CGMA STRATEGIC CASE STUDY MAY 2019 EXAM ANSWERS

Variant 4

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SECTION 1

Requirement 1 – stakeholder relationships

KHS hospital managers form a key stakeholder group because they are responsible for providing critical care for our patients, based on our needs, when they have created those facilities for the needs of their own patients. The KHS managers could restrict access to their units by keeping beds occupied with patients who could otherwise be returned to the ward. Those patients could then be returned to their wards when their places were required for critically-ill KHS patients. If KHS managers were to restrict access in this way then Denby might be forced to cut back on its own activities in order to reduce the number of patients who required critical care. Also, the KHS managers could mobilise public opinion against Denby if it could be demonstrated that there had been cases where KHS patients had suffered because of critical case beds being occupied by private patients.

Keeland's government could also be a major stakeholder here because it must always bear ultimate responsibility for the provision and management of KHS resources. This is potentially a controversial issue because voters are generally interested in the workings of the KHS. The occupation of critical-case beds by private patients could also become an interesting news story, which could put the government under further pressure. Given that the government may be unwilling or unable to offer additional funding to KHS hospitals, it may respond to any public concerns by changing the law to restrict the use of KHS facilities by private hospitals.

Denby should approach KHS hospital managers to discuss ways in which it can mitigate the problems created by its dependence on KHS critical care beds. It would be preferable for Denby to take the initiative and to attempt to resolve problems in a mutually satisfactory manner than to wait until there is a crisis. There are clearly financial implications, because foreign patients are required to pay for their treatment from the KHS while Keeland nationals are not. Perhaps Denby should offer to compensate KHS hospitals, bearing in mind that it is being paid for treating these patients, even though they will not be costing Denby anything while they are under the care of the KHS. There may be other ways in which Denby could compensate KHS hospitals. It could make facilities such as diagnostic equipment and laboratories available to those hospitals who provide their critical care support. That could have the advantage of offering facilities that the KHS would not otherwise be able to access.

Denby should aim to lobby the government in order to take some initiative over this issue. The government may otherwise be forced to take action because of concerns raised by press reports. The interaction between public and private hospitals involves much more than the issue of critical care. The most obvious is that Denby generates more than 60% of its revenues from treating KHS nationals who self-pay or are funded by health insurance. That relieves the KHS of the need to provide those patients with treatment using public funds. The KHS also benefits from the fact that private hospitals, including Denby, offer a backup resource for treating patients who would otherwise go over their deadlines. Denby might argue that the government benefits from the existence of a strong private health industry and that it might benefit from making such a case in response to criticism, otherwise it may be necessary to spend more on the KHS.

Requirement 2 – ethical implications

There is a potential ethical conflict arising from the fact that Denby cannot conduct operations without imposing on the KHS to treat a small proportion of its patients who require critical care during the recovery phase. Denby treats each of its patients to a very high standard and it would not operate on any given individual whom it expected to require critical care, but those precautions cannot eliminate the small proportion of patients who become seriously ill after their operation. There is a financial cost to the KHS because most of Denby's patients are citizens of Keeland and so are not required to pay directly for this treatment. There may be an even greater cost to any KHS patients who are displaced because beds are occupied by Denby's patients because they may need to be transported further afield for any critical care that they require, at a possible risk to their health.

Denby must investigate this conflict in some detail in order to establish the extent of the problem that it is creating for the KHS. The problem will be easier to address if it is quantified. For example, KHS hospitals that are equipped with critical care facilities will generally aim to have sufficient capacity to deal with emergencies. It would be useful to know whether Denby's referrals were actually causing problems. It would also be useful to break Denby's referrals down in order to establish the extent to which they were in respect of "discretionary" procedures, such as cosmetic surgery or overseas patients. Many of the operations that Denby carries out would have been carried out in KHS hospitals anyway, because the patients had been diagnosed with serious conditions that required treatment. If most of Denby's referrals are from such patients, whose underlying health was already a problem, then the problem is due to underfunding of critical care by the KHS.

Once Denby has determined the facts, it should consider whether it is in breach of any of the fundamental ethical principles. For example, the principle of integrity requires Denby to be straightforward, honest and truthful in its dealings. In this case, behaving with integrity would include working with the KHS in terms of scheduling operations so that any constraints on the availability of critical care are taken into account. Denby should delay non-urgent surgery in response to any shortage of critical care beds, even though it is unlikely that any given patient will require critical care. When Denby accepts referrals of KHS patients from local hospitals it should do so on the basis that the local KHS managers have taken account of the small number of patients who will subsequently be referred back for critical care.

