the “N3

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National Allocation Algorithm 2007-2008” (latest version). The allocation algorithm states that:

- **Centrally funded providers are:** acute trusts, ambulance trusts, care trusts, community trusts, GP branch practices, GP practices, mental health trusts, NHS diagnostic and treatment centres, NHS out of hours providers, PCT offices and sites, and Special Health Authorities;
- **Central funding is not available for:** dental practices, independent sector hospitals, independent sector and charity hospices, independent sector treatment centres, nursing homes, PCT managed NHS hospices.

This suggests that non-public sector providers and some public providers have to fund their own IT costs whereas IT costs are funded by Connecting for Health for other providers. However, the cost of IT systems is relatively small. DH told us that IT costs associated with connecting to the NHS system (through N3) may be as little as £15 per month or up to around £1000+ per month, depending on the requirements of the individual provider.⁹⁴ Even at the higher end of this range, these costs represent just 0.01% of total operating expenses for a provider with costs of £100m, or 0.2% for a provider with operating expenses of £5m. And most small providers would not need the higher-end connection, so their costs would be much lower. This suggests that there is no significant cost disadvantage in relation to the costs of the N3 connection.

Evidence on indirect costs

We also considered the extent to which non-public sector providers have to incur indirect costs (such as security checks) that public providers are not faced with.

The main process that needs to be completed to obtain a N3 connection is the “Information Governance assurance process” which is aimed at ensuring that data protection and security are guaranteed. The process is important as it ensures that sensitive health care records are stored safely and the risk of unauthorised access to such documents is minimised. All providers have to go through this process although most public providers have already completed this process. The process is onerous as it requires a self-assessment using the Information Governance Toolkit (IGT) and providers must then go through further tests of their systems. For example, providers have to ensure staff are trained in data security, equipment is leak-proof (no printers, USB ports, etc.) and remote access is appropriately restricted. This process is time-consuming and requires in-house technical capabilities in addition to those required to complete the baseline self-assessment process.

⁹⁴ Meeting with DH, 18/09/12.

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This can result in set-up costs and could discourage entry of small providers with little in-house IT expertise.

However, the costs and time involved in completing this process are mostly one-off and are likely to make up a small proportion of total costs. It is also clear that an Information and Governance assurance process that safeguards patient data is a necessary requirement..

8.3 Conclusions

A number of stakeholders raised issues around IT.

We conclude that while there may be some financial and non financial advantages to incumbent and public sector providers, we have not found them to be substantial. Specifically, we find that:

- most public sector providers have their direct IT costs funded centrally while non-public sector providers have to fund their own IT costs;
- direct IT costs do not make up a substantial proportion of total costs for most providers; and
- the time and costs associated with the Information and Governance assurance process are onerous for a small provider. However, some level of such checks is necessary to ensure the safety and integrity of patient data.

9.0 Education and training

9.1 Issues

The NHS relies upon well trained medical staff to deliver high quality patient care. New generations of staff require a solid programme of medical education. Around 4.5% of the Department of Health's total budget is spent on education and training, through the Multi-Professional Education and Training (MPET) budget. This is currently allocated to Strategic Health Authorities who then allocate funds to providers. The distribution of funding is changing from April 2013 when Health Education England will be responsible for distributing funding through new Local Education and Training Boards (LETB). Non-medical education and training and continuing professional development was not often raised by stakeholders and so has not been analysed in this section.

Education and training was raised in a number of submissions to the review and nearly a quarter of respondents to the discussion paper rated it as one of the most important factors facing their organisation that the review could consider. A number of concerns have been raised. One of the main concerns expressed is that non-public sector providers do not pay for the formal education and training of their staff, which is funded by the public sector.⁹⁵ A second concern is that some providers may be over or undercompensated for the education and training activities they undertake. A third, and related, concern is that some providers feel they are unable to gain access to trainees, and can suffer as a result, finding it more difficult to attract senior staff or developing a positive reputation with patients. A fourth concern is that the quality of medical education is compromised by the fragmentation of training and the provision of care.

We set out below the arrangements for funding education and training and assess the differential impact on providers. The evidence indicates that the funding system is not transparent and does not appear to be cost reflective. On balance the beneficiaries appear to be large teaching hospitals rather than those organisations that deliver training and those organisations that don't. Changes to the system of funding, in particular the introduction a tariff method for funding education and training from April 2013, are aimed at addressing such imbalances.

⁹⁵ Providers do of course fund Continuing Professional Development (CPD)

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9.2 Findings

The current funding system

In 2011-12, the central investment in education and training through MPET was £4.9 billion (approximately 4.5% of the Department of Health's total expenditure.)⁹⁶

The MPET budget is currently allocated by the Department of Health to SHAs. The budget is made available through three funding streams: the Service Increment for Teaching (SIFT), the Medical and Dental Education Levy (MADEL), and Non-Medical Education and Training (NMET).⁹⁷

- SIFT is used to fund undergraduate medical and dental student placements in hospitals and GP surgeries. It is split into two payments – approximately 25% is to fund clinical placements and 75% is to fund facilities fees. Both payments are typically based on historic allocations, plus an annual uplift when felt appropriate. It represents around 20% of the MPET budget. Most of it is given to service providers.
- MADEL is used to fund a proportion of junior doctors' salaries. It represents around 40% of the MPET budget. Most of it is given to service providers.
- NMET is used to fund pre- and post-registration education for nurses, therapists and other non-medical staff, such as scientists. It represents around 40% of the MPET budget. Approximately one quarter of it is given to service providers, one half to education providers, and one quarter to students.

