HEALTH ADVISORY

Cost of Mental Health Provision

Report for the IMHSA

30 September 2010

Contents

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Overview by Mark Britnell

1. Introduction

Between 1997/8 and 2009/10 the annual NHS budget grew from £42.4bn[1] (or 5.1% of Gross Domestic Product (GDP) to £122.4bn[2] (approximately 7.7% of GDP) and it is clear, especially in the light of current economic pressures, that such rises cannot continue.

Nevertheless, the government must still meet the healthcare needs of the electorate and so, in the face of a growing population and the rising cost of drugs and other healthcare resources, the NHS will need to rely more and more on improving efficiency. The Office for National Statistics estimates that, between 1997 and 2007, productivity in the NHS fell by 0.4% per annum while, in the private sector, it rose by around 2% per annum.[3]

The introduction of choice and competition into the provision of services has long been identified as a way to drive such efficiency, and indeed is a core theme of the recent coalition White Paper, which promotes both the idea that patients should be able to choose 'any willing provider' and the concept of a 'level playing field' between providers. The theory behind such policies is that more providers bring greater competition; greater competition brings improved value and quality (and potentially reduced price); improved quality coupled with greater choice leads to improved patient experience and outcomes.

Putting this theory into practice of course brings with it a number of challenges and so the development of an effective market within the NHS is still in its early stages. Taking as an example the provision of mental health inpatient services, this report investigates the inefficiencies which currently exist within the NHS market (and which therefore prevent the government, patient and taxpayer from receiving best value) and looks at the opportunities which exist to improve those inefficiencies and hence deliver better value. We conclude that more competition, not less, is the best way to improve patient outcomes.

Whilst this report focuses on mental health inpatient services, many of the issues identified have a wider application across service provision within the NHS as a whole, and we recommend that the current reform programme should be pushed further, faster, in the interest of patient care and the taxpayer.

2. Executive summary

Through our analysis we have identified, in broad terms, 2 overarching factors which lead to market inefficiency. These are:

- Factors that deter commissioners from making best value decisions: and
- Factors that prevent providers operating at maximum efficiency.

These two overarching factors are described in this executive summary. Further detail on these factors and on the analysis that we have carried out is then set out in the appendices which follow. We have not attempted to identify all factors which have an effect on the efficiency of the market for the provision of mental health services to the NHS, but have identified those which, according to our analysis and experience, appear to have the greatest impact.

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[1] H.M Treasury, (1997) Budget Brief 1997, http://archive.treasury.gov.uk/budget/1997/bbrief/b_brief.pdf

[2] Northern Ireland Assembly, (2008) Budget 08 – 11, http://www.northernireland.gov.uk/finalbudget.pdf; HM Treasury, (2009) Budget – Building Britain's future, http://webarchive.nationalarchives.gov.uk/+/http://www.hm-treasury.gov.uk/d/Budget2009/bud09_completereport_2591.pdf; The Scottish Government, (2009) NHS Funding, http://www.scotland.gov.uk/News/Releases/2009/02/09091905; NHS Wales, (2008) Board Paper 10 December 2008, http://www.wales.nhs.uk/sites3/Documents/802/1013.pdf

[3] The Institute of Fiscal Studies, Protecting NHS spending from 2011 likely to require large cuts to other department budgets or tax rises (2009), http://www.ifs.org.uk/pr/nhs_spending.pdf

2.1 Factors that deter commissioners from making best value decisions

2.1.1 Contract structure and pricing

Data gathered from private sector providers and NHS reference costs shows that the headline price of inpatient mental health service provision is comparable, on average terms, between public and private sector providers (see Appendix 3, Section 4). One would therefore expect to see a reasonably high degree of private sector participation on equal terms. This public sector price, as it appears to the commissioners, however, does not include the full costs to government. We return to this in Section 2.2 below.

Although prices are broadly comparable, contracts are awarded in different ways. NHS providers are generally awarded block contracts, with payment based on the size of the service provision available rather than on the number of patients treated. On the other hand, the private sector is awarded contracts on a per head or per treatment basis and therefore only receives payment for the services it delivers. This can mean that public sector providers are therefore paid for unused capacity.

Furthermore, since the structure of NHS contracts allows for NHS providers to be paid for unused capacity, it has been suggested to us that some providers can and do sell the same bed twice and therefore receive income from that bed from two sources. Anecdotally it has also been reported that some NHS commissioners have found that they are unable to access beds that they have paid for under block contract arrangements and are therefore not receiving full value for those contracts. We have not verified this directly but consider that it warrants further analysis.

Private sector providers also cite instances of NHS providers being awarded block contracts for three year periods in order to justify investment under Monitor 'Risk Evaluation for Investment Decisions' ("REID") guidance and thereby protect their risk ratings. There are a number of examples of NHS facilities being built at significantly greater expense than private sector equivalent facilities and, in these cases, it seems reasonable to infer that resultant pricing is higher than would be generated in a fully efficient market (see Appendix 3, Section 4).

In contrast, private sector providers are awarded contracts on a per head or per treatment basis and do not receive such long term block contracts to guarantee future income when building new facilities. They therefore only receive payment for the services that they deliver and commissioners are not tied into long term contracts which prevent them from renegotiating prices.

The difference in the way that the contracts are structured may lead to market inefficiency if commissioners make their purchasing decisions based on an inaccurate 'price per bed day' (ie one which does not allow for spare or otherwise contracted capacity). In this event, such block contracts can result in payment for spare capacity and therefore in many cases may not achieve best value for the taxpayer and patient.

