Monitor's Level Playing Field Consultation July 2012

Submission from the Healthcare Financial Management Association (HFMA)

Introduction

The HFMA is the representative body for finance staff in healthcare and – for the past sixty years – has provided independent and objective advice to its members and the wider healthcare community. We are a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through our local and national networks. We also analyse and respond to national policy and aim to exert influence in shaping the wider healthcare agenda. We have a particular interest in promoting the highest professional standards in financial management and governance and are keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

Our comments draw on the expertise of finance directors across the NHS as well as the HFMA's national committees and member faculties (a network of organisations with a common interest that share experience and expertise, and want to use their combined numbers to influence thought and policy in their sector).

Summary of key points

- We welcome the removal of advantages to any one party in providing NHS-funded healthcare and the drive to establish a level playing field. However, we recognise that barriers do exist that could prevent this aim being achieved and that changes are needed if these are to be removed or overcome
- We are broadly in agreement with the issues identified as posing potential barriers to a fair and/or level playing field
- The HFMA recognises the potential role of competition between all healthcare providers in eventually 'evening out' the playing field but as all providers are not operating on the same basis, we can see that there are issues that need to be addressed, particularly in the short to medium term. Ultimately, it is important that all players are competing on the basis of quality, access to care and patient outcomes
- In our view, plurality of provision does not necessarily require additional mechanisms to be put in place but may be further supported by changes to the way in which services are commissioned

- The HFMA recognises that it may be appropriate to delay the introduction of changes to the tax regime until the point at which an all foundation trust (FT) sector is achieved in relation to NHS provision of healthcare

- We would welcome clear and transparent definitions to support the consistent application of future corporation tax requirements in so far as they are applicable to NHS providers

- We are concerned that the situation in relation to social enterprises/ community interest companies is still developing and needs to be clarified fully. As part of previous NHS organisations established as a result of the Department of Health's (DH) Transforming Community Services (TCS) initiative, they do not have a financial history of their own and are currently outside of the NHS VAT registration scheme

- The HFMA supports a strong, rules-based payment mechanism based on accurate, granular costing taking into account the complexities of individual patients, specialist care, long-term conditions, clinical training and education and capital. At the same time, it is important to recognise the interdependence between certain specialities and the wider impact on changes in income at organisation, specialty and patient level. The payment mechanism is best supported by clear guidance in relation to what is expected of both commissioners and providers operating within a rules-based system

- The application of more detailed costing standards used by all organisations feeding into the process would best support a rules-based payment mechanism

- We suggest that strong commissioners can encourage changes in provision for example, so that services are provided closer to home/ in different ways or to fill gaps in the range of services provided

- We recognise that the cost of and access to capital has created barriers both within the NHS and between the NHS and the private sector. This is also an area of concern for newly established social enterprises formed from the provider arms of primary care trusts

- We are concerned that from a provider point of view, existing barriers in relation to 'commercial confidentiality' supporting innovative service design may ultimately be eroded by the need for greater sharing of information.

1. Introduction

1.1 The HFMA is pleased to contribute to Monitor's inquiry and would be happy to elaborate on any of the issues raised if that would be helpful. Our submission is based on the views of our members who work across the NHS and reflects their experience of delivering tangible improvements in the financial and operational environment year after year. We have focussed on those issues that Monitor highlighted in its June announcement that are relevant to our area of expertise and interest.

1.2 The HFMA agrees in principle with the areas initially identified as presenting potential barriers to a level playing field. We believe that the list accurately reflects the current and medium term issues but would also like to see the following areas considered in more detail:

- The NHS governance infrastructure and its associated costs. The requirements of public bodies to account for what they do/ demonstrate accountability are more onerous than those for the private sector – for example, the public reporting of Quality Accounts. We would therefore suggest that the same standards and requirements in relation to performance and financial reporting could be considered in relation to Any Qualified Provider. This would promote consistency in public reporting, facilitate comparisons between healthcare providers and support patients in choosing where to receive their care

- The differential impact of Care Quality Commission (CQC) registration. A number of NHS organisations have been the subject of adverse CQC reports in recent years. We recognise that this has a significant impact on the organisation; however the organisation has continued to operate while addressing the concerns raised. In our view, an adverse CQC inspection in relation to a private provider has a far greater chance of 'proving fatal' to that organisation as it can result in exclusion from framework style agreements and future tendering processes.

