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From the Secretary of State for ~~*Social Services*~~ Health

34

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Paul Gray, Esq.,
Private Secretary
10 Downing Street,
London, SW1.

30 September 1988

Dear Paul,

NHS REVIEW

My Secretary of State has asked me to circulate the enclosed paper, prepared for the NHS Review, on the management of capital assets and capital investment. Unfortunately it has not yet been possible to discuss this issue with the Chief Secretary and it is not proposed that the Paper should be placed on the agenda on 4 October. The Paper is therefore circulated, as we agreed, for information at this stage.

I am copying this letter and enclosures to the Private Secretaries to the Chancellor of the Exchequer, to the Secretaries of State for Wales, Northern Ireland and Scotland, to the Chief Secretary, to the Minister of State and to Sir Roy Griffiths in this Department, to Professor Griffiths and Mr. Whitehead in the No. 10 Policy Unit, and to Mr. Wilson in the Cabinet Officee.

Yours sincerely,

Geoffrey Podger

G.J.F. Podger,
Private Secretary

NHS REVIEW HC 45

MANAGEMENT OF CAPITAL ASSETS AND INVESTMENT

Note by the Secretary of State for Health

1. My first paper to the Group (HC37) set out four key aims for the management of capital:

- clear, devolved, responsibilities for decisions on the opening and closing of hospitals;
- maximum devolution of responsibility for management of capital programmes;
- some form of charging for the use of capital assets;
- access to private capital.

2. The first of these I propose to deal with in the context of other work on organisation and the functions of Regions and Districts. This paper outlines my proposals in the remaining three areas. These proposals are framed against the background of our previous agreement that delivery of health care should be based much more on explicit agreement on the timing, quality and cost of services to patients, and that the NHS should move towards a contractual way of working.

Devolution of responsibility for capital programmes

3. There is already scope for virement by health authorities between their revenue and capital accounts, and a recent change allows a useful carry-forward from one year to the next. Regions can also "broker" large capital expenditures between authorities and between years, while keeping within the overall annual cash limits. Below certain limits, new investment in buldings etc may be made on the sole decision of the Region.

4. To increase this flexibility, officials have recently agreed increases in the capital expenditure limits above which projects have to be referred up to the Department or the Treasury for approval. Schemes with a capital cost of over £15m (previously £10m) have to be referred to Treasury for approval. Schemes costing over £10m (previously £5m) have to be referred to my Department. This will be welcomed by the health authorities.

5. I propose that officials should look further at the use of existing flexibility for virement and carry-forward, and identify where further help can be given.

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Charges for capital

6. In proposing the introduction of charges for capital I have in mind six basic principles that I think we need to secure:

a. There should be a system of capital accounting in the NHS which requires appropriate valuation of the capital assets employed.

b. Health authorities should be required explicitly to take account of the cost of capital in costing the services they provide.

c. There should be a level playing field between health providers in the public sector and between the public and private sectors.

d. Government should retain effective control over the total level of capital expenditure in the NHS.

e. Whatever arrangements are introduced should be consistent with the achievement of value for money.

f. These arrangements need to be capable of adaptation to self governing hospitals.

7. I do not think we are likely to have difficulty in agreeing these principles, but it has become clear that officials have not as yet been able to agree how best they can be secured. I am concerned lest we find ourselves unable to say in our White Paper how we propose to implement what I believe will be seen as a key element of the more competitive NHS environment we are seeking to create. I think therefore that we need to agree among ourselves how best to go forward.

8. My proposals are set out in Annex 1. The crux of the problem is whether our objectives can be secured by a system of notional management accounts, as the Treasury believe, or whether actual charging mechanisms are required, as I believe. There are subsidiary questions about valuation, distribution of resources and disposal of assets, but I think that if we can settle the main question these others are likely to fall into place. A good deal of work has already been done, both in my Department and in the NHS, in developing valuation and asset accounting systems.

9. My reason for preferring real to notional charges is that these would provide more sharply the necessary discipline in the highly devolved and "trading" environment contemplated in the Review. Real charges would be essential anyway for transactions with the private sector, and to ensure the level playing field referred to in paragraph 6(c). Managers may not see the necessity for translating figures from management accounts into the actual prices they charge. And even if they were scrupulous in doing so, their revenue accounts would then be boosted by

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income for which there was no corresponding outgoing, unless a charging regime applied all the way up the line.

