

**Liquidating Care to Cure the Deficit?**

**The Case of West Hertfordshire Health Authority's**

**Review of Acute Care Services**

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## Liquidating care to Cure the Deficit?

### The Case of West Hertfordshire Health Authority's

#### Review of Acute Care Services

Following a review of its acute services and a four month public consultation exercise, West Hertfordshire Health Authority (WHHA) is proposing to close its four local acute hospitals and replace them with a single site facility. The new hospital is to be situated on an unidentified out-of-town greenfield site and will provide approximately half the acute beds currently available. This radical reconfiguration has been prompted by the Health Authority's relatively small deficit of £3 million. Such deficits are not uncommon. At the end of 1997, health authorities in England and Wales reported an accumulated deficit of £791 million.<sup>1</sup> There is growing evidence that many are trying to adopt similar policies of land sales, centralisation and contraction of services

A detailed analysis (Pollock *et al* 1998<sup>2</sup>) of WHHA's plans suggests that, despite the intuitive appeal of combining all acute services on one site, the policy is more likely to exacerbate than resolve the financial deficit. Secondly, the proposals mean a reduction in access to acute healthcare provision in the context of rising waiting lists both nationally and locally. They will also increase pressures on community and primary care resources. Not surprisingly, the public, the county council and five district councils in West Herts are united in their opposition to the scheme. The South West Hertfordshire Community Health Council (CHC) has referred the decision to the Secretary of State while local MPs recently took part in an adjournment debate in the House of Commons on the use of PFI in West Herts.

This article shows how if the health authority succeeds its application for capital funding under the Private Finance Initiative (PFI), all the current acute facilities could close within the next 5-7 years.

## The Problem

WHHA serves a population of 520,000 residents and has a budget of £316.2 million (1997/8 projected expenditure, all services). Its two local acute trusts provide four separate hospitals at Hemel Hempstead, St Albans, Watford and Mount Vernon. The acute trusts and the local community trust have a combined deficit in the order of £6-7m. The region plans to withdraw most specialist services from Mount Vernon hospital over the next five to ten years, a similar timescale to the health authority's proposed radical reconfiguration of services.

At a technical meeting between the five councils and the health authority on October 16th, 1998, WHHA stated that specialist services equivalent to 130 beds would no longer be provided locally for its residents but would be purchased out of area. The loss of specialist services is curious given the current commitment to access and the national promotion of 'hub and spoke' models of healthcare delivery (e.g. in cancer services). The withdrawal of specialist services will result in a loss of income to Mount Vernon and Watford Trust thereby aggravating its deficit. This may account for the haste with which the health authority has drawn up proposals to merge the two local acute trusts, Mount Vernon and Watford Trust and St Albans and Hemel Hempstead Trust. The ostensible reason is to save on administrative costs but the proposed savings are very small indeed.

## **Solutions to the deficits**

Trusts can in theory resolve their financial problems in four main ways : by increasing their income by increasing activity levels, selling some of their assets, shedding labour (staff) or what amounts to the same thing, changing the case mix in ways that minimise the need for labour. The WHHA solution relies on centralising services, reducing the number of acute beds from 1170 to 600 and increasing out of area treatment. While centralisation has enormous common sense appeal there is no evidence to show that mergers among hospitals or businesses increase efficiency or improve quality of care. Indeed, the recent York review concluded that ' there is no compelling reason to believe that further concentration of hospital services will result in improved efficiency ( through exploiting economies of scale) or to automatic improvements in the quality of clinical outcomes'.<sup>3</sup>

## **Does the solution address the underlying financial problem?**

WHA's policy is premised on the belief that the acute sector is too big and expensive. But its failure to analyse the true cause of the deficit means that its proposals will exacerbate the financial problems. In reality, the deficit is a function of government imposed cost increases and policies which have largely been missing from any public discussion of the NHS.

This can be explained quite simply. While hospitals and community trusts can pay their bills for clinical services out of their annual income, they cannot meet the additional burden of capital charges introduced in 1990. Under the capital charging system, NHS trusts, after covering all expenses including a charge for depreciation for the wear and tear of buildings and equipment, must pay interest and dividends of 6% on their assets : land, buildings and equipment. This 6% return is known as their financial target and, with depreciation, accounts for 8-10% of clinical income. When they were introduced the extra money for the health service did not cover the cost of capital charges. Moreover, the annual indexation of capital charges means that the capital charges can rise ahead of NHS pay and prices.

In effect hospitals must run like commercial businesses and make a surplus for their owners, in this case the Department of Health and the Treasury. It is the failure to produce a surplus for their 'owners' that lies behind the financial crises of recent years that have led to bed, ward and hospital closures and disposal of assets.

