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The Need for Financial Information Systems in the NHS: Issues and Developments.

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1.0 Introduction

A freeze on manpower levels means that the new geriatric care policy cannot be implemented and surgical waiting lists continue to grow as valuable acute beds remain blocked. The auditors report that the theatre facilities in the district are under-used, wasting expensive nursing staff time. One consultant steadfastly refuses to change his prescribing habits causing the pharmacy budget to greatly overspend its allocation. How are the revenue consequences for a local appeal's donated medical equipment to be found? These problems and more can be repeated for any district health authority but the financial information needed to estimate costs involved and to allow for effective planning and control of expenditure just does not exist at the level of detail and immediacy required. The kernal of the problem lies in the fact that responsibility and accountability for expenditure are not closely linked: clinicians are not directly accountable for their spending. This, along with other problems in information quality and its perceived value, had lain dormant for many years only to have been exposed harshly by the reaction of recent governments to the rising cost of the NHS and the steps they have taken to contain it. Apart from cutting back on funding this has also taken the form of detailed investigations into just what is needed to improve NHS efficiency from an information and administrative standpoint. Thus the Royal Commission (1978) recommended a major reassessment of information requirements, amongst other things, which the Korner committee (Steering Group on Health Services Information (1982)) was then set up to study and whose proposals are now being instigated (DHSS 1984). An administrative tier was removed and, acting on the recent advice

of the Griffiths Inquiry into NHS management, health authorities now have to appoint general managers who are supposed to act as a focus for the decision making process (DHSS 1984). If this is to have any chance of working it must be backed up with improvements in financial information and its more effective use in guiding resource allocation in the NHS, especially for the acute hospital sector which is the largest consumer of revenue resources (60% annually). A comprehensive financial information system is now seen as a priority rather than an academic exercise.

In this paper some of the problems facing the efficacy of such systems are outlined in terms of concept, as explored in section 2, and in practice (section 3). This is followed by an outline of the development of the costing system in the NHS since nationalisation (in section 4) and an examination of the current system and its inadequacies (section 5). Finally the prospects for future development are considered in section 6.

2.0 Issues affecting financial information system development

A good budgeting system backed up by reliable costing information is an established principle throughout industry. It enables progress towards set targets to be monitored and efficiency to be reviewed. The NHS, however, has traditionally operated outside this sphere of the economy for reasons stemming both from the nature of the services it provides and the environment in which it has operated in the post-war period. We shall return to the latter in the next section; here attention is focused on more general issues affecting the operation of costing and budgeting systems at the hospital level.

The difficulties start with trying to define the nature of health service outputs; just how is the improvement of the an

individual's health status to be measured? This remains an open area of research and the absence of any definite conclusions has forced the measurement of costs and the setting of budgets to focus instead on inputs to health care. This, in turn, has influenced the subsequent design of costing systems. Another major consideration is that of responsibility for expenditure which immediately brings up the concept of clinical freedom. The NHS is unique among major organisations in that its principal users of resources are not directly accountable for their expenditure. Clinicians, and here consultants are usually singled out for attention because, as clinical team leaders, they are ultimately responsible for patients in their care, have the clinical freedom to prescribe the treatment that they will receive. There are, of course, realistic constraints on this freedom which are implicitly recognised but even within these there are many opportunities for clinicians to upset internal hospital budgets by carrying out treatments which to them are clinically desirable and not obviously overstepping the bounds. Internal budgets are held by departments servicing the clinicians' needs such as pharmacy, radiology and nursing staff. This arrangement, arising from the long tradition that doctors get on with the curing and leave the administrators to handle the management of facilities, was entrenched by the first costing system. It employed a "subjective" classification of expenditure which related expenditure to subject headings such as salaries, drugs and dressings, catering supplies and so on. Unfortunately this obscures the fact that within a hospital some specialties place heavier demands on certain services than others. As long as there was reasonably generous funding for the NHS as a whole, however, these information inadequacies of the system did not seem to matter. Budgets were worked on an incremental basis; i.e.