10. I therefore propose that we should agree that all health authorities (and in due course, self governing hospitals) should be required to pay real charges for the use of their capital assets. Officials should work up a practical scheme for implementing such a system.

Access to private capital

11. It seems to me integral to the new environment we are seeking to create in the NHS that, where we can do so without jeopardising the principles I set out in paragraph 6, we should enable the NHS to cooperate closely with the private health sector and to compete directly with it. I believe that this means allowing the NHS, and in time self governing hospitals, a greater measure of freedom in relation to private funding than is presently the case.

12. My proposals are set out in Annex 2. They are deliberately limited to the NHS, and designed to be capable of being controlled from the centre. They also, in my judgement, represent a minimum package, given the interest both in and beyond the NHS that has become apparent over the last year or two.

13. In short I propose that, where health authorities can earn a good return on investment through income generation and other schemes, no compensating reductions should be made in public allocations; and the criterion to be applied should simply be "good" value for money. Furthermore, in situations where health authorities seek to contract out services, or to make land development arrangements requiring initial finance which a private developer is prepared to provide, financing from private sector sources should be allowed up to a limit. This limit should be set at, say, £100 - £200 million nationally (as compared with some £800 million capital grants, and £200 - £300 million from land sales) and be administered centrally. Authorities would bid for the use of this limit to cover their access to private funds.

14. Another proposal, which I have put forward for the current PES round, is for a central capital loan fund which would provide repayable short term finance. For example, an authority might wish to reorganise its estate to obtain overall savings and release redundant land, but might need capital funding in advance to make this possible. The loan fund would meet this need.

September 1988

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ANNEX 1

ACCOUNTING AND CHARGING FOR CAPITAL

Introduction

1. In the long term prices need to reflect the full economic cost of resources in both the public and private sectors, and there should be incentives for local managers to make optimal decisions on the use of the capital stock and on investment and disinvestment. There should be a level playing field for all participants in the competitive health services market. Integral to this is the way that the NHS accounts for the use of capital stock.

2. Since the NHS is likely to remain part of the public sector for the foreseeable future, any new developments in accounting for, or charging for capital, should be consistent with cash limits and with other control and management devices - such as option appraisal - that have proved their worth over the years.

Existing arrangements

3. Health authorities receive capital grants for new investment. These constitute about 8% of the national budget for hospital services. Proceeds from land sales adds another 25% to the capital programme. The current practice in the NHS is that investments are written off once they are made. Except in a few special circumstances there is no subsequent accounting for the cost of capital. Existing assets appear as a 'free good' to managers unless, of course, they have alternative uses within the NHS or can be sold off (health authorities are allowed to keep the proceeds of sales). There are no charges in respect of depreciation of, and interest on, the capital stock. This means that services provided with authorities' own assets appear cheaper than they should be and there is a cash incentive to retain such services in house, at least during the life of the assets concerned.

Capital accounts

4. A necessary requirement for handling capital more satisfactorily, is for health authorities to set up a system of capital accounts which would value all assets at their "current" or "replacement" cost to the NHS, depreciating them appropriately, according to their age. Such accounts would include appropriate charges for the assets used, based upon these valuations.

5. Valuation of Regional hospital stocks has been carried out in the past and experiments are under way in a number of Districts to build asset registers and capital accounts from the bottom up. But further work would be required to develop robust and convincing NHS capital accounts.

6. Capital charges would consist of annual depreciation plus interest on the current value of the capital stock. They would usually rise with new investment and fall with disinvestment. Differential land and building costs between RHAs would need to be addressed in setting any capital charges, in order to preserve the level nature of the playing field as between the public and private sectors, region by region.

7. Once such accounts were in place it would become easier to make comparisons of unit costs internally and externally and to set prices, with appropriate apportionment of capital costs. Such accounts will also provide clear information to authorities about the presence and notional cost of surplus and underused assets.