2. Tendering and commissioning behaviours

2.1 **Encouraging plurality**

2.1.1 We recognise that strong commissioning can facilitate plurality of provision. In our view, encouraging greater plurality of provision does not necessarily require additional formal mechanisms but could result from changes to the way in which services are commissioned and greater confidence amongst commissioners (perhaps facilitated by the NHS Commissioning Board).

2.1.2 Therefore, we would welcome further consideration in conjunction with the NHS Commissioning Board (NHS CB) of the way in which contracts are placed and the underpinning service specification. If clinical commissioning groups were to consider services in smaller 'packages' of care it may be possible for small and medium sized organisations to compete more effectively to deliver a contract.

2.1.3 In our view it would also be helpful for commissioners to consider whether a contract could be awarded jointly to more than one provider and focus on those providers working together to deliver a clear outcome for patients based on the optimum pathway of care. This supports the development of integrated care relying on co-operation rather than direct competition. To work, it must also be supported through the payment mechanism

2.1.4 The HFMA also recognises that fair, equitable, robust and transparent processes should underpin all procurement decisions, including those for commissioning in order to ensure that a wide range of healthcare providers is able to compete for a contract. This should apply at all stages of procurement specifically:

- during development of the service specification
- when engaging potential providers
- during the procurement itself.

2.2 **Private sector**

2.2.1 It may also be helpful for commissioners to consider offering contracts over a longer period of time than is the current practice in the NHS. The costs of entry into the market can be significant and when combined with a short initial contract period may limit the ability of private providers to respond.

2.2.2 Similarly, a 'de minimis' limit may be applied to a contract. However, we recognise that while this may afford some protection to the NHS from transient or financially insecure providers, it may also exclude those smaller providers whose very existence can depend upon the successful implementation of a new contract. A sensible balance therefore needs to be found.

2.2.3 As public sector organisations with clear statutory financial duties and the requirement to remain financially viable while operating a balanced budget, NHS providers cannot operate 'loss-leading' services unless they are subsidised from elsewhere in the organisation. We recognise that although the foundation trust regime allows organisations to run a planned deficit as long as they can demonstrate financial viability over the medium to long term, it is difficult to manage loss-making services for any prolonged period. In this context, we are concerned that, although the private healthcare sector is not currently as big in size and turnover as the NHS sector, private providers may be in a position to 'pick off' low risk, high volume procedures leaving unviable NHS institutions with practical difficulties ranging from increased costs to the unviability of some services.

2.2.4 As public sector bodies, NHS organisations are required to comply with European Union procurement legislation to ensure that contract opportunities are open to a wide variety of potential providers. The HFMA recognises that private providers will not be subject to this legislation in the same way and therefore incur a lower cost of procurement than an NHS organisation.

2.3 **Social enterprises**

2.3.1 In our view, a key issue for social enterprises in entering a market is that they have yet to establish a 'financial track record'. Formed from primary care trusts, new social enterprises in healthcare do not have a trading history in financial terms as their accounts formed part of those for the predecessor primary care trust. They are invariably self-contained but at present are unlikely to be able to compete alongside other NHS and private healthcare providers for new contracts.

3. NHS staff contracts and pensions

3.1 With staffing costs representing the largest category of expenditure within the NHS, the premium associated with the NHS pension scheme (and consequent impact on the level playing field) can be significant. Equivalent private providers are able to offer services at a

considerably lower price as they do not need to meet the employer's contribution to the NHS pension scheme.

3.2 At a detailed level, social enterprises in the healthcare sector are currently unable to participate in the NHS pension scheme for new employees and therefore offer the same employment benefits as an NHS organisation. Although from a cost point of view this is likely to help with competitiveness, it may also deter experienced staff from joining social enterprises as their existing NHS pension would not continue.

3.3 In the event of the re-provision of a service where TUPE arrangements apply, potential providers need to match NHS pensions for existing staff. This can be a significant added cost.