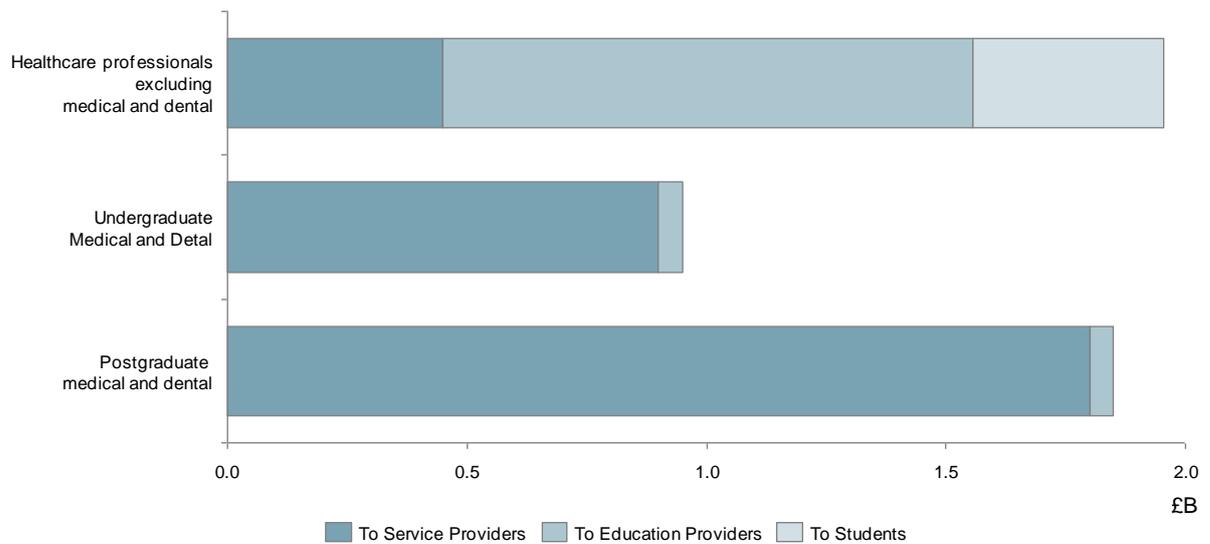
The distribution of MPET funding is presented graphically below:

⁹⁶ http://consultations.dh.gov.uk/workforce/education-and-training/supporting_documents/Distribution_of_MPET_funding.pdf

⁹⁷ http://consultations.dh.gov.uk/workforce/education-and-training/supporting_documents/Distribution_of_MPET_funding.pdf

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Figure 11. Distribution of MPET funding⁹⁸



The SHAs then allocate this funding across education and training providers, including higher education institutions and providers of NHS-funded services. For the purposes of the review we are concerned with the funds that are allocated to providers of NHS-funded services.

Government funding of education and training

An initial complaint in relation to education and training of medical staff is that private providers benefit while not making a contribution.

“In the main, NHS organisations carry the financial costs for the teaching and training of clinical staff, for other providers to then benefit from this.”
(Public sector provider)

The government does indeed fund the education and training of clinicians in England. However, all providers, including those not delivering NHS care, benefit from this funding of education and training by employing qualified staff without contributing to the cost of their training. While it may be a broader public policy issue that non-NHS providers benefit from public funding of training, in terms of a fair playing field, public providers would only be disadvantaged relative to non-public sector providers if they were not adequately remunerated for providing education and training.

Overall we do not consider that there is evidence that the Government funding of medical education and training, of itself, distorts provision between public and non-public sector providers.

⁹⁸ Adapted from: DH 2010. Liberating the NHS: Developing the Healthcare Workforce.

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Allocation of education and training funding to providers

There is no prohibition on who can provide education and training places, as long as trainees receive appropriate support and breadth of experience. Commissioners (including deaneries⁹⁹) choose which institutions receive which trainees and how many. All NHS trusts and foundation trusts currently provide some training.

There are some areas, for instance pharmacy, prosthetics/orthotics and palliative care, where the majority of training occurs outside of the NHS, often in a community setting. Although a statutory duty is written into the Health Act, it is very unclear where this duty lies at provider level. There is little funding for placements of some non-medical trainees, e.g. physiotherapists.

Existing education and training funding arrangements have faced criticism. For example, the Health Select Committee concluded that:

“The current arrangements under which providers are paid by the NHS for education and training are anachronistic and anomalous ... there is an almost total lack of transparency about how [funds are] spent.”
Health Select Committee. 2012. Education and Training and Workforce Planning

And found that stakeholders believed:

“Funding arrangements are not consistently applied between regions in England, and funding is often not made available to independent sector providers.” [Priory Group Submission to HSC. 2012. Education and Training and Workforce Planning]

As funds have been allocated through many different bodies we have not been able to determine what proportion of MPET funding is received by non-public sector providers. Health Education England have indicated they believe that the proportion is small. In addition, a participant in a stakeholder workshop reported that:

“There are barriers to the private sector’s ability to take on medical placements; this restriction is due to traditional relationships and the current resistance of the local deanery to change. Deans might regard private-sector insurance, placements arrangements and training as inadequate relative to those in NHS organisations.”

⁹⁹ The deaneries are responsible for the management and delivery of postgraduate medical education in addition to supporting the continuing professional development of all doctors and dentists. This includes ensuring that all training posts provide the necessary opportunities for doctors and dentists in training to realise their full potential and provide high quality patient care. The deaneries are also responsible for trainers, educational supervisors and educational leaders, their training needs and educational development. There are currently 14 deaneries in England.

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Funding differences across providers

The current allocation of funding for education and training is not transparent and may not factor in broader cost implications of training provision, such as supervision and contributions to standards settings. They are often based on historical agreements that are not necessarily cost reflective.

“Funding available to providers can be based on historical funding flows rather than the costs of providing education and training.”

