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CLASSIFICATION PROBLEMS AND THE DIVIDING LINE BETWEEN GOVERNMENT AND THE MARKET: AN EXAMINATION OF NHS FOUNDATION TRUST CLASSIFICATION IN THE UK

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ABSTRACT: *In this paper we argue that national accounting categories provide an inadequate basis for evaluating differences between public and private sector services. This is because accounting categories rely on economic concepts such as market price but do not take account of substantive public policy goals such as universality. The argument has important consequences for the structures and systems of delivery especially where nonprofit providers and social enterprise models are substituted for public bodies formerly integrated into the government's delivery system. Using an example taken from the UK's National Health Service, we show that the mechanisms for ensuring universality through redistribution are not sufficiently taken into account for classification purposes.*

Keywords: National accounts, NHS, contracting out
JEL Classification: H41, H42, H44

Problemas de clasificación y línea de separación entre el Estado y el mercado: un estudio del Servicio Nacional de Salud (NHS foundation trust) en el Reino Unido

En este artículo, los autores sostienen que la contabilidad nacional propone una base inadecuada para evaluar las diferencias entre los servicios que prestan, respectivamente, los sectores público y privado. Esto se explica porque las categorías de la contabilidad nacional se apoyan en hipótesis de mercado, pero no toman en consideración importantes objetivos de las políticas públicas, tales como la universalidad de los servicios de salud.

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Este argumento tiene importantes consecuencias para las estructuras y los sistemas de provisión de servicios, especialmente cuando los productores sin fines lucrativos y las empresas de la economía social sustituyen a los organismos públicos anteriormente integrados en el sistema público de salud. A partir de un ejemplo tomado del Servicio Nacional de Salud del Reino Unido, los autores muestran que los mecanismos que garantizan la universalidad mediante el reparto de riesgos no son suficientemente tomados en cuenta en las clasificaciones.

Klassifizierungsprobleme und die Trennlinie zwischen Staat und Markt: eine Untersuchung der Klassifizierung des NHS Foundation Trust im Vereinigten Königreich

In diesem Beitrag vertreten wir die Auffassung, dass die in den Volkswirtschaftlichen Gesamtrechnungen verwendeten Kategorien eine nur unzureichende Grundlage für die Bewertung der Unterschiede zwischen Dienstleistungen des öffentlichen und des privaten Sektors bieten. Der Grund hierfür ist, dass diese Kategorien auf den Annahmen eines perfekten Marktes basieren aber nicht substanzielle Ziele der staatlichen Politik wie etwa Universalität berücksichtigen. Diese Argumentation hat bedeutsame Konsequenzen für die Strukturen und Systeme der Bereitstellung, insbesondere wo Nonprofitanbieter- und sozialwirtschaftliche Unternehmensmodelle öffentliche Institutionen ersetzen, die zuvor in das staatliche Bereitstellungssystem integriert waren. Anhand eines Beispiels aus dem britischen National Health Service zeigen wir, dass die Mechanismen zur Sicherstellung von Universalität durch Risikostreuung für Klassifizierungszwecke nicht genügend berücksichtigt werden.

Problèmes de classification et ligne de séparation entre Etat et marché : une étude du Service national de santé (NHS foundation trust) au Royaume Uni

Dans cet article, les auteurs soutiennent que les catégories de la comptabilité nationale proposent une base inadéquate pour évaluer les différences entre les services fournis par les secteurs public et privé. Ceci s'explique parce que les catégories de la comptabilité nationale reposent sur des hypothèses de marché mais ne prennent pas en compte des objectifs importants de politique publique tels que l'universalité. Cet argument a d'importantes conséquences pour les structures et les systèmes de fourniture spécialement lorsque des producteurs sans but lucratif et des entreprises sociales se substituent aux organismes publics jadis intégrés dans le système public de santé. A partir d'un exemple issu du Système national de Santé du Royaume Uni, les auteurs montrent que les mécanismes qui assurent l'universalité via le partage du risque ne sont pas suffisamment pris en compte dans les objectifs de classification.

1 Introduction

In the UK and elsewhere, the focus of public service reform on new forms of delivery has raised questions about definitions of the public sector in the international system

of national accounts, a classification system often used by governments for performance indicators, service targets, and resource allocation (Office for National Statistics 2009).[1]

Instead of integrated government-run or directly-managed public service provision, the UK government has for some years advocated the use of social enterprise models, hospital foundation trusts, foundation or academy schools, and community not-for-profits. The system of national accounts is used to determine when these bodies are government- or market-controlled and when they are part of the public or private sectors. For classifications purposes the key question is whether provider units are exposed to a market through the price mechanism or whether their operating policy is controlled by government.

