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PRACTICAL POLICIES FOR THE REDISTRIBUTION  
OF WEALTH, POWER AND OPPORTUNITY

# IN PLACE OF BEVAN?

BRIEFING ON THE HEALTH AND SOCIAL CARE

(COMMUNITY HEALTH AND STANDARDS) BILL 2003

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The Health and Social Care (Community Health and Standards) Bill now before Parliament provides for the incorporation of NHS Trusts and non-NHS bodies as competing trading companies, "Foundation Trusts", that are no longer part of government but part of a market.

In response to fears that these changes would have a negative impact upon equity, the government has built into the Bill a series of safeguards which it says will guarantee the fundamental goals and principles of the NHS as a comprehensive and universal service, free at the point of delivery and providing equal treatment in response to equal need.

We are concerned that these safeguards are inadequate, and we explain in this briefing why we have come to this view. We strongly urge the government to withdraw the part of the Bill that creates Foundation Trusts in order that better public health safeguards can be devised.



# I. Introduction

At the heart of the controversial provisions in Part I of the Health and Social Care Bill now before Parliament is the proposal to allow NHS Trusts to earn and retain financial surpluses by trading in NHS and non-NHS work. The idea is that these surpluses will be used to lever in private borrowing for new investment, by providing funds for debt repayment.

Freedom to trade, to make surpluses, and to borrow require a change in NHS Trusts' legal status. The Bill therefore enables NHS Trusts seeking these new freedoms to apply to become independent "public benefit corporations" known as "Foundation Trusts".

These corporations will be run by boards of local "stakeholders" on a not-for-profit basis. As corporations they will be able to assume ownership of NHS land, buildings, and equipment.

The establishment of Foundation Trusts is part of the creation of a new market in health services where providers compete for NHS contracts and for private business. It is universally recognised that the workings of markets, by their nature, conflict with equity. Historically the National Health Service has attempted to achieve equality of access on the basis of institutions covering whole populations, redistributive funding, integration of delivery mechanisms, and services planned in response to health care needs. Foundation Trusts are market actors and will be driven by the logic of the market. The danger is that, under pressure to generate surplus income, the incentive will be to try to select patients, treatments and services on the basis of financial gain and risk.

The government has claimed that its new health care system will be tightly regulated, with a framework of legal safeguards to prevent the fragmentation and unfairness that resulted from the "internal market" introduced to the NHS in the 1990s. These safeguards include:

- local ownership and control
- legal incorporation as "public benefit corporations"
- a "lock" on NHS assets
- controls on borrowing
- a "cap" on private patient income
- no charging of NHS patients for care
- protection of staff under nationally negotiated agreements
- an "Independent Regulator" to ensure a comprehensive service

The purpose of this briefing is to examine whether this system of checks and balances is sufficient to promote equal access for equal need, the cornerstone of the NHS.

In part 2 we describe the legal form, powers and duties of Foundation Trusts, together with the role of the Independent Regulator. In part 3 we examine what practices the safeguards prevent, and what they allow. In part 4 we put Foundation status in the context of the government's other market reforms and consider the effects on equity. An Appendix presents some illustration of how these new arrangements might work in practice.

## 2. The new health service market

### What are Foundation Trusts?

Foundation Trusts will be established as “public benefit corporations” independent of Secretary of State control. A public benefit corporation is a new form of non-profit corporate body created specially for this NHS reform (Clause 1). They can carry out any type of business but their “principal purpose” is to provide goods and services to the NHS (Clause 14. 2).

### Who can apply for Foundation status?

The Bill allows both NHS bodies and private sector companies to apply to become Foundation Trusts (Clause 5). For the time being Primary Care Trusts will not be able to apply for Foundation status although the government has said that ultimately it wants all NHS Trusts to become Foundation Trusts.

### What are their duties and powers?

Foundation Trusts will not have shareholders on the board, but like any business organisation they will be expected to make and retain surpluses.

