

Engineering financial distress: transplanting banking techniques to the NHS?

 blogs.lse.ac.uk/politicsandpolicy/engineering-financial-distress-nhs/

1/19/2017

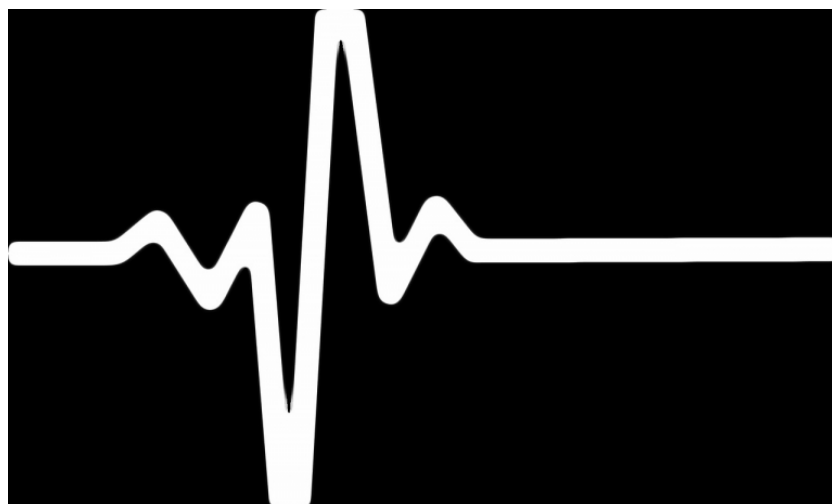
The NHS is in what appears to be an endless financial crisis. But why has the government been unable to address the problem? [Geoff Meeks](#) draws parallels between a model deployed by the banking industry and the way the NHS is financed to explain why the problem may ultimately be a political one.

In a 2013 [report](#), Lawrence Tomlinson, then Entrepreneur in Residence at the Department for Business, Innovation and Skills, outlined a model deployed by the banking industry to “artificially distress an otherwise viable business and through their actions put them on a journey towards administration, receivership and liquidation”. The model, identified (and castigated) by Tomlinson, is ingenious. And in its main thrust, though not in its details, its analysis of the relationship between a major stakeholder and its clients finds powerful echoes in the financial relationship between the government and the NHS.

In Tomlinson’s model, the process might begin with a bank’s client committing a technical breach of a loan agreement which has “no bearing on the performance or viability of the business”. Then a series of responses by the bank could tip the client into financial distress.

The first response might include classifying the client as distressed, which would make it very hard for the client to switch to an alternative bank. Then a fee was sometimes charged to continue with current lending, and the interest rate increased. With these and other extra costs, a previously viable business could become insolvent. And the process might culminate in liquidation of the borrower – a process which often realises much lower “fire sale” prices for assets than an orderly disposal.

Like the distressed commercial borrower in the Tomlinson model, the English hospitals are largely tied to a single funder – the government. Most have seen their finances sharply deteriorate in recent years. Just four years ago, only 25 of the 245 hospital trusts were in deficit. In 2016, 156 were in deficit.



Two main triggers helped precipitate this financial decline. First, the Public Accounts Committee (PAC) [report](#) that central government cuts meant that spending on social care provision by local authorities was reduced by 10 per cent in real terms between 2010 and 2015, while demand for such care was increasing. Hospitals were unable to discharge patients whose hospital treatment was complete. The government watchdog, the National Audit Office

(NAO), [reported](#) that towards 3 million hospital bed days per year have been lost on this account. The distressing consequences for patients awaiting treatment have been well publicized. But the blockage also deprived hospitals of the substantial income (approaching a billion pounds, according to the NAO) which could have been earned if those beds had been used to treat patients.

A second trigger was the programme of cuts, or “efficiency savings” demanded by NHS Improvement. NHS Monitor report that efficiency savings had been running at 1.5 per cent a year in recent years. Recently, NHS Improvement demanded 4 per cent. The (cross-party) PAC argue that such targets were “unrealistic” and were causing “long-term damage to trusts’ finances”, while NHS England [calculate](#) that 2 per cent is a “more reasonable requirement”. If hospitals fail to achieve their target cuts, they are to be punished – funding is to be withheld; they will have to borrow to fill the gap; the additional interest on the new borrowing will add to the financial pressures in future years.

In many circumstances, improving efficiency requires investment. Dr Sarah Wollaston, Chair of the Commons Health Committee [wrote that](#) “many NHS facilities [are] already struggling to cope with the existing demand in buildings designed for much smaller numbers and different options for treatment...[and] transformation of services ...will require investment of adequate capital resources ... [this needs to be] made now if the necessary long-term savings are to be made”. But, she reported, “capital allocation for health [is] already declining in real terms...[and] has been repeatedly raided to fund revenue overspends”. Twenty per cent of the capital budget was being diverted to day-to-day spending, reported the NAO in November 2016.