2.1.2 Whole of government cost

Our analysis also shows that, whilst the whole cost to government of private sector provision is fully reflected in the price charged to commissioners, the whole cost to government of NHS provision is not. This causes market inefficiency as commissioners are not incentivised to make decisions which provide best value to government (and therefore, by extension, to the patient and taxpayer), as they make their purchasing decisions based on only part of the cost.

The additional costs to government of public sector provision include lost tax receipts, pension contribution costs and the cost of unpriced risk within public sector cost of capital:

Private sector providers are subject to corporation tax, VAT and stamp duty land tax costs that NHS providers do not have to pay. This tax paid is therefore an additional cost to government of NHS provision as these revenues will not be received if an NHS provider is selected rather than a private sector provider. This typically adds something in the order of 2.4% to the true cost of NHS mental health inpatient provision, over and above the headline price (see Appendix 3, Section 1).

The cost of borrowing for public sector providers is significantly below the 'market rate' (see Appendices 2 and 3). Providing such sub-commercial funding to the NHS means that risk is not being properly priced. At some point on average, that risk can be expected to crystallise (ie when a Trust fails) and therefore the subsidy will need to become explicit, not implicit (ie government will need to provide financial support for that failing Trust). We estimate that this hidden funding cost adds something in the order of 2.1% over and above the headline cost of NHS mental health inpatient provision (see Appendix 3, Section 2).

Finally, pensions provided by public sector providers to the NHS are funded partly by the provider itself and partly by central government. The cost to government of selecting an NHS provider therefore also includes the cost of providing these uncosted pension entitlements for the employees of that provider. We estimate that this adds something in the order of 8.0% to the stated headline cost of NHS mental health inpatient provision (see Appendix 3, Section 3).

In summary, the effect of these issues is that the 'price' charged to the NHS for the provision of mental health inpatient services by public sector providers does not reflect the full cost to government of the purchase of that service provision. We have carried out some indicative analysis to quantify the cost of provision under the two different models (ie public and private sector). We estimate, based on our analysis, that the overall effect of these two factors on price could be of the order of £12.50 per £100 spent. (Our analysis is subject to a number of limitations, which are set out in Appendix 5). This implies that the true cost to government of NHS mental health inpatient provision is something like 12.5% higher than the headline prices on which commissioners make their buying decisions.

Given that differences between NHS reference costs (ie average costs reported by NHS providers) and prices charged by private providers on a per capita basis are minimal, this suggests that, once the additional cost to government is factored in, in many cases NHS provision is in fact more expensive than private sector provision on a whole cost to government basis.

2.1.3 Cultural issues

Many non-NHS providers also believe that a natural default behaviour exists within some commissioning bodies of referring patients to organisations and clinicians with which referrers (and their patients) have experience and history. In some cases this may be due to a simple lack of knowledge of other available providers, and in others an unwillingness to commit to new and unproven providers or inability to stimulate the market to generate alternative options. This may also stem, in some cases, from a philosophically driven desire to keep the traditional Government controlled NHS intact and a reluctance to promote "for profit" organisations.

Non-NHS Mental Health providers report that, in the case of secure Mental Health, PCTs often report to sentencing courts that there are no places available for patients to be placed in secure facilities, when in fact, whilst NHS providers may be full, local non-NHS providers do have capacity. The impression reported is not that commissioners are opposed to using the private sector, but rather that the commissioner has simply not considered non-NHS provision as an alternative.

Such behaviour reduces the effectiveness of the market mechanism as markets only work to deliver efficient pricing when they are used by participants. By failing to consider the full range of providers available, commissioners are not placing themselves in the best position to source best value provision and may be missing opportunities to save costs and improve patient experience.

2.2 Factors that prevent providers operating at maximum efficiency

In addition to the factors above, which can prevent commissioners from making the best value commissioning decision, there are number of factors within the market which prevent providers from acting as efficiently as they otherwise might. These tend to affect NHS providers to a greater extent than they do private sector providers, but all providers to some degree. To maximise market efficiency the effect of these factors should be minimised, for both NHS and private sector providers, allowing all providers equal opportunity to operate as efficiently as possible. Examples of such factors include:

- The 'Universal Service Obligation' which means that the NHS as a whole must ensure that all necessary services are available for patients who need them. In essence this means that some NHS providers are required to continue to provide services even if, economically, it would make better sense to discontinue that service.
- The failure regime which currently means that NHS providers and private sector providers are faced with differing scenarios in the event of failure. This regime currently protects creditors on failure of a Foundation Trust through the process of de-authorisation, artificially reducing funding costs to NHS organisations. Conversely, the same regime prevents asset values from being 'reset' on failure, meaning that successor organisations can be required to take on overpriced assets and contracts.
- The capital budgeting regime in the NHS which can be restrictive and can limit the ability of NHS providers to access capital even when they have a good strategic business reason to do so; and.
- NHS terms and conditions which many NHS employers believe restricts their ability to restructure or reorganise their workforce.

These factors are considered in greater detail in Appendices 2 and 3. All of these factors can cause providers to be less responsive than they otherwise might be or make business decisions that they otherwise would not make and therefore cause the market that those providers work within also to be less efficient.

2.3 Conclusion

We have examined a number of factors which mean that the market operates less efficiently than it otherwise could. Our analysis suggests that, on a whole of government basis, private sector provision is cheaper than public sector provision in many cases and that the price signals to which commissioners respond are not reflective of the true cost to government. This would suggest that, in order to achieve best value, commissioners need to include private sector providers in their appraisal process when making their purchasing decisions. It also implies that government has a role to play to ensure that the right price signals are sent to commissioners.