Foundation Trusts’ sole statutory general duty is to operate “effectively, efficiently and economically” (Clause 34). This duty is matched by freedom under law to “do anything which appears to [the Foundation Trust] to be necessary or desirable for the purposes of or in connection with its functions” (Clause 18. 1)

A surplus is what is left over from the income after expenditure on staff, capital, supplies, and other expenditure. Surplus is thus a function of the following variables: staff costs, income, capital, supplies, tax, bank charges.

$$\begin{array}{c} \text{Foundation Trust operating surplus} \\ = \\ (\text{NHS income} + \text{non-NHS income}) - (\text{staff} + \text{supplies} + \text{capital costs} + \\ \text{depreciation} + \text{tax}) \end{array}$$

It can be seen that changes in any one of these variables will have an impact on the surplus which can be generated.

### How will Foundation Trusts generate surpluses?

Foundation Trusts are given powers by the Bill to generate surpluses. They can:

- trade in NHS and non-NHS services (Clause 14)
- buy and sell land and other assets (Clause 18)
- create commercial arms or join existing commercial ventures (Clause 17)

- borrow money from private lenders and from private investors under the Private Finance Initiative (Clause 17)
- employ staff (Clause 18)
- sub-contract work to commercial companies (Clause 18)
- ask the Secretary of State to lower their annual costs by exercising discretion when valuing the assets that are transferred to them (Clause 13. 3)
- benefit from subsidies, loans and grants from the Secretary of State, including their NHS capital allocations for the next three years (Clause 11)

## The Independent Regulator

In addition to providing for the establishment of Foundation Trusts, the Bill establishes a new Independent Regulator to oversee their activities (Clause 2). The Regulator's powers include control over:

- the use and sale of public (former NHS) assets (Clause 16)
- decisions about what NHS health services an area needs and whether it will be provided by the public or private sector (Clause 14)
- the scale, nature, location, and duration of local health services delivered through Foundation Trusts (Clause 14)
- Trust dissolution and merger (Clauses 25 & 27)
- Foundation Trust borrowing levels (Clause 12)
- decisions about public consultation

## The new financial context

At the same time as providing for the establishment of Foundation Trusts the government is changing the way health service providers will be paid in the NHS.

This reform is necessitated by the switch to a system in which multiple providers, including Foundation Trusts and private hospitals, contract for NHS-funded work. The main feature is a new tariff system which will act as a currency in the health care market the government is introducing under the NHS Plan.

Foundation Trusts will operate under a new national tariff system, 'Financial Flows', which requires providers to adopt a centrally determined rate of payment for individual episodes of care based on average prices. The method also includes a mechanism known as case-mix adjustment, which segments the population into different price categories, for only some of which the Foundation Trust provider may choose to compete. Foundation Trusts will be able to concentrate on patient activity where they can make surpluses.

The government's intention is that every hospital treatment and procedure will eventually be costed. While NHS providers are bound by the tariff, for the first two years the private sector is not.

The tariff will not be calculated on the basis of actual costs but in the form of regionally adjusted average prices which will be adjusted for market prices. The independent sector will also have a special increment to take account of their set-up costs.

### 3. Does the legislation safeguard the NHS?

#### i) Local ownership and control

At the heart of the Bill is a transfer of ownership and control from the Secretary of State to independent corporations. Such a transfer has serious implications for the public interest because it is the government that has the legal duty to see that all medical facilities are available to all people. The question, then, is how far the alternative governance arrangements can be expected to ensure that this public responsibility is met.

The Bill sets out a model constitution for Foundation Trusts that provides for a membership, board of governors, and board of directors (Schedule 1). The idea is that in this way “national” ownership and “central” control are replaced by “social” ownership and “local” control.

But we find that the claim about local control is not supported by the arrangements and that therefore there remain questions about which interests will be served:

