



FINANCE COMMITTEE

AGENDA

4th Meeting, 2001 (Session 1)

Tuesday 13 February 2001

The Committee will meet at 10.00 am in Committee Room 1 to consider the following agenda items:

1. **Committee Business:** The Committee will consider whether to take agenda items 2 and 5 in private.
2. **Inquiry Into Resource Accounting and Budgeting:** The Committee will consider its lines of questioning for witnesses at agenda item 3.
3. **Inquiry Into Resource Accounting and Budgeting:** The Committee will take evidence from—
 - Hugh Hall, Chairman, CIPFA Scotland
 - Grant MacRae, KPMG
 - Dr Jean Shaoul, University of Manchester
 - Leslie Wilson, Director of Finance, Historic Scotland.
4. **Future Inquiries:** The Committee will consider an options paper for future inquiries.
5. **2002/03 Budget Process:** The Committee will consider a paper from the Clerk.

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The papers for this meeting are:

Agenda Item 2

Paper from Professor Irvine Lapsley

PRIVATE PAPER
to follow

Agenda Item 3

Paper from Hugh Hall

FI/01/4/1

Paper from Grant MacRae

FI/01/4/2
to follow

Paper from Dr Jean Shaoul (previously issued for 1st meeting, 2001)

FI/01/4/3

Paper from Leslie Wilson

FI/01/4/4

Agenda Item 4

Paper from SPICe

FI/01/4/5

Agenda Item 5

Paper from the Clerk

PRIVATE PAPER



Scottish Parliament Finance Committee Inquiry into Resource Accounting & Budgeting

Hugh Hall, Chair, CIPFA Scotland

The Committee has already received briefing from CIPFA's Professional & Technical staff particularly on the technical aspects of Resource Accounting & Budgeting (RAB) so I have avoided going into the technical detail here. I, instead, offer a general perspective on some of the strategic and management issues that should be considered in the context of the development and roll-out of RAB. I would be happy to elaborate on these issues when I appear before the Committee and also give further supporting information and technical detail if that would be helpful.

Key Objectives

It would be difficult to quibble with the broad thrust of the Government's drive to introduce RAB and the key objectives that lie behind it. I see these as fourfold:

- to provide meaningful and relevant resource and performance information necessary for effective planning and decision making: both short and long term;
- to focus on the value of assets - how these have been (and will be) utilised;
- to recognise consumption and investment rather than simply cash spend;
- to encourage good stewardship and improve accountability.

This is indeed, a refreshing development in public finance from what has perhaps hitherto been a disproportionate interest in cash spend and annuality. Handled properly, RAB has the potential to support more effective use of public funds and better, more informed decision-making.

While the overarching objectives of RAB are clear, there is, however, still a debate to be had over process, practical implementation, and added value.

Process

Let's go back to first principles. The starting point for RAB is not the accounting element - it's the budgeting element. We need to start with the aims and objectives of government and then identify the resources likely to be required to deliver these. Scotland's budget documents do this at a very macro level and it is right and proper that these are recognised as "all-in" costs including the cost of any assets consumed, loan interest charges, salaries and so on. Ideally, there should, of course, be a cascade of budgets down to organisational, departmental and individual level with a clear reconciliation at each level. The simple proposition is - what am I seeking to achieve and what do I need in terms of resources to meet my stated objectives?

The theory is sound but the difficulty comes in apportioning and allocating resource requirements and consumption against specific objectives. This challenge is true of general (revenue) overhead costs, even without the complications of capital charges, depreciation and so on. In the process of budget determination, there can be much resentment by front facing delivery functions at having to take on additional costs over which they have little control and which they feel do not add real value. This feeling of resentment is likely to be heightened where budget holders do not understand the source of these costs or feel that the costs do not represent "real money".

The measurement and allocation of indirect/overhead costs is fraught and the sheer scale of RAB has the potential to add greatly to the complexities and sense of frustration that may already exist. The difficulties associated with defining and determining "values" and "costs" are not, of course, peculiar to the public sector. They are a constant source of discussion within the accountancy and other professions.

It could be argued that the complexities of public sector finances are such that we should expect even greater challenges in getting to grips with the concepts (and practical implications) of measuring resources. Accounting and reporting standards are already continuously reviewed and updated and the expectation must be that RAB will similarly evolve over time as information requirements change, technology improves and aspirations develop. There are, however, some basic principles that should underpin the development of RAB if it is to stand up to scrutiny and gain universal acceptance. In order to achieve its overarching objectives, RAB needs to:

- provide *information* that is meaningful and useful;
- stand up to reality checks - in terms of its credibility and the extent to which it adds value (at a citizen, organisational and Parliamentary level);

- secure "stakeholder" buy-in. RAB should not be an imposition but should be introduced in an inclusive manner, so that managers and others can see that there is "something in it" for them.

Practical Implementation

To convert the principles and processes into workable solutions, there should be an appropriate balance struck between functionality and technical purity. Organisations can be data rich and information poor and decisions need to be taken on the balance between utility and accuracy. In this respect, reference should be made to how critical and material the various inputs are to the achievement of aims and objectives. What level of detail makes for sensible planning and decision making? How much control do the various hierarchies of budget holder have over the relevant cost inputs? This is where we can begin to make linkages between inputs/outputs/outcomes and proper stewardship/accountability.

While it is important to determine the cost of individual activities, if a budget holder's ability to take decisions is constrained by external factors then it is unreasonable to expect them to account for the resources consumed – this is perhaps a challenge for the next level of responsibility. The fundamental issue here is the relationship between authority/empowerment/responsibility. This should be the driver for RAB and the determinant of the mechanics that are required to support it. Otherwise, you run the risk of having an expensive and complicated RAB process for its own sake.

There is probably every reason to believe that RAB has been "hijacked by the bean-counters" – although the more likely scenario is that there are few others who are interested in taking the lead. A poll of policy makers and public sector managers is likely to find a good deal of ignorance and apathy about RAB. Conceptually and technically RAB can be difficult to grasp and relate to. When discussions on RAB emerge, the engagement of non-accountants (and even some accountants) is often characterised by a combination of the "emperor's new clothes" or downright cynicism. If RAB is to be a fundamental input to better planning, decision making and accountability, then attitudes will need to be changed.

Organisations will need the right skill set capacity to secure effective implementation of RAB. This does not mean an army of accountants - although an appropriate level of professionally qualified resource is necessary - it means having more sophisticated and knowledgeable managers who can understand not only the information itself but also the benefits that can be

derived from that information in the business context. While this latter point is about adequate training, it also has as much - or even more - to do with attitude and culture.

The level of technical preparedness for RAB is perhaps less of an issue but we still need to keep our eye firmly on the ball. The lead-in time combined with improvements in Information Communications Technology has probably smoothed the transition and should help to further the development of RAB. The challenge is to harness the technology to improve the quality of information and communication and not simply to extend the volume and complexity of data.

A final point on practical implementation - and this is linked back to culture - there is a need for strong leadership, and continuous improvement to help secure RAB's success. Mainstreaming the concepts and the information of RAB into routine "business" processes will secure buy-in from stakeholders and enable RAB to develop from being - for some - a technical inconvenience to become a useful tool that achieves business improvements and better service delivery. RAB should be in the organisational psyche, owned by the corporate team and backed up with investment in knowledge and understanding.

Added Value

The systematic approach to budgeting and accounting in the public sector should facilitate RAB implementation but there is a need to ensure that close attention is paid to the cost/benefits of RAB. All organisations/department affected by RAB should be asked to take stock. For example:

- What will the introduction of RAB add to the achievement of my business objectives and what do we perceive are the key benefits?
- What is our state of readiness to assume RAB and what are our aspirations for its further development and over what period?
- Do we have the necessary level of awareness, knowledge and understanding to ensure RAB is properly embedded in the organisation?
- What changes should be made to existing resources/systems/attitudes in order to successfully mainstream RAB and are the associated costs more than justified by the benefits?

These questions are illustrative but the point is that if organisations and departments undertake a baseline audit now of their readiness to embrace RAB, it will not only increase the prospect of added value being achieved now but it will enable them to make a more comprehensive assessment of the benefits in the future.

Conclusion

It is important to understand the limitations of RAB – it is simply a process. One of a range of tools, which if used properly, can actually support politicians, policy makers and managers in delivering public services more efficiently and effectively – and in turn can improve accountability through clearer/fuller disclosure and an alignment of resources consumed and performance against objectives. The challenge is to secure a process which achieves the right balance between being simple yet meaningful.

