Final Level

Management Accounting – Case Study

15 *FLCS*

PRE-SEEN MATERIAL, PROVIDED IN ADVANCE, FOR PREPARATION AND STUDY FOR THE EXAMINATION TO BE HELD ON THE AFTERNOON OF THURSDAY, 25 NOVEMBER 2004

INSTRUCTIONS FOR POTENTIAL CANDIDATES

This booklet contains the ***pre-seen case material*** for the November 2004 examination. It will provide you with context information that will help you to prepare yourself for the examination on 25 November.
You may not take this copy of the pre-seen material into the examination hall. A fresh copy will be provided in the examination hall.
The Assessment Matrix is available separately on the CIMA website, as is guidance on how to prepare for the examination. The matrix will also be provided in the examination hall.
Unseen material will be provided on the day of the examination: this will comprise further context information and the examination question.
The examination will last for three hours.
You will be required to answer one question, which may contain more than one element.

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Mayah Group of Hospitals

1. Introduction and context for change

The Mayah Group of Hospitals (MGH) is a public sector organisation operating over three sites in the city of Mayah in the north of Zamorna, a fictitious country in Western Europe.[1] This part of the country is affluent and the population has a better than average state of general health. There are, however, pockets of deprivation where there is a higher than average incidence of some types of disease and "life style" ailments such as obesity and smoking-related illnesses. The demographic profile of the region covered by MGH is shown in *Appendix A*. MGH is not the only public sector hospital in the region, but it is by far the largest and offers the widest range of services.

In Zamorna, health services are provided by a combination of public and private sector organisations. The public sector providers, such as MGH, are financed by a mixture of national and local taxation and most treatments are free to the patient at the point of delivery. However, the current government has encouraged greater private sector participation in a variety of ways, for example in providing finance for new buildings and, recently, by using (and paying for) private sector facilities to supplement those provided by the public sector. More contentiously, it is considering allowing expenditure on private healthcare and health insurance premiums paid by individuals to be partially tax deductible. A sizeable minority of the population is able to afford private healthcare or health insurance.

The Zamorna government has determined a range of objectives and targets that public sector providers must achieve. The objectives deal broadly with the efficiency and effectiveness of healthcare in the context of improving health and obtaining value for money. On many performance measures, both clinical and managerial, MGH has demonstrated a worse performance than the majority of hospitals of similar size in areas of similar demographic profile. Not only is it worse than other comparable organisations, but also in many areas of service its performance is declining.

The MGH Board had for some time recognised that its poor performance was largely for the following reasons:

(i) the increasing cost of providing services from three separate sites;

(ii) the changing health needs of the local population;

(iii) poor human resource relations with all categories of staff, partly because of poor communications and partly because of poor working conditions.

There is also a shortage of good, qualified staff but this is a common problem throughout Zamorna.

The need to achieve more cost-effective provision and improved quality of clinical services has been a key feature of Board discussions for some time. However, the real impetus for change was the government's demand for a thorough strategic review of MGH's operations. This was concluded six months ago and major redevelopment and reorganisation has become inevitable.

2. Organisation and management structure and corporate objectives

2.1 Organisation structure

There are three hospitals in the group under the same management. The main areas of business of these three hospitals are explained below. The group as a whole employs around 5,500 staff (full-time equivalents), 75% of whom are in clinical professions.

1 *NOTE: Zamorna is* **not** *the UK and the health system is* **not** *the UK's National Health Service (NHS).*

The district hospital (DH)

This is the largest hospital in the group. It provides a wide range of medical and surgical procedures from minor operations to treatment of major illnesses and injuries. Certain specialised procedures, such as organ transplants, are referred to a specialist hospital in another part of the country.

DH treats around 52,000 in-patients each year. It also has an out-patient facility treating around 160,000 cases each year and an accident and emergency department treating 85,000 casualties a year.

The average length of stay of in-patients in this hospital is 3 to 4 days, but there is a very large variation. The majority of treatment episodes are one- or two-day stays but some patients with serious illnesses or injuries may be there for six months or more.

The mental hospital (MH)

This hospital caters for patients with mental illnesses and psychological problems and disorders. It also provides residential rehabilitation and detoxification facilities for patients suffering from substance abuse. MH treats 150 in-patient cases each year and also provides day clinics to assist patients maintain their state of health once they have been discharged from residential treatment programmes. Many of its patients are from neighbouring districts as it is the only hospital in the region providing this type of facility.