- Decisions about health service provision rest ultimately with the Independent Regulator, which grants and may amend Foundation Trust authorisations.
- Applications for Foundation status – which specify the range, volume and location of services to be provided – are to be made before a membership is formed and before the constitution is approved or implemented. Consultative requirements for this part of the process are not fully laid down in the Bill, and there is no requirement to publish Foundation Trust applications or get local consent, and the Regulator will determine the form consultation takes.
- The membership of a Foundation Trust, upon which the government depends for its claims of local ownership of control, is not based on geographical area or existing political constituencies. Foundation Trust members have no accountability to the wider community and the public benefit generally. The frail, the disadvantaged, and users of specialist services are likely to be disenfranchised.
- Up to 49 per cent of the Board of Governors may be appointed. Only one staff representative need be appointed to the Board of Governors and no staff can be appointed to the Board of Directors. Members and governors cannot veto the unelected directors, who effectively control Foundation Trust policy.
- NHS consultative and complaints machinery is waived for Foundation Trusts. The Secretary of State is not required to establish Patients Forums or independent advocacy services for Foundation Trusts under the NHS Reform and Health Care Professions Act 2002 and the Health and Social Care Act 2001. The Regulator will decide what the new local authority overview and scrutiny committees must be consulted about.
- The Office for National Statistics says that key directors are not publicly controlled and that in this respect Foundation Trusts are private not public bodies..

## ii) Legal incorporation as “public benefit corporations”

The government has stressed the character of Foundation Trusts as non-profit businesses by creating the new legal status of “public benefit corporations”. The device is an acknowledgement that profit-taking is a drain on scarce NHS resources and shareholder control conflicts with health service accountability..

But upon examination the government’s arrangements do not preclude profit-taking and shareholder influence . Opportunities for profits and shareholder participation that the “public benefit corporation” safeguard does not preclude are:

- through contracting out clinical and non clinical services to for-profit companies
- through joint ventures and spin off companies with commercial partners
- through professional fees to the many private sector advisers that will be necessary to draft and interpret governance, financing, and contracting arrangements
- through the Private Finance Initiative (PFI). Almost all PFI deals rely on investment by shareholder organisations
- through private borrowing other than under PFI

## iii) The “lock” on NHS assets

The government has insisted that the transfer of public assets to Foundation Trusts does not amount to privatisation. The Bill ostensibly prevents former NHS land, buildings, equipment and other property from being sold for private gain: “An NHS foundation may not dispose of any protected property” by selling it or offering it as a guarantee for private finance (Clause 16. 1).

However, this “lock” is not an absolute one:

- not all transferred property counts as “protected”
- the boundary line between “protected” and unprotected property is a shifting one, entirely at the discretion of the Regulator (Clause 16. 1) In addition, a foundation trust may opt to subcontract out certain services such as cancer, cardiac, and elective surgery to the for-profit sector, in a separate privately operated facility, for example, a Diagnostic and Treatment Centre, thereby freeing up NHS estate. It may then ask the Regulator to “unlock estate” in order that the Foundation Trust can dispose of it
- Foundation Trusts can negotiate with the Regulator to deregulate property. In order to sanction sale of property, the Regulator only has to be satisfied that it is no longer necessary for the provision of services to the NHS (Clause 16. 3)
- the Regulator controls the consultative requirements attached to the closure or sale of former NHS hospitals and land

These provisions do not adequately protect public assets. For example, PFI hospitals will usually seek to dispose of old sites after opening their new premises. In the past proceeds from these sales were returned to the NHS as a whole, but the Bill does not make clear how such surpluses will be valued and who will profit from them.

#### iv) Controls on borrowing

New borrowing facilities are provided for Foundation Trusts through a departmental lending facility and the freedom to use private finance. The Bill requires the regulator to establish a “prudential borrowing code” to control this facility.

However, the purpose of the borrowing code is to ensure that Foundation Trusts can pay back their borrowing. It is not concerned with the allocation of investment among Trusts. The “prudential borrowing code” does not protect equity in that:

- capital will not be allocated to Foundation Trusts according to regional or national priorities
- exploitation of the freedom to borrow will depend on individual trusts’ ability to repay the loans
- Foundation Trust borrowing will be at the expense of other NHS Trusts. Foundation Trust borrowing, but not private finance, will count against the department’s capital spending limit. Capital allocations to NHS Trusts are only guaranteed for the next three years. Thereafter, Foundation Trust borrowing could pre-empt capital spending by non-Foundation Trusts

#### v) The “cap” on private patient income

The need to generate financial surpluses will provide Foundation Trusts with an incentive to increase private patient business. The government has responded to fears that this will lead to an expansion of private activity by declaring a “cap” on Foundation Trusts’ private patient income limiting it to current levels.