This paper has been prepared to help stimulate discussion at the Finance Committee. It is not intended to be comprehensive nor does it deal with the detailed technicalities. RAB needs to be seen in perspective. It is clearly not a panacea for public finance but it is an important step along the way to improvements in planning, decision making and accountability. It should help to secure a more effective assessment of performance and outcomes through the supply of more meaningful and comprehensive financial information.

There are challenges ahead on a whole range of fronts - from technical measurement issues to the more “touchy-feely” (and in many respects more important) attitudinal problems. These can and should be overcome. Better returns are achievable – and not simply in monetary terms but in terms of services and an improved quality of life for the people of Scotland.

Hugh Hall
Chair, CIPFA Scotland

February 2001

Policy Implications of Accruals Accounting: The Case of the NHS Acute Trusts**Paper written for Scottish Parliament Finance Committee**

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SUMMARY

The Government's Resource Accounting and Budgeting Act will change the way public sector bodies record their finances. The introduction of accruals accounting, the system of financial reporting used by private sector corporations to show their shareholders how profit has been generated, realised and distributed, means in essence treating a public sector body as a wealth accumulating entity and accounting for capital via a system of depreciation, interest and dividend charges. This paper uses the case of the NHS acute trusts to demonstrate empirically the effects and implications of introducing accruals accounting based on current cost accounting valuation methods and requiring public sector bodies to make a 6% return on the value of their assets.

In the early 1990s the Government reconfigured the NHS hospitals as public corporations in the public sector providing acute healthcare services. This paper firstly examines empirically the validity of both the implicit assumptions and the explicit objectives of introducing capital charging into the NHS Trusts. It compares the incidence of capital costs and charging; the relative efficiency of the public and private sector in respect of both asset and labour utilisation; and assesses the value and implications of capital charging as a managerial solution to the perceived problems of the NHS.

The analysis demonstrates a number of important points. Firstly the original problem definition was wrong. Capital costs were not a major cost. But the Government's 'solution' to the 'problem' threatens the financial viability of a significant number of hospitals and the ability to deliver healthcare services in the future. The real problem was a lack of revenue. It challenges the myth of public sector management inefficiency.

The paper secondly examines the implications for capital expenditure by showing how the regime operates to constrain investment options in ways that fly in the face of financial prudence, sound planning and the legitimate aspirations of the population. It also shows how it paves the way for PFI/PPP solutions to capital investment decisions – solution that other research has shown to be expensive, poor value for money and unaffordable without cuts in service provision, asset sales, subsidies and the diversion of resources to the PFI project.

The final section draws out some of the wider implications of this research for the NHS and other public services.

Policy Implications of Accruals Accounting: The Case of the NHS Acute Trusts

The Government's Resource Accounting and Budgeting Act will change the way public sector bodies record their finances. The introduction of accruals accounting, the system of financial reporting used by private sector corporations to show their shareholders how profit has been generated, realised and distributed, means in essence treating a public sector body as a wealth accumulating entity and accounting for capital via a system of depreciation, interest and dividend charges. One of the first public sector organisations to introduce capital charging as the system has become known, is the NHS. This paper therefore uses the case of the NHS acute trusts in England to demonstrate empirically the effects and implications of introducing accruals accounting based on current cost accounting valuation methods and requiring public sector bodies to make a 6% return on the value of their assets. While the financial arrangements for hospitals in Scotland are slightly different, the story is essentially the same.

The paper is structured as follows. The first section explains the background to the introduction to capital charging in the NHS, its meaning, assumptions and objectives. The second section draws on research carried out a few years ago and outlines how the system works in terms of the Government's assumptions and stated objectives, which are essentially the same given for resource accounting in the rest of the public sector. The third section draws on more recent and up to date analysis that considers the implications of the capital charging regime in the acute hospitals and its (adverse) impact on the trusts' revenue budget. It then considers the various 'solutions' to the financial dilemma facing the trusts, the implications for capital expenditure, the way capital charging paves the way for PFI, and lastly some alternative funding mechanisms. This is important given the Government's current emphasis on modernising the dilapidated public infrastructure. While the focus of the sections two and three is different, there is inevitably some overlap between the two. The final section draws out some of the wider implications of this research for the NHS and other public services.

Introduction of capital charging: its meaning, assumptions and objectives

The 1989 White Paper "Working for Patients"¹ laid the groundwork for reconfiguring the NHS as business units in the public sector, purchasing or providing healthcare services. One little known or understood aspect of that reorganisation was the introduction of capital charging which, it was claimed, would improve efficiency, from which all would benefit, and increase patient choice².

Capital charging means firstly that the Trusts, as healthcare providers, have to charge their purchasers the full cost of providing healthcare services without any cross subsidies. This includes the cost of capital and a charge for depreciation. Secondly they have to take responsibility for the repayment of past capital and future maintenance and enhancement of their infrastructure and equipment. Capital charges are represented in the financial accounts as the charge for depreciation (for the consumption of productive capital), interest on the debt which has been assigned to the Trusts as a result of past capital expenditure, and dividends to the Government on the Public Dividend Capital (PDC), the equivalent of the Government's shares in the Trusts. The Trusts are required to make a financial surplus, equivalent to at least 6% of the value of their asset base, after paying out all the operating expenses, which include depreciation, in order to cover interest and dividends. Although in 1999 the requirement to make interest payments was removed and subsumed into dividend payments - the reasons for which will become apparent - the system is still essentially the same.

In other words, the 1990 legislation that followed the White Paper required the hospitals to repay the Government for past capital expenditure on their assets provided 'free' decades ago, on the basis of what it would cost to replace them today, via interest charges and dividends to the Government as the ultimate owner. It should be noted that the private sector values its assets on an historic cost basis with occasional revaluation. The effect of current cost valuation is to increase the value of the asset base and thus make capital charges - to be paid for out of revenue - cripplingly high. The Government further required hospitals to make a depreciation charge for their use of equipment, buildings, etc., thereby requiring hospitals to assume responsibility for their capital consumption and replacement. But assets would be revalued every five years and reindexed in the intervening years to take account of inflation. Thus in a period when land values and building costs were rising, capital charges would also rise. However, there was no guarantee that revenues would also rise to meet the increased charges.

NHS hospitals have three statutory duties - all financial. They have to make a surplus, after paying their operating costs, equal to 6% of the value of their land, buildings and equipment in order to pay their interest charges and dividends to the Treasury. A rate of 6% was chosen quite explicitly "in order to ensure that there is no inefficient bias against private sector supply"³, *not* in order to reflect the real cost of capital to Government. Bringing public sector capital accounting in line with private sector conventions in respect of returns on capital makes the substitution of private capital for public capital provision a logical move. It disguises the most significant difference between the two sector. Whereas enterprises in the private sector operate in order to accumulate capital and wealth, the public sector's *raison d'etre* is to provide much needed services that could not otherwise be provided so cheaply on a universal basis in the private sector. In addition, hospitals have to breakeven after paying interest on the debt assigned to them and they had to keep within their external financing limit (EFL). Hospitals are only allowed to borrow to finance their investment not operating costs.

The capital charges would be circulated back into the healthcare economy. The Government said that NHS purchasers *as a whole* were to be fully funded in the aggregate for the total amount that NHS providers *as a whole* charged for capital. But the individual Health Authorities were to be funded on a weighted capitation basis not for the facilities within their area as a whole. Thus individual trusts would not necessarily be fully recompensed for their capital charges.

Previously the capital for new buildings and equipment came in the form of a Government grant with no dividend or repayment obligations. The proponents of capital charging, even those who opposed the present system, argued that as a 'free' good, hospitals had no incentive to use capital efficiently⁴⁵⁶⁷⁸⁹¹⁰. Several investigations had criticised the NHS's surplus property, the under-utilisation of its assets and the poor maintenance of the estate¹¹¹²¹³¹⁴.

The White Paper argued that capital charging would make the Trusts more efficient and managers more aware of the cost of capital; and would enable comparisons to be made between different parts of the NHS and between the NHS and the private sector. There was little public debate about capital charging and it was presented as a technical part of a set of health reforms whose centrepiece was the internal market.

But high capital charges may be due to hospital specialisms, the responsibility for teaching the next generation of clinical staff, research, case mix, geographic location (in city centres or remote areas), and historical, demographic and social factors beyond the immediate control of management. Inability to reduce or manage high capital charges would lead to painful service reductions in high cost or low population density areas and the development of acute services based on the purchasers' ability to pay rather than perceived need derived from epidemiological information.