DH. 2010. Liberating the NHS, Developing the Healthcare Workforce

“The current MPET allocations to Strategic Health Authorities (SHAs) are based on a number of historic factors with some of the bases for the calculations having not been uplifted for a number of years. This has led to elements of the allocation being neither transparent nor equitable. Although improvements have been made in recent years a more comprehensive review of allocations is required.”

HEE Board Paper 8, November 2012. Future MPET allocations policy proposals.

The Health Select Committee also found inconsistencies in funding:

“[Central payment for education is] only partially based on student or trainee numbers; it is not linked to quality; it is unjustifiably inconsistent between different professional groups, parts of the country and types of provider.”

Health Select Committee Report. May 2012. Education and training and workforce planning

The Department of Health told us that, as part of a review commissioned on education and training activity and funding, a costing exercise was carried out on a sample of 21 providers across 3 SHAs – London, Yorkshire and the Humber and the South West.¹⁰⁰ According to the impact assessment for a new tariff arrangement, the Department of Health found that the average cost of an undergraduate medical placement is about £35,000 per annum. However, the funding that a provider receives to reimburse them for this cost varies quite considerably from between £10,000 and £90,000 per annum. Moreover, the Department of Health review found that undergraduate medical education in secondary care is currently funded at £120m more than cost, with just £22m invested in non-medical placements.¹⁰¹

¹⁰⁰ DH (2013). Education & training tariff impact assessment.

¹⁰¹ DH (2013). Education & training tariff impact assessment

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The main beneficiaries are likely to be the large teaching hospitals that have historically undertaken most of the education and training.

Reputational (dis)advantages for some providers

We received some submissions from providers that the inability to gain access to trainees may make it more difficult to attract staff and build a positive reputation. In particular, some private sector providers have argued that lack of access to trainees limits their growth as an organisation:

"We are criticised for not providing education and training when we don't have access...in reality we would like to provide them so that we can be a more holistic organisation." (Interview – private sector provider)

By contrast a public sector provider stated:

"We are able to attract a much higher calibre of staff due to our reputation as a leading teaching hospital. We will trump a competitor by a factor of 5 [or] 10:1 on some services because we have the best people." (Public sector provider)

Changes to the current system of funding allocation

The deficiencies in the current system have been acknowledged by the Department of Health, which has set out revised future funding arrangements for education and training as a result.

A new body, Health Education England (HEE), has taken over responsibility for developing a more transparent allocation policy for distributing funding to new LETBs. LETBs will be the vehicle for providers and professionals to work with HEE to improve the quality of education and training outcomes. The LETBs will be hosted by and report annually to HEE, and have been promised local autonomy, subject to following HEE's national strategic direction. The intention is that all LETBs will be operational from April 2013. All providers of NHS-funded services will be required to be members of a LETB.¹⁰²

The HEE Transition team have been working with the DH Education Funding policy team to develop a proposed allocation methodology for HEE funding.¹⁰³ The current proposal, which will take a number of years to implement, focuses on the use of tariffs and activity levels, with the tariffs based on reference costs from providers. The categories covered are:

- future workforce funding (undergraduate medical and dental education, postgraduate medical and dental education and non-medical education and training);

¹⁰² DH (2012) World Class Education and Training, for World Class Healthcare: Introducing Health Education England and DH 2012

¹⁰³ HEE Board Paper 8, November 2012. Future MPET allocations policy proposals

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- workforce development;
- education support;
- management costs; and
- national activity funding.

The aim is to narrow the range of per capita funding that currently exists between providers. The new tariffs, based on the costing exercise with three SHAs, will be introduced over a transitional period. This will last for three years for most providers, but could last for up to twelve years in limited instances where the impact of tariffs on funding may be significant.

HEE's funding plans will cover all providers of NHS-funded services¹⁰⁴. This is further reflected in the LETBs operating principles, one of which is to have an inclusive approach to providers. This guidance advises that investment decisions by LETBs to ensure the security of supply of the workforce need to take account of all providers of NHS services and not just primary care and large trusts. Further, each LETB must fully engage with all sizes of provider and give due weight to their workforce issues in all decisions¹⁰⁵. In particular, the policy direction is to spread smaller placements around different types of provider. It is expected that there may be a move towards propositions of collective delivery of education and training, i.e. private and VCS providers working together with public sector providers to offer education and training.¹⁰⁶

In the 2010 consultation paper, *Liberating the NHS: Developing the Healthcare Workforce*, it was proposed that the current funding of the MPET budget from NHS funds could be replaced with a levy on providers of health care. In principle, providers of both NHS and non-NHS care could be required to contribute. However, owing practical challenges of such a levy, further work is being undertaken before decisions are made whether to introduce it.

The fragmentation of training

The fair playing field review covers distortions to the playing field for the provision of NHS funded clinical care. While not within this remit, stakeholders have raised concerns that any move away from public sector hospital provision towards 'a fragmented system' could cause a number of problems for the successful education and training of the future clinical workforce. This fragmentation could be exacerbated by some of the fair playing field issues that are assessed in this report such as 'cherry picking'. Although, these questions are beyond the scope of the review, Monitor notes

¹⁰⁴ DH 2012. *Liberating the NHS: Developing the Healthcare Workforce*

¹⁰⁵ Local Education and Training Boards (LETB) Operating Principles: From Design to Delivery

¹⁰⁶ Health Education England meeting (February 2013)

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that as a matter of public policy just as coordination of care around the patient is important, so is coordination of the delivery of education and training.

9.3 Conclusion

The funding of education and training is an issue of importance for many stakeholders, as reflected in the number of submissions received on the issue by the Review.

We do not consider that the Government funding of medical education and training, of itself, creates any disadvantage for non-public sector providers relative to public sector providers. Non-public sector providers do not directly contribute to the funding of medical education and training, but neither do public sector providers. Instead it appears to be overwhelmingly public sector providers that are funded to provide medical education and training, and that nationally the funds made available may exceed the costs of providing that medical education and training by up to £120m. Although we recognise that apparent widespread lack of accounting for these funds makes accurate estimation of the costs of training difficult.