Our analysis also shows that there are a number of less easily quantifiable factors which cause providers to act in an inefficient way or which cause commissioners to make decisions which do not give best value to the taxpayer/ patient and which therefore mean that the market is not functioning as efficiently as it could.

Appendix 1 – Approach overview

Based on our knowledge of the NHS market and our experience of working with both public and private sector clients we identified a list of factors which cause inefficiency in the market for the provision of mental health inpatient services to the NHS. These factors fall into two overarching categories, as discussed in the overview set out in the earlier pages: those which cause commissioners to make commissioning decisions which may not result in best value for the tax-payer and best patient experience; and those which cause providers operating in the market to operate less efficiently that they otherwise could.

In order to carry out our analysis, having identified the factors, they were then divided into two types: quantifiable and unquantifiable.

These factors are set out below and greater detail on these is also set out in Appendix 2.

Quantifiable factors	
1	Taxation
2	Cost of Capital (including valuation of estates)
3	Pensions / Staff Costs
4	Pricing and contracting issues
Un-quantifiable factors	
5	Cultural issues
6	Policy interventions in provision
7	Transactions policy
8	Policy 'noise'
9	Availability of capital
10	Staffing contracts
11	Variable commissioning skills
12	Adverse effects of budgetary demarcation

Quantifiable factors are those for which supporting data exists and which can therefore be financially quantified (to a greater or lesser degree of accuracy). In general the quantifiable factors affect the cost base or price of the affected suppliers, making it more or less expensive for them to deliver a given service. The approach to quantification of these factors, along with the findings from this quantification work, is set out in Appendix 3. In order to carry out this quantification it has of course been necessary to make a large number of assumptions. The limitations of the analysis are set out in Appendix 5.

Unquantifiable factors are those which we believe may be significant but where the factor is difficult to quantify because of a lack of reliable and robust data on which to measure the effect.

Appendix 2 – Summary of factors

Below are the factors identified which may cause inefficiencies in the NHS market. This is generally either due to differences in the price or cost of provision of mental health services between public and private sector providers, which can lead to suboptimal commissioning decisions, or due to factors which cause providers to be less efficient than they otherwise could be. The factors, and their effect on NHS providers, private sector providers and commissioners can be summarised as follows:

1. Taxation

There are two types of taxation contributions which have a significant impact on whole of government costs: Corporation Tax and VAT. Private sector providers contribute Stamp Duty Land Tax but, given the relatively rare occurrence of land deals, this has a far less significant impact than Corporation Tax and VAT.

1.1 Corporation Tax:

Private sector providers are subject to corporation tax which reduces their returns. NHS providers are exempt. It is likely that Foundation Trusts (FTs) will eventually be subject to corporation tax, although the current proposal that FTs should only pay tax on private earnings means that FTs will pay tax on a smaller proportion of their income than private providers.

1.2 VAT:

Private sector providers also pay higher amounts of VAT as the VAT they pay on "contracted out services" is irrecoverable, and therefore constitutes a cost to the business. The NHS, on the other hand, is able to access certain VAT reliefs not available to private sector providers; in particular, the ability to recover some VAT through the "contracted out services" rules.

The net effect of this is that, from a whole government perspective, the cost of private sector mental health services is the price paid less tax receipts to HMRC. For NHS providers, it is merely the price paid. When making their purchasing decisions, commissioners consider only price paid and not the whole of government cost. They therefore may not be making the best value commissioning decisions on behalf of the taxpayer.

2. Cost of capital

Capital is available (but not necessarily readily available) to NHS providers as Public Dividend Capital (PDC), which is charged to their Income and Expenditure accounts (I&E) at a rate of 3.5%. Foundation Trust Financing Facility (or equivalent) borrowing (an alternative source of funding to NHS organisations) carries costs which are substantially cheaper than alternative borrowing available to other sectors. In some areas of public sector provision this is mitigated somewhat by the use of PFI/LIFT scheme funding (which is more expensive, at around 6-8% per annum), however there are relatively few mental health PFI facilities.

Non-NHS providers and NHS providers with large PFI projects have a higher cost of capital than the artificially low NHS cost of capital. Even then, PFI projects benefit from a Secretary of State guarantee which reduces borrowing costs.

Despite the significantly higher cost of servicing capital, some private sector providers nevertheless believe that NHS Mental Health service provider costs are inflated due to poor capital procurement practices which mean that some NHS providers pay excessively for their buildings (see Appendix 3, Section 4). This results in higher annual financing costs and therefore higher prices charged by those NHS providers in order to cover those costs.

Providing such sub-commercial funding to the NHS means that risk is not being properly priced. At some point on average, that risk can be expected to crystallise (ie when a Trust fails) and therefore the subsidy will need to become explicit, not implicit (ie government will need to provide financial support for that failing

Trust). In such a situation, in short, the sub-commercial pricing of funding causes inefficiency in the market as government intervention (and funding) is required to support those failing market participants.

3. Pensions/Staff Costs

The NHS staff pension scheme is an unfunded pension with a notional employer contribution rate (currently 14% of salary) which does not reflect the full market cost of providing the pension (in many cases well over 30% of salary). The NHS provider therefore does not have to bear the full cost of providing this staff benefit but government as a whole does (or will in the future as liabilities crystallise). A private sector provider wishing to attract people from the NHS does in principle have to bear that cost if that provider is to match the benefit. In reality this is only the case for TUPE transfers but this is nonetheless a significant additional cost for the independent sector to bear in those cases. For mainstream recruitment the cost is lower, being a small increment on salary (circa 3%) plus pension costs of 6-10%.