Management accounts versus full cost charging systems

8. The NHS Review is working towards a mix of three main different forms of financing for the NHS in future:

i. the familiar form of block budgeting for health authorities in a management line relationship;

ii. internal trading, at arm's length, between different health authorities and between health authorities and self-governing hospitals;

iii. more external buying and selling services with the private sector.

9. Existing Treasury guidance on fees and charges and on contracting out already recommends full cost charging for trading and comparisons between government bodies and the private sector. It also recommends full cost charging for trading between government bodies themselves. This would apply to self-governing hospitals, and to inter-authority payments for patients treated under contract in the "internal market".

10. Under the proposed funding arrangements, health authorities and self governing hospitals would need to include in their contract prices the full cost of capital used in providing services as described in para 8(ii) and (iii) above. It follows that they would pay the income received in respect of capital charges to the higher authority supplying capital. Correspondingly, purchasing authorities would need to be provided with larger budgets to cover these capital charges on services purchased from providing authorities or self governing hospitals - as happens now, in principle, with contracting out. To this extent, therefore, a system of real charges for capital is inevitable.

11. The question remaining therefore, is what, if anything, should be done about accounting for, or charging for, capital under the continuing arrangements involving the type of financing

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described in para 8(i) above - the familiar block budgeting in a management line relationship. The present public sector practice where capital is, in effect, written off as soon as it is invested, is unacceptable. It must be replaced either by a system of notional management accounts, or actual charges as would apply in "trading" situations.

12. A system of management accounts could be set up resembling those used by some private companies to control their subsidiaries. They would entail notional budgeting and "repayment" arrangements to reflect capital charges together with performance targets such as making an agreed return on capital and preserving the net worth of assets. The basic discipline would be enforced by the line management relationship, and managers would need to take account of the capital costs shown in their management accounts when dealing with "trading" situations, but not otherwise.

13. Instead of relying on management accounts, and indirect performance indicators based upon them, it would be possible to move to a system of full cash budgeting for, and repayment of, capital charges within and between NHS management tiers. Most of the management processes would be the same, but there would be a number of differences:

i. a cash system would provide stronger and more consistent incentives for authorities than a system of management accounts, because they would apply automatically, across the board;

ii. If interest was repaid to the Exchequer there would be an increase in gross spending but there would be no increase in net public expenditure.

iii. there would no longer be any need for adjustments to revenue budgets for the scale of contracting out, or for the scale of the internal market, because all NHS expenditure would appropriately reflect capital charges;

iv. there could be greater incentives to efficiency savings because authorities could retain capital charge allocations (instead of the proceeds of asset sales) after disposing of assets. They could then use the released capital charge element for other purposes. (However, it would be necessary to guard against any running down of assets to enhance short term performance);

v. there would be auditing and transaction costs in handling real cash transactions between authorities.

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Conclusion

14. It is necessary in any case to improve capital accounting in the NHS so as to determine full costs and charges for internal and external transactions and comparisons. It will also be necessary to set up a complementary system of budgeting for and repayment of capital charges for the purposes of trading between health authorities and self-governing hospitals and the private sector. As to the choice between cash transfers and management accounts for directly managed services, cash accounts would put all internal budgetary transfers between tiers of the NHS on the same footing as the external and internal market transactions of the NHS. This would have merit both in fully levelling the playing field and in obviating the need for continual adjustments to revenue budgets for changes in the scale of contracting out and the internal market. The resulting increase in gross spending would have mainly presentational disadvantages. While there would be costs associated with the extra cash flows which would have to be set up, these should in the longer term be outweighed by the greatly increase efficiency and effectiveness of capital management.

15. These arguments favour a system of cash transfers across the board, rather than a mixed system of notional management accounts, and cash transfers. Early announcement of an intention to introduce a cash transfer system would be a clear signal of the Government's commitment to a more competitive health market.

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ANNEX 2

THE USE OF PRIVATE FINANCE IN THE NHS

1. This note suggests some modifications of the rules on unconventional finance (in particular the use of private capital) to encourage private provision and to give the NHS more scope to take advantage of commercial opportunities.

Schemes to be encouraged

2. It is established policy to encourage the following types of schemes:

* private provision in NHS hospitals (paybeds) - new powers in the Health and Medicines Bill will allow authorities to make a profit.