It suffers from a disadvantage of being located some distance from the Mayah city centre and transport services and other amenities are poor. This means many people in need of the clinic's services are frequently unable or unwilling to travel to the clinic.

The maternity and child welfare clinic (MCWC)

This clinic provides maternity and child welfare services. In an average year, the clinic will have 2,500 deliveries and treat 4,500 children for various illnesses and diseases. The number of deliveries is likely to decrease over the next few years due to the changing demographics of the region and the increase in popularity of home births and use of private sector clinics.

Typically, new mothers leave hospital within two days of the birth of their child unless there is a complication. Most children are treated as out-patients. If their condition is serious or requires major surgery, they are referred to the children's ward of the district hospital.

2.2 History of current organisation

The current configuration of hospitals has come about by accident rather than by managerial design. Until 10 years ago, the two hospitals and the clinic were three separate organisations with their own management board and funding streams. The government of the day was keen to reduce the costs of managing and administering health services and had forced the three boards to review their management structures and operations.

In 1995, in response to these government pressures, a consultation paper was issued that suggested merging the maternity and child welfare services with a similar clinic in a neighbouring district. The neighbouring clinic would provide maternity services and Mayah clinic child welfare. There was also a proposal to re-site the mental health services hospital to a low-usage building within the district hospital complex. This would provide a much more accessible location and allow considerable cost savings.

The financial and organisational logic was compelling but the public outcry to both sets of proposals resulted in them being abandoned. A compromise solution was to merge the three organisations' management under the current organisational structure. This allowed some cost savings but did nothing to improve the service levels. There are now serious tensions within the organisation, mainly between clinical and administrative staff, that have led to a high staff turnover in recent years and a difficulty in recruitment.

A further problem is the age and condition of the district hospital's buildings. The main building was built over 80 years ago and does not lend itself to the major renovations necessary to provide the facilities required by modern hospitals. The other peripheral buildings are newer but they are spread out around the city and most are in need of refurbishment.

2.3 Management structure

The MGH Board currently has nine members – four executive and five non-executive Directors. There is a vacancy for a sixth non-executive Director that has been unfilled for over twelve months. Brief details of the Board are as follows:

Executive Directors:

Chief Executive: John Asta has worked in the hospital sector since leaving university with a degree in biotechnology. He started his career as a clinician and moved into management eight years ago. He has been Chief Executive of MGH since 2001.

Director of Finance and Performance Measurement: Olivia Owulu is a qualified management accountant and holds an MBA from an American business school. She worked in the private sector until five years ago when she was headhunted for this position.

Director of Human Resources: Dolores Rossiter is a recent recruit to MGH. She is an American citizen who moved to Zamorna last year with her husband who is a consultant anaesthetist, also now working for MGH.

Director of Planning: Georges Papadopoulous is the longest serving member of the Board. He was a senior manager at the maternity hospital before it merged with Mayah. The responsibilities for planning were until that time undertaken by the Director of Finance. The decision to split the role and award Georges a director's post led to the resignation of the then Director of Finance and the appointment of Olivia Owulu.

Non-Executive Directors (all part-time appointments):

Non-Executive Chairman: Professor Frances Cluna is a full time academic at the local university. Her area of expertise is pharmacy and pharmacology. She is also politically astute and understands the political imperatives of managing any public sector organisation. She has been Chairman for three years.

She has known John Asta since university and it was as a result of his invitation that she applied for and was appointed to the position of Chairman.

Non-Executive Directors

Brigitte Binardi is a retired social worker who has been a non-executive director on a variety of health sector boards. She is also actively involved in voluntary work in health-related charities. She is an advocate of MGH maintaining a full service provision, and wholly opposed to private sector involvement in the health service. This frequently brings her into conflict with colleagues who generally take a more pragmatic view and accept change is inevitable.

Carlos Cluntz is a local businessman who runs his own successful computer company that specialises in systems and software design. He is a relative newcomer to the role of non-executive having joined the Board only six months ago. He is frustrated by the administrative complexities and bureaucracies inherent in hospital management.

Dr Indira Mehra is an industrial chemist who works full time for a large pharmaceutical company. She has been a non-executive director at MGH for three years and Vice Chair for the past twelve months, although she has been ill for much of the past six months.

John Vance is a freelance stress management consultant. His business involves delivering one-day seminars to employees of client companies and also individual stress counselling, contracted either by organisations for their staff or by individuals.