There are several assumptions implicit in all this. Firstly, there was the assumption that the NHS was inefficient in its use of capital and less efficient than the private sector. Furthermore, the problems of the NHS could be solved by increased efficiency rather than increased funding about which little was said. Secondly, that a public service providers such as the NHS operate on a similar basis to a commercial enterprise. Thirdly that efficiency could be increased by the imposition of private sector accounting techniques and lastly that a system of capital charging based upon current cost valuations represents the cost of the buildings and equipment used to deliver services.

However, the Government provided no evidence to support the validity of any of these assumptions and assertions. Neither did it demonstrate the importance of capital relative to labour or purchasing costs. Similarly there was an absence of empirical detail to establish the likely outcomes and problems of implementation and hence evaluate the claims and promises that were made. Yet the justification for disposing of surplus property was that it would reduce maintenance costs. But since expenditure on maintenance was between 2.9% and 6.7% of revenue expenditure in 1985-86, and 6% in 1998, the sale of property, while desirable, would have very little impact on total costs.

The obligation to pay capital charges would act as a powerful incentive to sell off surplus assets and to refrain from acquiring expensive new facilities. The financial logic of such a system entails minimising the value of the capital base. While central Government would still provide the finance for any additional investment, the trusts would be acquiring a liability and extra expenses in the form of increased depreciation charges, interest charges,

dividends and debt repayment to the Government. The implications for the capital investment programme will be developed in the third section of the paper.

Capital charging, asset and labour utilisation, costs and efficiency

This section summarises the results of research carried out to assess the validity of the Government's assumptions about capital charging and efficiency, the relative efficiency of the public and private sector hospitals, the impact of capital charging, and the likely implications for the delivery of healthcare services¹⁵¹⁶. It uses the kind of numbers and measures the Government and accountants use when they talk about efficiency - inputs to outputs as measured in financial terms. The data is derived from a compilation of the annual report and accounts of all the acute hospital Trusts in England since achieving Trust status¹⁷ and two of the major private sector hospital groups. It is supplemented by interviews with finance directors of a few hospitals.

1. How important is capital in running NHS hospitals?

Table 1 shows that the amount spent on capital, the sum of depreciation, interest and dividend on the PDC, accounts for 9% of total income received, whereas purchases of all bought in goods and services account for 28% and labour 63%. Thus the most important cost to control is not capital but labour. Yet the Government introduced capital charging because capital was assumed to be a major cost. But more importantly, it is hard to see how introducing capital charging can achieve powerful cost reductions through more 'efficient' asset utilisation in an activity that like all public services is labour intensive.

Although it is small as a percentage of total income, it is a significant item in a cash strapped service. Since it is a charge that must be met, and since purchases are already low, then labour must be squeezed to provide the surplus to cover the capital charges or revenues must be increased. This is its real significance.

2. How do private hospitals pay for capital?

The three major private hospital groups which account for 50% of the beds in the private hospital sector are BUPA, General Healthcare (BMI), and Nuffield. BUPA, part of a mutual insurance group and the largest of the private sector groups, pays no dividends or interest charges and has a policy of reinvesting the surplus. Nuffield is a charity, a non profit making organisation which therefore pays no dividends. Thus these hospitals do not pay the full cost of capital and their capital is, to some extent, a free good. Only the General Healthcare hospitals operate on a *'for profit'* basis and pay the full cost of capital.

Two points follow from this. Firstly the Government confused the private sector with profit for distribution to shareholders and thereby assumed that all the private sector hospitals paid the full cost of capital. Secondly an examination of the accounts show that BUPA could not breakeven if it had to pay interest and dividends on its capital. Neither could General Healthcare make an adequate profit if its assets were valued on the same basis as the Trusts.

3. If the Trusts are to be compared with the private hospitals, how similar are they?

The private hospitals are much smaller, having typically fewer than 100 beds. Their (rising) income is largely derived from the insurance policies of their patients. Their prices per case are usually higher than those in the public sector - as one finance director of a private hospital implicitly admitted when he said that they do not normally seek work directly from GP fund holders or the Health Authorities, despite the fact that they operate at about 50% of capacity.

They do not carry out a full range of medical and surgical treatments but concentrate on elective surgery and acute care, usually of the less complex variety. The public hospitals on the other hand, at least on a regional basis, carry out a full range of treatments, including accident and emergency, obstetrics, paediatrics, gerontology, to name but a few, and are required to have contingency plans to meet a wide variety of disasters, epidemics, etc. The private hospitals perform fewer services 'in house' and buy in more goods and services, often from the public hospitals.

They therefore carry out a very different mix of activities.

Their accounting policies are based on historic cost conventions and management decisions, subject to conformity with statutory and Accounting Standards Board requirements. That is, they record their assets at the original purchase price with occasional revaluation. The Trusts' accounting policies, on the other hand, are set by the Government. The Trusts are required to value their assets at current replacement cost (CRC) which is much higher than the original cost. The significance of this will be developed later.

Thus the private sector hospitals differ from the Trusts in terms of their income base and ability to charge premium prices, their patients and activity mix, as well as their accounting and financial regime.

4. How well do the Trusts use their assets?

Asset utilisation is typically measured as income divided by total fixed assets or, as is preferable because it corrects for bought in goods and services, value added or net output divided by total fixed assets. The larger the ratio, the higher or better is the asset utilisation.

Table 2 compares the Trusts with: private sector hospitals, despite their different mix of activities; hotel groups because most hospitals are hotels for the ill; and the giant food retailers because they use expensive space to deliver a service and they are considered as exemplars of private sector efficiency (or at least they were until their recent fall from grace). Despite the handicap of low income per case, and high asset valuations, the results of this comparison are really quite surprising: the publicly run hospitals are not inferior. Contrary to the assumptions of the White Paper, asset utilisation is superior to that in private sector organisations like Marks and Spencer, Forte and BUPA. Despite the private sector's advantages of historic cost valuation and commercial freedom of manoeuvre, the public sector's margin of superiority over private sector operations such as Forte and Tesco in hotels and retailing is greater than 2:1. And this margin has since increased.

The comparison with private sector hospitals is particularly interesting; asset utilisation in acute Trusts is arithmetically the same as in General Healthcare and twice as good as in BUPA hospitals. Despite the triple handicap of current cost asset valuation, low income and a huge demand for their services, the Trusts performed better than BUPA and the same as General Healthcare.

5. How well do the hospitals use their labour?

The private hospitals spend a smaller proportion of their income on labour: BUPA spends 37-39%, General Healthcare spends 40%, while the Trusts spend 62%. But this is not the result of paying lower wages. Their wage costs per employee are very similar despite the fact that the private hospitals employ few or no senior medical staff as patients pay their consultants and anaesthetists directly or via insurance without the payments going through the hospital accounts. In practice they pay their staff similar wages to NHS staff. Their staffing levels are much lower than would be expected on the basis of income - about one-third the level of the Trusts. But the finance directors were adamant, as indeed were their nurses, that there were **more** staff per comparable case than in the public sector. This of course must be true since no one pays to go privately to get **less** personal care. But this in turn means that the lower staffing levels are not achieved via different and more efficient work practices but by concentrating on activities which maximise throughput with conveyor belt treatments and cases with a lower labour content. This is a result of concentrating on elective surgery rather than providing a full service. Thus their lower labour costs depend upon their ability to choose their case mix - like the privatised buses - not technically superior efficiency, and farm out the difficult cases to the NHS.

6. What is the impact of capital charging on the Trusts' financial position?

Table 3 compares three groups of Trusts: those with below average capital charges, average charges and high charges. The above average group had the lowest income and a high proportion of their assets in equipment that carries a higher depreciation charge than buildings, and a correspondingly higher depreciation charge. But the really interesting point is the surplus to income figure. This reflects their ability to manage costs: the higher the ratio the

lower their costs and the more 'efficient' they are. The above average group is the most cost efficient. But because of capital charges they have a lower than average surplus, the lowest accumulated reserves and are the least able to meet their financial targets.

Thus the system of capital charging penalises the specialist and small hospitals and the most efficient hospitals. The source of the problem is the low income relative to their high asset base. The scale of the problem can be demonstrated as follows. Since the Trusts are required to make a 6% return on their asset base and the average Trust has a 5% surplus/income ratio, it is quite simple to calculate the total income required for the acute sector as a whole. In 1995 the hospitals needed an income of £1.43bn more than they actually received - a sum equivalent to the income of 22 average size Trusts. And the situation has not improved. Unless they are bailed out by the Government, some Trusts must sell their buildings and land and/or close to bring their income into line with their assets.