* partnership with the private sector in joint schemes - breaking down the barriers between NHS provision and private provision.

* income generation schemes - the provision of a wide range of services and facilities for profit (shopping malls etc).

3. In addition health authorities are being pressed to take advantage of commercial opportunities in respect of:

* contracting out NHS provision to the private sector.

* the use of existing (high value) NHS land for commercial development and the provision of alternative NHS facilities elsewhere - perhaps with reduced running costs.

The rules on unconventional finance

4. Two basic principles underlie the rules on unconventional finance

(i) any proposal must offer best value for money in Exchequer terms (in practice this means comparing the proposal with the publicly financed equivalent - whether or not such public finance is in fact available).

(ii) where private finance is used it is expected that there will be a compensating reduction in the (public) capital allocation unless Ministers decide otherwise.

5. As means of ensuring respectively value for money and effective control over the size of the public sector these rules are eminently sensible. But they significantly inhibit some schemes we otherwise want to encourage. These schemes will almost inevitably include a cost of servicing the private capital (and therefore fail to meet the first criterion) even though they might represent good value for money and an appropriate return on that capital; while the requirement for compensating reductions in other schemes is a continuing source of difficulty since usually in service terms they have higher priority. Indeed the very purpose of a compensating reduction is to prevent an expansion in services and it is likely to be applied even where such expansion could lead to more health care and increased income.

"Trading" schemes

6. The schemes described in paragraph 2 involve the NHS operating on a trading basis. That distinguishing characteristic applies to certain privately financed Department of Transport schemes (the Dartford crossing where tolls are to be imposed) for which no compensating reductions are to be made. Consideration of similar NHS schemes, case by case, hardly seems appropriate however in view of the relatively small sums involved for individual schemes. A way round this would be to remove restrictions on access to private capital (without a compensating reduction) for those three categories - private provision in the NHS, joint public/private schemes and income generation initiatives. There would need to be auditable criteria to ensure that the removal of restrictions was limited to those categories of scheme.

7. Clearly it would still be necessary for a health authority to demonstrate good value for money and an appropriate return on the investment. But, for these three categories, it is proposed that the investment decision should be determined locally on normal commercial criteria. Modification of the two general principles of unconventional finance in the way described should lead to an expansion in private health care provision and a closer mix of public/private care.

Contracting out and commercial opportunities

8. As for the two categories of scheme in paragraph 3 - contracting out to the private sector and land development opportunities - there is a growing commercial interest in joining with authorities in such schemes; and contracting out, whether it be geriatric care or elective surgery, is often seen as a very attractive option.

9. So far as contracting out is concerned the present rule of thumb is that the use of private provision (especially surplus capacity) by an authority is an ad hoc way may be disregarded, but that long term contracting out represents substitute

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provision and falls for consideration under the unconventional finance rules (best value for money and compensating reductions).

10. As to land development, typically developers are offering, perhaps on a full design and construct contract, to provide a new hospital in advance of the release of high value land occupied by the existing facilities. Clearly however in this context the rules prevent private finance being used simply as a way round cash limits and avoid high financing costs.

11. Such schemes may however represent the only realistic way of achieving higher efficiency and/or an improvement in patient services. One approach to reflect the special needs of the NHS, would be to modify the rules on unconventional finance by allowing access to private finance for these two categories within an agreed limit (say £100m-£200m nationally) within which compensating reductions would not be made, for use only on schemes where the financing costs were at least partially offset by reduced running costs.

Conclusion

12. A major aim of the Review is to encourage private health care provision and to reinforce the income generation initiative. One approach to this would be to give health authorities complete freedom to use private finance for private facilities, and for joint provision. The current rules on unconventional finance inhibit the use of private finance to enhance public provision and they should therefore be modified - whilst preserving essential safeguards. It is therefore proposed that:

* for NHS private provision, joint private/public provision and income generation schemes there should be no compensating reductions in public allocations, and a requirement only to demonstrate good value for money and an appropriate return on the investment.

* for other schemes compensating reductions would be applied only above £100m-£200m a year nationally where financing costs were at least partially offset by a reduction in running costs.