However the “cap” is not all it seems:

- The cap allows the amount of private work to grow each year proportional to income. But the proportion of private patient income
- Clause 15 (1) of the Bill, originally stating that “An authorisation must restrict” non-NHS trading, has been amended in Committee to read “An authorisation *may* restrict”. This substitution leaves it at the discretion of the Regulator
- The cap allows the amount of private work to grow each year in line with growth in income. This means that private care in the NHS can increase annually despite the cap. It also introduces another inequity because the proportion of private patient income varies among trusts. Trusts with the highest proportion of private income generation are in London. So hospitals like the Royal Marsden will have a built in advantage under the cap because they will be allowed to earn higher levels of private income.
- Discussions in Committee have made it clear that the cap will not cover income generated by providing occupational health services to business nor to charging for other care or ancillary services



- The cap does not cover income generated by or in joint ventures with commercial partners, or through subsidiaries or spin-off companies, that is not reflected in the Foundation Trust's income and expenditure account

This provision gives Foundation Trusts and the Regulator freedom to negotiate unlimited increases in the volume of health service work produced for sale by Foundation Trusts. The impact on NHS-funded services by this potential shift in the employment of scarce health service resources is incalculable.

## vi) No patient charges

The Bill's passage has been accompanied by frequent assurances that it does not affect the fundamental principle of free care to NHS patients. But elements of the reforms may precipitate a move to a fee-for-service system and are in line with the Prime Minister's recent call for new thinking about "co-payments" in public services.

- Foundation Trusts do not have a statutory duty to provide free health care. This requirement can only be imposed through contracts with primary care trusts.
- Foundation Trusts can form joint ventures with private firms and health care corporations whose business is to generate commercial and fee-paying revenue streams such as health insurance and "top –up" charges for hotel services and "additional" elements of care
- Foundation Trusts will control the increasingly complex boundary between NHS care and means-tested personal care. They will control discharge to the time-limited "intermediate" sector and the incentive will be to define entitlements as restrictively as possible
- Foundation Trusts may include local authorities as partners. Local authorities funding include charges and local taxation. They will be able to extract charges from local authorities for personal care resulting from delayed discharges

The Bill thus fails to rule out charged care within a Foundation Trust context whilst at the same time devolving crucial decisions about care to organisations with incentives to maximise charges.

The situation is made more uncertain by the government's decision to allow non-NHS bodies to apply for Foundation Trust status or form partnerships with Foundation Trusts. BUPA, PPP and US health maintenance organizations including United HealthCare, Evercare, and Kaiser Permanente are among the organisations that might exploit this freedom. These bodies bring extensive expertise in marketing chargeable health services including health insurance. Granting foundation status to non-NHS bodies such as these will blur the dividing line between public and private services.

## vii) Protection of staff under nationally negotiated agreements

In response to concerns over staff protection and potential for "poaching" the government has declared that Foundation Trusts will be bound by Agenda for Change and other national pay agreements.

However, there is nothing to this effect in the legislation itself – the Bill gives Foundation Trusts the power to employ staff (Clause 18. 2) and in exercising this power to “do anything which appears to it to be necessary for the purposes of or in connection with its functions” (Clause 18. 1).

- Foundation Trusts will have freedom to employ staff largely on the conditions they choose. Current national negotiation of hospital consultants’ contracts becomes redundant.
- Special waivers for Foundation Trusts have been built into Agenda for Change (paras 8.1-8.2) which allow them to offer extra premiums and special benefits packages without the agreement of the NHS Staff Council or Strategic Health Authority or consultation with other NHS employers
- A Foundation Trust could (under Clause 18) contract out work to private firms or commercial subsidiaries, allowing the transfer of NHS staff to the private sector where national agreements for many staff may not apply

### viii) The “Independent Regulator”

This follows the model adopted for other privatised former nationalised services such as gas, telecoms, water and postal services. Powers formerly exercised by the Secretary of State are transferred to the Regulator. The Regulator’s control over the creation of trusts represents a fundamental shift in planning powers.

The general duty of the Regulator is not onerous. The Regulator must act “in a manner that is consistent with the performance by the Secretary of State of the duties under sections 1, 3 and 51 of the NHS Act 1977” (Clause 3). But the Department of Health says “consistent with” only means “takes account of”. The Regulator is not bound by the duty to provide a comprehensive, universal, and free NHS service.