The approach involves some well known difficulties (Jones 2000, Organization for Economic Cooperation and Development 2002, United Nations 2003). For example, the taxonomy includes a category of supplier that both operates in the market *and* is controlled by government, the so-called 'public corporation'. As a result a profit-seeking provider can be classed as public and nonprofit institutions (NPIs) can be classed as part of government, of the public corporations sector, or private. However, little attention has been paid to the relatively restricted grounds on which these distinctions are made.

In this paper we argue that operational definitions of the concept of control are based on economic factors and take insufficient account of concrete public goals central to health systems, such as universality and social solidarity. The result is that new provider bodies may be classed as public corporations or part of government even though they involve loss of public controls formerly used to secure equity goals.

Using an example taken from the UK's National Health Service, we show that the mechanisms for ensuring universality through redistribution are not sufficiently taken into account for classification purposes. The argument has important consequences for the structures and systems of delivery especially where nonprofit providers and social enterprise models are substituted for public bodies formerly integrated into the government's delivery system. In section 1, we describe the national accounts classification system. In section 2, we identify issues which have arisen with respect to the public/private and market/non-market boundaries. A case study of the application of these categories to nonprofit bodies in the English NHS is examined in section 3 in order to explore limitations of the crucial concept of 'government control'. Findings and implications are discussed in section 4. The effect of NHS classification on UK fiscal measures is shown in an appendix.

2 The classification system

In Europe, the System of National Accounts (SNA) and the European System of Accounts (ESA) regulate the classification of public and private, and market and non-market *institutions*. Producer units that are integrated within government departments

1 'Robust classifications are needed to produce good quality National Accounts, which are internally consistent and comparable across the world. In addition, because of the wide use of National Accounts statistics (and those based on them) as performance indicators, targets, and the basis for distributing large sums of money, classification issues can and do take on political significance' (Office for National Statistics 2009).

(central or local) and do not have a separate institutional presence are classified as general government bodies. Producer units that are market institutions can be classed as either public or private. The public sector as a whole consists of general government bodies plus markets institutions that are public. The private sector consists of private market institutions.

Two of the key distinguishing criteria ask whether institutions are *controlled* by government or the market and whether their production costs are covered by *sales* at *economically significant prices*. We turn to definitions below.

2.1 Distinction between government and corporate sectors

Institutionally separate producer units are classified either to 'government' or 'corporate sectors' according to the influence of markets on their corporate policy. In general, government institutions are those controlled by government and corporate institutions are those controlled by the market. Corporations are defined as 'any legal entity set up for the purpose of producing goods or services for the market so that its owners may make a profit' (United Nations 1993:10.35).[2] All corporations have in common a reliance on 'sales', a state of affairs in which 'more than 50% of the production costs are covered by sales' (Commission of the European Communities 1996:3.32) under conditions of 'economically significant' prices, that is, prices that have 'a significant influence on the amounts the producers are willing to supply and on the amounts purchasers wish to buy' (United Nations 1993:6.45). Firms not governed by prices in this way are said to be part of the government sector.

Corporations so defined can be either public or private. A public corporation is an institution that operates in the market *and* is controlled by government. Public corporations are government-controlled market bodies that although subject to government rules also have 'a large amount of discretion in relation to both the management of the production process and also the use of funds' (United Nations, 1993). A private corporation operates in a market and is not controlled by government.

2 A new version of the SNA, SNA 2008, was published in 2009, in which the term 'corporation' was modified to include all entities that are: 'a. capable of generating a profit or other financial gain for their owners, b. recognized at law as separate legal entities from their owners who enjoy limited liability, and c. set up for purposes of engaging in market production' (United Nations 2009:66). The concept of ownership was also expanded in the formal definition: 'A legally constituted corporation is a legal entity, created for the purpose of producing goods or services for the market, that may be a source of profit or other financial gain to its owner(s); it is collectively owned by shareholders who have the authority to appoint directors responsible for its general management' (United Nations 2009:66). The modification does not materially change the argument in this paper, which is based on SNA 1993, and other key terms referred to in this paper are unchanged by the new version. An exception is the delineation of the government and the public sectors from the other sectors of the economy where further criteria for determining government control over general policy are specified (for example, exposure to risk). However, this addition does not change the essentially abstract basis of the control concept and therefore the argument in this paper.