Evidence from the Department of Health indicates that there is currently wide variation in the per capita funding of students and trainees that reflects historic funding allocations rather than costs. This does not necessarily favour public sector over non-public sector providers. Those favoured by the current pattern appear to be those providers that have historically undertaken significant volumes of education and training, likely to be the large teaching hospitals. We note that the funding system is changing from April 2013 to a more transparent system that is intended to more accurately reflect costs going forward. We support such moves to align funding more closely with the costs of provision.

We have received representations that the provision of education and training by leading teaching hospitals can confer a reputational advantage, and that non-public sector providers can experience difficulty in accessing funding of education and training which can lead to a reputational disadvantage for the those providers. In future the new LETBs will have as one of their operating principles to have an inclusive approach to providers.

10. Research and development

10.1 Issues

Medical research funding is provided and used by a range of different organisations. The UK Clinical Research Collaboration (2010) estimates that businesses and private not-for-profit providers received £4.8 billion of research funding in 2009/10. This estimate includes pharmaceutical funding. Universities received £1.8 billion and public research institutes received £1.5 billion of total funding in 2009/10.

Certain stakeholders believe that public providers may have access to a greater pool of research funding than non-public sector providers. As such, it has been suggested that this could give public sector providers an advantage over private providers.

However, research and development were not identified as an important fair playing field issue by stakeholders. It was not raised in the initial request for evidence. Additionally, none of the respondents ranked it as the most important subject for their organisation in response to the discussion paper.

An issue stakeholders raised was the coordination of medical research with clinical activity. If patients with certain conditions are treated outside hospitals with research facilities or close links to universities it may be more difficult for researchers to work with those patients. This problem may become more prevalent if simpler procedures are increasingly performed in a community setting. There is clearly a strong case for the careful coordination of medical research (and coordination to overcome similar issues in medical education). Further discussion of this falls outside the scope of the Review which is concerned with the provision of NHS funded clinical care, however, we have shared stakeholders concerns with the Department of Health.

This section sets out:

- the sources of funding for research and development in health care;
- evidence on whether public providers have access to a greater pool of research funding than non-public sector providers; and
- evidence on whether such differences give public sector providers an advantage over private sector providers.

There are many sources of funding for research and development (R&D) in health care, including government funding, charities and private funding. Funding sources and funding recipients do not have to be of the same organisation type.

A report by the UK Clinical Research Collaboration (UKCRC) in 2012 estimates the total expenditure on health-related research and development,

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performed by UK public, private and not-for-profit organisations (although not necessarily conducted in the UK) in 2009/10 at approximately £8bn.¹⁰⁷ This estimate includes pharmaceutical research. Of the £8bn, the UKCRC estimates that £3.5bn is provided by the public and not-for-profit sector. The primary funding bodies for public funding of medical research are:

- the Medical Research Council (MRC) – one of seven UK research councils funded by Central Government (via BIS). In 2011/12, the MRC spent £759.4m on research; and
- the National Institute for Health Research (NIHR) – an organisation funded via the DH with the aim of improving the health and wealth of the nation through research. The institute manages its activities through four main work strands, which together received £921m of funding in 2010/11.¹⁰⁸

Charitable funding makes up a significant proportion of the £3.5bn of public and not-for-profit research funding. For example, large charities such as Wellcome and Cancer Research UK have provided funding of £341m and £230m respectively in 2009/10. The Association of Medical Research Charities estimates spending by its members to be £1.14bn in 2011.

Private funding of research amounts to approximately £4.5bn according to UKHRA. However, as much as £3.3bn of this funding is likely to be directed towards pharmaceutical research, which implies that private funding of non-pharmaceutical research may be in the order of £1bn.

10.2 Findings

Access to research funding

This section considers whether there are systematic differences in the ability of different providers to apply for funding.

There are a number of ways through which the NIHR provides funding for research in the NHS. There are no constraints on the type of provider of NHS services that can apply, except for a basic requirement that they are capable of fulfilling the role of research sponsor as set out in the Research Governance Framework for Health & Social Care. This applies to all organisations who wish to host health research.¹⁰⁹ NIHR is reviewing its eligibility requirements to make sure that the position is absolutely clear. For instance, in the guidance for the latest NIHR Research for Patient Benefit competition, it says: “All NHS bodies and providers of NHS services in

¹⁰⁷ UK Clinical Research Collaboration (2012), UK Health Research Analysis 2010.

¹⁰⁸ Source: <http://www.ukcrc.org/researchcoordination/healthresearchanalysis/ukanalysis/>

¹⁰⁹ Research Governance Framework for Health & Social Care: 2nd Edition, DH, 2005

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England are eligible to apply, provided that they are capable of fulfilling the role of a research sponsor".¹¹⁰

In fact, most providers' interests are less in project and programme funding, and more in Service Support funding, to meet the costs of clinical and other staff that support research led by others. Service Support funding, provided through the NIHR Clinical Research Networks, is something which all providers can and do access.

Access to public funding provided by the MRC is not restricted by the type of provider. The criteria that are used to assess funding proposals do not vary by organisation type. However, data from 2010/11 shows that the MRC's funding recipients only involve universities and institutes.¹¹¹ This is likely to be due to the nature of the funding as it includes fellowships for researchers and studentships. It shows that the majority of research funding goes to universities and MRC research institutes. However, this outcome does not suggest that private providers are not able to apply for funding.

With respect to other types of funding such as private funds or charities, providers appear to have equal access. Research on a sample of charities and private funds indicates that non-public sector providers could apply for the funds available.

Overall, the large majority of funding appears to be accessible by all provider types.