In Committee the government has made clear that its policy is to apply a “light touch” to Foundation Trust regulation. According to the Department of Health guidance, Foundation Trusts will be required only to meet “reasonable demand for regulated services ... taking into account its forward business plan and contractual commitment”.

This “light” regulatory approach diminishes the ability of the Secretary of State to fulfil statutory health care duties in the following ways:

- the Bill does not impose health care duties directly on the Regulator
- the Bill includes no mechanisms for ensuring consistency with the Secretary of State’s duties from a Regulator who is independent
- Relations between the regulator and other NHS regulators are not spelt out. The Bill does not say whether the independent regulator must adhere to the labour market framework produced by Workforce Developments Confederations. Nor does it secure the planning functions of Strategic Health Authorities and Primary Care Trusts
- the Bill does not transfer to the Regulator the Secretary of State’s duty under the NHS Reform and Health Care Professions Act 2002 “to ensure that the areas for which Primary Care Trusts are at any time established together comprise the whole of England”. If PCTs become Foundation Trusts, as the government apparently intends,

there will be no statutory body to ensure that universal care is provided for the whole population

#### 4. The financial context - potential for subsidies and funding crises

The establishment of Foundation Trusts within the context of the new tariff system has the potential to create winners and losers among NHS providers and among communities. The government has said it will reimburse Foundation Trusts at the regional tariff rate. However, some Foundation Trusts will be able to keep their prices low because of the discretion the Secretary of State has over subsidies. These hidden subsidies create winners.

- All NHS organisations have inherited costs which cannot be controlled and which are difficult to estimate. Trusts' ability to generate a surplus will depend on the value of their asset base (which determines the annual cost of capital), the type and mix of services provided, the need for technology, and staff training and research. Foundation Trusts which have low costs and prices will do better than high cost NHS Trusts because the government has said it will reimburse Foundation Trusts at the regional tariff rate, thereby allowing them to generate a surplus (see example).
- Some hospitals receive subsidies from central government towards teaching and education which enable them to keep their prices low, whilst others are operating with financial deficits that make them vulnerable to even small reductions in income.
- The value of public assets transferred to Foundation Trusts is to be set by the Secretary of State, with the consent of the Treasury (Clause 13. 3). This provision allows the Secretary of State to adjust the annual charges Trusts will have to pay to the government for use of the transferred property, which will in turn be reflected in the prices that they charge to the NHS. If the asset value is low then the Trust can make a surplus. This seems designed to allow the Secretary of State to channel subsidies to Foundation Trusts.
- The regional tariff will be set independently of hospitals' annual capital charges and PFI payments. This raises potential affordability problems for Trusts. Trusts with PFI deals pay relatively high amounts for the use of their buildings compared with trusts that do not have PFI deals.
- Unregulated income generation will create inequalities between Foundation Trusts in wealthier areas of the country and Foundation Trusts in less wealthy areas. Trusts in wealthy areas will attract commercial partners more easily. Trusts which have extensive disposable assets will be better able to raise private finance by borrowing against them. Moreover the Foundation Trust will be able to raise private finance on its deregulated assets by entering into joint ventures or creating subsidiaries below the level of the board.

Changes to the payment system could have a catastrophic effect on trusts that cannot keep their costs low. Among high cost trusts are those that have entered PFI deals to build new hospitals. PFI deals double and sometimes treble the share of income that has to be spent on buildings, leaving less money available for other hospital costs. The high building costs will not be allowed for in the regionally adjusted tariff and could pave the way for a funding crisis.

Similarly, primary care, community mental health, and older people's services could find scarce resources are being directed through the national tariff system to acute services in Foundation

Trusts. This could destabilise Primary Care Trusts and non-Foundation Trust provision leading to rising deficits and service closure. At the same time Foundation Trusts may have to offload the unprofitable aspects of care including chronic diseases and Accident and Emergency services in order to balance the books and appeal to the Regulator to alter the terms of their licence.