2.2 Nonprofit institution classification

Public corporations have strategic significance; they are classified under the category of NPI as providing contracted out services to the National Health Service (NHS) in the UK. This has allowed the UK government to argue that contracting out is different from and need not involve privatization.[3]

However, NPI corporations need not be public bodies. They are defined solely as institutional units that do not distribute their surpluses as profits and classified as market or corporate bodies 'when they charge fees which are based on their production costs and which are sufficiently high to have a significant influence on the demand for their services. Their production activities must generate an operating surplus or loss (United Nations, 1993:4.58).' Schools, colleges, universities, clinics, hospitals, can fall into this category and NPIs of this type may not be charities or 'public services': 'their real objective often being to provide educational, health or other services of a very high quality using their incomes from endowments merely to keep down somewhat the high fees they have to charge (United Nations 1993:4.58).' It can be hard to determine whether this type of corporation is public or private, as debates about the UK's university sector demonstrate (Lane 2005). In the USA non-profit hospitals are almost always classed as 'private' notwithstanding the formal constraints that state legislation can impose on them in exchange for tax-exempt status (Heins et al. 2010). However, under SNA 93 and 2008 NPIs can be allocated to the public sector, as is the case in many European countries. In the Czech Republic, for example, nonprofit institutions such as public universities, school corporations and public research institutions are allocated to the general government sector (Statistical Office of the Czech Republic 2008). Public NPIs are also reported in Holland (Statistics Netherlands 2001) and Italy (Italian Institute of Statistics 2001).

These uncertainties arise because national accounts involve the behavioural assumption that economically rational purchasers and producers in a market will adjust output in response to price signals. Accordingly, institutions are categorized consequently to the type of output and not the nature of their activity. This model of rationality creates specific difficulties for nonprofit classification. So far as production is concerned, the accounts accommodate two basic types of behaviour, that which is

3 The relationship between contracting out and 'privatization' is not clear. For example, the 'purchaser-provider split' according to which direct management is replaced by a system of contracting, allows for providers to remain as part of a public administration, although at arm's length. This was the case with the National Health Service 'internal market' introduced in 1990 (Pollock 2005). Contracting in the internal market was accordingly non-commercial and based on administrative agreement not private law contracts (Pollock et al. 2007). Even adoption of commercial contracting does not of itself amount to privatization in the sense that the provider body is only subject to regulations equivalent to those imposed by companies act legislation. In the UK, for example, the internal market was in 2004 augmented by a system of 'foundation trusts hospitals' incorporated as 'community benefit companies' under special non-profit company legislation. Foundation trusts were classified to the public sector because of the additional government control over corporate policy that this form of incorporation allowed. Here again the dividing line is jurisdiction-specific; in the USA non-profit hospitals are almost always classed as 'private' notwithstanding the formal constraints that state legislation can impose on them in exchange for tax exempt status (Heins et al. 2010). Nonprofit providers in many European health and social care systems are also classed as private.

mandated by government on the basis of policy and executive authority, and that which is the rational response of producers in a competitive market. Non-profit-maximizing behaviour is not otherwise accommodated.

Operational definitions reflect the absence of clear guidance. For example, the UK Office for National Statistics found scope for interpretation in the definition of 'sales'. A term that can also include sales to government (Office for National Statistics 2003:290). Recognizing the European trend towards activity-based pricing, in which hospital are paid by the government according to the volume of patient activity they undertake, the ONS pointed out that the payment mechanism could include different policy objectives. In 2003 UK purchasing authorities had several types of contracts with health providers. The predominant contract with NHS Trusts was a 'block contract', where 'service availability' access is purchased rather than particular treatments. There were also 'cost and volume' contracts, which contain a mixture of charging for access up to a certain limit, topped up with additional charges according to volume of patients treated. Contracts with private sector providers are more prescriptive and relate to purchases of specific treatments (Office for National Statistics 2003:4).

The classification committee decided that the predominant type of NHS payment to trusts was a block grant (Office for National Statistics 2003:3) that did not constitute 'sales'. This decision depended on the committee's judgement that payments to NHS trusts and foundation trusts included reimbursement for keeping essential hospital facilities available and not just reimbursement for costs incurred in treating patients. Market bodies were not paid availability fees of this type and therefore the pricing systems were different for public and private hospitals.

Authors of the United Nations Handbook on Non-Profit Institutions in the System of National Accounts have made the related point with respect to the definition of 'control' in government accounting classification (United Nations 2003:5). They argue that existing sectoral guidelines are difficult to apply to nonprofit institutions because under the classification rules NPIs must be both financed and controlled by government to be classed as government sector bodies but the concept of 'control' is hard to pin down: 'the definition of 'control' offered by SNA does not always apply easily to institutional arrangements within a given country. That is especially true in the case of hospitals, clinics, universities and schools, where government provides a significant part of the organizations' financing but has varying degrees of control over their management and operations. Therefore, different countries are likely to include different types of NPIs in their government accounts, causing potential disparities in estimates.'