essentially the same funding as the previous year plus an allowance for expansion and development. This was regarded as standard practice and meant that as a result detailed costings had little perceived value. Although it was recognised as long ago as 1952 that this was not the best way to proceed in developing an accounting system it was not until 1974 that functional budgeting, a much better approach, was formally adopted. This attempts to relate expenditure more closely with line responsibility in management. Thus, for example, all expenditure related to a district's works department: salaries, equipment, materials, utilities, etc., come under the responsibility of the District Works Officer, or equivalent, who is allocated a budget to meet these expenses. This type of budget management works suits general service sectors better than direct treatment sectors because, where the latter are concerned, the direct involvement of clinicians in setting and adhering to a budget is still excluded. Specialty budgeting, allied with more detailed specialty costing, is now advocated as a way of overcoming this problem and recent developments in this are examined later.

3.0 The need for financial information systems in the NHS

Costing systems have not been developed in an administrative vacuum but have changed in line with attitudes to their usefulness over the years. In the past 10 years, for example, economic recession has led successive governments to review their strategy of funding the public sector meaning, for the NHS, an increasing emphasis on growth through greater cost efficiency in the use of existing resources rather than their constant volume addition. Whether or not this course of action is justifiable has

provoked much debate; its relevance here is confined to the fact that it has provided the catalyst for recent fundamental changes in managing the NHS making the requirments for detailed financial information and closer accountability of expenditure a high priority. Previously this was attempted largely through ministerial exhortation but that has never been really effective and its failure has prompted tougher financial sanctions in recent years. Cash limits on expenditure in the NHS were introduced in 1976 and since then real annual growth in revenue funding has dwindled to the point where some authorities find it barely possible to maintain existing levels of service let alone develop new ones. This has been exacerbated for authorities in the south-east in particular as measures introduced in the mid - 1970s to allocate resources more equitably among the regions and away from this part of the country have begun to take effect.

Although government concern over the cost of the NHS is not a new phenomenon (within five years of its inception it was already undergoing scrutiny by the Guillebaud Committee into whether or not its expense was justified Report of the Committee of Inquiry, 1956)) it had never previously backed this up with any drastic measures to curb expenditure. There were several reasons for this. An expanding post-war economy meant that money could usually be found for increasing health service provision without too much difficulty, especially in view of the widespread popular and political support it enjoyed. Following the report of the Guillebaud Committee, which found in favour of the NHS, a more positive approach to funding the health services prevailed. The 1962 Hospital Plan, for example, saw the launching of a massive capital expansion plan focusing particularly on the development of the acute hospitals and the technical progress of medicine in

that sector. The consequence of this in later years, of course, was a needs for large increases in revenue funding to support these services; a factor not adequately taken into consideration at the time. Clinical advances were not matched by similar advances in the accounting structure but as long as the money was there and the end of year accounts balanced the problems of measuring hospital output and being seen to be putting a price on health could be conveniently side-stepped. It did not seem to matter that only lip-service was paid to the needs for comprehensive financial management. Although the need better accounting frameworks were recognised early on, short term considerations of cost of implementation and disruption to existing administrative practices appear to have been the bases on which initial objections to the proposals won the day. The problem then became one of inertia with the innate conservatism of the NHS bureaucracy forming an effective resistance to accounting improvements for many years. Unfortunately this attitude was self-reinforcing; the more cost information was seen to be ineffective, the less people were concerned in implementing it. The inevitable consequence of that was that when the squeeze on resources came, the NHS was in no position to meet the demands that were suddenly placed upon it for the quality of cost information necessary for detailed monitoring and controlling of expenditure. The familiar tales of crisis management which have emerged in recent years tell their own story.

4.0 Development of the costing system

Prior to their nationalisation the majority of hospitals were either voluntarily maintained or the responsibility of local authorities. This fragmented and unco-ordinated management structure meant a piecemeal development of financial information systems which existed only on an elementary basis in the first place. Most voluntary hospitals, for example, based their accounts on a structure originally devised in 1869 - the "Uniform System of Hospital Accounts". The newly established NHS required more uptodate methods and, accordingly, in 1948, a uniform financial accounting system was introduced. Unfortunately, although provision existed for cost accounts to be kept from the outset, they were not immediately introduced and the focus placed instead on mechanically accounting for overall expenditure rather than any more creative approach which costing information would have enabled. A gap of two years ensued while Bevan, the Minister of Health, left it up to a committee of regional and hospital treasurers to provide proposals for a costing system. In 1950 an Interim Report appeared, the main conclusions of which were introduced later the same year (Min. of Health, 1950) This, the "Interim" system as it became known, was intended as a temporary measure but it ended up remaining in operation for the next seven years. Cost accounts were organised subjectively and hospitals were classified into 19 "types" for comparitive purposes. The focus was on inpatient costs with only crude notional adjustments for outpatient expenditure (five outpatient attendances being reckoned the equivalent of one inpatient.)