It can also be argued that, as the NHS pension scheme is heavily subsidised by the taxpayer, it can have the effect of blocking employees from moving to independent sector providers, whilst enabling them to move between NHS providers. This creates additional cost for private sector employers trying to recruit employees, especially where NHS employees have particularly generous pension arrangements (see also Appendix 4, case studies).

Finally, some private sector providers also find that the consultants' clinical excellence awards scheme, available to consultants working within the NHS only, can also make it difficult for private sector providers to recruit in comparison to public sector providers. Whilst the local element of these awards is funded by the employing provider, the national awards are funded centrally, providing a subsidy to consultants' pay.

These unfunded contributions to employee pension schemes, again, are not included in the 'price' that commissioners see and are therefore not considered when the commissioning decision is made. This leads to suboptimal decisions from a whole of government basis and therefore creates an inefficient market.

4. Pricing and contracting issues

There are a range of issues surrounding pricing, the main cause being that there is a lack of transparency between NHS and non-NHS contracts.

Data gathered from private sector providers and NHS reference costs shows that the headline price of inpatient mental health service provision is comparable, on average terms, between public and private sector providers. One would therefore expect to see a reasonably high degree of private sector participation on equal terms.

The NHS is generally awarded block contracts, with payment based on the size of the service provision available rather than on the number of patients treated. On the other hand, the private sector is awarded contracts on a per head or per treatment basis and therefore only receives payment for the services it delivers. This can mean that public sector providers are therefore paid for unused capacity and that private sector providers, in the absence of block contracts, need to include a higher premium for risk in their pricing.

Furthermore, since the structure of NHS contracts allows for NHS providers to be paid for unused capacity, it has been suggested to us that they can and do sell the same bed twice and therefore receive income from that bed from two sources. Anecdotally it has also been reported that some NHS commissioners have found that they are unable to access beds that they have paid for under block contract arrangements and are therefore not receiving full value for those contracts. We have not verified this directly but believe that it warrants further analysis.

Private sector providers point out that such block contracting arrangements do not incentivise efficient staff behaviours as there is no incentive to ensure that wards are fully occupied – and indeed staffing is easier if they are not fully occupied.

Private sector providers also cite instances of NHS providers being awarded block contracts for 3 year periods in order to justify investment under Monitor 'risk evaluation for investment decisions' ("REID") guidance and

thereby protect their risk ratings. There are a number of examples of NHS facilities being built at significantly greater expense than private sector equivalent facilities and, in these cases, it seems reasonable to infer that resultant pricing is higher than would be generated in a fully efficient market.

In contrast, private sector providers are awarded contracts on a per head or per treatment basis and do not receive such long term block contracts to guarantee future income when building new facilities. They therefore only receive payment for the services that they deliver and commissioners are not tied into long term contracts which prevent them from renegotiating prices.

The difference in the way that the contracts are structured may lead to market inefficiency if commissioners make their purchasing decisions based on an inaccurate 'price per bed day' (ie one which does not allow for spare or otherwise contracted capacity). In this event, such block contracts can result in payment for spare capacity and therefore in many cases may not achieve best value for the tax-payer and patient.

5. Cultural and behavioural differences

Many providers feel that the natural default behaviour of some GPs and other 'referrers' is to 'keep it in the family' and refer patients to organisations and clinicians with which they (and their patients) have experience and history. This is more likely to be an NHS provider than a private sector provider. In some cases this may be due to a simple lack of knowledge of other available providers, unwillingness to commit to new and unproven providers or inability to stimulate the market to generate alternative options. This may also stem, in some cases, from a philosophically driven desire to keep the traditional Government controlled NHS intact and a reluctance to promote "for profit" organisations. In some instances there is an explicit presumption that NHS providers should be used and in others commissioners have undertaken to consider NHS providers in preference to private providers. In a market where all providers are not considered equally inefficiencies are likely to arise as a better value provider simply may not be considered at all.

In the Mental Health market in particular, in any given area commissioners may feel uneasy commissioning from non-NHS providers because of the possibility that the diversion of large amounts of business away from the NHS might destabilise the NHS provider, possibly forcing it to fail. Because mental health services require some lead time and capital to establish, commissioners may not feel confident that a failed NHS provider can be readily replaced. Faced with the prospect of a failing provider on this scale, most commissioners would feel exposed to demands for more funds to avoid the closure of the service (or its admission to an ill-defined failure regime). In such a situation commissioners will likely make only small scale purchasing decisions, ie putting incremental pressure on their incumbent provider, rather than making wholesale change.

This doesn't however necessarily lend itself to the best decisions on expenditure of public funds.

An alternative approach might be to start a process now which is aimed at delivering more efficient provision in the medium term - ie tendering now for services in say three years' time. The commissioner could then continue to use the incumbent through the bid process and, if they lost that process, either continue to use them until the new contract (for all of the services) commences or broker a transfer earlier of the existing NHS business to successful bidder. This is an approach that has been taken by East of England SHA with regard to the management of Hinchingbrooke hospital.

In order to maintain an efficient market, the key is to commission the services from whichever provider is best able to offer value for money and quality, in a way that demonstrates responsibility both in guardianship of public funds and in delivery of consistent and reliable care.

6. Policy intervention in provision

Examples of policies or legislation which cause NHS and Non-NHS providers to be treated differently are:

- Universal Service Obligation.
- Public Sector Oversight.
- Legislative compliance.

The NHS as a whole has a 'Universal Service Obligation' which means that it must ensure that all necessary services are available for patients who need them, even in areas where it may not be economic to do so. In essence this means that some NHS providers are required to continue to provide services even if, economically, it would make better sense to discontinue that service (in the case of Mental Health provision an example being the provision of 24-hour local assessment and admission to acute mental health wards, often under the Mental Health Act). This requirement will reduce the efficiency of the market where these policies lead to over or under-pricing of (often small scale) services which cannot reasonably be competed.