3 Addressing classification issues

In 2009, a revised Set of National Accounts (SNA 2008) was established to clarify the public private boundary and, by extension, the place of NPIs in it by refining the criterion of government control on which both are based. The amendments were intended to redraw the accounts so as to show 'the full set of NPIs as evidence of "civil society"' (United Nations 2009). This is an important policy adjunct because data of this type can be used as a basis for performance indicators, targets and

substantial resource allocation. Hitherto, data on NPIs had not been separately identifiable.

The SNA revisions were based on the work of a team led by L.M. Salamon and H.S. Tice at the John Hopkins Center for Civil Society Studies (Salamon and Tice 2005) and a special task force on the harmonization of public sector accounts (Dupuis et al. 2006).[4] The revisions were intended to address among other things criticism that the concept of government 'control' was too vague and the source of inconsistent classification by national accountants (International Monetary Fund 2009, Jones 2000, United Nations 2009).

A second complaint was that the classification in national accounts fails to recognise substantial variation in types of regulation. For example, nonprofits in the USA are invariably classed as private although there is considerable variation in state level regulation. The federal government is a critic of the tax exemptions enjoyed by nonprofit hospitals and insurers (United States Government Accountability Office 2005), which, it is argued, under the pressures of competition operate like profit-maximizing firms. Similarly in Europe nonprofit sectoral classification is often difficult because of variations in governments' performance management controls (Maarse 2006).

Empirical research has largely failed to settle questions about the virtues of nonprofit ownership in itself, the reliability of evidence for claims that nonprofits behave differently from profit maximizing firms (Auteri 2003, Pollock 2005), and the need for government regulation (Heins et al. 2010). Differences in the degree of autonomy afforded nonprofit models have confounded attempts to evaluate the effectiveness of contracting out reforms, and numerous studies have failed to provide conclusive evidence about the relative effects of public, private and nonprofit ownership on efficiency and quality (Eggleston et al. 2008, Devereaux et al. 2002, Currie et al. 2003, Pollock et al. 2007). Variation in results can be partly attributed to a failure to examine variation in the regulatory environments under which different types of provider organizations operate, including differences in quality standards and patient entitlements (Eggleston et al. 2008, Liu et al. 2007, Figueras et al. 2008).

Until government control is clarified it is difficult to say what the alleged benefits of contracting out to NPIs, if any, flow from ownership and competition (that is, market fragmentation), and which from government administration and integration.

4 The United Nations Statistics Division Handbook on Non-Profit Institutions in the System of National Accounts 'was prepared in close collaboration between the Johns Hopkins University Center for Civil Society Studies and the Economic Statistics Branch of the United Nations Statistics Division. Particular mention may be made of the contributions by Lester M. Salamon, Regina List, S. Wojciech Sokolowski and Helen Tice of the Johns Hopkins University Center for Civil Society Studies; Helmut K. Anheier, formerly at the Johns Hopkins University and now at the Centre for Civil Society, London School of Economics and Political Science, University of London; and Cristina Hannig, Károly Kovács, Jan W. van Tongeren, Vu Viet and Magdolna Csizmadia of the United Nations Statistics Division (United Nations, 2003:iii).'

3.1 The non-functional approach

The SNA classification only defines an institution as having a market or non-market purpose; it therefore does not address the basic question of the function of a 'public service' or address broader public policy goals such as universality. In fact, function is explicitly rejected as a classificatory criterion in the distinction between market and non-market activity. According to the SNA, the nature of the activity itself has no bearing on sectoral classification (United Nations 1993:5.41). There is, for example, no concept of a public health care system.

This non-functional approach is intended to facilitate international comparison by acknowledging that individual states have different views about the role of government. The analysis is nonetheless normative for it extends to the SNA the principle that any service is capable of delivery through the market. The approach lends itself to a policy analysis in which markets are the default position, a position also adopted by the European Court of Justice (ECJ) when interpreting the legal code of the European Union's (EU) single market. Uncertainty surrounds the EU's treatment of public services since a series of landmark judgements by the European Court established that national health systems involving private or 'market' providers are not necessarily immune from Community competition law (Hervey 2000). The European Commission acknowledges that for an increasing number of services, the important distinction between economic and non-economic activity has become blurred (Commission of the European Communities, 2003). One reason for this is that the European Court takes contracting-out into consideration when determining whether services are purely social in character or commercial. Thus the EC Treaty relies on an abstract concept of market control that is similar to that used by SNA.

