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August 28th 2006

Opportunities and Challenges in the NHS – As the Reform measures begin to take effect

Efforts to reform public services are constantly in the news, and a lot of attention has been paid in particular to reforming the National Health Service in England. Plagued by increasing costs, indifferent patient care, and growing public impatience with its seeming inability to raise productivity and improve the timeliness of patient care, steps are being taken to try and shake up the behemoth.

We think that some of the tectonic plates in the public health care system are, at last, starting to move. In particular a clearer divergence of interests is appearing between the funders of patient care, the Primary Health Care Trusts (PCT's), and the deliverers of health care, the NHS Trust Hospitals and Foundation Trust Hospitals (partially freed from the clutches of NHS funding rules). As the plates start to move, so opportunities are opening up for consultants as increasingly empowered managers grapple with complex issues in trying to balance spending with health needs, and in allocating resources more efficiently.

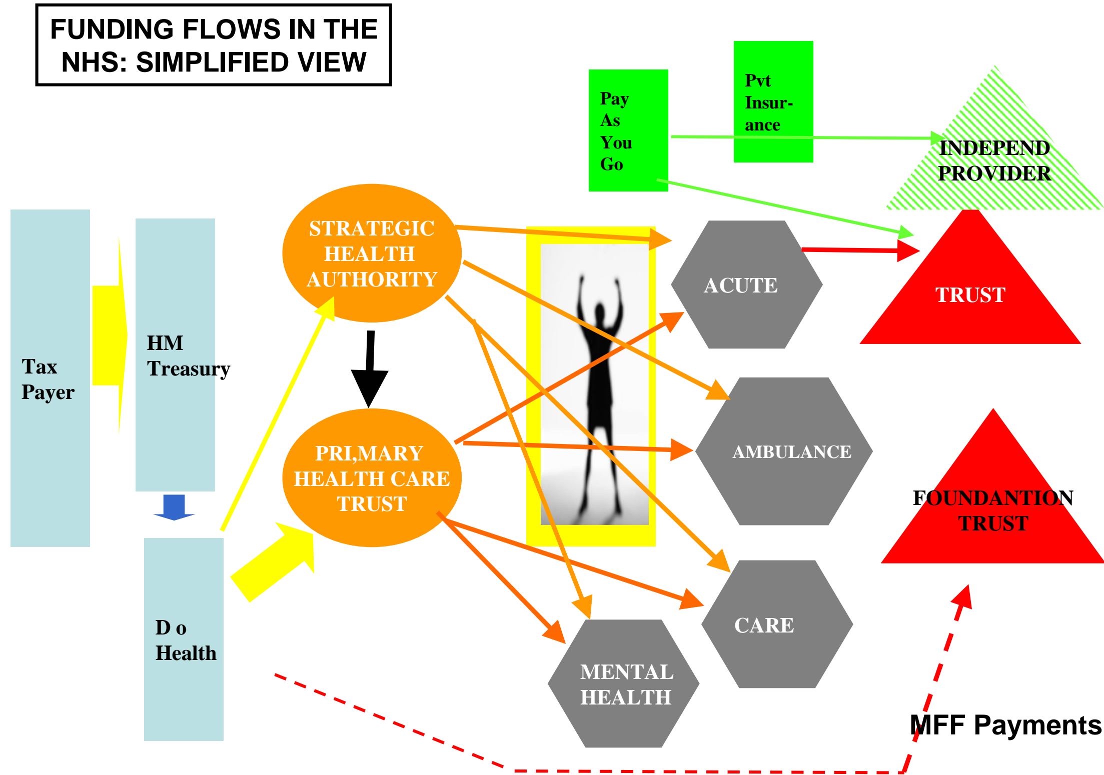
Dissecting the System

Unravelling the NHS though is a bit like picking up a large ball of string, hopelessly muddled and entwined in itself. It requires either the patience of Job, or an Alexander like slice through a NHS "Gordian Knot" to try and make sense of it all.

The following is a summary of how some of the planned changes are likely to create a ***raft of new opportunities for stakeholders in the "industry"***, many of them clearly marketing and consulting opportunities.