Capital charges affect trusts differently because the level of payment is not related to income but to asset valued at current replacement cost. Trusts with high asset values have to devote more of their income to paying capital charges than those with small buildings in cheap locations, with little equipment or responsibilities for training the next generation of clinicians. Since capital charges are included in the prices to health authorities, this means that some Trusts can only generate the surplus required to met the charges by charging higher prices for comparable treatments<sup>3</sup>. This is why some hospitals are more costly than others and why they are castigated for being less 'efficient'.

meaning economical. For some trusts, the system is highly disadvantageous and many fail to make sufficient surplus. The two acute trusts in West Herts are among those in difficulty. Both have incomes which are low relative to their assets. The problem is not lack of efficiency but lack of income; not only is the entire hospital system inadequately funded relative to its size but those with high asset values are especially under-funded and can never break even unless they can reduce their asset bases<sup>2</sup>.

This raises a very basic issue for WHHA's radical reconfiguration. Without reducing the fixed asset base and thus the value of the estate, the major source of the deficit will not be tackled. But WHHA has promised the local community that it will retain up to 70% of its current asset base as part of an expanded community sector. And this is the problem. The combined asset value of a new hospital plus the retained estate is likely to exceed the existing asset values while halving capacity.

What is more, under WHHA's plan, the acute trusts will reduce caseload, and thus income, while simultaneously increasing the size of the total estate. Consequently capital charges are set to rise in both absolute and relative terms while income is set to decline! This will leave less money for clinical care and the trusts will have to cut labour to meet their financial target and adopt 'challenging' performance targets for an already overstretched workforce. Any failure on the part of the remaining staff to push patients through faster will lead to a further loss in income, and so on, down the slippery slope. This strategy prepares the ground for recurrent crises, further cuts, and ultimate closure.

Much of the debate has been obscured by the lack of rigour, precision and detail in WHHA's 'vision' document. For example, the estimated cost of the greenfield hospital site with 500- 600 beds was originally put at £150m (a figure which was confirmed by the health authority's own management consultants and experience around the country). It was then reduced to £87m and most recently £67m. However, what kind of 600 bed hospital can be built for £67m when the going rate exceeds £150m? Until it is clear how much the hospital will cost, the basic assumption that merger and redevelopment will save money cannot be verified.

### ***Financial viability.***

The two acute trusts currently have an income of £141 million, an asset base of £161 million and 1100- 1172 acute beds. With the community trust's income of £51 million and assets worth £38 million, this gives an acute and community sector combined income of £192 million against total assets of £200 million (Table 1). Although in 1996/7 the acute trusts made a surplus of £2.7 million, this was insufficient to cover the 6% return (£9.7 million) on their own asset base. They would have had to earn a surplus of about 7% on their income in order to break even. The average surplus earned by acute trusts in England and Wales was then about 5%, though West Herts only managed 2%. Evidence from PFI proposals shows that increases in surpluses (sometimes called 'efficiency gains') can only be made at the expense of staffing levels. One estimate suggests that, because of the need to increase the rate of surplus to meet private sector payments, up to 1000 clinical posts are lost for every £200m of capital investment procured through private finance.<sup>9</sup>

Throughout the consultation period, WHHA declared itself unable to estimate the value of the estate it would retain after building the new hospital, although it pledged that 40-70% of the sites would remain in use as community hospitals. However, as table 1 shows, the effect of retaining old estate whilst building a new hospital will be to increase the value of the total community and acute trusts' asset base from the current £200 million to £252-300 million, thereby increasing capital costs and compounding the deficit. Assuming an average rate of surplus (5%), the acute and community trusts require a combined income of £240 million to break even under the current cost regime. In order to break even under the redevelopment proposals and assuming the same rate of surplus, the new acute trust and the old community trust will have to increase their income to between £300-360 million despite a cut in acute beds of around 50%.

On October 16th, 1998, the health authority admitted to the five councils for the first time that the overall cost of the asset base would rise but hoped that this would be offset by the economies of consolidating services on one site. However, even if such reductions were to occur they will be

insufficient to meet the enhanced capital costs. On the other hand, it is not clear how the Trust will be able to increase its income. Indeed, Trust income will fall for three reasons. First, the health authority is proposing to transfer specialist caseload accounting for 120 beds of current provision to (unspecified) out-of-district providers. Second, it proposes to shift general acute caseload equivalent to a further capacity of 135 to 170 beds away from the local acute Trusts to (unspecified) out of area providers. At the meeting of 16th October the health authority gave the estimated cost of re-providing 120 general acute beds elsewhere as £6 million but they were unable to provide details of caseload. This figure seems very low, given that the two Trusts' combined income of £141 million to support 1100 beds. Moreover the health authority will not have the advantage of the economies of block contracts to lever reductions in prices from external providers. Third, the health authority is also planning to open an additional 60 community beds to accommodate some of the 40% of current acute caseload that the health authority deems an 'inappropriate admission'. The location, staffing, and funding of these beds has not yet been identified. The health authority have openly admitted that it is possible that no extra revenue will follow the estimated increase of 18,000 patient contacts to be treated in the community sector annually. All these additional service changes plus the cost of the new hospital will have to be met from the current revenue of the two acute Trusts