Potential advantage from access to R&D funds

It is useful to consider the potential advantage that providers may have from receiving a larger proportion of research funding. Providers that undertake research may benefit from the following:

- **Potential direct impacts:** advances made through research may improve the effectiveness/efficiency of care.
- **Potential indirect impacts:**
 - facilities and equipment purchased through research funding may also be employed in the provision of care;
 - improved ability to attract high-quality staff, if the possibility to engage in research drives the choices of the best medical staff;

¹¹⁰ <http://www.ccf.nihr.ac.uk/RfPB/Documents/RfPB%20-%20Guidance%20for%20Applicants%20Competition%2021.pdf>

¹¹¹ MRC, Available: Grants, fellowships and studentships in the 2010/2011 financial year (£100,000 and above), <http://www.mrc.ac.uk/Fundingopportunities/Applicanthandbook/Successrates/Recipientsoffunding/index.htm>

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- general reputational benefits, improving the ability to attract staff beyond those specifically interested in research, and patients.

Stakeholders have not suggested that access to research funding is an issue that gives an advantage to particular provider types.

10.3 Conclusion

The evidence in the previous section suggests that the majority of research funding sources are accessible by all provider types. As such there does not appear to be a fair playing field issue.

11.0 Market forces factor

This issue was raised by 4% of respondents to the initial call for evidence and 10% of respondents to the discussion paper ranked it as one of the most important fair playing field issues that their organisation faces.

- Around three quarters of these respondents were concerned that some providers were advantaged or disadvantaged by commissioners restricting referrals to higher cost providers (those with higher market forces factor MFF values). This concern is addressed in the supplementary paper on participation¹¹².
- The other respondents were concerned that imperfections in the way that MFF is calculated could mean that some providers are over or under-compensated given the actual costs they face. This paper addresses this concern.

11.1 Issue

The DH has found that the cost of providing NHS-funded services varies between local areas. In particular, based on its own analysis and analysis by the University of Warwick, DH found that the cost of non-medical staff varies from one local area to another and the cost of medical staff is different inside versus outside of London. Other costs that vary include the cost of buildings and the cost of land. Together, DH found that the costs that vary across local areas account for 71.9% of the running costs of the NHS.¹¹³

Therefore, to ensure that NHS providers in high cost areas do not receive 'too little' compensation and that NHS providers in low cost areas do not receive 'too much' compensation, Payments by Results (PbR) tariffs are adjusted using the MFF to reflect local cost differences. Put another way, without these or similar adjustments, there is a risk that there would be too little participation in high-cost areas and too much participation in low-cost areas.

However, such adjustments could distort the fair playing field if the use of MFF results in one provider being paid more or less than another, while at the same time serving the same group of patients and facing the same costs.

Our analysis suggests that the risk of such a distortion occurring is limited by the way the MFF is calculated and, importantly given the focus of this review, there is no reason to expect that one group of providers (for example, public sector) would be systematically advantaged or disadvantaged compared to another group. And indeed we have not found evidence to suggest that this is the case in practice.

¹¹² www.monitor-nhsft.gov.uk/FPFR

¹¹³ DH (2012), "Payment by Results – PbR and the Market Forces Factor (MFF) in 2012-13".

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11.2 Findings

Some stakeholders told us that inaccuracies in the MFF calculation meant that the adjustments to PbR tariffs did not properly reflect the (unavoidable) cost differences caused by differences in local market conditions.¹¹⁴

“The existing MFF structure appears inconsistent and illogical. Almost all NHS staff are now paid in accordance with the nationally mandated Agenda For Change pay structures. Local variation in this respect therefore does not arise.” (Public sector provider)

This would make some local areas more or less attractive to supply than others, leading to too much or too little participation in them. This could ultimately result in differences between local areas in terms of patient access to health care services.

However, to the extent such inaccuracies exist, they are unlikely to advantage or disadvantage one group of providers over another (as distinguished, for example, by ownership type or size). This is because:

- first, all providers located in and serving a given PCT catchment area will receive similar (accurate or inaccurate) MFFs and so will face a similar advantage or disadvantage to other providers in and serving the catchment area; and
- second, the MFF calculation removes any significant differences between the MFFs received by two providers located nearby to one another (and so potentially serving a similar group of patients and facing similar labour market conditions), but in different PCT catchment areas.

We have only identified one way in which the MFF applies differently to different groups of providers: specific MFF values are only calculated for public sector providers. Private sector and VCS providers instead receive the same MFF as their nearest public sector provider.¹¹⁵ This ‘shortcut’ could distort the playing field if the ‘nearest’ public sector provider is located such that it is simultaneously:

- distant enough to mean that its costs conditions are not a good proxy for those faced by the relevant private sector or VCS provider; and

¹¹⁴ We note that the existence of nationally mandated pay structures would not, of itself, eliminate local cost pressures. As noted by the DH (2012) paper above, indirect costs can emerge such as “greater use of agency staff and higher vacancy and turnover rates”. Grade inflation could also emerge.

¹¹⁵ DH (2009), “2009-10 IS mini-roadshow”.

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- close enough to mean that the relevant private sector or VCS provider is likely to serve a similar group of patients.

It has not been possible to rule this possibility out empirically. However, given the tendency for providers to locate near to the population they serve, we consider that this outcome is unlikely to be common. We note that this possibility was not raised by any stakeholders in either the initial call for evidence or our subsequent discussions with them.

11.3 Conclusions

Our conclusion is that the way MFF is calculated means that it is unlikely to systematically disadvantage one groups of providers over another in principle and we have not found any evidence to suggest otherwise in practice.

Nevertheless, there are good reasons to continue work to ensure that the prices paid for NHS funded services reflect (unavoidable) cost differences between local areas. This is needed to avoid situations of under-supply or over-supply in different local areas.