In the NHS universal system, efficiency, universality and equity have been achieved by retaining facilities within government rather than distancing them as stand alone businesses within a broader 'public sector' or as part of the private sector. Universal cover has relied on equitable and needs-based methods of funding services through planning and cross-subsidization among hospitals, clinics and other curative services on a geographic basis. By design, the differentiation of provider units as separate accounting entities and cost centres undermines cross-subsidization of this type.

Similar integration is found in other developed country health systems. Thirteen OECD countries provide universal, tax-financed health care (Australia, Canada, Denmark, Finland, Iceland, Ireland, Italy, New Zealand, Norway, Portugal, Spain, Sweden and the United Kingdom) whilst ten countries (Austria, Belgium, France, Germany, Greece, Hungary, Japan, Korea, Luxembourg, and Poland) provide cover through social insurance systems (either through competing, non-competing or single payer sickness funds) (Paris et al. 2010). Tax-financed systems are often associated with high levels of provider integration and social insurance systems with the more widespread use of contracting out. However, whilst an OECD survey (Paris et al. 2010) found wide variation in the public/private mix of acute inpatient hospital provision (which accounts on average for three quarters of hospital beds), the authors also reported that in all OECD countries except Belgium, Japan, Korea and the Netherlands, acute care was mainly provided by the public sector. The contribution of nonprofits also varied widely. For example, following Italy's adoption in 1978 of an NHS-type health care system, most publicly financed care was delivered in public ambulatory clinics and

hospitals (France and Taroni 2005). However, some Italian regions relied more heavily on nonprofit and for-profit hospitals.

The social insurance system undoubtedly complicates the picture in Europe because funding flows are more complex than those in tax-financed systems and it is often difficult to establish from published accounts the levels of integration among payers and providers. For example, whilst Germany is often held up as an example of competing sickness funds, extensive negotiation reportedly takes place between insurers and providers in order to protect hospital infrastructure (Mossialos et al. 2002).

In adopting an abstract and formalistic approach to control, the SNA and European Court fail to address the extent to which contracting out reforms help or hinder redistributive mechanisms of this type. Neither addresses the extent to which movement between sectors advances or impedes substantive, non-economic government objectives.

4 Case study – NHS contracting out to NPIs: trusts and foundation trusts

From 1948 until 1991 NHS hospitals and services, all largely tax-financed, were owned by government and directly managed by geographically coterminous area health boards. In common with many other European countries, in 1991 the UK government began emulating insurance-based health systems by introducing a purchaser-provider split and internal market. As part of this reform programme, NHS hospitals (and later, community health services) were corporatized as 'NHS trusts' and for the first time endowed with their own institutional identity, including an accounting system that partially mirrored the accounts of private business. Trust status introduced a degree of separation from government although in practice funding continued to follow historical patterns of allocation and government regulation remained extensive.

In 2003, a further reform of the English NHS created 'NHS foundation trusts', a special type of NPI or 'public benefit corporation' established by parliament. Under this measure, government control of NHS trusts was abolished and hospitals and community services could transform into competing, nonprofit, independent corporations. A separate system of regulation was established under the Office of the Monitor, arms-length from government. Both NHS and non-NHS bodies, including private companies,[5] can apply to Monitor to become foundation trusts subject to certain authorization criteria. Although their principal purpose is to provide goods and services to the NHS, foundation trusts can in addition carry out any type of business. Their sole statutory general duty is to operate 'effectively, efficiently, and economically' (House of Commons 2003:s.39). They do not have shareholders but are expected to make and retain surpluses for new investment or for servicing loans raised on the financial markets. The scale of borrowing depends on

5 Under s.5(1) of the Health and Social Care (Community Health and Standards) Act 2003, organizations other than NHS trusts can apply for foundation trust status: 'An application may be made to the regulator by persons (other than an NHS trust) to be incorporated as a public benefit corporation and authorized to become an NHS foundation trust, if the application is supported by the Secretary of State.' A private body is entitled to make such an application but it must be prepared to accept nonprofit incorporation for that part of its business for which foundation trust status is sought.

their ability to make surpluses. They are paid by the NHS through an activity-related tariff system.

The policy devolves financial risk on to foundation trusts and opens up provision to external providers to create a competitive market. In order that providers can remain viable and manage financial risk, they are given new freedoms over cost control and income generation. These are (table 2):

Table 2 – Powers of foundation trusts to generate income

- Trade in NHS and non-NHS services
- Buy and sell land and assets and retain the proceeds
- Create commercial arms or join existing commercial ventures
- Subcontract clinical services to commercial companies
- Borrow money from private lenders within a prudential borrowing regimen
- Ask the secretary of state to lower their annual costs by exercising discretion when valuing the assets that are transferred to them
- Benefit from subsidies, loans, and grants from the secretary of state, including their NHS capital allocations for the next three years
- Retain surpluses under the new national tariff system
- Control boundary between the NHS and charged-for health and social care
- Flexibility to direct or transfer staff into the private sector (Pollock et al. 2003).