2.4 Corporate aims

The MGH Annual Report states that the Group has four main aims within its overall mission, which is *"To serve the people of the region by improving standards of health and providing high quality services".* The four main aims are:

- to deliver high quality healthcare to the residents of the region in which MGH operates;
- to provide value for money in terms of output per € spent;
- to improve the health of the local population by the use of pro-active measures;
- to recognise the needs of all the organisation's stakeholders and treat them with equal respect.

With the possible exception of value for money, these objectives are not quantified and are difficult to measure. When Carlos Cluntz joined the Board of MGH he felt little more than lip service was paid to these aims and he attempted to persuade his fellow Directors that it was necessary to translate them into tangible goals and actions. To help achieve this, he argued for the introduction of a balanced scorecard approach. He has not had much success; the pressure of dealing with frequent "urgent" management issues meant that merely important issues were usually forgotten or ignored.

3. Future service needs and proposals for change

The strategic review required by the government concluded that major investment and reorganisation of services were required to meet the government's financial and other performance targets. A selection of comparative performance targets is shown in *Appendix B*. Organisations that consistently under-perform on these key targets will be subject to a government-instigated review.

The MGH Board initially drew up a "long list" of proposals for redevelopment. These proposals were evaluated firstly against the non-financial criteria listed below:

- provision of a locally available and accessible in-patient facility;
- critical mass of service provision to ensure adequate staff coverage and the ability to recruit and retain high quality staff;
- access to relevant treatments and therapies;
- expansion capability for future service development;
- minimum disruption to existing service provision;
- acceptability to other health providers in the locality.

On the basis of the outcome of this evaluation, the Board reduced the choice of proposals to three. As well as meeting the minimum requirements of the non-financial evaluation, these three proposals were considered to have the greatest potential to offer value for money. Whichever proposal is chosen, at least some of the finance for the capital costs must be sought from private sector providers probably as part of a "Build, Operate, Lease" arrangement.

The main features of the three proposals, their expected strategic benefits and practical constraints are discussed below. The expected effects on performance measures are shown in *Appendix B*.

Proposal 1

Main features

Build a completely new hospital on a new site that would provide the full range of services currently available within MGH (excluding very specialised procedures, as now). A suitable "brown-field" site has been identified just outside the main city centre, approximately two miles from the current hospital. The seller, Romstat Properties, has had difficulty selling this land because the planning authorities have consistently refused applications for housing

development. The cost of this land is currently €10 million. The sale value of the land and buildings on the existing three sites is estimated as €25 million as their location is suitable for housing and / or commercial development.

Benefits

There would be a public sector full-service health provider in the district, which would meet with widespread support from the public, local health groups and politicians. There would also be economies of scale from single-site provision of services that would allow substantial improvement in many performance measures.

A government requirement is that major redevelopment projects that propose full-service provision, such as Proposal 1, should have a formal procedure in place for ongoing evaluation of the project after completion. Some, especially the Finance Director, consider this a benefit but others think it is a waste of time and money and that the money would be better spent directly on patient care.

Additional income would be provided by the government for the provision of services as a consequence of increased activity (that is, higher numbers of patients treated for comparable health complaints).

Constraints / concerns

Government approval is required for all capital investment projects over €70 million irrespective of how they are to be financed. When building costs are taken into account, this Proposal will almost certainly exceed this limit and the process of obtaining approval will inevitably introduce delays into the decision process.

A potential area of concern is the need to obtain planning permission from the local authority for the change of use of the three former hospital sites. The estimated sale value of these sites assumes they will be accompanied by planning permission for housing development. A representative from the local government office was invited along to discuss this issue with the Board. Board members have been given to understand that there would be no problems in obtaining the necessary permission, subject to an environmental audit. A firm of environmental consultants has been asked to prepare a detailed report on the likely environmental impacts of the proposed redevelopment.

Proposal 2

Main features

This Proposal would be to build a completely new hospital on a new site that would provide services only for acutely ill patients, out-patients and accident and emergency. Other services would be "de-merged" and possibly re-merged with other, similar units in neighbouring districts. Maternity and child welfare services could be merged with a neighbouring clinic on the other side of the city. Mental health services could be taken over by a private organisation that has for some years shown interest in such a venture. The private organisation, however, does not wish to buy the land and buildings. MGH would therefore retain ownership of the land and buildings and lease them to the private provider for the duration of the contract, which is likely to be for an initial period of five years.

