These notes refer to the Health Act 1999 (c.8) which received Royal Assent on 30 June 1999

HEALTH ACT 1999

EXPLANATORY NOTES

COMMENTARY ON SECTIONS

Part I - the National Health Service

Sections 15 to 17: Changes to the NHS trust financial regime

158. These sections, together with paragraph 84 of Schedule 4, effect changes to the NHS trust financial regime. The existing financial regime, as set out in the NHS and Community Care Act 1990, was introduced to support the purchaser/provider split. In the White Paper *The new NHS*, the Government signalled its intention to amend the existing regime.

159. The main changes made to the NHS trust financial regime in the Act are:

- NHS trusts' originating capital debt will be comprised wholly of public dividend capital;
- additional borrowing by NHS trusts other than from the Secretary of State will be at his direction and subject to conditions he may determine, with the consent of the Treasury;
- investment of temporary surpluses by NHS trusts will be at the direction of Secretary of State.

160. *Sections 15 and 16* change the form in which the originating capital debt of NHS trusts is financed. Assets are transferred to the ownership of a trust by the Secretary of State. These assets are matched in value by a debt, which the trust then owes to the Exchequer (the Consolidated Fund). This is known as the trust's originating capital debt (OCD).

161. The originating capital debt is currently split into two. One part is made up of interest bearing debt (IBD). This type of debt is rather like a bank loan, with defined interest and repayment terms. It is repayable in equal instalments twice yearly in September and March over 25 years. The interest on the debt is based on that charged for an equivalent National Loans Fund loan at the date of establishment. Loan interest is charged on the diminishing balance. The other part of this debt is made up of public dividend capital (PDC). This is similar to share capital or equity, with the Government holding a share in the trust (normally 50%), on which the trust pays dividends to the Government.

162. In practice the total interest and dividend payments are adjusted so that the total return on capital must equal 6% of the trust's average net assets. (The 6% is determined by the Treasury and reflects the long-term cost of Government borrowing.) The Government therefore believes there is now no reason to have separate forms of financing. The Act therefore replaces the current dual system with a simplified single form of financing for NHS trusts' originating capital debt.

163. The process of phasing out interest bearing debt has already begun for long term loans. Section 16 provides for the replacement of the remaining originating capital debt IBD. It converts the interest bearing debt portion of existing trusts' originating capital debt to public dividend capital. Section 15 provides for the originating capital debt of newly

established NHS trusts to be issued wholly as public dividend capital. As a consequence of this it provides that OCD will now be known as originating capital.

164. Unlike interest bearing debt, public dividend capital currently has no repayment terms. To prevent NHS trusts building up cash reserves as a consequence of the removal of IBD, therefore, the Government intends to introduce procedures requiring trusts to make repayments of PDC rather than build up cash surpluses.

165. *Section 17* provides that additional borrowing by NHS trusts (over and above their originating capital) will be subject to Secretary of State direction, and amends the current provisions regarding the interest on loans by the Secretary of State.

166. NHS trusts have a duty to obtain value-for-money when they enter into borrowing arrangements. This will usually result in borrowing from the Secretary of State (in effect the Exchequer) since the interest rates on offer will reflect the Government's own credit rating. NHS trusts can borrow from the private sector, but any borrowing must not be secured borrowing and must offer better value for money than borrowing from the Secretary of State.

167. In future it is intended that, in the main, NHS trust borrowing will be from the Secretary of State. There are certain limited circumstances when a trust needs the ability to borrow from sources other than Government. An example is where an NHS trust wishes to enter "step-in" contracts in Private Finance Initiative schemes. Typically these arrangements involve a contract for a loan between the private sector provider and a bank. The trust's "step-in" term allows it to take on the private sector provider's liabilities under the contract if, for defined reasons, the provider is no longer able to meet them. In such circumstances the trust would in effect be borrowing from the bank. The intention, therefore, is to restrict the ability of NHS trusts to borrow from the private sector rather than rule it out altogether. Section 17 amends paragraph 1(1) of Schedule 3 to the 1990 Act to provide that the ability of NHS trusts to borrow is subject to the Secretary of State's power of direction.

168. Existing legislative provisions (paragraph 1 of Schedule 3 to the 1990 Act) allow the Secretary of State to provide interest bearing loans to trusts, with interest rates determined in accordance with the National Loans Fund. Section 17 revises these provisions to allow the Secretary of State, with the consent of the Treasury, to decide the circumstances and terms and conditions of any loans given to NHS trusts. The Secretary of State, with the consent of Treasury, will be able to decide the interest rate and any charges as appropriate, and will aim to ensure that they are compatible with the funding regime in the NHS and good treasury management.

169. *Paragraphs 84(3) and (4) of Schedule 4* make provision regarding the ability of NHS trusts to invest money. Under paragraph 7 of Schedule 3 to the 1990 Act, NHS trusts are able to invest temporary cash surpluses in Government securities, or other approved public or private sector deposit facilities such as local authorities, nationalised industries, banks and building societies. There is a cost to the Exchequer, however, in allowing NHS trusts to hold large sums of money other than in Paymaster Accounts (where the Government acts as the bank): the sums paid to trusts by Health Authorities would have been borrowed by the Exchequer from the market. It is intended that in future, therefore, any surpluses will be invested in Paymaster Accounts, thereby allowing the Exchequer to take account of these balances in deciding the overall amounts which the Government needs to borrow from the market.

170. For practical reasons, however, NHS trusts will be permitted to hold limited surpluses with other institutions (e.g. their High Street bank), but these will be restricted to an upper limit, to be determined by the Secretary of State and the Treasury. This will enable NHS trusts to continue to use commercial bank accounts for their day to day transactions, if this is value for money, and allow them some flexibility around the levels of cleared balances within which they are required to manage. This is in line with the procedures currently in place for Health Authorities.

171. Paragraph 84(3) of Schedule 4 therefore creates a new paragraph 7 in Schedule 3 to the 1990 Act. It allows NHS trusts to invest money in any investments specified in directions by the Secretary of State. Paragraph 84(4) provides that the maximum amount of these investments may also be set, with the consent of the Treasury. These changes will have the effect of reducing overall Exchequer borrowing costs. Furthermore, they should result in reduced administrative costs for trusts in planning and managing their investments, as where to invest and under what terms will be determined by the Secretary of State.