## 5. Conclusion

The potential of this Bill to generate new inequities within the NHS arises in several ways:

- Foundation Trusts' ability to retain all the proceeds from land sales will provide a "dowry" to those with a generous pre-existing asset base, and give them the power to raise private capital for new investment
- the Secretary of State's freedom to decide the value of the asset base and the charge on assets together with the discretion over subsidies could give Foundation Trusts a competitive advantage in the market place allowing them to generate a surplus on NHS income through hidden subsidies
- the ability to generate a surplus for new investment, combined with the freedom to enter into joint ventures with for profit corporations for the sale of both NHS and non NHS health care services including private insurance, could see some patients getting better access to care as a result of ability pay
- Foundation Trust borrowing will count against the health department's capital spending limit. Capital allocations to NHS Trusts are only guaranteed for the next three years. Thereafter, Foundation Trust borrowing could preempt capital spending by non-Foundation Trusts
- Foundation Trusts have the freedom to set their own terms and conditions of service for staff, both within and across staff groups, and the ability to attract staff on their terms will widen inequalities between and among staff groups
- Foundation Trusts will have the ability to subcontract services to the for-profit sector and transfer staff which could result in staff terms and conditions being eroded and widening inequalities
- Foundation Trusts will have an incentive to redefine eligibility for NHS care at local level thereby introducing new charges for services which were once provided by the NHS, e.g. personal care and intermediate care and rehabilitation. This will increase the lottery in access to care and widen inequities in access for patients.

A comprehensive and universal health care system aiming for equity through planning is being replaced by a market system of fragmented and competing providers under the rubric of Foundation Trusts.

The loss of national ownership and control is likely to lead to greater inequality, with the development of multiple systems of health care (both public and private) where increasingly access is on the basis of ability to pay, and where the level and quality of provision will depend on the wealth and resources of local communities.

## Appendix: How it will work in practice

### Example 1

Hospital A, a large teaching hospital in Birmingham, is planning to enter into a joint venture with two different multinational corporations for the delivery of pathology and radiology services. The business case rests on the hospital providing the land and assets, while the companies provide the private finance for the refurbishment and equipment and will design, build and operate the facilities and services.

The companies will receive a guaranteed annual income for a period of ten years to cover the costs of borrowing, refurbishment and operating services. All clinical and non-clinical staff will be transferred under the contract except perhaps for the doctors.

The Trust anticipates that it will become the major provider of pathology and radiology services in the area supplying services to local PCTs, GPs and four other major hospitals. It also intends that the medical school researchers will use the facilities for their research and clinical trials and the university will provide part of the income through grants provided by the pharmaceutical industry as part of clinical trials. The income is therefore dependent on a number of income streams internal and external to the hospital and the NHS.

Clinical and non-clinical services will pass to the control of a large for-profit multinational, which will be guaranteed annual income and profits. The Hospital and University hope to share the profits from NHS services and research and have each created a subsidiary company so that surpluses can be redirected into the business or into new ventures such as an expanded cancer and cardiac services.

Issues:

- how is the Trust accountable to local people for its decision to contract out services?
- which body will ultimately ensure that the needs of all the different interest groups are met?
- what will happen if the income streams fail and how are risks being shared?
- who has ownership of patient data and research material and who profits from its sale?
- how will quality of care be safeguarded and how will contract monitoring be undertaken?
- will new staff be protected and will existing staff undergo new appraisal systems or job grading?

### Example 2

Trust B in Oxfordshire is planning to outsource its maternity, cancer, cardiac and older people's services to a group of doctors who have created a company and have in turn entered into a joint venture with a large US corporation which is leasing the doctors facilities and equipment. These services will be located in a nearby building not owned by the Trust. Services, staff and patients will transfer to these facilities under the direction of the company.

The Trust intends to contract out services and will now ask the regulator to change the terms of the license in order to deregulate the buildings and assets which currently house maternity, cancer, cardiac and older people's services. This will enable the Trust to generate a surplus from land and estate which can be sold off or used to enter into a new joint venture with the private sector.

Issues:

- when and how will local people, patients and staff be consulted about service changes and privatisation of clinical services?
- how will quality of care be safeguarded and who will be responsible for the risks if services fail?
- how will the NHS complaints procedure work?

- when are local people consulted about land disposals and service closures?
- how are surplus land and assets valued?
- who owns the surplus for land sales and receipts?