From a public health perspective, the key question is what these powers (and accompanying changes in resource allocation) mean for the core principles of the NHS, namely, progressive tax-based funding, equal access for equal need, and comprehensive, universal services free at the point of delivery.

In 2003, we argued that the new system would depart from these principles because the required regulatory safeguards and controls were weak or non-existent in the following respects: 'The safeguards to ensure that equal care is available to everyone who needs it are insufficient [. . .]. Foundation trusts will find themselves driven to select patients, treatments, and services on the basis of financial risk rather than healthcare needs' (Pollock 2003).

Since 2004, the regulator, whose principal duty is to ensure the efficient operation of the sector, has used his powers of interpreting legislative controls to extend these freedoms. For example, foundation trusts originally had a 'cap' placed on the generation of private patient income because it was recognized that increased private patient activity could threaten a core principle of the NHS to provide services free at the point of use. Monitor sought to interpret the legislation in such a way as to avoid the cap. Although rejected by the courts in February 2010 (Gainsbury 2010:7), the measure is an example of interpretative scope in secondary legislation and the potential for a regulator effectively to make new laws with equity effects.

Another development post-establishment was the introduction to the English NHS of 'payment by results' (PbR) in the form of a diagnosis related group (DRG) system known locally as the 'national tariff', which has been rolled out progressively and now covers much of clinical activity.[6] Until such a time as the national tariff was fully in

6 'PbR is being phased in gradually. The system began in a small way in 2003–4. In 2006–7 the scope of PbR was extended to include non-elective, A&E, outpatient and emergency admissions

place, it could be argued (and in fact was argued by the Office for National Statistics (2003)) that foundation trusts were not market actors because they did not generate their income from sales. That argument is now weaker than formerly.

4.1 Classification – are foundation trusts controlled by the market or the government?

When NHS trusts were set up in 1991, they were classified by the UK's Office for National Statistics (ONS) as public corporations because they were seen as public trading bodies or 'market units controlled by government (Office for National Statistics 2003).' When in 2003 NHS foundation trusts were created with even greater freedom from government control, the ONS reviewed NHS trust classification and reclassified them to the government sector, to which it also classified the new foundations trusts. The Public Sector Classification Committee (PSCC)[7] reasoned that, pending the full introduction of the national tariff (the activity-based reimbursement system that in 2003 partially introduced economically significant pricing to the NHS hospital sector), the system of pricing applied to the trusts did not qualify as sales under international classification rules. They argued that the pricing systems were different for public and private hospitals.

The effect was that foundation trusts with greater autonomy from government than ordinary trusts were classed as part of government whereas their predecessor bodies had been classed as part of the market. This reversal cannot be explained by reference to changing guidance, which remained constant throughout.

There were other potential inconsistencies in the classification. For example, the national tariff system and other market reforms were instituted in advance of a new regulatory framework spelling out the failure regime for foundation trusts (the circumstances under which they would be allowed to declare themselves bankrupt). It was therefore unclear what financial support would materialize in the event that a trust got into terminal financial difficulties; and judgments about reliance on sales could make little sense in the absence of a clear failure regime.

Clear differentiation between government and market sectors has also been impaired by complicated accounting rules associated with public private partnerships (PPPs) that the SNA acknowledges are still under consideration by national accountants (United Nations 2009:10.59). The accounting treatment of assets built under a private finance initiative (PFI), a public-private partnership (PPP) or a build, own, operate, transfer (BOOT) scheme, affect estimates of a trusts profitability and efficiency. Most new hospital building undertaken by NHS foundation trusts has been via PFI, a system of financing in which the private sector raises investment funds on behalf of the government. Few schemes (2%) are included on trusts' balance

for all Trusts. As at 2009–10 the main exclusions from PbR are primary care, community services, mental health services and the ambulance service (House of Commons, 2010:41).'

7 An ONS classification committee makes National Accounts classification decisions in line with the international statistical guidance. Now called the National Accounts Classification Committee (NACC), until 2004 it was known as the Public Sector Classification Committee (PSCC). The role and membership of the two bodies are similar (Office for National Statistics 2011).

sheets (House of Commons 2011:272) and there is extensive evidence that the policy has impaired public health goals (Gaffney et al. 1999a, b, Pollock et al. 2002, Pollock et al. 2011).