Where hospital capital spending is funded by the Government through public dividend capital, they are charged an interest rate of 3.5 per cent. The government is meanwhile borrowing funds at 1 per cent; and lending to banks at little more than one quarter of 1 per cent. Investment in human capital has also been squeezed. Nurses’ pay has been reduced by up to 10 per cent in real terms, [according to the Royal College of Nursing](#). The [PAC report](#) that there has been a substantial rise in resignations; but funding for training has been cut. At the same time, caps have been imposed on the use of more expensive agency staff.

What options are open to a hospital which is financially distressed? A commercial business might try to raise prices, to close unprofitable activities, to reduce service levels, or to increase the utilization of its physical and human capital. An NHS hospital, by contrast, has no power to raise, say, the price of a cataract operation; it cannot close an A&E department which is loss-making on the tariffs imposed on the hospitals; and if, say, it reduces staffing levels, it can expect to be denounced by the Care Quality Commission, and perhaps have its senior management forced out of their jobs. Can it raise the utilization of beds? The Nuffield Trust [report](#) that bed occupancy is running at 95 per cent on average, a figure which would be the envy of the hotel trade, which in the UK achieves around 75 per cent. Clinicians have argued that 85 per cent is the maximum safe level.

And in relation to the utilization of employees the PAC [reported](#) that in 2014 the service was short of 50,000 clinical staff; the GMC report that a quarter of doctors below the rank of consultant are sleep-deprived; and the Royal College of Physicians found 80 per cent of trainee medics suffering, at times, “excessive stress”. These data do not suggest there is a great deal of slack in the system.

Management of information by the funder has been central to both the bank and the hospital arrangements. In the banking case, once the borrower was classified as at risk, a review of the borrower was often commissioned from an outside organization. This was completed at the expense of the borrower, but the information in the review was withheld from the borrower. The borrower was also forbidden access to its regular relationship manager, denied the information-sharing that access had previously allowed. And information on the value of its assets was “managed”: according to Tomlinson, the value of assets in its balance sheet was revised downwards by valuers who were appointed by the bank and depended for their continuing income on the bank – raising the probability of balance sheet insolvency.

In the hospital case, the information [from the Prime Minister](#) was that “the Government has not just given him [Simon Stevens, Head of NHS England] £8billion extra, we’ve given him £10billion extra”, to which the Chair of the

Commons Health Committee [responded](#) “the claim does not stand up to scrutiny”, and it was “not only incorrect but risks giving the false impression that the NHS is awash with cash”; it was denied too by the Head of NHS England himself.

The Health Secretary then maintained that “in 2016-17 the NHS will receive the sixth biggest increase in history”, whereas the independent King’s Fund and the Health Foundation [explained](#) that, properly measured, it went down to 28th place in the ranking since 1975-6. After a wide-ranging review of the hard information, the NAO recently concluded that the “financial problems are endemic and this is not sustainable”.

Still, the misinformation seems to prevail in the public mind. In a survey reported recently by the Financial Times (31.12.16), the general public in the UK typically believed that the country spent towards 20 per cent of GDP on health. This is more than *twice* the actual share. On this measure, the King’s Fund [rank the UK](#) as 13th of 15 similarly prosperous countries – the original EU15. The UK share has fallen in recent years, and, on current government plans, the Office for Budget Responsibility [project that](#) it will continue to fall in the next few years.

Before the cuts of recent years, the NHS was meeting most of its performance targets and achieving high approval ratings from the public – in 2010, 70 per cent were very or quite satisfied with the way the service was run, [the highest on record](#) – while spending on health as a share of GDP was only [half the corresponding share](#) expended by the US. It has been argued that US health outcomes were on average no better than those of the much more parsimonious UK.

Returning to Tomlinson, why would a bank “artificially distress an otherwise viable business”? It is alleged that in the case of RBS, for example, if the client borrower ended this process being broken up, with assets sold at bargain, fire sale, prices, the buyer would frequently be RBS’s West Register subsidiary, which made a healthy profit when it sold these assets on. RBS’s restructuring division, Global Restructuring Group (GRG), recorded profits of over a billion pounds in 2011 – very welcome to RBS management when the Bank overall was in serious deficit. GRG has since been closed down in the face of criticism; and a compensation fund established for clients who suffered detriment.

But why would a Health Secretary, charged with maintaining the health of the Health Department, adopt such a seemingly perverse strategy? While I was searching for an explanation, a colleague pointed to the words in Mr Hunt’s book, *Direct Democracy*: “Our ambition should be...in effect denationalizing the provision of health care in Britain”.

About the Author

Geoff Meeks is Professor Emeritus of Financial Accounting and honorary Director of Research at University of Cambridge, Judge Business School. His recent research papers address bank failure (Abacus 2013), corporate tax avoidance (Fiscal Studies 2014), and distortions in the takeover market (Accounting and Business Research 2016).