Before proceeding further, it might help to consider the following. In an insurance based health system, every visit to a doctor generally initiates a flow of money to the health service supplier, ie the doctor or hospital. In these systems it is easier to record what is happening at a patient level, and it is important to realize that what the insurance company sees as a "cost", is seen as revenue by the health service suppliers. There are some similarities between this approach and what happens in the NHS. "Funding" for the NHS equates to what an insurance company might pay a supplier for delivering health care. However, whereas in the insurance based system accountability may rest with the insurance company and patient for the flow of monies, in the NHS it is rather more complicated ! But remember that what represents a a cost, or "funding" for one part of the NHS system also represents revenue for other parts of it.

The main flows of money through the system are outlined in the diagram below.



Treasury Determines Overall Funding In NHS

Current funding for the NHS originates with the Treasury, who effectively determine the level of health demand in the system. Ex post, demand equals what is spent, and what is spent is determined by the Treasury. How the Treasury knows what is the “right” level of supply is a very good question in itself.

Monies then flow first into the Department of Health, who disburses them to the **Primary Health Care Trusts** (PCT’s). These newly reorganized agencies then “commission” (ie pay for) health care with health care providers – on behalf of the patients. Patients seem to inhabit this system as a curious after-thought. A lot is done in their name, but they are rarely able to determine what service they will get. Some monies also flow to the Strategic Health Authorities, whose reduced role is to continue to provide for some “national” planning element in the system. However, while they may disburse monies for particular programmes, experience has shown that it does not always end up where it was intended to go.
As can be seen, the PCT’s play a crucial role in the system, since they commission work with the various executive elements in the system, or the Trusts, who actually deliver the health care. But the PCT’s are also involved in the delivery of health care, which can give rise to conflicts of interest within the system.

Health Supply Situation Complicated – few incentives to change

On the supply side, there are a range of health providers, including Trust Hospitals, Foundation Trusts, who have a private (charitable ?) status, and a number of other Trusts, such as for Ambulances, Mental Care etc. So far so good. Well, not quite. The PCT:s are also health care providers, via their role as supporters of GP's, as well as Community Hospitals. So some of their "commissioning" money goes into supporting their own activities, and is not always passed on to other suppliers. They suffer from a degree of conflict of interest, in that efforts to provide prophylactic care and first line support via the GP's, will mean that they can effectively divert funds to themselves, before "commissioning" additional work ie referring patients (!) to the suppliers of health care.

But the picture gets even more complicated. The amounts of monies flowing to the Care Providers, we'll refer to them as Trusts from now on, does not come exclusively from the PCT's. The PCT's commission work at a given national tariff for each procedure, or HRG (Health Resource Group), and this effectively defines the ***revenues*** the producers, the Trusts, can obtain for each patient treated. These reference prices are often, and wrongly, regarded as "costs" by the Trusts. The trouble is that while the reference prices might describe, ex post, what it might have been the average "national" cost to perform a procedure e.g. a hip operation, across the country, it may fail to accurately describe a single hospital's actual cost structure. And thereby hangs a proverbial tale .

The Trusts actual costs, if known, may differ substantially from what is "allowed" under the system. Where local costs are higher than allowed, they are covered by additional payments called Market Force Factors (MFF's) , that emanate from the Department of Health, and flow into the pockets of the Trusts. There are substantial regional differences in costs, but these are not allowed to influence the actual allocation of resources. No sense in sending patients from expensive South Eastern hospitals up to cheaper Northern ones is there!

Hence the system, as it currently stands, has remarkably few incentives for anyone to become more efficient and streamlined. It could even be a disadvantage, since it might actually suggest fewer resources are needed, so lowering budgets for the following year. And, of course, any surpluses are grabbed back by the Treasury, just in case any Trust or PCT might think of investing them in additional services. The exceptions here are the Foundation Trusts, who are allowed to keep their surpluses, but also have to fund their deficits.

Change Is In the Air.

It is against this background that the current set of reforms need to be seen. For instance an increased role of *payment by results* for procedures actually carried out. It remains quite remarkable that under the current rules, there is no bonus for treating patients early, so no differences between spot and future prices. There is no real margin given as an allowance for the different levels of difficulty and skill needed (quality measures) in determining revenues for procedures either. If costs go too high, for the purposes of determining the national average, they are simply "truncated" ie ignored !!