The 1950s witnessed a flurry of research into costing systems. The Nuffield Provincial Hospitals Trust (NPHT) had already been

doing some experiments into hospital costing when the Minister commissioned them, together with the King's Fund, to prepare a joint report on what they considered would be the best form of costing system. Their reports (King Edward's Hospital Fund for London 1952; NPHT 1952) recommended that costing should be done on a departmental basis although they disagreed on the scope it should take and on how costs should be measured. Interestingly, the King's Fund regarded budgeting, hitherto given no attention, as an equally important concept for development along lines similar to costing with costs themselves being being considered in terms of actual versus budgeted expenditure rather than simple comparisons of totals. The NPHT differed from this view, preferring instead a "standard costs" approach where the cost at a given hospital would be compared with a selection of hospitals chosen as a national "bench mark" of costs. Both were agreed that departmental costing and budgeting were an "essential step" in the development of a useful costing system for the NHS. The proposals contained in the report were clearly too radical, however. The government was already alarmed at the burgeoning cost of the NHS (it had just set up the Guillebaud Committee to enquire into its running costs) and it was obviously not prepared to meet the expense and trouble of the Joint Report recommendations. The Minister took no immediate action on the report and, instead, after consulting with hospital authorities he concluded that such a change "... would not be practicable...". Instead time was bought by the setting up of a Working Party in 1953 with the following terms of reference:

"To devise a system of costing the departments and services of a hospital within the framework of a subjective accounting system... with full regard to the present needs to limit the cost in money and manpower of introducing and operating such a system

to the minimum... (Min. of Health, 1955).

The Working Party reported in 1955 with proposals for a 2-tier costing system specifically designed to minimise the strain on hospital administration. It comprised the "Main Scheme" - large hospitals with expenditure in excess of 150000 per year and expected to produce full accounts - and the remainder which were only expected to produce unit costing for selected departments. Those hospitals on the main scheme (and there were 221 of them when it was introduced in 1957) were to produce costs over all wards with departments being divided into three main groups; patient services, medical services and general services. A better attempt was also made at calculating the actual costs of treating outpatients. Day cases were also accounted for for the first time and costs per case introduced as a basic unit of costing. It was also intended to introduce some experimental ward costing schemes but nothing came of it and it remained another of those concepts ahead of its time; it was not for another 20 years that any major cost trials of this type were undertaken.

The Working Party recommendations were put into practice (Min. of Health 1957) amidst high hopes that cost statements might be produced at more frequent intervals than the statutory annual period and that authorities would take advantage of their freedom to extend the Main scheme to other hospitals as they saw fit. This optimism proved ill-founded, however, as revealed in an interesting account of the first 3 years of the system's operation by Montacute (1962). He surveyed officers and members of 144 management committees and boards of governors, examining not only the frequency and speed of preparation of their interim statements but also the attitudes of those involved in their prepation and use. The findings were revealing. Only a third of

them completed returns on a quarterly basis and many fewer than that on a monthly basis. Even more disappointing was the speed at which they were done and the use to which they were put. Only 10% completed interim statements within four weeks and only 2% attempted to make any link between them and departmental budgets, although this, as Montacute noted, was probably as much due to the fact that few formal budgeting systems existed anyway. Despite this it was noticeable that among those authorities which did take the time and effort to complete interim statements 75% of them found they had a positive impact on their management and planning ability.