Also, as discussed further in the Participation supplementary paper, this Review has identified the need to assess whether budget limits combined with local cost differences, are putting commissioners under pressure to limit patient choice to 'cheaper' areas and, if so, whether anything should be done in response.

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12.0 Case mix

This issue was raised by 11% of respondents to the initial call for evidence and 5% of respondents to the discussion paper ranked it as one of the most important fair playing field issues that their organisation faces.

12.1 Issue

Under PbR, the prices paid to NHS providers are, in general, intended to reflect the average cost of providing a service.¹¹⁶

However, as highlighted by the evidence below, the differences in the characteristics of patients mean that some are more costly to treat than others (for example, due to complications or comorbidities) and the costs they actually incur may be higher or lower than the average depending on the mix of patients they treat.¹¹⁷

This raises the possibility that some providers will be under-compensated and some providers will be over-compensated under PbR. Indeed, the combination of receiving average cost prices and the possibility of serving non-average cost patients, gives providers an incentive to target low cost patients and avoid high cost patients (so called 'cherry picking').

A fair playing field issue is created if some providers can and do act on this incentive and other providers cannot.

At the outset we note that these 'cherry picking' concerns are one part of a broader pricing issue and highlight the importance of robust reimbursement mechanisms – supported by high quality cost information and strong commissioning. It is critical that providers are fairly remunerated for the services they deliver. In practice, this means that the prices paid to providers should be linked to the efficient costs of providing services. But the prices paid to providers may not reflect efficient costs for a number of reasons, including but not limited to:

- prices may not exist for some services;
- prices may have been set too high or too low inadvertently, due to weaknesses in costing information available and/or changes in costs over time;
- commissioners may not know what to pay for some services;
- prices may have been set with reference to historic models of delivery and have not kept pace with recent changes;
- some providers may have market power and increase prices and/or reduce quality; and

¹¹⁶ PwC (2012), "An evaluation of the reimbursement system for NHS-funded care".

¹¹⁷ A related issue to 'patient selection' is 'service selection'. This occurs when providers supply some services but not others as a result of the prices being paid for some services not reflecting the (efficient) costs of supplying them. They are related because some services may be more or less profitable than others in part as a consequence of patient selection.

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- some providers may treat a different mix of patients than is anticipated and reflected in the prices paid for the services, either by chance or design (for example given their specialisms) – as is considered here.

These are complex and interrelated issues and all of them are critical to the efficient supply of NHS funded health care services. Without robust reimbursement mechanisms, there is a risk that there will be over-supply of some services, and under-supply of others – both would be against taxpayer and patient interests. Accordingly, a significant amount of research and work is on-going to improve the way that providers are reimbursed for the health care services they provide. This includes work by the Monitor, the Department of Health, Monitor and the NHS Commissioning Board, as well as studies by the Nuffield Trust, the Institute of Fiscal Studies and others.

It is also possible that some of these issues could distort the playing field by putting some providers at a disadvantage to others. But this need not be the case. For example, the lack of reimbursement for a particular service would not distort the playing field if there were no differences between providers in terms of their ability to support that service with the income from other services.

We have not sought to tackle all of these important issues as part of this Review and instead have focused on a narrower set specifically raised by stakeholders in our initial call for evidence: the scope for selecting patients (considered here); the impact of the market forces factor (considered earlier in this paper); and bundling (considered in the supplementary paper on Participation). This does not reflect our view on the relative importance of the different issues, which will require continued detailed and on-going research and work to address.

12.2 Findings

We examined the evidence on both the extent to which (a) differences in case mix cause differences in costs that are not reflected in the PbR tariffs and (b) some providers can and do treat a higher or lower cost mix of patients than others.

Differences in case mix causing differences in cost

The evidence suggests that differences in case mix cause differences in cost. For example:

- The Nuffield Trust found that “There is a poor match between tariff and costs at case level. Only 17% of tariff chargeable cases had costs which fell between 90% and 110% of their tariff payments”. This

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finding was based on an analysis of data from Patient Level Information and Costing Systems (PLICS).¹¹⁸

- For example, the figures below shows cost per patient from one foundation trust for very common procedures – normal delivery with and without Caesarean section... These figures highlight that there can be significant variation in per patient costs within a single Health Resource Group (HRG).

Figure 12. Analysis of actual costs within an HRG¹¹⁹: Normal Delivery between 16 and 40 years without Caesarean Section