That said, under commissioners' contracts with private sector providers, those providers are also contractually bound to provide the contracted capacity or face heavy penalties, and so they also have significant restrictions on ceasing provision (the difference of course being that they would likely have had greater say over the services that they provided to begin with). In Public Private Partnership (PPP) deals in other sectors, such contracted capacity requirements have led to the collapse or near collapse of major corporates (eg Laing and Jarvis).

Furthermore anecdotal evidence cited by some private sector providers suggests that NHS providers do not always carry out their Universal Service Obligation within the mental health sector. According to a recent Laing and Buisson report, many prisoners have to wait several months to be transferred out of prison and into a secure mental health facility, as compared with the 14 day average transfer time recommended by the Bradley Review. This is because the NHS providers of those services are unable to offer beds to those patients. (Dr. Judy Renshaw, "Waiting on the Wings", Laing and Buisson, January 2010).

Similarly NHS providers argue that the oversight that they undergo from public review bodies (such as PCT oversight and scrutiny committees or the Independent Reconfiguration Panel (IRP)) is more stringent than that exercised in the private sector by Boards of Directors etc. Providers also face scrutiny from Monitor, stringent procurement regulations and can be subject to freedom of information requests which, as well as adding administrative burden, can mean disclosing commercially sensitive information. NHS providers believe that the level of scrutiny can be onerous and can lead to uneconomic decisions and an untimely decision-making process.

Private providers on the other hand would counter that stock exchange requirements, tax authority scrutiny and lender, Board and private equity investor overview can hardly be considered "light touch" governance regimes in comparison. Private sector providers have also for many years experienced the regulatory impact of clinical governance under the Care Standards Act 2000. The National Minimum Care Standards and the associated inspection regime are stringent and have only applied only to non-NHS providers.

It may be that once all of the legal provisions applying to the Care Quality Commission have been fully implemented there will be level playing field for regulation. Private providers however believe that historically they have been scrutinised more closely than their public sector counterparts in such quality reviews.

It is also worth noting that, providers registered both as charities and companies have to meet both corporate and charity governance standards including dual accounting standards.

Clearly policies and legislation which govern the oversight of quality standards is vital in order to protect the standard of care received by patients. Nevertheless, in order for the NHS market to function efficiently, these policies need to affect all providers to the same degree and need to be as streamlined as possible.

7. Transactions policy

When NHS providers fail, they are not generally wound up in the way that private or third sector entities would be. This means that over-scoped assets/contracts are not marked back to market value (through for example sale or write-down). Successful NHS Trusts / FTs may be asked to take over these failing providers and may therefore be burdened with higher capital charges or less favourable contracts than would be the case in the free market. Of course, it is the responsibility of the prospective merger partner to protect its future sustainability and so this should not occur in theory and ongoing improvements in governance and increased trust independence (especially for Foundation Trusts) should substantially reduce the problem.

The potential that local monopolies may be created by mergers of successful and unsuccessful NHS Trusts may also be an issue. The role of the CCP should prevent any such monopolies having a detrimental effect on the market in theory.

8. Policy noise

Central and SHA policy often seems conflicting (either in content or intent), making it difficult for commissioners and providers to plan ahead and understand the general "direction of travel" of policy. This is a barrier to efficient operation for both NHS and private sector providers. With the new Government seeking significant reform, it is inevitable that this 'noise' will be particularly acute today, but in the longer term, the stated desire of government to reduce its oversight and increase provider independence should reduce the inefficiency caused by this.

9. Availability of capital

While NHS providers enjoy lower capital costs, the capital budgeting regime in the NHS is restrictive and limits the ability of NHS providers to draw down capital even when a good business rationale exists. (Providers are subject to 'Foundation Trust Financing Facility' or equivalent review for all debt applications and DH review for Public Dividend Capital. Whilst an FT has greater freedoms than other NHS Trusts, even it is not permitted to mortgage or sell its protected assets or to change its mandatory services portfolio without significant difficulty. This gives the NHS considerably less flexibility to respond to changing market conditions and therefore allows them to be less efficient than they otherwise might be.

Given the White Paper's proposed loosening of FT borrowing restrictions, this issue may reduce in time.

10. Staffing contracts

Stringent NHS terms and conditions can create difficulties for NHS employers looking to restructure or reorganise their workforce and can result in an inflexibility that makes it difficult for NHS employers to respond to changes in the market. That said, Agenda for Change does allow Trusts more flexibility than many currently employ to promote better working practices and more competitive pay arrangements. In order to deliver best value, they will need to exploit fully this flexibility. (See also: M Britnell, "Mark Britnell on the future for Agenda for Change", hsj.co.uk, 25 February 2010).

Conversely, anecdotal evidence suggests that some NHS facilities are run using a high number of agency staff. This can be expensive and may lead to the provision of poor quality care. Further, such agency staff do not have the same contractual protection as full NHS staff, or indeed private sector staff. Facilities which do depend on such agency staff can therefore be closed or restructured at low levels of cost. That said both public and private sector providers have equal opportunity to employ agency staff.

11. Commissioning skills and strategies

The NHS itself is generally not highly experienced in commissioning and procurement, which means that processes are often poorly conceived and structured, or that many services which could be tendered are not, leading to market inefficiency.