It was obvious, therefore, that the 1957 system was not working out as expected and still not serving the needs of management information, even if these were not well defined at the time. Insufficient distinction between treatment and non-treatment costs and no integration of cost information with budgeting meant that enthusiasm for costing as a management tool was waning. With the new decade came the Hospital Plan and attention shifted towards capital planning to the detriment of service planning which still lacked a suitable formal structure, particularly in considering financial consequences of actions. Eventually, in 1965, another attempt was under way to revitalise the costing system. Although circular 65(90) (Min. of Health 1965) at last officially recognised that the 1957 system had been only a "partial success", blaming luke-warm management reception and the inadequacy of performance indicators, it was not abandoned completely but given a major revision. Cost statements were streamlined and the system extended to cover all hospitals. The biggest advantage that this brought about was that for the first time reasonably comparable cost information on all hospitals became available. The subjective framework remained, however,

and with it the problem of too little information too late. It was becoming clear, however, that it would no longer be enough to make marginal changes to the cost accounting side of the system in isolation and, as plans to reorganise the NHS were in the air, so the whole accounting system was re-examined. The committee of regional treasurers convened a working party under the aegis of the DHSS to draw up proposals for it taking account of the new administrative system. The result was the Revised Accounting System which was adopted by the DHSS in 1974 and a subsequently amended version of which forms the costing system in operation today (DHSS 1977).

5.0 The Current System

Although functional budgeting has now been introduced and the subjective costing system amended the financial management system is still not in tune with the needs placed on it. Subjective analysis of expenditure remains because it is still necessary for the production of a national, service wide materials and wages price index. This is a classic example of needs being dictated by the central requirements rather than local managerial ones. Costs themselves are produced as an annual statement for each hospital, although it is becoming possible to produce them more frequently and the Standard Accounting System (SAS), a computerised accounts package, which is being introduced, will make this more feasible. In the meantime it is regional aggregations of these statements with hospitals classified by "type" that still form the basis of the annual Hospital Costing Returns (eg. DHSS 1984) and the only basis on which to make comparitive, if highly dubious, judgements on relative hospital cost performance. The expenditure of each

hospital is analysed by subject heading (such as medical staff, pharmacy, and radiography), with a secondary analysis by one of five patient types: inpatient, outpatient, day patient, day case and accident and emergency case (see table I). These figures, obtained from the routine SH3 bed statistics, provide the basic units of cost measurement; cost per inpatient case, per inpatient day, outpatient attendance and so on. In addition there are certain memorandum accounts for activity areas in hospitals which would otherwise fall between several different expenditure headings such as intensive care units and operating theatres. Some of the other primary cost categories also have a set of workload related cost statistics produced at frequent intervals, notably laundries, steam production and utility consumption. Hospitals are still classified into "types", of which there are now 21 (see table II). The inadequacy of this is shown by the fact that multi-specialty acute hospitals are split into 4 groups according only to the number of beds they have and making no allowance for case mix or location. This makes the published statistics for the country a misleading basis on which to make inter hospital comparisons let alone inter regional ones and this problem is compounded by factors ranging from the amount of local discretion allowed in apportioning costs over expenditure headings, to outright errors in coding the basic information. Other difficulties are created by the mismatch of data (for example, patient statistics relate to the calendar year while financial statistics relate to the financial year ending in March), and the absence of useful data; short to medium term planning is not helped by the lack of any distinction made between fixed and marginal costs. The system remains, therefore, incapable of tackling the demands currently being placed on it.

6.0 Future Prospects

In the longer term, into the 1990s and beyond, the aim is to produce patient-based statistics not only on costs but on types of treatment, socio-economic characteristics and other information which will enable a high level of detail and maximum flexibility of cost presentation; by wards, related to patient age or treatment type and other indicators as well as by specialty. There have been a number of patient costing experiments (eg. Harper (1979), Prowle (1981)) but it remains a method for the future - as envisaged by Korner - requiring major changes in routine data collection before becoming fully effective.