7. Implications for service delivery

In effect the reconfiguration of the NHS as business units in the public sector established entities akin to the former nationalised infrastructure industries. They were required to operate as commercial entities and make a surplus to cover the cost of capital as though they were normal commercial corporations despite the fact that they were required at least in principle to provide a universal and comprehensive service. Yet no country in the world has been able to operate healthcare on a commercial basis for the entire population. This was why there was a decades long struggle for a publicly funded NHS and other public services.

Increasing the surplus means improving flow or altering the activity mix to improve throughput via conveyor belt treatments that minimise the need for labour. But the results are perverse from three points of view. Firstly, only those treatments that maximise patient flow and income will be given. Increasing Trust income when this is effectively static at a national level means stealing market share and forcing other Trusts out of business: grocery store economics. It means concentrating services at certain sites, and closing others, especially the more expensive inner city sites, to reduce costs. There will be ever larger and fewer hospitals, increasingly inaccessible to those without cars.

Secondly it involves a policy of early discharge and short stay. So the increased efficiency is achieved by passing the costs onto primary care and the patients' families. While this may be an efficiency gain for the individual Trust, it is hardly consistent with the notion of social healthcare provision and social efficiency.

Thirdly the reconstitution of hospitals as businesses with financial objectives jettisons any attempt to **plan** the provision of health services based on the perceived need derived from epidemiological information. The logic of a financially driven system entails forms of treatment which are high tech and short stay based; favouring those living in the suburbs rather than the inner cities; and those who are basically well rather than those who are chronically sick.

The rhetoric employed to justify charging for capital focused on efficiency and capital or asset usage. But this research, using the publicly available financial information and forms of analysis used by the Government and accountants when discussing efficiency, challenges the claims about the importance of the cost of capital and the assumptions that the hospitals were inefficient in their use of capital and labour. While the system was resource neutral at the aggregate level, there were winners and losers within the Trusts, and the losers were not necessarily the 'inefficient' Trusts. Finally, far from increasing patient choice, the inevitable reduction in the number of hospitals and treatments has already reduced patient choice - outcomes far removed from the promises.

Implications for capital investment programmes

This section summarises the evidence as it relates to the implications for capital investment. Capital charging cannot be understood without reviewing how it relates to other aspects of Government policy such as PFI/PPP. Indeed, capital charging is not so much an end in itself but a means of restructuring the public sector. It is part of a process that leads to different forms of privatisation, via various outsourcing mechanisms, of public services that cannot be

sold as business enterprises for political or financial reasons as they are simply not cash generative enough.

With much of the NHS stock old and antiquated, billions of pounds of refurbishment and new hospitals are needed. But the planning of service delivery is affected by the mechanisms used to finance investment independently of the overall level of resources. In other words, financing mechanisms are about more than raising money: they shape the decision making process for service planning due to the constraints and incentives placed on existing stakeholders by the financial systems and the introduction of new stakeholders. The financial arrangements therefore set the context for investment planning and influence the set of options available for the service.

1. What is the impact of Capital Charging on operating expenditure?

Two main points emerge from Table 4. Firstly, while the Trusts' average income rose from £61m in 1992 to £78m in 1998, it failed to keep pace with rising costs, and the average operating surplus, needed to pay interest and dividends, fell from £4.6m to about £3m in 1998. Secondly, **after** accounting adjustments (provision for clinical negligence, book adjustments for loss of assets on disposal, etc.) and paying interest and dividends the average Trust surplus disappeared and its deficit rose to £0.4m in 1998. A number of Trusts were unable to pay their interest charges. Even more were either not paying any or paying dividends equal to less than 6% of their Public Dividend Capital (the Government's equity stake) to the Government. Thus many of the trusts were not making the full 6% return on their assets to the Treasury/Department of Health, as under the system of capital charging they were supposed to do because they simply could not afford it¹⁸. By 1998, the average accumulated retained surplus had declined to £0.165m.

Only in 1992 and 1994 did the Trusts as a whole make a sufficient surplus to meet their capital charges. That they performed best in the early years reflects, in part, the fact that the first wave of Trusts included the most financially secure hospitals. As all the hospitals became Trusts, the deficits grew. The situation really deteriorated after 1995. The cause is to be found in the rising value of the estate. While this was stable at about £60m until 1995, it rose rapidly thereafter to £69m by 1998.

While the accounts revealed that the Trusts as a whole built or acquired £2bn worth of new assets in this period, this was counterbalanced by £2.2bn depreciation and more than £1bn of asset sales for the three years after 1995 (see second column of Table 5). In other words, the estate was actually contracting. Hence the cause of the higher capital base is to be found in the rising value of the *existing* assets after 1995, due to indexation and revaluation in line with the rising property market.

This meant that capital charges and hence the surplus had to rise simply to keep pace with the rising asset base as Table 6 shows and the required surplus was usually larger than the actual surplus. Thus capital charging played a major role in the increasingly parlous state of the hospitals' financial situation since irrespective of any increase in NHS costs, Trusts had to trim expenditure to meet the rising capital charges consequent upon the rising value of the assets. Although capital charges only accounted for 9% of income, they were a significant cost in a cash strapped service.

A rising asset base due to property inflation or rising construction costs therefore has important financial consequences for public sector entities whose assets are valued on a current replacement cost basis and which are required to make a return on such assets.

2. What can Trusts do to resolve the deficit?

There are essentially three ways that the Trusts (or indeed any business enterprise) can meet their financial targets: reduce costs, increase income and if all else fails, reduce their assets since this reduces the required surplus. This is because the 6% return on the asset base is derived as follows:

$$6\% \text{ financial target or surplus} = \frac{\text{Income-expenditure}}{\text{Capital stock}}$$

We consider income first. When aggregate income is set by Government, individual Trusts can only increase their income at the expense of neighbouring Trusts - if demand and capacity exists. Trusts tried to boost their income by increasing charges for non-healthcare services such as canteens and car parks, opening shops and increasing the number of private beds. While Government funding did increase as Table 4 showed, this was insufficient to meet either the increase in capital charges consequent upon the rising asset base or rising NHS costs. This can be demonstrated by calculating the necessary income to generate the required 6% surplus on their asset base, assuming that Trusts could keep costs down to 95% of their income - something they were unable to achieve after the first few years. So this is a very conservative estimate. Table 7 shows that by 1998, income would have had to rise to £18.5bn, to meet the costs of their capital stock. In other words, throughout most of the period from 1992-1998, the acute Trusts faced significant underfunding relative to their asset base. And even this £18.5bn would not take into account the rising cost of drugs, wages, etc.

Alternatively, Trusts must reduce their costs. While the average cost of all external goods and services rose from £17m in 1992 to £24m in 1998, a rise of 50%, internal or labour costs, which account for 61% income, rose from £37m to £47m, a rise of only 25%. This was achieved by reducing staffing levels, outsourcing domestic services and altering the composition of staff as Table 8 shows. While medical and dental staff rose, the number of nurses, midwives and ancillary staff fell.

But reducing staff in a labour intensive service may be self-defeating. The increasing workload for those who remain leads to errors, high staff turnover and absenteeism. In some cases hospitals reported that they lost income due to a shortage of staff in key areas and lack of staff to process the throughput. Another option is to alter the case mix in favour of treatments that are short stay and less labour intensive. But this is hardly consistent with most people's notion of a public healthcare service.

Finally, if all else fails, wards or hospitals must close, and patients must wait for treatments. Thus capital charging exerted pressures to downsize hospitals, as the proponents of the 1990 had intended. Using the same methodology described above, it is possible to estimate the size of the NHS estate the funding was capable of supporting. Table 7 demonstrates that funding supported a much smaller asset base, equivalent to the closure of one quarter of the Trusts. It is this that lies behind the hospital or ward closures that most Trusts have made.

Asset sales generally rose throughout the period as Table 5 shows. However, this is not an option open to all hospitals all the time. Trusts were encouraged to downsize, although the gains were less than expected. At least two trusts were advised by healthcare planning consultants that:

"Since 25%-30% of an average NHS trust's funds are expended purely on the maintenance of real estate and capital equipment the financial advantages to be gained from appropriate downsizing in line with clinical trends are considerable. These financial advantages are also of course service advantages, because the less money spent on supporting physical infrastructures, the more money can be redirected to treating more patients."¹⁹

But premises costs, as defined for NHS purposes, including the costs of energy, water, computers, software etc., average a mere 6% of Trust income and capital charges, which are included in the above quotation, a further 10% of income, making a total of 16% not 25-30%. Some studies have shown that the reduction in costs due to bed and ward closures are small and one showed that there were no further economies of scale once hospitals had 600 beds²⁰.