If this Proposal was selected, MGH would have no managerial responsibility for the operation of maternity, child welfare and mental health services although there would be some need for co-operation on referrals to and from the main hospital. The Romstat Properties' site would also be suitable for this Proposal, although it will be larger than necessary. The proceeds from land sales would be around €15 million, which is €10 million lower than with Proposal 1, as MGH would retain ownership of the land and buildings occupied by the privatised mental health service.

Benefits

This Proposal is likely to yield the greatest improvement in many performance measures, both managerial and clinical. It would also allow the Group to focus on "core" business. The maternity and child welfare services will benefit from greater specialisation – for example, with more patients, the enlarged organisation in the neighbouring district can employ more specialist staff on a full-time basis rather than, as at present, sharing specialist human resources.

The benefits to the mental health service are less obvious, other than freeing MGH management time.

There will be an increase in the volume of activity of comparable treatments, but a decrease in overall activity because of the de-merging of maternity and mental health. However, because treatments have widely varying costs, it is possible that income from activities will increase while the overall volume of activities decreases.

Constraints / concerns

This Proposal would cause some local opposition, although the Board believes it can manage the protests and political interference more successfully than ten years ago.

As noted above, the land identified for Proposal 1 is being considered for this Proposal also although there would be land to spare, at least for the foreseeable future. The Romstat Properties' board is unwilling to split the site into two or more lots so MGH must buy it all or look for another suitable site. A suggestion would be for MGH to buy the entire site and then sell the surplus land, if a buyer could be found at all given Romstat's difficulty in selling the entire site.

As with Proposal 1, government approval for the capital spend would be required.

The company secretary of MGH has informed the Board that although there are no major legislative issues that might affect the redevelopment, there is a minor concern in respect of the Human Rights Act because certain sections of the population would have to travel a short distance outside the region to obtain treatment. This is being investigated.

It is also apparent that some staff will no longer be required by MGH. The MGH Board believes these staff will be taken over by the acquiring providers and that there will be no serious opposition by the staff concerned and no severance costs for MGH.

Proposal 3

Main features

This is the "minimum" change Proposal. This would mean refurbishment of existing premises and some reorganisation and relocation of service provision. This Proposal barely meets the non-financial criteria but is included as a benchmark.

Benefits

The main benefits are:

(a) That it is likely to be the lowest-cost Proposal and can be completed in the shortest time.

(b) That as it is below the government's capital cost approval level, the MGH Board could approve the expenditure and financing.

Constraints / concerns

This is considered the least favourable Proposal by the Board and most staff but is included to provide a benchmark against which the undoubted higher costs of the other two Proposals will be compared. However, if this "minimum" change Proposal is chosen, many clinical staff have indicated they will leave, causing a staffing crisis.

A major constraint on "rebuild" redevelopments is the need to maintain capacity while the renovations are taking place. This involves closing down sections of the hospital one at a time and transferring the activity to another part of the hospital or buying the required services from

another health provider, either in the public or private sector. There will therefore be a substantial amount of upheaval and dual running costs for a period of time with this Proposal.

A further potential problem is that private providers of funds are likely to be less than enthusiastic about loaning this amount of money for what is mainly a refurbishment project, other than at an unacceptably high cost of finance over a relatively short (15 years) period of time. An alternative way of raising the money would be a combination of public appeal for funds and government grants. It is also possible some European Union funds would be available for some aspects of the renovation.

4. Selection criteria, short-listing and choice of contractor

4.1 Selection criteria

The MGH Board advertised for expressions of interest from building contractors and development consortia. All potential bidders were provided with information about the three Proposals under consideration. They were required to submit details about their organisation and any proposed sub-contractors, and also to demonstrate a proven ability to deliver on similar sized contracts. At this stage they were not required to submit estimates of costs.

The selection process was done in two stages by a project planning team that consisted of staff from the finance and planning departments. The first stage was to review all bids to determine whether they met the six basic selection criteria listed below. The project planning team established these criteria, which were based on criteria used by similar organisations undertaking similar redevelopment reviews.

(i) An ability and willingness to contract for any of the three Proposals.

(ii) Evidence of sound contractual arrangements, existing or proposed, between the lead contractor and sub-contractors.

(iii) An ability to provide, or arrange, financing for the project although the MGH Board is hopeful that the Zamorna government will provide some assistance with the capital costs.

(iv) An outline redevelopment plan including profiles of the management team and evidence that a suitably qualified workforce is available for design and construction.

(v) Statement of ability to observe the environmental and regulatory requirements of the chosen Proposal.

(vi) Statement of compliance with MGH's policies on equality and diversity.

