FAREWELL TO DODGING AND WEAVING

The NHS financial framework is changing to a much more business-like, commercial model. **Nick Timmins** looks at its likely effects

The past 18 months of headlines about the National Health Service have been dominated by deficits. But even if finance is likely to make fewer headlines after May when the health department is expected to announce that the service has at least technically broken even, debate over money is not about to go away.

Indeed, financial management will affect doctors and other health workers every bit as much over the coming years as in the past one—even if this time its expression will not so obviously be about frozen posts, real redundancies, reduced training opportunities, and cancelled or slipped orders for supplies and equipment.

The whole financial framework of the NHS is changing to a more commercial model, which is likely to remain in place whoever becomes the next prime minister. The changes revolve around the drive towards foundation trust status; the framework around that; and the requirements that Monitor, the foundation trust regulator, will be applying to applicants.

Balancing the books

First the framework. Over recent years, several financial fiddles that had allowed the NHS to hide its true financial position have progressively been eliminated. These include capital to revenue transfers, which allowed trusts to eat into their capital to meet annual requirements in order to balance the books. Another is unplanned support—the sort of dodge whereby an NHS

organisation in surplus lent money, sometimes literally overnight, to another in deficit so that both sets of books seemed to balance. Planned support has also been stopped, in the sense of formal brokerage sanctioned by health authorities, from one organisation to another.

These changes, as Patricia Hewitt, the health secretary, is keen to tell anyone prepared to listen, have begun to bring to an end a situation where, to put it crudely, parts of the NHS in the north and the midlands, which have the highest health needs but tended to end up in surplus, ended up lending money,

interest free, to organisations in the south, which had healthier populations but tended to overspend. The money owed was often not paid back.

Eliminating the fiddles has helped reveal the service's true financial position. To that extent it has, by the reckoning of the health department's chief economist, contributed to the deficits the NHS ran up in the 2004 and 2005 financial years.

In their place will come interest bearing loans that hospitals will have to pay

back. This is an arrangement much more like that in the commercial world—in effect, a banking facility. It is, as Mrs Hewitt put it recently, “much more transparent. We will no longer have a system where hospitals overspent, the deficit got huge, then got written off against a recovery plan, but the overspending just started up all over again.”¹

Takeovers and mergers

Where does that leave hospitals currently heavily in debt? Having, as before, to draw up recovery plans. In some cases, however, they are likely to be taken over by foundation trusts.

The first such takeover has just happened. Heart of England, a foundation trust that in its first year made a £5m (€7m; \$10m) surplus on its £265m turnover, has effectively acquired nearby Good Hope Hospital in Birmingham which, a year ago, had an accumulated deficit of around £20m on a turnover of just over £100m.^{2,3}

Good Hope's board had judged it “no longer financially viable”: a polite way of saying insolvent. Heart of England was initially given a management contract which this month turned into a takeover—not a traditional NHS merger. Heart of England was given a few million pounds in one-off payments, effectively as a sweetener. And £17.5m of Good Hope's accumulated deficit was turned into public dividend capital—capital effectively underwritten by the Treasury—and put on Heart of England's books. The foundation trust will pay a low rate of interest—around 3-3.5%—on capital which is technically repayable but in practice is rarely repaid.

In the past, the money effectively loaned to cover Good Hope's historic debt would have sat on the West Midland strategic health authority's books as brokerage—money the health authority hoped it would one day get back to spend on services. What has happened instead is that the authority has now accepted that it will not be repaid. In effect, it has written the money off. The health service and the public sector as a whole, however, have not because Heart of England will pay the Treasury interest on the money that can at least notionally be said to be being recycled back into NHS finances.

Repayment depends, of course, on Heart of England remaining a going concern, with Monitor having moved the trust's rating for financial strength down a notch for taking on the additional risk of Good Hope.

This may sound like a technical accounting change. In practice, however, it is more than that. It gives the NHS a way to write off debt at

one level without actually writing it off at another—instead putting an obligation on Heart of England to service the debt.

No similar takeovers are in the immediate pipeline. But such deals are a potential double win for the health department. They get more hospitals to foundation status more quickly, and they provide an answer for some of the 15 to 20 NHS trusts that are in such deep financial trouble that the department believes their position to be irrecoverable within 10 years.

Such takeovers “won't be the solution in every case,” Patricia Hewitt has said, but they “may well be the solution in some cases.”¹ These changes affect clinicians because they add to the growing number of hospitals being subjected to the foundation trust financial regime.

Looking after the pennies

The third part of the change, and the one that will most directly affect clinicians, is service line reporting. This entails breaking down a hospital's services by specialty—or even subspecialty and procedure—and working out which ones make money and which ones lose it under the tariff, the NHS price list now used to pay for procedures.

This information is important to foundation trusts, which have to make a surplus in order to invest. Bill Moyes, chairman of Monitor, says: “Where they have unprofitable lines, trusts can see whether that is due to staffing levels, or inefficient use of theatres, or other issues they can tackle. If they are being efficient and it is still unprofitable, that may suggest that the tariff is wrong—so this type of work can be used to help refine the tariff.

“Where that is not the case, they could have a discussion with their primary care trust about whether doing higher volumes—more cases—would make it profitable, or

whether they should exit the service and let someone else do it.”⁴

To some, such a commercial approach may seem to cut across the ethos of the NHS. But in the hospitals that have piloted

it—Chelsea and Westminster, University College London Hospitals, and Frimley Park in Surrey—at least some of their leading clinicians say it is helping to redesign serv-

ices. Once clinicians are given the data and are able to examine the reasons why a service is unprofitable, it puts them in the driving seat of redesign. In other words it produces engaged clinicians, not top down orders simply to pare budgets or save money.

At present, a foundation trust can be required to provide anything that a primary care trust designates to be a core service. But as the range of NHS suppliers increases “the time may come when a foundation trust may be able to walk away from an [unprofitable] service, provided we are confident that the primary care trust has alternative suppliers,” Mr Moyes says.

Service line reporting is gradually being rolled out across existing foundation trusts, but Monitor will eventually expect all applicants for foundation trust status to have such data. “Once they have the information, they would be pretty stupid not to use it,” Mr Moyes says. And at the same time, the Healthcare Commission is taking steps to measure quality using the same service line approach.

All of this is bringing some of the disciplines of business and the commercial world to NHS provision. It brings challenges for clinicians. But at least some of the changes also bring opportunities, not least for greater control over how services are designed and how they operate.

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