Diverging Interests between PCT's and the Trusts

Despite this, the NHS is slowly but surely having to adapt and change. Fiscal responsibility is being taken much more seriously, and it is now important that hospitals actually balance their books, and are being asked to fund their own deficits (to a degree).

The other big change is the **growing divergence of interests** as between the PCT's, the Commissioners, and the Trusts. PCT's are being allowed to shop around to take work (ie patients) to lower cost providers, frequently privately owned, who may be able to under-cut other NHS providers. Or, importantly, offer a much quicker delivery, thus enabling PCT's to boast that they have met various waiting time and queuing targets. The PCT's, as commissioners, are also being encouraged via Practice Based Commissioning, to try and do more treatment locally, and so, all things being equal, reduce the flow of patients to hospitals.

Benefits of specialization amongst suppliers

On the supply side, Trusts, particularly Foundation Trusts, will be able to decide which bits of "business", ie patients, they want to bid for. For the first time, understanding how their actual costs deviate from the "tariff" prices, could start to influence their resource allocation decisions. A "low" cost hospital, with a specialist unit, might be able to take patients more quickly and more cheaply than those of a neighbouring Trust. It could then expand, while the less efficient hospital could actually face falling waiting lists. Not because they have miraculously got better at delivering health care, but because their patients, once presented with a choice, may vote with their feet and seek better and /or quicker treatment elsewhere.

More seriously, in the longer term, growing competition between suppliers may start to lead to lower activity levels in some parts of the NHS. Activity is a key cost driver, since the more patients you have, the more you can amortize your fixed costs. Lose activity, and your basic cost level starts to rise sharply, threatening your future existence even in the relatively cosy environment of the NHS. Doctors and nurses, you have been warned !

Ipswich Cuckoos

Recently a case has come to light that rather undermines the main "drift" of the reformers case – which is to provide timely, effective patient care, including choices as to where and when the procedures are carried out. All at "affordable" costs to the NHS.

Ipswich NHS Trust managed to greatly reduce its waiting list for operations and procedures, something that is expressly wished for as part of the Reform process. What a good thing, you might think ! Well, alas, no. Within the arcane world of the NHS this has actually called forth the wrath of the local PCT. They had effectively imposed (yes really) a waiting time for procedures to be measured in hundreds of days. In short there was a buffer or stock of patients always there, waiting for treatment. When the Trust actually main serious inroads into this list of human unhappiness, what did the PCT do ?
It refused to pay the Trust for the "additional" work, and there is now a dispute between them. One result being that in the absence of revenue, the Trust is presumably now allowing the waiting lists to grow again, while they sit around and do what, very little one can assume !!!

If repeated across the NHS, this example shows that there are still very serious obstacles to meaningful reform in the system, as mid tier bureaucrats effectively block the intentions of elected politicians, who, it can be argued, are at least trying to improve the delivery of health care.

The Opportunity ? :

At BVA (together with Develin Partners), we are actively offering tailored Activity Based Costing and Value Based Management Solutions to Foundation, and aspiring Foundation Trust Hospitals. We think that as the reforms start to bite, so additional degrees of freedom will open up, and give some of the future "winners" more room to make striking improvements in their health care offering – to the ultimate benefit of the patients (you and me). The core to this will be a much improved understanding of where actual costs lie, and to allocate them much more accurately to actual HRG and treatments. In this way managers in the NHS can start to manage their businesses better, and hopefully avoid the current round of knee-jerk "slash and burn" exercises as they lower head-count to meet more exacting financial targets.

From what we can tell, there is some progress, although whether it is proportionate to the massive increasing in funding the NHS has enjoyed is another question. Waiting lists appear to be coming down measurably in England unlike in Wales and Scotland. However, as the money flows start to ebb, so the race will be on amongst health care providers to decide where to position themselves in the forthcoming competition for patients. Who knows, perhaps one day consumer sovereignty might even appear within the NHS – but probably not in my life time !!

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