The concept of professional behaviour is also an issue. For example, Denby should avoid encouraging negative press reports about private hospitals. If a patient at one of Denby's hospitals requires emergency admission to a critical care facility then that

should be arranged without hesitation, but Denby should not schedule operations without some consideration of their impact on the KHS. It would be an abuse of the law and medical ethics to work on the basis that the KHS has no choice over the acceptance of critically ill patients. On the same basis, Denby should do everything in its power to minimise the number of patients who become ill after a procedure.

SECTION 2

Requirement 1 – share price

The fact that the share price was unchanged can be interpreted in many different ways. In an efficient market, the share price reflects all relevant information and does so in an unbiased manner. One possibility is that the markets had inferred that Denby would make such a purchase and so the impact of that decision was already incorporated into the decision. That would be very consistent with an unchanged share price, bearing in mind that the decision to invest has not been formalised with a contract. Failure to react to the markets would also use information that had become available through unofficial means, such as leaks from KHS managers or staff about the discussions between Denby and the Health Board.

Another interpretation is that the market has considered the information in the announcement and evaluated this investment as delivering the required rate of return, and no more. The markets could form the opinion that the future cash flows from this investment will barely cover the K$160 million investment and so the project has a zero net present value. That would not be considered a poor investment because the shareholders will be receiving their required rate of return from this project and so they will continue to benefit from investing in Denby. If this is the case then Denby's Board should proceed on the grounds that the project delivers the required rate of return, even though it would have been preferable for a higher return that would have increased shareholder wealth.

The fact that the shareholders seem to view this project as a zero NPV project does not mean that it is. The stock market will not have full access to all of the information and future plans that were developed by Denby's Board. Apart from anything else, it might not be in Denby's interests to release all of that information. The investment may be beneficial to Denby even if the shareholders do not have sufficient information to see that is the case. Indeed, a fall in the share price would not necessarily mean that the Board was making a mistake in proceeding.

The shareholders might not realise the extent of the potential future problems associated with Denby's use of KHS critical care facilities and so the markets might not fully appreciate the advantage that this will bring about. The additional facilities that are being acquired may be viewed as a source of expense rather than an improvement to the business. The markets may not realise the possibility that, say, the investment will prevent a curtailment of future business activities. It may never be in Denby's interests to release that information to the market and so the share price may never increase in response to this investment. The shareholders will simply be unaware of a potential decrease that the Board has averted.

Requirement 2 – strategic options

Evaluating this investment as a source of strategic options requires some discussion of Denby's business model. Firstly, the question of whether Denby will have the ability to offer critical care services will depend very much on Denby's ability to staff the units.

The KHS is closing CCUH as an economy measure and so it might plan to make some of its staff redundant, in which case they would undoubtedly be interested in any offer that Denby might make, particularly if it offers better conditions than the KHS. That said, the KHS plans to build a new critical care facility at the Western Hospital and will undoubtedly be keen to retain the trained and experienced staff from CCUH. The new unit at the Western Hospital may be even better than the existing one at CCUH and staff may be keen to stay with the KHS in order to experience working at the forefront of their field.

Assuming that Denby can staff CCUH's critical care then it would open up a differentiation strategy with regard to the procedures offered in Capital City. Denby could then promote itself as offering a full service for all surgical patients, including the provision of critical care facilities. That may be a particularly satisfactory means of attracting patients because it does emphasise the possibility of a serious condition arising after an operation at one of Denby's hospitals. It will also draw attention to the fact that the critical care facility is not offered to the majority of Denby's patients because most hospitals are too far from CCUH.

The additional cost of providing this care could attract some patients to the hospitals in Capital City. This may be a counter-intuitive approach to cost differentiation, but the charge could emphasise the advantages of being treated at those hospitals rather than competing private hospitals. That may interest those self-pay patients from Keeland and overseas who can afford to pay the extra. The overseas patients will be incurring significant expenses in any case, because of travel and possibly accommodation for family members. Any additional charges could prove a deterrent to insurers and to KHS managers when making referrals to private hospitals because they are quite cost-sensitive. Denby may have to offset the charges for those market segments by offering additional discounts, otherwise it could lose the market in Capital City.