3.4 However, if TUPE does not apply and a service and the associated income transfer to another provider, the incumbent provider can be left with costs to reduce/ remove. If remaining staff cannot be redeployed, the provider may incur redundancy costs which may be shared with commissioners. However, in our view, it is unlikely that this is a risk-sharing arrangement which could be agreed with clinical commissioning groups given that their allocations will relate solely to commissioning patient activity and the running cost allowance.

4. Corporation and value added tax

4.1 The HFMA is aware that there has been considerable debate surrounding the corporation and value added tax requirements for providers of NHS funded care. However, we welcome this opportunity to reflect the views of our members in this area. The HFMA recognises that it may be appropriate to delay the introduction of changes to the tax regime until the point at which an all foundation trust (FT) sector is achieved in relation to NHS provision of healthcare. In this respect we would like to highlight the following issues:

4.2 Corporation tax

4.2.1 We recognise that the current corporation tax requirements on profits from commercial activities favour NHS providers and that the ultimate goal should be to achieve an equitable approach for all sectors.

4.2.2 However, in our view, any changes to the existing tax regime would need to be supported by a circular flow of funds to avoid there being less money available to treat patients. It is therefore important to achieve equal treatment between the NHS and the private sector. Mechanisms available to the private sector to reduce the tax burden would also need to be made available to the public sector.

4.2.3 We would also welcome further consideration and clarification of the impact of corporation tax in relation to NHS commissioning support services which are to compete with private providers in the future. Based on our current understanding and the proposed direction of travel, the services they provide will be in competition with the private sector. This implies that they will be subject to corporation tax in the future in order to compete on a level playing field with private sector providers.

4.2.4 In our view therefore, the rules underpinning how different NHS organisations are treated and where the tax liability falls is of critical importance. We recognise that there is an inherent difficulty in defining sources of funding as private or public. We

would therefore welcome clear and transparent definitions to support the consistent application of future corporation tax requirements in so far as they are applicable to all NHS providers.

4.3 Value added tax (VAT)

4.3.1 The HFMA recognises that the treatment of VAT is not currently uniform across all providers of NHS funded care leading to differing cost bases that at present are not reflected in the tariff.

4.3.2 The situation for social enterprises is also unclear. It is important to understand whether or not they are part of the NHS VAT registration scheme as many existing exemptions do not currently apply, limiting competitiveness compared to other NHS organisations.

4.3.3 From a commissioning perspective, it is important that the focus is on seeking out the best services available for the patients concerned rather than having to spend time and effort considering how contracts are influenced by differing VAT implications.

5. Payment systems

5.1 As demonstrated in our responses to consultations released by Monitor earlier this year, the HFMA supports a strong, rules-based payment mechanism based on accurate, granular costing.

5.2 In our view, the costing approach supporting the payment mechanism needs to recognise the extent to which costing and the associated standards can force a distortion of costs. For example, an elective centre undertakes high quality routine work, as compared to an NHS trauma centre that has to be prepared for all types of patient. In the former, service provision can be planned and equipped to a different level which needs to be recognised within the detail of the costing approach. Without an appropriate level of costing sophistication, the costs of theatre or scanning services supporting the elective centre might simply be divided by the number of patient 'activities' to obtain a unit price. However, if the same approach is used to obtain a unit price for the trauma centre, the additional costs of out of hours staffing, on call consultants etc will inappropriately inflate the cost of routine surgical or imaging procedures and deflate the cost of emergency activity.

5.3 The situation is currently exacerbated by:

- the setting of national tariff prices at healthcare resource group level as each HRG can cover a range of different procedures of differing complexity
- the allocating of a significant proportion of costs on the basis of length of stay taking minimal account of patient acuity. As in 5.2 above, more complex patients are likely to have too little cost attributed to their care.

5.4 The fear among NHS practitioners is that even with the same tariff on offer to both public and private providers, the private sector can cherry-pick the simple cases and make a profit while foundation trusts are required to provide mandatory/ protected services as well as being relied upon to provide emergency back-up facilities if complications subsequently develop as the 'provider of last resort'.

5.5 Therefore, in our view, it is vital that the accurate make-up of costs is reflected in future tariffs including any adjustment for unavoidable costs and the cost of capital. We are aware that private and independent providers are unlikely to have the same level of infrastructure costs as NHS providers supporting emergency and non-elective healthcare services. This is also the case where NHS organisations have significant major investments particularly existing private finance initiative (PFI) schemes (see 9.1). As a result, the costs for some providers are inherently higher than for others (as demonstrated in 5.2 above) while the national tariff currently embeds reimbursement at the average.