If the advent of GP commissioning does not take advantage of arrangements for accessing high quality commercial skills (probably through an arrangement for sharing these resources across commissioners), the quality of commissioning is likely to remain variable or could even decline if the pool of talented managers is shared over an increasing pool of commissioning organisations. On the other hand, if GP commissioning leads to the growth of high quality organisations that offer support services to GP commissioners, and compete to do so, this may see a competitive and free flowing market which has the effect of improving commissioning outcomes.

In order to maximise market efficiency, services should be commissioned from whichever provider is best able to offer value for money and quality and commissioners will need the skills to ensure that this happens.

12. Adverse effects of budgetary demarcation

It has long been recognised that the boundaries between NHS and Local Authority budgets can lead to difficulties in moving able patients back into community care. Section 75 agreements, now common between PCTs and Local Authorities, are often designed to target these barriers and ensure that patients are quickly moved to the most appropriate care setting. Anecdotal evidence suggests that a similar issue arises in relation to specialist commissioning budgets. Depending on the region in which the commissioning is taking place, either when a patient moves from medium to low secure care or from low secure to step-down care the responsibility for and costing of commissioning will move from the local Specialised Commissioning Group (SCG), which is typically a group of the local Primary Care Trusts (PCTs) to the individual PCTs. This can lead to patients remaining in more expensive care for longer than necessary as individual PCTs are not incentivised to accept additional patients as the cost of treating those patients will be subtracted from their individual budget, rather than being shared across the budgets of all of the PCTs within the SCG.

Appendix 3 – Quantifiable methodology and findings

Overview

The methodology that has been applied in analysing the quantifiable factors is as follows:

Cost base factors:

- A number of NHS and non-NHS institutions that deliver mental heath care services to the NHS have been identified;
- The impact of each of the quantifiable factors identified in Appendix 1 on the differing cost bases of each of the two types of provider (public sector and private sector) has been assessed; and
- These impacts have been aggregated to demonstrate an overall impact for each provider type.

Pricing factors:

- Again, a number of non-NHS institutions that deliver mental heath care services to the NHS have been identified;
- The average price charged on a 'per bed day' basis by private sector providers has been compared with NHS reference cost data (as an approximation of NHS price).
- The average capital 'cost per bed' has been calculated for a number of recently completed NHS facilities and has been compared with the average capital 'cost per bed' reported by a sample of private sector providers.

Factors capable of quantification

Quantifiable factors were identified in Appendix 1 and described in Sections 1-4 of Appendix 2. They are:

Cost factors:

- Taxation.
- Cost of Capital (including valuation of estates).
- Pensions/Staff Costs.

Revenue factors:

- Pricing.

Further detail on how the cost impact of each of these factors, or price differential has been quantified is set out below:

The cost impact of each of these factors has been summarised in tabular form at the end of each section. Each table sets out the quantified differential in cost per £100 incurred by either NHS or private sector providers.

Price differentials have been set out in percentage terms.

Individual factors

1. Taxation

1.1 Corporation Tax

Tax policy and practice differs between our selected institutions. We have investigated the impact of these differences, drawing on our taxation specialists, and from this initial analysis it is clear that private sector

providers incur increased corporation tax costs which reduce their profitability. NHS providers (and charities) are exempt from paying corporation tax.

Due to the high level of assets held by Mental Health providers, amounts of corporation tax incurred do however tend to be lower than in other areas of health provision, due to the offset of capital allowances and other related losses.

In analysing the individual taxation faced by providers, we examined the levels of tax paid by each institution. The tax payable per £ of operating costs (t/C) was calculated for each provider. The differential in t/C between public and private sector institutions was then sought and was then applied to the operating costs to highlight the difference.

On example of how the corporation tax impact was modelled is as follows:

- NHS Provider A has operating costs of £10m and tax payable of £nil.
- Non-NHS Provider B has operating costs of £20m and tax payable of £200,000.
- Provider A t/C = £nil/£10m = nil.
- Provider B t/C = £200,000/£20m = 0.01.

Increased cost incurred by Provider B compared to Provider A = £100 x (0.01-0) = £1 per every £100 of operating costs.

There are interdependencies between the corporation tax factor and other factors which we should be aware of, but have not been specifically modelled. For example, if the VAT difference were removed by allowing private sector providers to claim VAT back under Contracted Out Services rules, the cost base of these private providers would decrease and therefore taxable profits and tax payable would increase. The modelling work has considered the impact of each factor in isolation therefore these interdependencies have not been modelled, but should be borne in mind when interpreting the results.

#	Description	NHS Provider	Non-NHS Provider
1.1	Additional cost incurred per £100	-	£1.19

This impact is lower than expected, given that the corporation tax rate faced by private providers is 28% of taxable profits. This is a result of private sector losses (including capital allowances) being offset against profits, giving a lower rate of actual tax payable.

1.2 VAT

The primary activity of the NHS is a statutory requirement and as such is regarded as non-business and not subject to VAT. Under the normal business activity rules VAT recovery is not possible on costs incurred in providing healthcare services, however, VAT can be recovered by NHS bodies on certain "eligible services" contracted out under special legislation applicable to Government Departments: the "contracted-out services rules" (COS).

Unlike NHS provision of healthcare, the provision of healthcare by the private sector is non-statutory. COS is therefore not applicable to private sector provision of healthcare and as such the VAT on related costs is not recoverable in this way by private sector providers.

The KPMG tax team looked at eight example institutions to identify their total non-pay expenditure (pay costs are not subject to VAT for any type of provider), what proportion of this expenditure was subject to VAT, and the total COS recovery on this expenditure based on a VAT rate of 17.5%. These amounts allowed the COS recovery as a proportion of non-pay spend subject to VAT to be calculated for each of the institutions and then averaged.