In the meantime attention has focused on specialty based costing and budgeting as a first stage in this process and there have been several trial projects undertaken on both. The key difference between specialty budgeting and budgeting as it is currently practised is that the former involves the clinicians themselves in setting out their needs, negotiating what is achievable for a given period and being directly responsible for managing a budget of their own. Projects, such as those undertaken by the CASPR research team have examined the potential of these ideas in practice and how they might be implemented in detail (Wickings et al. 1983). Gaining the co-operation of the clinicians is obviously essential and can be encouraged by letting them retain part of any savings they may make on their agreed allocations for projects of their own. Costing information needs to be seen to be effective so up-to-date statistics reported at frequent intervals are essential if interest and co-operation are to be maintained. There are other operational

factors to be considered too such as whether individual consultants should be budget holders or whether it should involve team responsibility including, for example, senior nursing staff. Another important consideration is whether incremental or zero-based budgeting is adopted. The former is easier to operate because most expenditure is fixed in the medium term - especially salaries which usually form the largest single component of any budget - and any changes from one period to the next are likely to be only marginal. Zero-based budgeting, on the other hand, assumes that the budget is to be started from scratch at the beginning of each accounting period and it therefore focuses attention on the need to justify all proposals for expenditure each time round. It is more time consuming to operate in this way but avoids the potential slackness which can creep into the incremental approach over time. Trial schemes currently in progress under the auspices of the DHSS will look in more detail at these sorts of questions. For a more detailed review of several specialty budgeting approaches the reader is referred to Carter (1983).

Specialty costing has tended to be looked at separately from budgeting, with the result that often fails to stress their inter-dependence for financial management as a whole. Several approaches have been developed; some using existing data sources, others requiring special data collection. Regression techniques, based on existing data sources, are the best known and most widely used. Quite sophisticated models have now been developed including a version which can differentiate between costs dependent on the number of cases treated and costs dependent on the size of the facility (Bailey and Ashford, 1984). Others include those by Coverdale, Gibbs and Nurse (1980), used by the

DHSS in regional resource allocation, and Ashford, Butts and Bailey (1980). The cost accounting approach, on the other hand, provides more detailed information than regression methods but at the expense of time and the need to set up a special data collection system for the hospital or unit being investigated. Nevertheless important work has been done here by Magee and Osmolski (1978); the results of which have been transferred to other hospitals for further trials (Hillman and Nix, 1983). It also forms part of another modelling approach, otherwise largely based on existing data sources, which is currently under development at Leeds (Forte and Wilson, 1985). Again, for a more detailed review of the various specialty costing models which have been developed in Britain in recent years - and not without controversy - the reader is referred to Forte (1985).

Financial management and information systems are entering a new phase of development. Long overdue changes are being made and for the first time the importance of having reliable costing and budgeting is being realised by more than just a handful of committed people. Hindsight shows that much of the current confusion in planning and allocating resources could have been avoided many years ago by more careful attention being paid to this. As it is the NHS has to live with the mistakes of the past for several years to come; at least until some of the Korner proposals come into operation. In the meantime progress can be made, chiefly through specialty costing and budgeting. Not only can these methods provide more of the right management information but they also have the potential to break down the traditional barriers between administrators and clinicians which have no rightful place in a caring health service.