The system of national accounts is concerned with this balance sheet question and asks whether a PPP is a financing arrangement for the procurement of public sector infrastructure (a *financing lease*), in which case the asset and the liability are public; or whether the PPP primarily represents the procurement of infrastructure-based services (an *operating lease*), in which case the asset and liability are private. The basic test for this determination is 'economic ownership'.

According to accounting guidance, economic ownership devolves to the party that enjoys the economic risk and rewards of a business (United Nations, 2009:2.47). But in practice the complexity of the PPP contract makes it very difficult to judge where risks and rewards lie, as those that relate to the property are often bound up with the risks and rewards of providing the service (Cearns 1998). Furthermore, auditors acting for the private partner in a PPP deal may assess the risks and rewards differently from the public sector's auditors. As a result, PPP assets can appear in both public and private sectors simultaneously (on-on balance sheet treatment, as in the case of roads) or in no sector at all (off-off balance sheet treatment, as in the case of most hospitals) (Edwards et al. 2004).

This is crucial for nonprofit policy because economic ownership of assets (or 'balance sheet treatment') has significant implications for the cost base of organizations. Assets that are on the public balance sheet are subject to different rules from private assets (Hodges et al. 2003). They are required by the government's financial regime to show a return of a prescribed amount, to show an annual cost of depreciation at a rate determined by the Treasury, and to be revalued at intervals determined by the Treasury. Several of these standards are inconsistent with Generally Accepted Accounting Principles (GAAP)[8] and each affects the cost of capital and therefore the unit costs of services. This will be a significant issue under conditions where there is a common pricing regime but not a common capital financing regime, and where there is competition between NHS entities and between the NHS and the private sector, including the nonprofit sector.

5 Discussion

The above case study illustrates ambiguities and uncertainties in economically-based sectoral classification. Reallocation of NHS trusts to the government sector was possible without change to statistical guidance because the boundary between government and market, and therefore between public and private, is blurred. The availability of a 'public corporation' classification, which has public and private characteristics, is a crucial source of interpretative licence.

The flaws in this system are attributable to the high level of abstraction and limited criteria within which public/private distinctions are discussed. The economic basis of classification does not provide an adequate account of the extent

8 GAAP refers to a set of privately agreed accounting rules applicable in a given jurisdiction.

to which concrete public goals like universal access are advanced or retarded as entities cross the public/private, government/market divides, such as is the case when market reforms are introduced to health and social care, schools, universities and other traditional 'public services'. Claims about the advantages and disadvantages of 'privatization' are of limited use when these factors are not taken into account. The approach contributes substantially to the analytical marginalization of public service, articulation of which is absent or attenuated, that has been noted by several heterodox economists (Chang 2002; Shaikh and Tonak 1997) and political theorists (Tuck 2008).

Alternative analytic frameworks have proved insufficient to counteract this marginalization. For example, studies of accountability in government and of the scope of public law show inconsistencies in the application of public law to bodies that are independent of government *and* have public service functions (Grace 2003, Finer et al. 1995, Organization for Economic Cooperation and Development 2002). The result is a legal patchwork and potential loss of accountability with the substitution of private contract law for public law remedies (Freedland 1994). Faced with this uncertainty, in 1999, the Public Administration Committee of the House of Commons considered the question, 'why is there no firm or clear theoretical framework for British public administration that dictates which functions should rest directly under the control of elected politicians or quasi-autonomous bodies' and called for greater clarity (House of Commons 1999: paragraph 14, Flinders 2004).

The legal concept of 'public interest' expresses broad, community-based or social ends and it is generally assumed that public interest considerations have an important role to play in analyses of private individual or commercial rights. However, this notoriously protean concept appears in many broad issues of law with little fixed meaning; in practice it offers inadequate guidance to the institutional structure of public accountability and little defence of 'public service' (Freedland 1994).

The traditional focus of public administration was civic principles such as equity, democracy, public salaried employment, hierarchical management and accountability through elected representatives (Dunsire 1999). That focus has been substantially supplanted by the broad school of 'new public management' premised, like its economics counterpart, on propositions about the shortcomings of traditional public sector management and the superiority of the market as an organizing principle (Osborne 2006). Eliminated from this perspective is a 'common good' conception in which the state is more than the mere technical apparatus of government. There is a tension between new public management and a universalist, solidaristic health care system that privileges citizens' and human rights. It is perhaps no surprise that economists and new public management exponents have relied on the private insurance industry, from which these principles are absent, for health service reform templates such as internal markets and purchaser-provider separation.

The approach has made it difficult to draw a definitive line between market regulation and government control or to specify a clearly defined point at which providers can be deemed to be independent of government. A focus on substantive public goals such as universality and equity of access would provide an alternative basis for identifying the distinctiveness of 'public services'.