The trusts were told that there had already been a 'significant downsizing of acute hospitals in the UK' and that due to the cost of maintaining the estate 'there are very compelling reasons not merely to welcome this trend but also to actively accelerate it where possible and appropriate'²¹.

3. How does Capital Charging Impact on New Investment?

First of all, the 1990 Act made capital financing the responsibility of the trusts not the Government. As Table 5 shows, since 1996-97, the bulk of NHS capital expenditure has been financed by resources generated internally

by hospital and community health service sectors (efficiency savings and land sales).

Secondly the capital charging system allows the Government to substitute the circulation of debt for the issue of new capital in the public sector. The impact on the finances of the NHS of this circulation of debt, and any receipts on land and property sales, can be seen in Table 9: capital refunds represent a return to the Government from revenue. In 1998-99, capital refunds from internally generated resources accounted for 7% of the entire NHS budget (not just hospitals).

Thirdly capital charging means that any capital expenditure that *increases* the value of the assets is only affordable if offset by lower operating costs. An identical new hospital will necessarily be more expensive than the existing one as Table 10 shows since the net book value of an old Trust is less than the current replacement cost of a new one. New hospitals will be cheaper to run in terms of maintenance and utility costs - a relatively small proportion of income. But in the absence of new technologies that change the mode of service delivery and reduce costs significantly, the scale of the increase in capital charges means that a new hospital or a new wing must lead to cuts in staffing, the main cost.

Not surprisingly, the Trusts were reluctant to undertake new capital investment and did not make full use of their ability to borrow from Government sources. Between 1992-95 alone, they underspent on their EFL or capital budget by an average of £200,000 per annum and the backlog of repairs and maintenance has since risen from £2.4bn to £3.4bn—a consequence of underfunding and the reluctance to take on an additional long term commitment for debt servicing.

In the former state owned monopoly enterprises such as water, rail and energy, the regulator is required by statute to ensure that the companies can continue to finance their activities, which include investment and returns to the providers of finance, by allowing prices to rise. But the hospitals are not able to raise their prices. Indeed the system of reference costs introduced by the Government means that they will only be reimbursed on the basis of the **average** price for healthcare treatments.

In Durham, Carlisle, Worcester and Norwich, plans for new hospital building programmes that had already received approval in principle from the Treasury before 1990, were therefore radically altered. The Business Cases squared the circle with 'challenging performance targets', a euphemism that meant increased work effort by staff, and smaller facilities. But even these smaller facilities to be built under PFI are more expensive than either the present (net book) value or the replacement value of the existing hospital (Table 10). Thus new facilities come at a cost - reduced service provision - when waiting lists lengthen and demand by any measure is not set to decline. So although the Government routinely boasts that it is embarking on the largest hospital building programme in the NHS, this is being accompanied by the largest bed closure programme.

Any honest, objective appraisal of capital charging would have to conclude that their outcomes have been perverse from a healthcare perspective. In future, decisions on new capacity will be made on basis of accident of geographic location, land values, etc., as opposed to healthcare needs and equity. Furthermore, the reconstitution of hospitals as trading entities along the lines of the old nationalised industries has fragmented the healthcare system and made planning and co-ordination more difficult. The problem lies in the use of the value of existing assets as the key determinant of financial planning rather than clinical need and clinical supply measures.

4. Capital charging and PFI

In the absence of new capital, NHS Trusts have no alternative but to pursue the Private Finance Initiative (PFI) to finance new investments. The introduction of capital charges provides a funding stream within the revenue budget to pay for private sector finance. In principle, investment via PFI has the same effect as capital charging except that the annual payments are made to the private sector not recycled back in the healthcare economy - a point that will be developed later – as the Trusts will no longer own the assets.

But PFI has proved to be more expensive than both the cost of replacement (Table 10) and traditional public procurement²². This raises questions about the validity of the whole system of capital charging based on current

replacement cost. It means that the annual fee paid to the private sector will finance a considerably smaller facility than would have been the case if funded by the Treasury. Costs are higher due to the higher cost of capital in the private sector, the enormously high transaction costs (both parties' advisors fees and bidding costs), and the profit margin that the private sector requires. A number of PFI consortia have been able to refinance their projects and considerably reduce their costs.

Most PFI projects involve centralising hospitals on a single, usually cheaper site and releasing land for sale. The Royal Infirmary at Edinburgh provides an example of this.²³ However the unequal bargaining power of the trusts and the PFI consortia mean that the assets are often sold below their market value. Even with land sales, PFI projects have been unaffordable resulting in even further downsizing and reduction in service provision under conditions where the hospitals are already unable to cope.

A fuller explanation of both the costs and implications of PFI in the NHS can be found elsewhere²⁴. But the point is that as yet, little thought has been given to the financial implications of this for the NHS as a whole. Unless the Government makes good the leakage of capital charges, trusts operating under the PFI will draw funding from the system as a whole at the expense of providers remaining under public ownership. The capital charging system will continue to require the remaining NHS Trusts to fund new investment in the private sector. From financing to resourcing, the playing field is tilted towards the private sector. It provides the mechanism for back door privatisation and running down of the NHS. Thus capital charging cannot simply be considered on its own but in conjunction with other public policy measures that have both followed its introduction and for which it paves the way.

5. Debt Financing as an Alternative to PFI

Dissatisfaction with PFI has led to a number of alternative proposals. But most of these reduce to calls to allow Trusts to borrow money, either through bond issues or through loans from financial institutions. The NHS is almost totally dependent on national taxation for its funding, and consequently does not have a stream of revenue coming from other sources that can be used to underwrite loans.

The Government could in principle allow capital to be raised directly from the capital markets at the local level. Indeed the inter-war period saw a rapid expansion of local authority hospital provision largely financed in this way. But the local authorities borrowed against revenues from local taxation. One of the defining elements in the 1948 settlement was the transfer of responsibility for general hospital provision from local to central Government, with a concomitant movement from local to national taxation as the basis of funding. In other words, where funds are raised locally, there may be a case for local borrowing. Where they are raised at national level, as is required for the purposes of a *National Health Service*, there is no such case.

But as we have already shown, the hospitals are already struggling to breakeven. As it is, they have refrained from making use of their full powers to borrow from Government at what must be assumed are lower rates of interest than can be obtained on the capital markets. Thus additional debt financing of any kind is simply not financially feasible.

Not only does debt finance not alleviate the role that capital charges have played in healthcare planning and downsizing service provision over the last 10 years (and would continue to play), it would exacerbate it. It is clear from the foregoing that new arrangements for financing the capital infrastructure need to be put in place. It is to this we now turn.

6. Alternative Financial Arrangements for the NHS

Firstly, in the absence of sufficient income to finance the cost of capital, capital grants with no repayment obligations remain the only financially viable alternative to PFI. Secondly, the system of capital charging should be scrapped. Its effect on healthcare planning at individual Trust level has been highly destabilising. The cost of capital as reflected in capital charges amounts to less than 10% of income. As such it is not a major cost and not worth the disruption it has caused as others, who favour it in principle, have said.

If reversing the transformation of NHS Trusts into trading bodies seems imperfect from the perspective of business theory, the financial regime needs to reflect the fact that the NHS is a non-market entity. The capital charging regime requires the Trusts to behave like private firms. But they do not have private firms' freedom to adjust costs by curtailing services, generating extra income, and creating surpluses. It encourages competitive behaviour between neighbouring Trusts despite the need to act in concert to provide a comprehensive range of services at a regional level. **One of main, if not the only, functions of turning hospitals into trading bodies has been to make it easier for the private sector to gain access to NHS revenues via the PFI.**

Thirdly, the National Beds Enquiry used supply measures as the key determinants in planning services, not asset values as the capital charging requires. The contradiction between these two policies has not yet been addressed by Government, in spite of strongly-worded criticisms of the negative effects of Trusts' statutory financial duties on healthcare provision in the most recent White Paper, the *New NHS: Modern, Dependable* (1999).

Conclusion

While this paper has concentrated on the NHS acute sector, many of the issues as they relate to resource accounting for the rest of the public services are very similar. The financial evidence has refuted the assertion about the importance of capital costs in determining operating efficiency or the operating surplus and the hospitals' poor asset utilisation. It casts doubt on the implicit assumption of their inefficiency. These results are relevant for the rest of the public services since hospitals and the Universities are likely to be the most capital intensive of the public services.