4.2 Expressions of interest and short-listing

Twelve companies or consortia submitted expressions of interest. Ten companies or consortia were eliminated because they failed to meet adequately all the criteria. This has resulted in a short list of only two contractors who have now been asked to submit cost estimates for the three Proposals.

Contractor 1 – ArkFin Consortium

Fifteen companies are involved in this consortium as main or sub-contractors. The "lead contractor" is the main building firm, Arkwright plc, a UK-based construction company, whose shares are listed on a UK stock exchange. Its five-year financial summary is shown in *Appendix D*.

Arkwright plc has been established for over 50 years and has a sound financial history, apart from a three-year loss-making period some ten years ago. This was due to the company under-pricing its bids in order to win large public sector contracts. A shareholder revolt caused management changes and the company returned to profitability within two years.

Two non-executive Directors (NEDs) of MGH expressed concern about the short-listing of ArkFin. The consortium has been assembled specifically for the MGH contract and some of the participating firms have little or no experience of major health sector construction work. Also, Arkwright plc's contractual agreements with its sub-contractors were contained in a briefer

document than the Board had expected. Arkwright plc's Chief Executive argued that the relationship with its sub-contractors was a commercial one and, as the lead contractor would hold ultimate responsibility for completion of the contract, the MGH Board did not need to concern itself with the details. As there were only two companies being short-listed, and to re-advertise for expressions of interest would involve an unacceptable delay to the start of the project, the NEDs' concern was over-ruled by the rest of the MGH Board.

Contractor 2 – LinMel Group

This is a US group that was originally a construction company but has now diversified into other areas, including providing financing for its larger projects. It has been working in Europe for some years on similar large-scale public sector projects with private finance involvement. It has a good reputation for delivering on time and within budget. The senior management team of LinMel believes the company can provide all the services necessary using its own companies but reserves the right to sub-contract if necessary. Its five-year financial summary is shown in *Appendix E.* Its shares are listed on a US stock exchange.

4.3 Submission of cost estimates

The two short-listed contractors were asked to submit outline cost estimates and finance terms for all three restructuring Proposals. Key information from the two bids is shown below.

Proposal 1 - Centralised services in new hospital

	ArkFin	*LinMel*
	€ million	*€ million*
Building costs (including costs of equipment and fittings)	115·00	105·00
Total finance required (net of proceeds from land sales – see *Note 1*)	100·00	90·00
Annual lease charge – see *Note 2*	7·82	9·37
Finance period	25 years	25 years
Estimated completion date (number of months from date of signing contract)	+36	+40

Note 1: This is the sum of:	*€ million*	*€ million*
Building costs	115·00	105·00
Cost of the Romstat Properties' land	10·00	10·00
Less estimated sale value of land and buildings of all three old sites	(25·00)	(25·00)

Note 2: The lease payments are for the provision of finance for the total capital cost of the redevelopment, that is €100 million (ArkFin) or €90 million (LinMel).

Proposal 2 – Centralisation of acute services in new hospital and de-merger of maternity, child welfare and mental health services.

	ArkFin	*LinMel*
	€ million	*€ million*
Building costs (including cost of equipment and fittings)	100·00	93·00
Total finance required (including net cost of land – see *Note 1*)	95·00	88·00
Annual lease charge – see *Note 2*	7·43	9·16
Finance period	25 years	25 years
Estimated completion date (number of months from date of signing contract)	+30	+35

Note 1: This is the sum of:	*€ million*	*€ million*
Building costs	100·00	93·00
Cost of the Romstat Properties' land	10·00	10·00
Less estimated sale value of land and buildings of old DH and MCWC sites	(15·00)	(15·00)

The cost may be reduced if MGH decides, and is able, to sell the portion of the Romstat Properties' land that would be surplus to immediate requirements with this Proposal.

Note 2: The lease payments are for the provision of finance for the total capital cost of the redevelopment, that is €95·0 million (ArkFin) or €88·0 million (LinMel).

Proposal 3 – "Minimum" proposal to refurbish and reorganise.

	ArkFin	*LinMel*
	€ million	*€ million*
Building costs (including structural work)	30·00	28·50
Annual cost of finance	3·05	2·90
Finance period	15 years	15 years
Estimated completion date (number of months from date of signing contract)	+36	+30

The following contractual obligations and conditions will be imposed by MGH on the winning contractor if Proposal 1 or 2 is chosen.