### Example 3

Hospital C, in London, is applying for Foundation Trust status. It has signed a deal for a large replacement PFI hospital which is due to open in 2 years' time. As part of the deal the region provided a loan to the Trust on the back of anticipated land sales.

The Trust faces a major affordability problem when the new hospital opens. Its current spend on capital will rise from 8 to 15 per cent of annual income. It is therefore anxious to get Foundation Trust status because of the freedoms to generate new sources of income.

The prices the trust currently charges are low partly because it receives a large subsidy from R&D and education income, and partly because its capital charge is low. This means that its current prices are 92 per cent below the regional tariff. The Trust has been guaranteed the regional tariff when it gets Foundation Trust status.

This means that for every £100 million income it will be able to generate a surplus of £8 million. Its current service income is £200 million which the Trust estimates will provide £16 million to lever in new debt and borrowings.

Issues:

- are these subsidies sufficiently transparent?
- are they equitable?
- how is their cost-effectiveness to be assessed?

### Example 4

Trust D in London is currently sitting on estate worth £300 million. This estate will be surplus to requirements when its new PFI hospital opens.

The Foundation Trust is anticipating that the Department of Health valuation of the estate will be significantly less than the actual sale value, enabling it to generate a surplus. The valuation of the estate is at the discretion of the Secretary of State.

Issues:

- what determines the valuation of land and assets and the Public Dividend Capital payable?
- what local consultation is there over land sales and service closures?
- how is PFI debt included in the regional tariff?
- will the PFI debt be guaranteed?
- what controls are there be on how the surplus is used?

### Example 5

Under pressure to minimise financial exposure and maximise revenue, Trust E in Devon is approached by United Healthcare, a large US corporation which specialises in intermediate care and rehabilitation.

The firm has successfully piloted schemes using the 2001 Department of Health Guidance on Intermediate Care, developing eligibility criteria which will enable the Trust to assess patients' risk of care and also enable the Trust to time-limit NHS care and introduce charges for personal care. In line with the Guidance it has introduced a two week time limit on NHS care for people with hip fracture and a one week time limit on people admitted with respiratory conditions such as pneumonia.

It also has piloted a scheme which offers patients the choice of taking out "top up" insurance in case they need extra non-NHS care and any extra services outside of the NHS.

Issues:

- are the Trust's financial duties in conflict with its role as a provider of NHS care?
- is there scope for restricting NHS care and shifting patients into chargeable care?
- is the marketing of "top-up" insurance and charging for "non-NHS" care an appropriate activity for NHS Trusts?

## Example 6

The large teaching hospital F in Teeside has over 100 commissioners but some of the commissioners say they cannot afford to pay at the regional tariff. The Trust is negotiating preferential access rates for elective care on the basis of the PCTs' ability to pay and is offering different levels of care and treatment.

It is also entering into joint ventures with companies to offer patients access to treatments and care which are not currently available on the NHS or which some PCTs cannot pay for, for example, fertility treatments, expensive cancer treatments and speech therapy and chiropractic.

Issues:

- what scrutiny and oversight arrangements exist to monitor such situations?
- how is equity maintained in the event of differing purchasing ability across Primary Care Trusts?
- will some patients be able to access more care due to services not being available on the NHS?

## Example 7

A Primary Care Trust G in Northumberland has a low resource allocation for its population needs. The PCT has managed to cope because its main hospital has low prices as a result of having low land values and special subsidies for education. The hospital is now applying for Foundation Trust status and has been told that it will be reimbursed at the regional tariff, which is 20% above its current prices. The PCT is concerned that the effect of the regional tariff will be to divert scarce NHS funds into the Foundation Trust and it will not have enough left over to pay for GP services and community based care.

Issues

- how will the PCT be remunerated for the additional costs of implementing the regional tariff when the hospital assumes Foundation Trust status?
- how will PCTs manage to reconcile the extra costs of the Foundation Trust with competing claims of GPs and community services?
- what discretion will the Foundation Trust have over its surplus when neighbouring community based and primary care services have insufficient funding to pay for care?
- if community services fail because of insufficient funding, what special measures does the regulator have to prevent service closure?

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