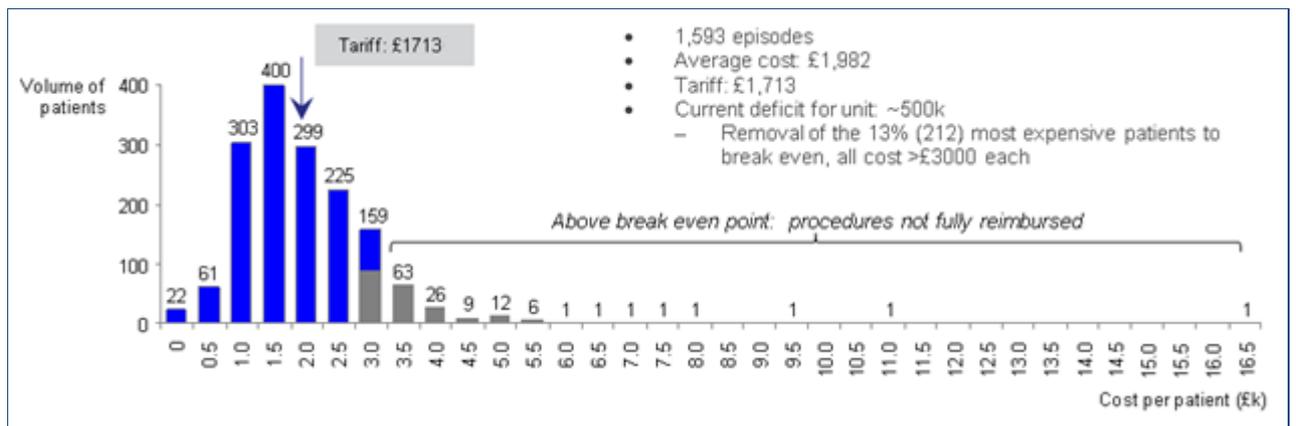
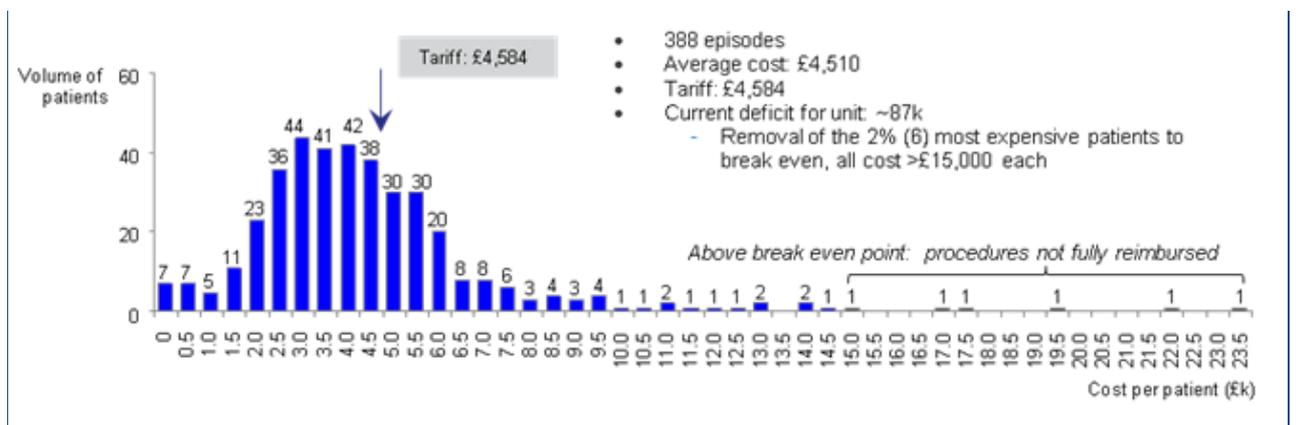


Figure 13. Analysis of actual costs within an HRG¹²⁰: Normal Delivery between 16 and 40 years with Caesarean Section



¹¹⁸ Nuffield Trust (2012), "Patient Level Costing".

¹¹⁹ Uses tariff of NZ01B Normal delivery 18 years and over without CC (£1,324) multiplied by inner London market forces factor 1.2939 Note: Excludes private patients. Costs rounded to nearest £500. Source: 2010-11 data from 1 FT of 1593 births.

¹²⁰ Uses tariff of caesarean section with complications (£3,311) multiplied by inner London market forces factor. Note: Excludes private patients. Costs rounded to nearest £500. Source: 2010-11 data from 1 FT of 1593 births.

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PwC also found that there is significant variation in per patient costs. Based on an analysis of PLICS data for 14 acute providers, PwC found some HRGs where the most costly patients were more than 20 times the median cost patient. PwC also found that per patient costs sometimes exhibit a ‘double peak’, suggesting that there are potentially two patient types and that, “Splitting the HRGs into two classifications would be more appropriate.” The same research showed that patient age and the number of co-morbidities are significant drivers of cost variation.¹²¹

Our interviews with stakeholders also supported this evidence. For example, one interviewee said, “It has become apparent through the review that the lack of cost reflective pricing causes a range of issues but from a FPF [Fair Playing Field] point of view, the key issue is around cherry picking (for services and for less commonly for less complex patients).”

The Department of Health has also identified, “A list of procedures which may be prone to patient selection [...]” The list of was based on analysis of the difference between the types of patients treated by private sector providers and the types of patients treated by public sector providers.¹²²

Various adjustments to the standard PbR tariff are available to help ensure that providers receive the right level of remuneration given the mix of patients they treat. The adjustments are for: short stay emergencies (allowing for up to a 75% reduction on the standard PbR tariff for emergency stays significantly below the national average stay); long stays; and specialised service top-up payments (for children, neurosciences, orthopaedics and spinal surgery).¹²³ However, since these adjustments are only applicable to a subset of services or situations (e.g. very long stays), it is unlikely that they will fully compensate for the variation in per patient costs.

Consistent with this, the Department of Health introduced a new flexibility in 2012-13 designed to ensure, “Fair reimbursements for the services delivered to patients,” which is discussed further below.¹²⁴

Differences in patient mix of different providers

As illustrated by the quotes below, a number of stakeholders told us that some providers can and do treat a different mix of patients to others. There were mixed views as to whether public, private or VCS providers tend to treat the higher or lower costs patients.

The fear among NHS practitioners is that even with the same tariff on offer to both public and private providers, the private sector can select the simple

¹²¹ PwC (2012), “An evaluation of the reimbursement system for NHS-funded care”.

¹²² DH (2012), “Draft payment by results guidance for 2013-14”.

¹²³ Ibid.

¹²⁴ Ibid.

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cases and make a profit while foundation trusts are required to provide services to all patients as well as being relied upon to provide emergency back-up facilities if complications subsequently develop as the 'provider of last resort'." (Representative body)

"A major concern of the "any qualified provider" scenario is the opportunity for independent sector providers to 'cherry pick' high volume low cost "easy" services from the NHS providers."(Representative Body)

"NHS keeps the easy patients, and passes on the more difficult ones to our organisation (e.g. learning difficulties, social issues, language barriers)."(Private sector provider)

"Specialist services are unlikely to be dealt with by private sector. "Tariff is flawed at [the specialist] end – those that are reimbursed for bog standard hip replacements...are slightly over-reimbursed, and the complex-end are under-reimbursed."(Public sector provider)

We sought to validate these views by examining various sources of secondary research. On balance, this research suggests that public sector providers tend to treat more costly patients than private sector providers.