#	Description	NHS Provider	Non-NHS Provider
1.2	Additional cost incurred per £100	-	1.20

2. Cost of Capital

To capture the effect of differences in Cost of Capital, the following calculation is made:

The annual cost of financing capital faced by each provider is calculated as follows:

- It is assumed that all providers have a similar relative asset base and therefore 2 providers with the same cost of capital will have the same £ per £100 cost impact on their cost base. A standardised asset base for each provider is therefore calculated as follows; mean asset base/ mean operating cost x actual operating cost.
- The standardised asset base is then multiplied by cost of capital ("K") to give the annual amount spent on financing capital.
- The cost per £100 is then calculated for each provider.
- The corporation tax cost of capital factor is calculated separately, so the Cost of Capital calculated here is post-tax in order to avoid double counting.

Public Finance Cost of Capital

Assumptions in the calculation of public finance cost of capital ("Kpu") are as follows:

Cost of capital is the 3.5% dividend payable on Public Dividend Capital.

- No corporation tax is incurred.

The public cost of capital, Kpu = 3.5%.

Private Finance Cost of Capital

Assumptions in the calculation of private finance cost of capital ("Kpr") are as follows:

- Cost of equity ("Ke") ranges from 10.5%-13.5% and is based on sample information from recent PFI and LIFT schemes.
- Cost of debt ("Kd") is based on an underlying interest rate plus bank margins, based on sample information from recent PFI and LIFT schemes.
- Gearing ("Gd") is 90% and is based on experience of recent PFI and LIFT schemes.
- Underlying interest rate ("i") is 4% and is based on the 20 year swap rate on 3 September 2010.
- Bank margins plus credit spread ("m") are 3.0% and are based on experience of recent PFI and LIFT schemes.
- Effective tax rate ("t") ranges from 6%-22% and is based on Treasury Green Book Guidance and various studies of operational PFI SPVs (it is correct to include effective tax rate, even though NHS bodies do not incur corporation tax, as the private bodies who are sourcing the finance do incur corporation tax and this will therefore be reflected in the cost of capital).
- The private cost of capital, Kpr is calculated in the normal way as a weighted average of the cost of equity and the cost of debt:

  Kpr = ((1-Gd) x Ke) + (Gd x (i+m) x (1-t))
- A Kpr range is calculated using the range of Ke and tax values stated above and the midpoint Kpr within this range has been used in the modelling calculations.

Obviously NHS providers with PFI or LIFT schemes would have similar cost of capital to private sector providers. For this reason we have limited our analysis to NHS providers where no private finance is involved as there are relatively few NHS Mental Health facilities funded via PFI.

#	Description	NHS Provider	Non-NHS Provider
2	Additional cost incurred per £100	-	£2.07

3. Pensions/Staff Costs

The NHS Pension Scheme is an unfunded pension arrangement. Certain employers of staff involved in NHS activities are allowed to participate in the pension scheme. Employers are charged a notional contribution rate by the Treasury, currently 14% of pensionable pay.

The KPMG Pensions team carried out estimates of what an employer (who is not able to access the NHS Pension Scheme) may have to contribute in order to provide NHS equivalent benefits.

We estimated the costs for each of two broad tiers of pension benefits provided by the NHS Pension Scheme:

- A tier for members who joined the scheme pre 1 April 2008.
- A tier for members who joined on or after 1 April 2008.

The KPMG Pensions team prepared the costs on two measures:

- The cost insurers would be expected to charge in current markets to provide the benefits – the "insurance cost". This represents a no (or very low) risk measure to the employer.
- The accounting cost of the benefits – the "accounting cost". This is the cost that an employer would be required to disclose in their accounts.

The difference between the insurance cost and the accounting cost lies in the degree of certainty attaching to the promised pension. Under the accounting cost regime (where the pension fund buys equities and benefits from the higher returns associated with the equity risk premium) the pension is underwritten by the business. The employer therefore buys the pension at relatively low cost, and the employees get certainty of provision (to the extent that the survival of the business is certain, which is great in the case of the NHS). For a private provider to achieve this level of certainty, they would have to go for the higher cost option of funding the pension with government securities. Therefore the insurance cost is taken as the basis of calculating the equivalent benefits.

Any estimate of the cost of providing NHS equivalent benefits depends on the assumptions underlying the estimate:

- Both these estimates were calculated using market conditions as at 1st September 2009.
- The insurance cost reflects KPMG's current experience of insurance pricing bases reflecting transactions we have carried out with FSA regulated insurers.
- The accounting cost reflects KPMG's reference basis for IAS 19 accounting used during audit reviews of pension disclosures.
- In our calculations we have assumed an average employee contribution rate of 6% pa.

For the purposes of calculating the cost impact, the model assumes that the pensionable pay is equal to the salaries and wages paid by the institutions. Each institution was designated a percentage access to the NHS Pensions Scheme as follows:

- All NHS institutions have full access to the scheme.
- All private sector institutions types have no access.

The calculation performed was: pensionable pay multiplied by the difference between the insurance cost of the equivalent benefits and the notional contribution rate, multiplied by the percentage access to the NHS Pension Scheme.

The pension distortion is a legislative concession which allows the NHS to defer the cost of funding its pension scheme, thus significantly reducing the pension related cost to providers with access to the NHS Pension Scheme. The impact is modelled as an increase in cost for private providers.

#	Description	NHS Provider	Non-NHS Provider
3	Additional cost incurred per £100	-	£8.08

4. Pricing and contracting

4.1 Price comparison

We took NHS reference cost data as an approximation for prices charged by NHS providers to commissioners and compared this with the average of price data supplied by a sample of private sector providers for a range of categories of mental health service provision.