Denby could use the location of CCUH in Capital City to further focus on the market for overseas patients. Creating a hospital that is both better equipped and designed with the needs of overseas patients in mind could create a further opportunity to focus on the market for foreign patients. Denby could build on the acquisition of CCUH itself by looking into further ways to meet overseas patient needs. For example, Denby could provide accommodation packages in nearby hotels to meet the needs of accompanying spouses or relatives. Denby has the advantage here because it is acquiring the full capacity of an additional hospital. Competitors would probably have to build additional capacity or divert home patients to other towns in order to match any such initiative by Denby.

SECTION 3

Requirements 1 and 2 – economic risk

Economic risk arises because changes in the value of the K$ affect the cost of treatment when expressed in other currencies. If the K$ strengthens then foreign patients will have to spend more of their own currency in order to settle the cost of their treatment. Medical treatment is generally expensive and the volatility could force patients to pay a great deal more when the volatility works against them. The corresponding upside that the bill may decline in terms of patient home currencies is unlikely to compensate for the downside risk that the patient could be left struggling to settle the bill.

Keeland has a reputation for offering excellent medical care, but it is not the only country to offer such care. The volatility of the K$ could encourage patients to seek

private hospital care in other countries that have good private hospitals. Denby could find itself in competition with overseas private hospitals, simply because their home currencies are more stable. If patients know how much their care will cost if they go elsewhere then all of Keeland's private hospitals could lose revenue.

Managing economic risk is complicated by the fact that it is difficult to tell how willing potential patients would be to seek treatment elsewhere. A patient who is seeking a life-saving operation may be willing to pay significantly more if it is believed that Denby offers the best treatment. Some patients will be based in countries that have historical links with Keeland and so there could be shared cultural values that might motivate them to pay more to be treated there. Even geographical factors, such as the length of flights and the need for visas could make it more attractive to seek treatment in Keeland, provided the potential cost is not too great.

It may be difficult for private citizens to hedge their currency risks through financial instruments. It would be undesirable for Denby to bear the currency risk on the patient's behalf because that would increase the volatility of Denby's revenues. That volatility may not be quite so bad if patients come from several countries and there is a tendency for the K$ to move differently against each. In that case, Denby could consider invoicing in home currencies. One possible compromise would be for Denby to invoice at the time of scheduling a procedure. The patient could then lock in an exchange rate by settling the invoice immediately. That would not be particularly problematic for Denby because it could spread the volatility across many advance payments.

Requirement 3 and 4 – gearing

Lenders will be reluctant to advance funds to a business that might force them to foreclose. Foreclosure involves costs and bad publicity for the lender. Denby operates in an industry that is likely to be sensitive to economic pressures and so the risk of foreclosure could be high.

The state of the economy could make patients reluctant to spend their savings and so they may become less willing to buy private medical treatment. Employers may cut back on the provision of private health insurance for staff, reducing the ability of health insurers to pay for private care. The loss of revenues could make it more difficult for Denby to service its existing debts and could make further borrowings problematic.

Lenders may be reluctant to tie up funds in K$ loans during a period of economic uncertainty, given that the fund could be converted and invested overseas. The funds could be invested in a stronger country that has a more stable economy, which would reduce the impact of changes in Keeland's economy for the banks. The interest rates paid by overseas borrowers will be lower, but there will be a corresponding reduction in risk.

Debt covenants protect lenders by giving them rights to foreclose in the event of default. Thus, a covenant only has value because it may deter misbehaviour by the borrower. For example, signing a debt covenant may mean that Denby is unable to take out further loans, which would possibly affect the security of existing loans. The covenant might also grant the lender the right to foreclose in the event that key performance, gearing and liquidity ratios fell to dangerous levels. None of this protection would prevent the fact that these rights would only come into effect once Denby was at risk.

The debt covenant cannot alter the possibility that a declining economy could have an impact on Denby's assets. If demand for private medical care falls then the value of

private hospitals may decrease, which would diminish the value of lenders' security. The existing loans might, in any case, be mortgaged against specific assets and any further debts may be secured against a very limited range of assets. Nothing that the Board can sign would protect or preserve the value of those assets in the event of default.