The key cost to control in public services is labour not capital. The asset base would have to fall quite dramatically before it had an appreciable impact on costs. Manufacturing industry has long understood this and aims to keep labour rather than machines busy. To take the example of the operating theatres: Maximum use of the theatres would require more beds and nursing staff resulting in higher overall costs when revenues are largely fixed. Some might claim that the reorganisation of the NHS has resulted in a higher level of patient episodes and other measures of healthcare activity with a reduced level of funding in real terms. But it is difficult to see how capital charging, which was only one of a series of measures encompassed by the reorganisation has been responsible for it. Indeed, this was not one of the stated objectives.

The comparison with the private sector was instructive because it showed that private hospitals were no more efficient in the use of either their physical capital or labour. It showed that there are two ways of reducing labour costs: alter the case mix and/or improve patient flow. But both of these solutions lie outside management's control and in any event are hardly congruent with any notion of public service provision. But in any event, short stay and early discharge means increasing the hospitals' efficiency by displacing the burden onto social services or the patients' and their families, if it is not to lead to re-admissions. In other words, while efficiency is normally seen as an input/output relationship, this analysis suggest that efficiency may be more appropriately conceived as involving the (re)distribution of the inputs and outputs between different stakeholders. The alternative solution, as exemplified by Britain's rapidly disappearing manufacturing industry, entails rationalisations, mergers, closures, etc. But under the accounting rules, asset sales result in accounting losses that count as a charge against the surplus that trusts must make to meet their financial target rate of return, as a result of valuing assets on a current replacement basis that is higher than its market value. After all, hospital buildings and equipment have little value outside the hospital sector. Thus the sale of assets means eroding the surplus created by operating activities.

It refutes the image promoted so long and hard that it became axiomatic that the public sector in general and the NHS in particular is wasteful and inefficient. The financial evidence has shown firstly that the public hospitals were far less wasteful than the private sector and secondly that the private sector is not more efficient than the public sector. Yet all the emphasis has been on the importance of increasing the efficiency of the NHS and bringing it up to the best levels of the private sector that lags behind it.

This study also shows the difficult nature of the concept of efficiency. There are several sources of efficiency: technical progress, relative autonomy to minimise costs and managerial efficacy. Private hospitals are not distinguished by efficiency (or inefficiency); and their facilities are usually less technically advanced than the public hospitals. Their advantage lay in their ability to choose their case mix, unhampered by any public or social

obligations. The implication for the NHS hospitals is that they too must throw off the shackles of socially necessary service provision.

Capital charging is not so much an end in itself but part of a process whereby public services are in effect reconstituted as business units operating on a for profit basis in the public sector. Yet public services differ markedly from Plcs in several important ways. They have unusually high labour costs, despite low wages, which makes them non-cash generative. With incomes set by the Government, they can only increase their income at the margin and at the expense of others. They operate in a sector that must be able to provide a wide variety of services on a national or regional basis - in a sector that requires planning not competition. Finally they provide services that have never anywhere been provided for more than a small fraction of the population on a 'for profit' basis because they were not commercially viable.

In the context of static or declining resources where capital charges must be met, then some combination of a reduction in labour costs, service provision and capital base must follow. It is this that lies behind the lengthening waiting lists, the increase in staff turnover and staff shortages, and hospital and ward closures.

Capital charging is being introduced across the public sector with the explicit aim of selling off surplus assets for which the National Asset Register has been produced. It facilitates a method of financing the procurement of public services via PFI/PPP that is more expensive and poor value for money and must result in higher costs and lower service provision. As more and more of public services are procured in this way, it will become increasingly difficult to scrutinise public expenditure or even to know what does constitute public expenditure.

The logic and significance of this accounting regime in the context of declining or static revenues and increased demand means that the Government has established the preconditions for a financially driven healthcare system. As yet however, political pressure has meant that this system has not been allowed to run on autopilot. The additional charges arising from the system have to some extent at least been mitigated by additional payments: unfettered market forces have not always been allowed to operate, particularly in London; and some of the trusts have been cushioned from the full effects of the logic of the financial system, for a short period, at least. But this is not set to continue.

There is no reason to think that the results will be materially different across the rest of the public sector. This analysis does not augur well for the introduction of capital charging elsewhere. It virtually guarantees that the social and welfare services will become an arena of intense political struggle and re-ignite the tensions that were to some extent at least assuaged under the post-war regime.

Table 1 : Income and Cost Structure of The NHS Trusts

	Averages for Trusts £000s			
	1992	1993	1994	1995
Number of Trusts	42	92	168	234
Average Income per Trust	61,712	60,560	62,878	65,894
Purchases/Income	0.29	0.29	0.30	0.30
Labour costs/Income	0.61	0.62	0.61	0.61
Capital charges/Income	0.10	0.09	0.09	0.09

Source: Fitzhugh Directory of NHS Trusts

Table 2 : Asset Utilisation

	Value-Added/Tangible Fixed Assets					
	1989	1990	1991	1992	1993	1994
Hotels						
QMH (Hotel)	0.14	0.14	0.07	-0.89		0.23
Forte (Hotel)		0.37	0.29	0.27	0.32	0.26
Ladbroke Hotels	0.10	0.10	0.10			
Retailers						
M&S (Retail food and clothing)		0.57	0.56	0.52	0.53	0.56
Tesco (Retail food)		0.46	0.41	0.38	0.37	0.34
Sainsbury (Retail food)		0.48	0.48	0.46	0.44	0.38
Hospitals						
General Healthcare Group (Hospital)		0.66	0.87	0.74	0.78	
BUPA Hospitals			0.42	0.39	0.38	
NHS Trusts				0.74	0.75	0.73

Sources: Annual Report and Accounts (Various), MicroExstat 1994

Table 3: Comparison of Capital Charges in 1995

Capital Charges as % Income 1995	Below average 4-7%	About average 8-10%	Above average 11%+
Number of Trusts	72	131	31
Average	£000s	£000s	£000s
Income	63,281	68,657	60,183
Depreciation	1,949	2,835	3,096
Capital charges	4,014	5,704	6,621
Surplus/income	0.04	0.05	0.07
Equipment/fixed assets	0.05	0.10	0.09
Income/assets	0.73	1.05	0.85
Net surplus for the year	477	898	681
Cumulative surplus/deficit	1,125	1,013	320

Source: Fitzhugh Directory of NHS Trusts

Table 4: Financial performance of acute trusts in England

(£000)	1992	1993	1994	1995	1996	1997	1998
No of Trusts	42	92	169	235	241	239	238
Average total income per Trust	61,712	60,560	62,690	65,743	69,586	74,081	77,745
Average operating surplus	4,578	3,400	3,828	3,468	2,904	2,950	3,315
Net interest paid	2,516	2,665	2,415	2,358	2,433	2,536	2,427
Dividends paid	982	77	601	471	356	637	1306
Average net surplus after paying interest and dividends	1,026	561	736	515	63	-297	-423
Average cumulative surplus	1,001	140	687	940	856	547	165
Average value of assets	60,123	58,665	61,534	59,996	62,089	64,838	68,745

Source : Fitzhugh Directory of NHS Trusts

All acute hospital trusts in England

The number of Trusts increases between 1992-1995 when nearly all hospitals acquired Trust status

Table 5: Financing of Hospital and Community Services (HCHS) capital expenditure 1986-7 to 1998-98

	HCHS capital (£m)	Charges and receipts from land sales (£m)	Internally generated resources (£m)	Net HCHS expenditure (£000)
1986-87	1,051	149		902
1987-88	1,106	201		905
1988-89	1,191	280		912
1989-90	1,423	232		1,191
1990-91	1,551	178		1,372
1991-92	1,639	169		1,470
1992-93	1,785	113	363	1,309
1993-94	1,782	213	674	895
1994-95	2,049	208	890	951
1995-96	1,996	282	930	984
1996-97	1,711	393	1,000	318
1997-98	1,514	446	1,207	-139
1998-99	1,449	561	1,236	-348

Internally generated resources refers to "that element of trusts' capital expenditure which they fund directly from their charges to healthcare purchasers." Expenditure in excess of internally generated resources is funded through loans from the secretary of state for health (trusts' external financing). Only the latter constitutes additional Government expenditure.