- MGH will start the lease payments only when the buildings and specified support services are available and performing to defined quality standards.
- The buildings will be maintained as part of the contract throughout the lease period. At the end of this period, the hospital group can acquire the buildings, renew the financing contract, or put it out to re-tender. These end-of-lease terms are still to be negotiated.
- Penalty deductions will be applied if the building and specified support services are not available or not performing to defined quality standards.

4.4 Choice of contractor

After some delays, the decision was to award the contract to ArkFin, despite the lack of experience with this type of contract of some of the member firms in the consortium, as its bid carried the lowest annual charges for Proposals 1 and 2 and its estimated completion dates for these two Proposals were shorter than LinMel's proposal. Its completion date for Proposal 3 is slightly longer than LinMel's but the MGH Board believes it is unlikely Proposal 3 will be the preferred choice.

The MGH Board called a special meeting to review the evaluation team's recommendation. Some of the Non-Executive Directors, especially Carlos Cluntz, were strongly opposed to the choice of ArkFin as the costs and completion dates suggested by the contractor appeared extremely optimistic. The costs factor in particular caused concern. As Mr Cluntz pointed out, it was not sensible to give the contract to the lowest-cost bidder if those costs were cut so fine they threatened the long-term survival of the contractor and its associates. However, the dissenting Non-Executive Directors were over-ruled by the overwhelming support given by the executives and the reluctant compliance of the other Non-Executive Directors.

4.5 Resignation of Non-Executive Director and launch of investigation

Two days after the special meeting to approve the award of the contract, Carlos Cluntz made a very public resignation. He stated his reasons as the "unjustifiable and unsupportable" choice of ArkFin. He very readily agreed to discuss the reasons for his resignation with local health groups, media and politicians. The resulting public outcry has led the government to send a senior health executive from a neighbouring region to conduct an investigation. This investigation is expected to take between six and eight weeks.

Appendices A, B, C, D, E and F follow

Appendix A

Demographic statistics for the region

	Actual as at 2003	*Forecast for 2013*
Population total	518,000	534,000
Percentage:	*%*	*%*
aged under 4	5·2	4·8
aged 5 – 16	12·5	11·7
aged 17 – 25	10·6	9·7
aged 26 – 45	26·3	24·3
aged 46 – 60	17·4	18·5
aged 61 – 80	20·3	22·5
aged over 80	7·7	8·5

The male / female split is roughly equal until the age bands 61 – 80 and over 80 when there is an increasingly higher percentage of women than men.

Population in 2003 by social category (to nearest 000)

Total population of working age	292
By category:	
Professional	18
Managerial / technical	90
Skilled	125
Semi skilled	46
Unskilled	13

Notes:

1. No forecast is available of future population by social category.

2. Unemployment in the region is 5·5% compared with the national average of 7·5%. It is mainly concentrated in the semi-skilled and unskilled categories. Unemployment in the other categories is typically of the "between jobs" type.

3. Unemployed people are included within the relevant social category.

Performance measures

	MGH	*Average for comparative organisations*	*Expected outcomes (1st full year of activities)*		
			Proposal 1	*Proposal 2*	*Proposal 3*
Hospital waiting times					
Out-patients:					
percentage of treatments completed within 3 months	68%	60%	75%	80%	72%
In-patients					
percentage of patients admitted within 3 months	65%	75%	78%	80%	70%
percentage of patients admitted within 12 months	95%	100%	100%	100%	100%
Complaints					
Number of complaints received and investigated	1,250	950	1,050	950	1,150
Number of complaints upheld	175	50	75	60	80
Number of staff complaints – all causes (harassment, unfair dismissal etc)	185	85	85	50	65
Financial					
Percentage under/(over) spend on cash limit	(5%)	0	0	0	0
Staff costs as percentage of total operating costs	75%	70%	73%	70%	75%
Average cost per out-patient treatment (excluding accident and emergency cases)	€850	€775	€775	€765	€825
Average cost per in-patient treatment (excluding maternity)	€1,450	€1,425	€1,550	€1,425	€1,550
Approx fixed/variable cost ratio	$^{75}/_{25}$	$^{68}/_{32}$	$^{70}/_{30}$	$^{68}/_{32}$	$^{75}/_{25}$

Note: Expected outcomes are at 2003 cost levels.