5.6 We welcome the recent document 'A methodology for approving local modifications to the national tariff' which goes some way towards meeting our concerns through the introduction of upwards local modifications to tariff. In addition, some reflection of unavoidable costs is likely to be required during any period of transition.

5.7 In our view, it is important to recognise the interdependence between certain specialities – for example, the need to provide critical care services to support surgical specialties and the wider impact on casemix changes to the operation and financial viability at organisation and specialty level.

5.8 The HFMA is also aware that the marginal rate emergency tariff of 30% creates an artificial distortion to the income received by NHS organisations under tariff. Although designed to facilitate joint working with commissioners in order to reduce demand for emergency services, healthcare providers have little control over activity growth while earning little or no margin on this activity even if it is delivered efficiently.

5.9 In our view, the issue of simple procedures attracting the same price as more complex procedures in the same HRG based on an average– could be resolved with a more granular currency and costing approach. The NHS may retain the more complex work, but a more granular currency, costing approach and associated tariff would appropriately reflect the additional costs involved.

5.10 In our experience, a refined and more granular tariff could be best supported by the application of more detailed costing standards used by all organisations feeding into the process. Specifically, the *Clinical costing standards* that have been developed by the HFMA Costing Special Interest Group in conjunction with the DH and involvement of finance professionals from a variety of organisations. The HFMA believes that the standards provide a cost-effective starting point for developing more detailed national guidance as they already exist, represent best practice for costing at the lowest possible level in the NHS (i.e. the patient) and are increasingly used, particularly in the acute healthcare sector. The standards and supporting material can be found at: www.hfma.org.uk/costing.

5.11 To operate effectively, a more granular tariff would be supported by clear guidance in relation to what is expected of both commissioners and providers operating within a rules-based system. In our view, it is important that discussions between commissioners and providers focus on quality, care and outcomes and are not diverted to matters of interpretation or the management of expectations.

5.12 In addition, price negotiations can introduce instability for providers by causing contract negotiations to become protracted. Foundation and aspirant foundation trusts need to be able to demonstrate financial stability on an on-going basis with commissioner 'sign-up' to financial projections, which could be compromised if contracts cannot be agreed. Similarly, all parties must abide by the contract once agreed to enable providers to be reimbursed appropriately. Reimbursement rules should be appropriately and consistently applied, irrespective of the nature of the service provider.

5.13 We are concerned however, that most community healthcare services continue to be provided under a system of block contracts. This affects new social enterprises established following the TCS initiative as most of their income still comes from block contracts. We would therefore urge both Monitor and the NHS CB to consider the effective expansion of payment by results to include community services at the earliest opportunity to facilitate their position in the healthcare market.

5.14 Recognising that the sector regulator and the NHS CB have now defined their roles in more detail, we would welcome a shared perspective in developing the tariff in order to promote the viability of both commissioners and providers within the total resource envelope. Mutual agreement on the prices set, the development of risk sharing arrangements for providers and commissioners and clear overall system management will be key to operational success and guaranteeing a level playing field for all providers.

6. Barriers to exit

6.1 The HFMA considers the key barrier to exit, particularly for existing NHS providers, is the fixed costs remaining within an organisation once a service is terminated. In our view, established NHS providers find it very difficult to reduce or remove fixed costs particularly relating to their estate including associated finance leases such as private finance agreements (PFI).

6.2 In the event that a commissioner moves a contract for a particular service to another provider, staff may be redeployed and facilities sometimes used for another purpose. However, this is not always the case and can leave a provider in a vulnerable financial position with capacity it may be unable to fill or redevelop (see 3.4).

7. Teaching and training for clinical staff

7.1 The HFMA is aware that there are differences in the funding and provision of clinical teaching and training between the public and private sectors, although we recognise that the private sector contributes to this area particularly through the development of clinical research.

7.2 However, non-NHS providers of NHS funded care may benefit from a competitive advantage as a significant number of their staff are likely to have received NHS training while the costs of providing training rest largely with the NHS.