Table 6: Capital Charges

(£m)	1992	1993	1994	1995	1996	1997	1998
Required capital charges	6,593	6,328	6,183	6,189	6,586	7,010	7,372
Required capital charges/income	0.11	0.10	0.10	0.09	0.09	0.09	0.09
Required capital charges/assets	0.11	0.11	0.10	0.10	0.11	0.11	0.11
Actual Capital charges	6,484	5,550	5,530	5,418	5,650	6,293	6,979
Actual Capital charges/income	0.11	0.09	0.09	0.08	0.08	0.08	0.09
Actual Capital charges/assets	0.11	0.09	0.09	0.09	0.09	0.09	0.10

Source: Fitzhugh Directory of NHS Trusts

Table 7: Three potential solutions to rising capital charges

(£000s)	1992	1993	1994	1995	1996	1997	1998
(1) Reduce costs by		11,046		29,567	197,848	224,769	192,781
(2) Total hospital funding needed to match the asset base	3,030,180	6,476,600	12,405,320	16,846,900	17,956,220	18,595,400	19,633,680
(3) Reduce hospital assets to match the funding level to:	3,204,700	5,213,067	10,757,783	13,546,300	11,666,050	11,750,017	13,148,383
Or number of Trusts to close		3		8	53	58	47

Source :Fitzhugh Directory of NHS Trusts

All acute hospital trusts in England

Note: Solutions assume surplus/income=5%

All acute trusts in England

The number of Trusts increases between 1992-1995 when nearly all hospitals acquired Trust status

Table 8: Staff Composition of the Acute Trusts

	1992	1993	1994	1996	1997	1998
Number of trusts	42	92	169	241	239	238
Medical and dental staff	179	171	174	184	198	206
Nurses and midwives	1,056	1,012	986	891	889	890
Allied professionals	166	138	122	289	304	311
Ancillary staff	314	287	253	243	249	250
Admin/clerical	373	363	365	436	445	447
Works	48	45	41	0	0	0
Senior professionals	163	156	166	0	0	0
Other	19	22	27	50	39	37
Total staff	2,319	2,192	2,135	2,093	2,125	2,141

Source : Fitzhugh Directory of NHS Trusts

All acute hospital trusts in England

The number of Trusts increases between 1992-1995 when nearly all hospitals acquired Trust status

Data not available in 1995

Table 9: NHS sources of finance 1993-4 to 2000

	Total NHS expenditure (£m)	Public (%)	Charges (%)	Miscellaneous (%)	Capital Refunds
1993-94	31,275	94.7	3.1	1.1	1.2
1994-95	33,266	94.5	2.4	1.0	2.2
1995-96	34,878	94.3	2.3	1.0	2.5
1996-97	36,330	93.7	2.1	1.2	3.0
1997-98	38,110	94.2	2.1	1.0	2.7
1998-99	41,369	88.3	2.1	1.7	7.9
1999-2000	43,068	91.9	2.1	4.0	2.0
2000-01	45,680	91.9	2.1	N/A	N/A

Table 10: Asset valuation of a sample of hospitals

(£m)	Net book value (after depreciation)	Cost or valuation	PFI construction cost
Carlisle (2000)	87	33	65
Bishop Auckland (1998)	18	24	41
University College London Hospital (2000)	295	308	400
Norfolk and Norwich (1998)	18	39	144
Swindon and Marlborough (2000)	21	37	105
Greenwich (2000)	47	56	84
Bromley (2000)	67	83	118

Source: Annual report and accounts

¹ Department of Health, *Working for Patients : The Health Service : Caring for the 1990s*. This includes the White Paper (Cm 555 HMSO) and nine working papers, HMSO, London, 1989.

² Department of Health, *Working for Patients : The Health Service : Caring for the 1990s*. This includes the White Paper (Cm 555 HMSO) and nine working papers, HMSO, London, 1989, para 2.23.

³ H.M. Treasury, *Appraisal and Evaluation in Central Government*. The Green Book. The Stationery Office, London, 1997.

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⁵ Lapsley, I., "A Case for Depreciation Accounting in UK Health Authorities", *Accounting and Business Research*, Vol. 12, No. 4., Winter, 1981, pp21-29.

⁶ Association of Health Service Treasurers, *Managing Capital Assets in the National Health Service*, Chartered Institute of Public Finance Accountants, London, 1985.

⁷ Lapsley, I., "Managing Capital Assets in the National Health Service: A Critique", *Financial Accountability and Management*, Vol 2, 1986, pp227-232.

⁸ Perrin, J., *Resource Management in the National Health Service*, Van Norstrand Reinhold, 1988.

⁹ Mayston, D., *Managing Capital Resources in the NHS*, in A. Culyer, A. Maynard and J. Posnett (eds) "Competition in Healthcare", Macmillan, London, 1990.

¹⁰ Heald, D., and Scott, D.A., "NHS Capital Charging after Five Years", in A. Harrison (ed) *Health Care UK 1995-96: An Annual Review of Healthcare Policy*, Kings Fund, London, 1996.

¹¹ Davies, C., *Underused and Surplus Property in the National Health Service*, Report of the Enquiry, Department of Health and Social Security, London, 1983.

¹² National Audit Office, *Use of Operating Theatres in the NHS*, Report of the Comptroller and Auditor General, Session 1987-88, HMSO, London, 1987.

¹³ National Audit Office, *Estate Management in the National Health Service*, HC 405, Session 1987-88, HMSO, London, 1988.

¹⁴ Audit Commission, *NHS Estate Management and Property Maintenance*, HMSO, London, 1991.

¹⁵ Shaoul, J., "Charging for Capital to Improve Efficiency?", *Management Accounting Research*, 1988, Vol 9, pp95-112.

¹⁶ Froud, J., Haslam, C., Johal, S., Shaoul, J., and Williams, K., "Persuasion Without Numbers? Public Policy and the Justification for Capital Charging in the NHS Hospital Trusts", *Accounting, Auditing and Accountability Journal*, Vol 11, No 1, 1998, pp99-125.

¹⁷ Health Care Information Services, *The Fitzhugh Directory of NHS Trusts: Financial Information*, 4th edition, Health Care Information Services, London, 1996 and 1999.

¹⁸ The system of capital charging was revised in 1999. All Government loans were converted into public

dividend capital and subject to dividend payments. This in principle at least would permit the Government to waive some of the financing charges when necessary and thereby alleviate the hospitals' financial situation.

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Gaffney, D., Pollock, A., Price, D., and Shaoul, J., "PFI in the NHS – is there an economic case?", British Medical Journal, 1999, Vol 319, pp116-119.

²³ Shaoul, J., (1999), "The Looking Glass World of PFI", Public Finance, January.

²⁴ See a series of articles in the British Medical Journal July 1999 by Gaffney, Pollock, Price and Shaoul.

SUBMISSION TO FINANCE COMMITTEE OF THE SCOTTISH PARLIAMENT**RESOURCE ACCOUNTING AND BUDGETING (RAB)****Leslie Wilson, Director of Finance, Historic Scotland**

1. Historic Scotland is an Agency within the Scottish Executive Education Department. It is responsible directly to the Scottish Ministers. Its financial direction is given by the Scottish Ministers. It publishes its own Annual Report and Accounts but its accounts are also consolidated into the Resource Accounts of the Scottish Executive.

2. As an Agency Historic Scotland is obliged to publish its Accounts on an accruals basis and has done so since the accounting year 1993-94. All its accounting records are held in a format which enables it to produce accruals reports. However, until now, the Agency has been managed on a cash basis. The Agency, therefore, has had to maintain two sets of accounts. The transfer to accruals accounting will simplify matters for the year-end accounts and will reduce this aspect of the workload not only for the Finance Department but also for the external auditors. For day to day purposes the computer system manages both sets of accounting records and the new regime will not reduce the general work volume. It remains to be seen how onerous the RfR (Request for Resources) and NFR (Net Financial Requirement) monitoring will be.

3. The accounts direction was amended in 1998-99 to instruct the Agency to produce the accruals accounts on a resource basis. Generally speaking, the differences in the accounting policies were sufficiently minor to make this change straightforward for the annual accounts. Some minor changes were needed to fit with the accounting policies of the Scottish Executive in anticipation of the consolidation of the accounts.

4. One policy issue arising from the introduction of resource accounting which has required attention across the whole of the United Kingdom and has been a major topic for consideration by the FRAB (Financial Reporting Advisory Board) is whether, and if so, how non-operational heritage assets should be recognised on the balance sheet. The Board's initial position was that all assets should be included on the balance sheet. After a major

study conducted by HM Treasury assisted by the 'heritage departments', and including Edinburgh Castle as a test case, the matter has been resolved to the extent that non-operational heritage assets are not included in the balance sheet where the cost of valuation is not warranted in terms of the benefits which the valuation would deliver or it is impossible to establish a sufficiently reliable valuation. This was an issue not only for Historic Scotland but also for many museums and galleries as holders of national assets and treasures. Many heritage assets are unique and there is no agreed market value, nor is there any likelihood that they would be subject to transfer to cause a market to exist.