Appendix C

Financial statements of Mayah Group of Hospitals

Profit and loss account	*Note*	*For the year 2003* *€000*	*For the year 2002* *€000*
Income from activities	*1*	231,520	215,250
Other income	*2*	14,500	23,500
Expenses connected with activities		(257,350)	(245,200)
Surplus / (deficit) on activities		(11,330)	(6,450)
Profit / (loss) on disposal of assets		550	(365)
Surplus / (deficit) before interest		(10,780)	(6,815)
Interest receivable		650	425
Interest payable and other finance charges		(250)	(125)
Surplus / (deficit) for the year		(10,380)	(6,515)

Balance sheet	*Note*	*€000*	*€000*	*€000*	*€000*
Fixed assets:					
Intangible			150		150
Tangible			132,655		135,260
Current assets:					
Stock		3,520		2,560	
Debtors	*3*	19,250		22,500	
Cash and short-term investments		780		250	
Total current assets			23,550		25,310
Current liabilities:					
Amounts due within 1 year			(25,025)		(19,500)
Total assets less current liabilities			131,330		141,220
Creditors falling due after 1 year			(650)		(560)
Provisions for liabilities			(2,350)		(1,950)
Total assets less liabilities			128,330		138,710
Financed by:					
Capital and reserves:					
Public capital	*4*		122,710		133,090
Revaluation reserve			3,520		3,520
Other reserves			2,100		2,100
Total capital and reserves			128,330		138,710

Notes

1. Income from activities is money provided by government, based on standard rates for the activities undertaken.

2. Other income is mainly from the treatment of private patients.

3. Debtors is mainly money owed by the government for treatments provided and from other hospitals whose patients have been treated by MGH. Money owed by private health insurers for patients treated privately is also included here.

4. Public capital is roughly the equivalent of shareholders' capital. Public capital plus reserves is the value of the organisation to its owners; that is the public.

Five-year financial summary for Arkwright plc

	2003	*2002*	*2001*	*2000*	*1999*
	£ million	*£ million*	*£ million*	*£ million*	*£ million*
Profit and loss account					
Group turnover	2,650·30	1,850·20	1,622·20	1,450·00	1,205·50
Group operating profit	247·50	195·20	175·20	125·00	95·50
Profit on disposal of fixed assets	5·60	12·50	65·00	-	6·50
Net interest payable	(35·20)	(25·00)	(22·50)	(19·50)	(19·80)
Profit before taxation	217·90	182·70	217·70	105·50	82·20
Taxation charge	(62·50)	(51·20)	(65·00)	(25·20)	(21·20)
Profit for the financial year	155·40	131·50	152·70	80·30	61·00
Dividends declared	(38·50)	(32·50)	(28·55)	(18·50)	(16·50)
Profit retained	116·90	99·00	124·15	61·80	44·50
Balance sheet					
Intangible assets – goodwill	171·85	-	-	-	-
Investment properties	465·00	465·00	449·50	187·30	175·30
Other fixed assets	225·00	179·50	145·00	132·70	132.70
Net current assets	935·50	705·55	595·00	438·50	345·20
Non-current creditors and provisions	(40·50)	(15·10)	(16·50)	(25·00)	(21·50)
Capital employed	1,756·85	1,334·95	1,173·00	733·50	631.70
Represented by:					
Called-up ordinary share capital	240·00	240·00	240·00	150·00	150·00
Share premium account	425·00	425·00	425·00	235·50	235·50
Revaluation reserve	161·00	161·00	108·05	72.20	72·20
Profit and loss account	480·85	363·95	264·95	140·80	79·00
Shareholders' funds	1,306·85	1,189·95	1,038·00	598·50	536·70
Long-term debt	450·00	145·00	135·00	135·00	95·00
	1,756·85	1,334·95	1,173·00	733·50	631·70
Statistics					
Number of shares in issue at year end (millions)	480·00	480·00	480·00	300·00	300·00
Basic earnings per share	0·32	0·27	0·32	0·27	0·20
Dividends per share	(0·08)	(0·07)	(0·06)	(0·06)	(0·06)
Shareholders' funds per share	2·72	2·48	2·16	2·00	1·79
Dividend cover (times)	4·04	4·05	5·35	4·34	3·70
Debt : debt + equity	25·61%	10·86%	11·51%	18·40%	15·04%
Interest cover (times)	7·03	7·81	7·79	6·41	4·82
Profitability (profit before tax/turnover)	8·22%	9·87%	13·42%	7·28%	6·82%