7.3 We would envisage that a more complete analysis of training costs and more granular approach to costing would be of benefit here. This would enable quantification of the costs associated with both upfront and ongoing training for clinical staff and the appropriate reimbursement of both public and private providers of training.

7.4 Although teaching trusts may currently receive separate funding streams to cover training costs, NHS providers also identify significant additional costs in relation to the continuing professional development of clinical staff, which may not be accurately reflected in existing cost analysis and reimbursement arrangements.

7.5 The HFMA therefore recognises the need to separately and appropriately deal with income and expenditure relating to training and education which is reflected in our clinical costing standards (see 5.10 above). It is important that a clear framework is developed to enable consistent and fair financial allocations to support training and education irrespective of where it is provided.

8. Incumbency advantages

8.1 The HFMA welcomes the consideration given to the advantages held by those providers who are already established in a particular health economy. In our view, this can make it difficult to achieve a situation of genuine plurality of provision and we can see why considering this issue is important if competition is to be encouraged to drive efficiency.

8.2 However, we do recognise that there is a key role for commissioners here. Once commissioners are clear about what it is they want to buy they need to make sure this is specified clearly and where necessary encourage changes in provision. For example, so that services are provided closer to home/ in different ways or to fill gaps in the range of services provided. To be able to do this commissioners need to work closely with qualified providers, understand any barriers that may prevent potential providers coming forward and also make use of incentives/ levers to stimulate supply (while ensuring that they do not fall foul of competition law).

8.3 For example, commissioners could make use of the following incentives/ levers:

- use of local developments to help potential new providers enter the market
- setting service specifications to include imaging in local clinic premises
- improving access to potential providers
- non recurrent support for new entrants
- using contracts that recognise that the level of work will increase during the contract life.

8.4 Incentives and levers need to be built into contracts that are agreed with providers while at all times ensuring that the commissioning process itself remains transparent (see 2.1.4).

8.5 We recognise that incumbent healthcare provider(s) will have an inherent degree of knowledge which can be used to the organisation's clear advantage. In our view, this should not prevent commissioners from challenging existing provision and seeking alternative solutions if a service specification is better provided elsewhere.

9. Costs of capital

9.1 It is widely recognised by NHS practitioners that an uneven playing field exists *within* the NHS itself in relation to the costs of capital: organisations with PFI schemes already have higher (fixed) costs than those with publicly funded schemes, yet no allowance is currently made for this within the national tariff. Private finance schemes must be managed within the overall resource envelope of an individual organisation as with any major investment. In the experience of our members, the higher the cost of capital the greater the focus on securing savings from clinical services and the greater the potential impact on safety and quality of care. However, we do recognise that there has been a clear benefit to patients of PFI schemes where treatment is delivered in new state of the art facilities.

9.2 The cost of and access to capital is a particularly difficult issue for newly established social enterprises/ community interest companies. Even if potential lenders are identified new organisations are intrinsically considered to be higher risk and as a result, the cost of capital is itself likely to be quite high. At a detailed level, social enterprises in the healthcare 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.

9.3 We recognise that the public dividend capital (PDC) rate paid on public investment can give NHS providers an advantage over non-NHS providers. However, it should be borne in mind that whereas PDC is paid to the DH on an annual basis, shareholders in a private sector company may not routinely receive a dividend payment on their investment.

9.4 As interest is payable on loans from the commercial or banking sector, this may generate significant differences in the cost of capital between foundation and non-foundation organisations (the latter being unable to enter into commercial borrowing). In our view, this is likely to be an issue in the short to medium term before an all foundation trust sector is achieved.

9.5 We recognise therefore the importance of all NHS organisations having a clear understanding of their costs, including the cost of capital and being able to allocate those costs on a reasonable and appropriate basis. This could be supported by a consistent approach across the NHS to costing and the valuation of assets.

9.6 We would also welcome clarification in relation to the financial metrics used to measure the financial performance of licensed providers. With the licence replacing the compliance framework for foundation trusts, our members would welcome the opportunity to debate the way in which financial metrics may be modified in the future and reflect the financial environment within which private sector providers operate.

10. Access to capital

10.1 We are aware that to establish a truly level playing field, all healthcare providers require comparable access to finance for investment and freedom to conserve assets to support growth.