5. The main argument for inclusion of heritage assets on the balance sheet was that it would influence the decision making of managers in determining the best use of resources. Historic Scotland was able to demonstrate that other more appropriate mechanisms existed to review the condition of heritage assets (monuments) in its care. For example, Historic Scotland undertakes a 5-7 year rolling survey of the condition of monuments in its care and the resultant data is used to determine the maintenance requirements. Financial valuation is not appropriate. All properties which are operational heritage assets (e.g. parts of monuments used as visitor centres or retail outlets) are subject to valuation by the District Valuer and are fully accounted for in the usual way and have always been treated in this manner.

6. Another issue being addressed is the treatment of grants. Traditionally, the primary measure of control has been cash limits and Accountable Officers have a responsibility to ensure that all expenditure is within the ambit of the vote and that expenditure approved by Parliament is not exceeded. This form of control will be continued under resource accounting and budgeting and one potentially difficult consequence has emerged. The presumption under cash accounting is that if cash is not spent it is not recorded. In accruals accounting with its timing considerations the expenditure impact arises when the underlying activity happens. This does not cause a problem when the activity is under direct control, but it could lead to difficulties when the actions of third parties determine the accounting impact and flow of resources. In Historic Scotland an example of this is the historic building repair grants scheme. Following guidance from the National Audit Office (now Audit Scotland) a few years ago the accruals account recognises work as and when it is done by the grant recipient and not when the grant is claimed. The precise timing of the historic building repair is subject to many outside influences, including the weather, as well as decisions made by the

grant recipient. Another major factor is lottery funding which can enable the grant recipient to commence work in advance of the issue of grant. The consequence can be an acceleration of the work which could result in the resource expenditure limit being exceeded, even although the grant is for an approved amount and for an approved purpose. An accelerated programme of work would not necessarily become apparent until after the year-end, by which time it would be too late to take corrective action. It would in any case be undesirable to slow the work if this would result in a greater cost to the project overall. To reduce the risk of over-shooting the resource allocation, it might prove necessary in practice to reduce the number of grant offers made to provide a cushion but this would be sub-optimal in terms of the use made of the resources available.

7. The implementation of resource accounting and budgeting in the Agency has required a considerable amount of time to be devoted to it, particularly by the Finance Department in preparing a different style of budget and new reports for budget holders. In support of this there has been a major training programme for all affected staff to explain the principles of accruals accounting, highlighting the differences and generally preparing the Agency for the transfer. While the principles have been explained it is only in the management of budgets in the course of the closure of this year, and next, that the full implications of resource monitoring will be fully understood. As we approach the transition from cash to accruals, decisions and actions taken in January, February and March 2001 could have a significant influence on resources in 2001-02. Although a considerable amount of training has already been given, it is anticipated that further training will be required as experience in the new system is gained.

8. The issue of capital charging will take a little longer to be fully implemented. For the first two years these costs will be charged against the AME (Annual Managed Expenditure) budget provision. This will have the advantage that the ordinary day-to-day issues of management and control will be addressed and, when capital charging arrives in full, the underlying principles of the new accounting regime will be more thoroughly understood.

9. In conclusion, the implications for resource accounting are being effectively managed by Historic Scotland which, as a Next Steps Agency, has some advantage as a result of having produced accruals accounts for a number of years. The lead-in time from the first implementation of the reporting side of RAB two years ago to the budgeting side now has

allowed most of the major issues to emerge and to be thoroughly discussed. The next phase involving full financial control will require an understanding not just by the management of the Agency but by those who monitor its performance. The new information about debtors, creditors and depreciation, for example, will need to be assessed very carefully and sensibly in the early years until the profile of the accounts is stable and well understood by all concerned.

L Wilson

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FINANCE COMMITTEE INQUIRY TOPICS

At its meeting on 30 January, the Committee agreed to consider potential topics for an Inquiry, following completion of the current RAB Inquiry. This paper expands upon the suggestions raised by Members and proposes likely issues and timescales. The topics which are listed below have been mentioned at previous meetings of the Committee. Members are, of course, welcome to propose alternative suggestions.

In considering a future inquiry, members are reminded to take account of the Committee's commitments as part of the budget process. Once a topic has been identified and agreed the committee will be invited to agree a detailed remit; a suggested structure for the Inquiry; and potential sources of written and oral evidence.

1. Tax varying powers

This topic was first proposed to the Committee at its meeting on 14 December 1999. At the time, the Committee decided not to prioritise examining the issue.

Should Members decide that it is now appropriate to do so, the following are suggested as possible areas for investigation:

- What level of income would be generated (or lost) by the exercise of the tax varying power?
- What steps have been taken by the Inland Revenue in preparation for the possibility of it being invoked?
- For what purpose might the power be most appropriately utilised? Would funding be raised for specific purposes or simply to augment the total Scottish Budget?
- Could it be raised/reduced for only a short period of time?
- Are there difficulties in applying the relevant provisions in The Scotland Act, for example the practical definition of a "Scottish Taxpayer"?
- How prepared are Scottish/UK businesses for its application, for example in terms of payroll compliance?

Clearly, a full examination of this would require oral and written evidence (e.g. from the Executive, HM Treasury, Inland Revenue, private sector companies and analysts, and academic and selected media commentators). There are several options for analysing revenues to be raised and any concomitant effects on the Scottish economy. These may include as appropriate a combination of in-house resources and external research.

Suggested timescale: 4 months¹

¹ Timescale assumes fortnightly meetings.

2. The Barnett Formula

The UK Government has committed itself to the continued use of the Barnett Formula to allocate changes in expenditure to the devolved administrations. However, several committee members have in the past (e.g. 14 December 1999 and 1 February 2000) suggested that a re-examination of the issue by the Finance Committee may be appropriate, given the emergence of potentially relevant issues.

It is suggested that there may be two main elements to such an Inquiry: the current formula, and assessment of needs.

Understanding the current formula

Barnett only applies to **changes** in expenditure, and does not determine the overall level of funding.

- Is the Barnett Formula an appropriate mechanism for allocating changes in expenditure?
- Barnett only applies to the Departmental Expenditure Limit. What elements of the Scottish budget have in the past been “non-Barnetted” and what are the reasons for this?
- What are the processes by which decisions on “comparability” are reached?
- How transparent are the current arrangements?
- What are the reasons for the higher per-head expenditure in Scotland?
- What is the evidence of recent trends in Scottish spending relative to England, since the Formula was first recalibrated in 1992?
- How might this change over the next few years?
- How would Barnett be revised or replaced?

Scotland’s expenditure needs

Barnett is not a needs assessment formula and takes no account of relative need between Scotland and England. It simply redistributes resources according to population. However, there has been debate in recent years over the need for a needs assessment (e.g. as recommended by the House of Commons Treasury Committee 1997). The Committee may wish to examine existing evidence of need in Scotland and compare it with current funding levels.

Resources: Oral and written evidence (Scottish Executive, Scotland Office, HM Treasury, National Assembly for Wales, Northern Ireland, academic specialists).

Suggested timescale: 6 months

3. Private Finance Initiative/Public Private Partnerships

This has also been previously suggested as a possible Inquiry topic. Members then expressed concern that this is a potentially large Inquiry to which a considerable period of time should be allocated.

Possible areas for examination are:

- Is PFI/PPP the most appropriate form of funding capital projects?
- Does PFI/PPP offer value for money?
- What are the long-term implications for revenue budgets?
- What problems have been experienced since the introduction of this approach (e.g. accuracy of outline business cases). Is there evidence that initial difficulties are being addressed?
- Thus far, how robust have the procurement processes been?
- Is there enough expertise in the public sector to enable it to be an “intelligent client”?
- What has been the experience of staff involved in PFI projects?
- What are the issues surrounding provision of information on PFI/PPP projects?
- Does it ensure quality of service delivery?
- What are the experiences of risk transfer?
- What is the private sector experience of involvement in PFI projects?
- What are the alternatives to funding public sector capital investment?

Resources: The approach would be similar to other proposed Inquiries, involving the taking of written evidence and examining witnesses. Because of the potential wide-ranging nature of this Inquiry, it may be appropriate to appoint an adviser (possibly at an early stage to assist in defining the Inquiry’s remit). Alternatively, there may be some aspects that could involve applying for a project from the external research budget.

Suggested timescale: 6 months

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