- The research by PwC cited above found that for, "...for 408 HRGs (21%), more than half of all providers reported unit costs that were more than 50% away from the weighted average national unit cost." It also found that 25% of the variation in these reported costs appears to be driven by differences in average length of stay, which itself could be caused by differences in case mix. PwC did not conclude on what the remaining 75% was caused by, but suggested that patient mix, data recording and efficiency differences could matter. We note that this analysis was based on data from public sector providers and so it cannot be used to infer whether private sector and VCS providers face a difference case mix to another, but rather than different public sector providers do.
- Academic research, including analysis by Mason et al (2010), Browne et al (2008), Turner et al (2011) and Allen et al (2012) suggests that public sector providers tend to treat higher cost patients than private sector providers.¹²⁵ For example, Mason et al (2010) found "NHS organisations are treating a more complex case-mix than their private sector counterparts. In three out of four indicators of patient complexity – the number of diagnoses, number of procedures and income

¹²⁵ Mason et al (2010), "Private sector treatment centres are treating less complex patients than the NHS"; Browne et al (2008), "Case mix and patients' reports of outcome in ISTCs: comparison with NHS providers"; Turner et al (2011), "Innovation and the English NHS: A qualitative study of the ISTC programme"; Allen et al (2012), "Provider diversity in the English NHS: a study of recent developments in four local health economies".

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deprivation – NHS organisations were found to be treating significantly more complex patients than private providers.”

- We also found evidence to suggest that commissioners and private sector providers agree ‘exclusion criteria’ in their contracts which, according to the Centre for Health Economics, “...is arguable whether this is evidence of ‘cream skimming’ or whether it is good clinical practice that reflects provider capability. Whatever the motivation, the result is that ISTC case mix provision for a given procedure is likely to be less severe than the case mix for the NHS.”¹²⁶

We explored *why* these differences arise. One possible reason is that private sector suppliers can agree exclusion criteria within a particular HRG with commissioners, whereas public sector and VCS providers cannot. Another reason is that some providers are less willing to agree exclusion criteria with commissioners than others; put another way, some providers *perceive* that they *cannot* agree exclusion criteria. Both reasons could distort the playing field because they arise as a result of differences in the ability of providers to select patients (but might demand different solutions). We found that all providers can agree exclusion criteria with commissioners and, indeed, exclusion criteria even within an HRG are desirable and necessary for reasons of patient safety and the potential benefits associated with providers choosing to specialise in treating particular types of patient. We also found that some providers were unwilling to agree exclusion criteria, although it is not clear how widespread this lack of willingness is.

“Public sector providers see themselves as a “provider of last resort”. We are very reluctant to consider discontinuing any service unless directed by commissioners. Additionally, Commissioners are keen to turn off certain Trust provided services in the belief they can be more cheaply provided in another setting, but sometimes do little to develop those alternative locations.
(Public sector provider)

Clearly, reimbursing a provider at tariff for a particular HRG when they have agreed criteria that exclude the higher cost patients would result in that provider being over compensated. However, whether this happens in practice depends on the price and non-price terms different providers agree with commissioners. That is, commissioners could be negotiating lower prices or other improved terms with private sector providers to compensate for the fact they serve a lower cost group of patients.

With this in mind, DH introduced a new commissioning flexibility in 2012-13 stating that, “...commissioners should adjust the tariff price if, under the terms of contract, a provider limits the type of patients it treats resulting in lower

¹²⁶ CHE (2008), “Establishing a Fair Playing Field for Payment by Results”.

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costs than the average of the tariff category...”.¹²⁷ We do not know the extent to which this flexibility has been taken up by commissioners, but to the extent that such adjustments are made, they would clearly reduce the risk of under- or over compensation and therefore reduce the scope for selection that would advantage or disadvantage different providers.

12.3 Conclusions

There is evidence of significant differences in the costs of treating patients under a single PbR tariff. These differences create an incentive for selecting less costly patients. There is also evidence that private sector providers tend to treat lower cost patients than public sector providers, sometimes as a result of commissioners and providers agreeing exclusion criteria. This can put private sector suppliers at an advantage to public sector providers. However this depends on whether commissioners negotiate price reductions or other improved terms with private sector providers alongside such exclusions, and whether public sector providers renegotiate terms to reflect their case mix.

One way to address this issue would be to pay every provider according to the costliness of each individual patient they treat. This would mean that no provider’s case mix would be more profitable than any other provider’s case mix. However, there are important benefits to “average cost” reimbursement. One benefit is that it can avoid the (costly) complexity that can arise as a result of having too many tariffs. Another benefit is that it can provide providers with a strong efficiency challenge to “beat” the average cost.

The implication is that the evidence we have gathered further reinforces the need for on-going work to help improve the reimbursement system that is being undertaken by the Department of Health, Monitor and the NHS Commissioning Board. In particular:

- improvements in the quality of cost information needed to help decide what should be paid for NHS services will help address the underlying causes of the concerns. As noted above, Monitor has recently issued guidance to providers about how to allocate the cost of their services to individual patients;¹²⁸
- continued guidance and encouragement for commissioners to help them use the new commissioning flexibility introduced by DH in 2012/13 (noted above) where appropriate will help ensure that providers are properly remunerated for the mix of patients they treat. As part of this, we think that it would be valuable to monitor how much the new commissioning flexibility is being used and its impact on providers and patients.

¹²⁷ DH (2013), “Payment by results guidance for 2013-14”.

¹²⁸ <https://www.monitor-nhsft.gov.uk/costingguidance>