### *Meeting health care needs*

The plan is also incomplete in terms of healthcare need. Forced by its overall approach to juggle acute capacity against caseload and income, WHHA was still unsure, even at the end of the consultation period, about the population for which it has planned. Its trusts currently treat 17,000 patients annually from out-of-district, or approximately 20% of total caseload. WHHA do not appear to have included this caseload in its plan nor at the meeting of 16 October was it able to provide data regarding the 28% of residents who currently go out of district. It is curious that the health authority is prepared to risk the care of 72% of its residents with a radical reconfiguration while expecting the remaining 28% to rely on current forms of delivery. It seems unfortunate that these residents should be excluded from the benefits of the health authority 'vision'.

### Conclusion

WHHA is seeking to save money by admitting fewer people to hospital in the future and discharge those it does admit somewhat sooner. It proposes to redevelop the acute sector in a way which will increase the value of its hospitals whilst halving acute capacity. This must lead to a more widespread hospital closure programme than is currently conceived; and it will limit access to acute care in a way that shifts the burden onto families and social services without evidence of either clinical efficacy or sufficient savings to fund social services and primary care.

Yet this approach is becoming increasingly common because it arises from circumstances which are not unique to WHHA but systemic. The system of capital charging lies at the heart of the problem which up to 100 acute service reviews are currently addressing. It was introduced with a level of funding that ensured the contraction of acute care and the simultaneous privatisation of the remaining asset base. As Will Hutton has shown, WHHA's problems are replicated around the country.<sup>7</sup>

Informed debate and public scrutiny is impossible because the public documents contain so little detail. In such circumstances, public consultation and accountability is a farce. The WHHA's proposals were approved by its board despite the united opposition of five district councils, the County Council, and the chief executive's frank admission that consultation had failed to 'win over all or even some of the public' to its radical vision of a new healthcare system. Moreover WHHA submitted these proposals in a Strategic Outline Case, the prelude to PFI, to the DoH before the public consultation had even finished.

Accountability depends on accurate information. We recommend that CHCs and those wishing to scrutinise acute care reviews elsewhere ask for the following data :

- \* The current asset value, capital charges, rate of surplus, and income of each hospital included in the review.
- \* The cost and value of the new investment proposed at each site, the value of the retained estate and the projected income.



- \* The current and proposed levels of staffing, facilities, services, caseload and estate at each site.
- \* The caseload to be transferred to the primary and community sectors, the level of new investment to be undertaken there and the revenue to be switched from the acute sector to these other sectors.
- \* The sources of the finance for all capital projects.

<sup>1</sup> NHS (England) Summarised Accounts 1996-97. London : The Stationary Office  
1998 HC 923. 148 out of 429 Trusts failed one or more financial duties

<sup>2</sup> Pollock AM, Price D, Shaoul J, Gaffney D. Response to Choosing the Right Direction, a public consultation document on the future of health services in West Hertfordshire. July 1998.

<sup>3</sup> The Centre for Health Economics, York Health Economics Consortium, NHS Centre for Reviews and Dissemination. Concentration and Choice in the provision of hospital services. CRD Report 8 (Summary).

<sup>4</sup> Pollock AM, Gaffney D. Capital charges : a tax on the NHS. BMI. 1998; 317:157-8.

<sup>5</sup> Shaoul J. Charging for capital in the NHS Trusts: to improve efficiency? Management Accounting Research, 1998, 9: 95-112..

<sup>6</sup> Newchurch & Company, PFI Futures: capital investment after the White Papers, London, March 1998.

<sup>7</sup> Will Hutton. How Big Money is Stitching up NHS. The Observer, 13 December 1998, p12-13.

**Table 1 Will the PFI Cure the Deficit?**  
**Impact of Capital Charges on 2 Acute Trusts and 1**  
**Community Trust in West Herts - 1996/7 and Future**

	<b>Income</b>	<b>Asset Base</b>	<b>Surplus Required</b>	<b>Actual Surplus</b>	<b>Beds</b>	<b>Income required to break even *</b>
	<b>£M</b>	<b>£M</b>	<b>£M</b>	<b>£M</b>	<b>-</b>	<b>£M</b>
<b>1996/7</b>	192	200	12	4.3	1172	240
<b>2003</b>	Not known Less than 192	252-300 **	15-18	?	510-600	300-360

\* based on current Capital Charges of 8% of current income

\*\* PFI build of 150M plus 40-70% retained estate