Five-year financial summary for LinMel Inc

	2003	*2002*	*2001*	*2000*	*1999*
	$ million	*$ million*	*$ million*	*$ million*	*$ million*
Profit and loss account					
Group turnover	1,352·20	1,150·20	952·25	1,250·20	1,050·20
Group operating profit	235·00	184·03	142·84	225·04	178·53
Profit on disposal of fixed assets	0·00	0·00	25·30	0·00	0·00
Net interest payable	(28·00)	(28·00)	(22·50)	(22·50)	(22·50)
Profit before taxation	207·00	156·03	145·64	202·54	156·03
Taxation charge	(53·82)	(40·57)	(37·87)	(52·66)	(40·57)
Profit for the financial year	153·18	115·46	107·77	149·88	115·46
Dividends declared	(105·20)	(46·19)	(43·11)	(59·95)	(46·18)
Profit retained	47·98	69·27	64·66	89·93	69·28
Balance sheet					
Fixed assets	778·50	710·41	527·91	433·50	354·66
Intangible assets	52·50	50·00	50·00	45·00	45·00
Net current assets	192·87	216·16	227·46	237·43	228·62
Non-current creditors and provisions	(9·24)	(9·92)	(8·00)	(8·22)	(10·50)
Capital employed	1,014·63	966·65	797·37	707·71	617·78
Represented by:					
Called-up ordinary share capital	125·00	125·00	125·00	125·00	125·00
Share premium account	115·00	115·00	115·00	115·00	115·00
Revaluation reserve	25·00	25·00	25·00	0·00	0·00
Profit and loss account	399·62	351·64	282·37	217·71	127·78
Shareholders' funds	664·62	616·64	547·37	457·71	367·78
Long-term debt	350·00	350·00	250·00	250·00	250·00
	1,014·62	966·64	797·37	707·71	617·78
Statistics					
Number of shares in issue at year end (millions)	125·00	125·00	125·00	125·00	125·00
Basic earnings per share	1·23	0·92	0·86	1·20	0·92
Dividends per share	(0·84)	(0·37)	(0·34)	(0·48)	(0·37)
Shareholders' funds per share	5·32	4·93	4·38	3·66	2·94
Dividend cover (times)	1·46	2·50	2·50	2·50	2·50
Debt : debt + equity	34·50%	36·21%	31·35%	35·33%	40·47%
Interest cover (times)	8·39	6·57	6·35	10·00	7·93
Profitability (profit before tax/turnover)	15·31%	13·57%	15·29%	16·20%	14·86%

Note: The accounts of this US company are laid out in a similar form to those of Arkwright plc for ease of comparison.

Glossary of Terms

Acute hospital

A hospital that offers a wide range of medical and surgical services and procedures for both in-patients and out-patients. Usually also provides accident and emergency services.

Brown-field site

A site that has been built on previously and the old buildings demolished (as compared with a "green-field" site that has never been developed).

Build, Operate, Lease (BOL)

A type of lease arrangement whereby a company or consortium builds and services a facility and leases it to the client (in this case, MGH). Such a deal is usually over a very long period of time, typically 30+ years. Build, Operate, Lease arrangements typically incorporate aspects of both finance and operating leases. A finance lease is where the agreed term of the lease approximates the expected lifetime of the asset. These are often also termed *capital lease* or a *full pay out lease*. An operating lease is usually specific to the purchase of a specific type of equipment and typically there are break clauses in the contract, which can be cancelled much more easily than a finance lease. However, there are usually financial penalties for early termination.

Clinical staff

Staff employed to provide any form of medical or nursing treatment, including dentistry and midwifery.

Completed treatment

Successful or terminated treatment or series of treatments for the same complaint. Treatments may be terminated for a variety of reasons; for example a patient chooses to discontinue treatment or treatment is having no beneficial effect.

Efficiency adjusted annual cost savings

The reduction in operating costs (excluding staff costs) of providing an equivalent number of comparable treatments (compared with the current organisational configuration) directly attributable to improvements in efficiency of service.

Full-time equivalent

Staff numbers are expressed in full-time equivalents, as MGH employs a number of part-time staff. For example, an employee who works half of the hours of a full-time employee is half a full-time equivalent.

Health provider

Any hospital, clinic or surgery, public or private, that provides any type of healthcare.

In-patient

Patients who are allocated a bed and stay in the hospital for at least eight hours for treatment. In-patients do not necessarily stay overnight.

Out-patient

Patients who have short consultations or series of consultations with clinical staff and do not require the allocation of a bed.

Treatment and treatment episode

Any medical or surgical procedure or series of procedures for the same complaint.

End of the pre-seen material