Appendix

Excerpt from National Accounts Sector Classifications of NHS Foundation Trusts and NHS Trusts. PSCC decisions – PSCC case 2002/22 2 July 2003 (Office for National Statistics, 2003), showing effect of reclassification of NHS bodies on UK fiscal measures (emphasis added)

National Accounts and the public sector fiscal measures

98. The ONS decides on classification issues for the National Accounts, using internationally agreed standards. In Europe these standards are contained in the European System of Accounts 1995 (ESA95). ESA95 is based on the System of National Accounts 1993 (SNA93). SNA93 was produced by five international organizations. It was approved by the Statistical Commission of the United Nations. ESA95 was adopted into European Union law by Regulation (EC) No 2223/96 of 25 June 1996. National Accounts statistics supplied to the European Commission must comply with it. The ONS decided in 1998 to have one version of the UK National Accounts, consistent with ESA95. It has produced the National Accounts on this basis since September 1998.

99. National Accounts classification decisions are consistent with the principles of these international statistical manuals and supporting manuals and case law.

100. In the June 1998 Economic and Fiscal Strategy Report, the Government introduced the current policy framework for monitoring and controlling the public finances. The three main measures are the public sector surplus on current budget, public sector net borrowing (PSNB) and the ratio of public sector net debt to GDP. The first two of these measures of the Chancellor's fiscal rules either directly use or are closely based on National Accounts' concepts. ONS has responsibility for measuring the fiscal rules, but not defining them or determining the relevance of their application in specific circumstances. HM Treasury accepts ONS decisions on sector classifications in National Accounts to establish which units are within the public sector.

101. The National Accounts' measures are based on accruals principles. Before 1998 the public finances were presented on a cash basis, the main measure being the public sector borrowing requirement (PSBR). The PSBR was renamed the public sector net cash requirement (PSNCR) to avoid confusion with PSNB. The cash measure is affected by the sometimes erratic nature of cash receipts and payments and by one-off financial transactions. The National Accounts accruals-based measures exclude such factors and are viewed by Government as providing a better guide to the underlying fiscal position. The National Accounts' definitions also allow for international comparability and consistency with other sectors of the economy. The PSNCR continues to be produced, although it is no longer one of the preferred fiscal measures.

102. The third main fiscal measure is public sector net debt. Any borrowing that NHS Foundation Trusts have from the private sector, or overseas, will add to public sector net debt. In assessing the potential future obligations of the UK Government one should bear in mind the coverage of National Accounts. National Accounts are based on international standards, which only include liabilities where there is a legal claim to

make a payment that is not conditional on other events. For example, the Government's state old age pensions' liability is conditional on the number of claimants, so is contingent and hence excluded. An actuary may try to quantify this prospective risk, but National Accounts treats the risk as contingent. The same is true for contingent assets, such as the asset of expected future tax receipts. There are similarities here between National Accounts and commercial accounting. In commercial accounting contingent liabilities will be excluded form the main body of the accounts, although they will be shown as a separate note to the accounts. Public sector net debt also follows the international standards for National Accounts in respect to not covering contingent liabilities. In the case of NHS Foundation Trusts there are no contingent liabilities.

103. *The reclassification of NHS Trusts will have no impact on the public sector fiscal measures, since it is being moved from one part of the public sector to another.*

104. The European Union also uses a version of net borrowing, in the Growth and Stability Pact and the Excessive Deficits Procedure under the Maastricht Treaty. The European Union measure's definition covers only general government, whereas in the UK the focus is on the public sector. The public sector is defined as general government plus public corporations.

105. Any decisions on whether corporations are public or private sector have no impact on the UK's government debt and deficit Maastricht statistics. It is the distinction between market and nonmarket that is relevant here. The classification of NHS Foundation Trusts as non-market entities means that they will be classified as general government and hence included in these measures.

106. *The reclassification of NHS Trusts will impact on the government deficit Maastricht statistics.*

107. *The reclassification adds to the government deficit by 0.1 per cent of Gross Domestic Product in every year since 1992 except for 1996, when it adds 0.2 per cent.* The position in 1991 is unchanged. The latest estimate of government deficit for 2002 is comfortably within the reference percentages for excessive deficit specified by a protocol to the Maastricht Treaty, and the reclassification of NHS Trusts does not alter this. The impact of the reclassification is reduced because government purchases from NHS Trusts and receipts from government loans and public dividend capital were already components of the deficit.

108. There is no significant effect on the Maastricht government debt series, since NHS Trust debt is with central government and reclassification consolidates this debt into the central government subsector.

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