10.2 Unable to borrow from the commercial sector, non-foundation NHS trusts do not at this point in time have comparable access to potential investment. Although this is a short to medium term issue, before all NHS providers of healthcare have foundation status, it is an issue during the period of transition. Although NHS providers may have access to capital at interest rates below market rates, they are subject to capital rationing. Limited by either a capital resource limit and/ or the need to remain within a prudential borrowing limit, the amount which can be spent on capital assets is constrained, not least by the need to remain financially viable and operate a balanced budget. This is an important mechanism for safeguarding public funds.

10.3 For social enterprises established in the healthcare sector, access to capital assets such as buildings and vehicles is via leases established in line with contract length. This introduces significant uncertainty to both financial planning and operational performance. There is also the possibility that, in the longer term, social enterprises may face increased lease costs as former PCT assets are transferred to a new landlord (NHS Property Services).

10.4 We recognise that it is vital for any provider, from whichever sector to balance the length of a contract against the need to invest in capital while considering how to manage that investment and the associated capital asset at end of the contract if the latter is not successfully renewed. However, in our view the differing financial regimes within which NHS organisations currently operate present a very real barrier to achieving a level playing field in this area.

11. Information and IT

11.1 From our perspective, it is clear that shared information is a pre-requisite for greater co-operation between commissioners and healthcare providers, as well as with the sector regulator and the NHS CB. The drive to improve the quality of information underpinning the payment mechanism and analysis of patients' needs should continue not least to support the development of new currencies. This can be supported by clear guidance in relation to the recording and coding of patient activity data.

11.2 However, in our view it is important that all licensed providers are required to provide financial information to support the payment mechanism. This is vital to develop the understanding as to how all healthcare costs can be appropriately reflected in the tariff. This would clearly support the development of a level playing field as well as providing more accurate costs and subsequently tariff payments.

11.3 In our view therefore, we consider that there should be a 'level playing field' in relation to data requirements and information governance for all providers. This is also relevant to the access to and use of information for the purposes of market analysis to ensure that new providers exploring any commercial opportunities are aware of the data they can access.

11.4 From a provider point of view, we are concerned that existing barriers in relation to 'commercial confidentiality' may be compromised and ultimately eroded. Any proposed

new business model put forward by a provider is likely to be shared with a wide audience during consultation and a subsequent procurement process; competitive advantage may therefore be eroded over time. While we recognise that providers need to continually improve care standards and productivity, this may be seen as a disincentive to creative, competitive market practices.

11.5 We would therefore like to see a greater focus on the extent to which providers can access information while allowing organisations to retain an appropriate degree of confidentiality. In our view, this will help to reinforce the principle of openness and transparency, and subsequently demonstrate a level playing field.

11.6 This is also an area of concern for social enterprises as IT and information resources are currently provided by existing commissioners. Any investment in information and accompanying systems must currently be agreed with commissioners and reflected in contract prices in the future. We would welcome clarification as to where management responsibility and financial support for these systems will lie given the changes to the commissioning landscape from 1 April 2013.

11.7 Private providers are not subject to national targets, performance reporting or freedom of information requirements in the same way as public sector organisations and therefore do not have an infrastructure and associated costs in place to manage the related monitoring and returns. For example, a private sector provider would be unlikely to accept full exposure to the total level of demand for a particular elective procedure whereas an NHS provider is fully exposed to treating all patients requiring the procedure irrespective of the initial contract in place with commissioners.

12. Insurance

12.1 Independent sector providers including social enterprises are unable to join the Clinical Negligence Scheme for Trusts (CNST). When social enterprises were established in line with the TCS initiative, transferred services were included in the CNST but any future services taken on by a social enterprise fall outside of the scheme. Interim guidance from the DH (Bob Ricketts, 18 June 2012) indicates that new acute and elective services could be included in the scheme but we are concerned that this does not incorporate emergency and community services.

12.2 We recognise that healthcare providers can incur significant costs (even with the CNST in place) when a claim for clinical negligence is settled a number of years after a contract has ended. A cost is also realised in relation to the on-going settlements paid to some claimants. Not backed by a cash asset on an individual trust balance sheet, the payments represent a real cost to the NHS.