Our analysis suggests that, in some categories, NHS providers are more expensive than private sector providers, and in other categories private sector providers are more expensive than the NHS. On average, prices are broadly comparable between the two sets of providers.

#	Category	NHS Provider	Non-NHS Provider
4.1	Local Psychiatric ICU – Additional price % charged	6%	-
	Low secure - Additional price % charged	-	2%
	Medium secure - Additional price % charged	-	5%
	High dependency – personality disorder – Additional % price charged	8%	-
	Overall – Additional % price charged	1%	-

4.2 Facility cost comparison

We also compared the cost per bed of a sample of recent new build Mental Health facilities within the NHS with the cost per bed of recent facilities financed and built by private sector providers. Land costs are often not included within NHS Trust calculations where they are built on current Trust land; we have therefore carried out 2 comparisons: the first comparing the average NHS provider cost per bed with the average private sector provider cost per bed; the second carrying out the same comparison but including the equivalent private sector land cost (approximately £50k) within the NHS provider figures in order to make an allowance for land costs which may be excluded. (See also Appendix 4). Again, the additional cost paid has been expressed as a percentage:

#	Category	NHS Provider	Non-NHS Provider
4.2	Additional capital cost per bed (no additional land figure included in NHS figures)	32%	-
	Additional capital cost per bed (with additional land figure included in NHS figures)	56%	-

The capital cost per bed of the NHS facilities identified is on average 32% higher than the cost of comparable private sector facilities, before allowance for any land costs which may be excluded from NHS calculations. Naturally, this is not a sample size which has statistical validity but the evidence we have seen does seem to point to a case for examining whether the NHS is getting best value from its construction projects.

Appendix 4 – Case studies

Pensions/Staff Costs

As touched upon in Appendix 2, the cost of matching NHS pensions and therefore offering employees a similar package to that received when working for the NHS, can be so high that it prohibits the independent sector from recruiting employees from the NHS.

This is particularly the case for mental health providers trying to recruit senior employees who are likely to have Mental Health Officer (MHO) status. The MHO status class was introduced into the NHS pension scheme. This class was created for those employees working in psychiatry, an unattractive area of the NHS to work in, who were more likely to 'burn out' than peers in other roles within the NHS. The scheme allows anyone with 20 years full time continuous service to collect double pension years, for example someone who has worked for 30 years will have 40 years of pension contribution. The scheme was closed to new members in 1995 however this means that the most experienced mental health clinicians have access to it. It is very costly for private sector providers to match such a scheme and therefore very difficult for them to compete for the most experienced employees.

Facility costs

The Orchard Mental Health Unit was recently constructed at St Bernard's Hospital, Ealing at a cost of £26.8m. This is the cost of the 60 bed unit only and does not include the value of the land on which it is built. Such a cost of £430k per bed is significantly in excess of the equivalent private sector cost of £200-£250k per bed (including cost of land). If the cost of this facility is then reflected in the price charged over a 3 year block contract, this is likely to be significantly more expensive than the price charged by a provider who is able to build their facility for £200-£250k per bed.

An example of a recent private sector facility is the Calverton Medium Secure Mental health unit which is described by its owners as 'state of the art'. This unit cost £15.6m (including land costs) for a 64 bed facility, which is a cost of £244k per bed. This was the most expensive example per bed included in the data that we analysed.

Appendix 5 – Limitations of analysis

This report identifies factors which create inefficiencies in the market for provision of services to the NHS, looking particularly at differences in the operation of the market as between NHS and private sector providers. We have carried out analysis of the cost and revenue impact of some of these inequalities but, for a number of reasons, it should be noted that this analysis is limited:

- The number of providers analysed is a small subset of the total population within the market and the findings can therefore not be considered statistically robust. Every provider is different, for example due to adoption of different service models which affects the make-up of provider cost bases and therefore the impact on these of the inequalities identified.
- The quantified inequalities do not tell the whole story and it is not therefore valid to suggest that the quantitative results give the complete picture.
- NHS price data has been based on NHS reference costs. Historically such reference costs have included inaccuracies due to human error and process failures in the way that data feeds into these reference costs is gathered. This is however the best available indicator of NHS prices that we were able to identify in the course of the work.
- Comparison between NHS and private sector prices is difficult as the private providers categorise the services that they offer in a different way to the NHS reference cost categories. In order, for example, to achieve a price comparable with what NHS reference costs define as 'low secure', the private providers supplying data have blended their low secure and 'rehab step down' rates. They believe that this is in line with the definition of 'low secure' as referenced in the NHS costing manual.
- In some cases, the inputs used to estimate the size of the cost differences are not definitive.
- Cost data could not always be sourced that was in sufficient granularity for our purposes and assumptions had to be made in many cases. These are set out in Appendix 3.

Appendix 6 - Scope of work

The scope of the work is as follows:

- To identify the key factors that exist in the market which advantage one set of providers (ie public sector or private sector) over the other. These may be either quantitative (ie potentially measurable in terms of costs/ revenues) or qualitative.
- In the context of these key factors identified, identify the arguments for and against the hypothesis that private sector mental health provision is lower cost than public sector mental health provision.
- Carry out some high-level cost driver analysis, comparing costs suffered by public and private sector providers, based on publicly available information and information to be provided by the IMHA.
- Prepare a short report setting out the arguments for and against the hypothesis, including a summary of the above analysis. This will include review by senior members of the health team (including Mark Britnell) to ensure economic and commercial perspectives, as well as both public and private sector perspectives are well considered and represented. The report will include an overview of approximately 3-5 pages, along with an Appendix of supporting analysis.

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