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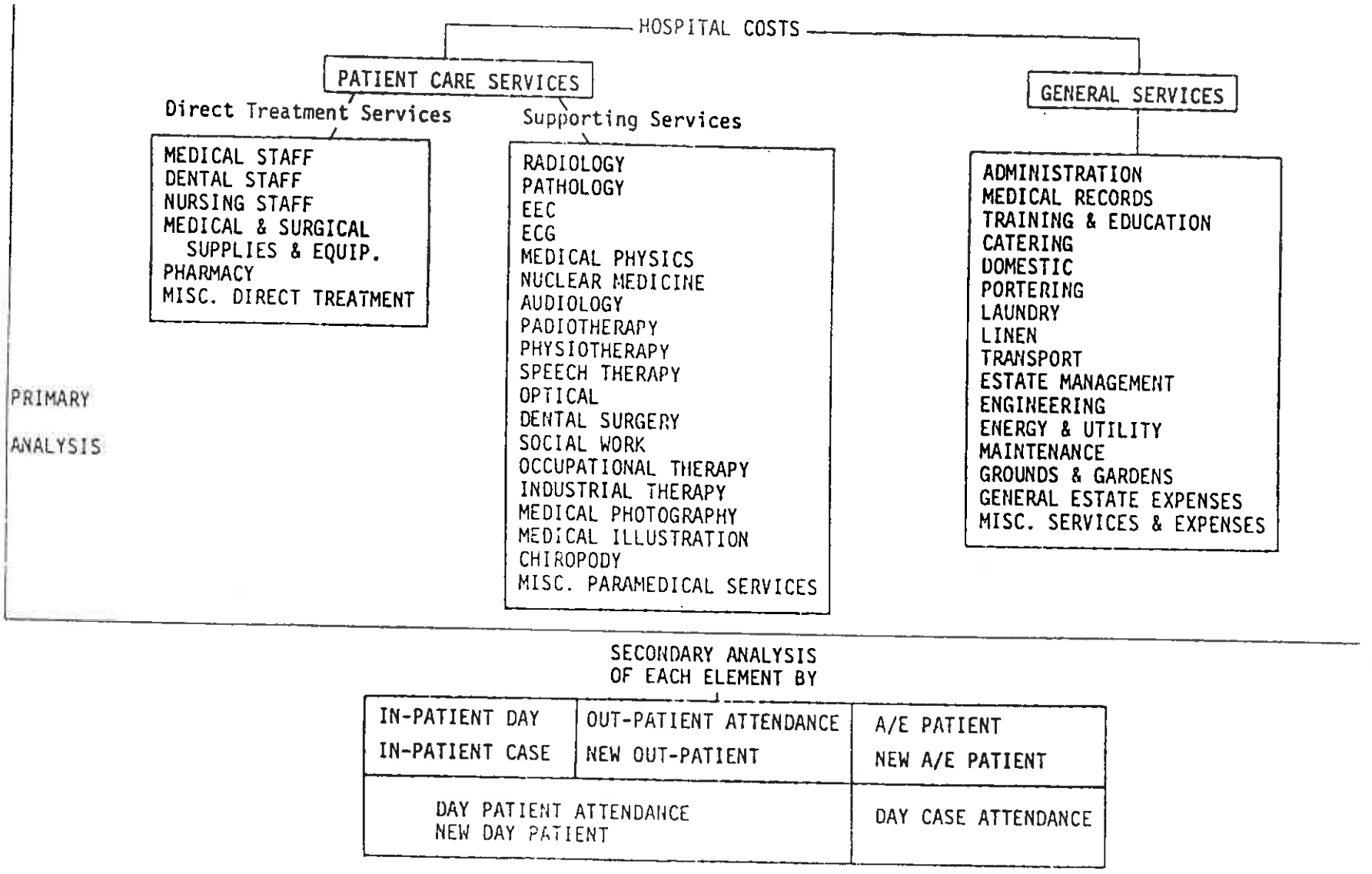

TABLE I : Current Costing System: Primary and Secondary Analysis Headings.

TABLE II : NHS Hospital Classification.

All hospitals are classified for costing purposes into one or other of a series of standard types which reflect the principal use to which their beds are allocated. The types currently in use and the corresponding definitions are shown in the following table.

Type of Hospital					
1	Acute	Hospitals with not more than 15 per cent of their beds allocated to the "excluded departments".	11	Maternity	Hospitals (including General Practice Maternity Hospitals) with 90 per cent or more of their beds allocated to obstetrics.
2	Mainly Acute	Hospitals with more than 15 per cent and up to 40 per cent of their beds allocated to the "excluded departments".	12	Psychiatric (Mental Illness)	Hospitals with 90 per cent or more of their beds allocated to mental disorder and 50 per cent or more of the psychiatric beds allocated to mental illness.
3	Partly Acute	Hospitals with more than 40 per cent and up to 60 per cent of their beds allocated to the "excluded departments".	13	Psychiatric (Mental Handicap)	Hospitals with 90 per cent or more of their beds allocated to mental disorder and more than 50 per cent of their psychiatric beds allocated to handicapped and/or severely handicapped patients.
4	Mainly Long-Stay	Hospitals with more than 60 per cent and up to 85 per cent of their beds allocated to the "excluded departments".	14	Orthopaedic	Hospitals with 90 per cent or more of their beds allocated to traumatic and orthopaedic surgery, including bone and joint tuberculosis.
5	Long Stay	Hospitals with more than 85 per cent of their beds allocated to the "excluded departments".	15	Tuberculosis and Chest	Hospitals with 90 per cent or more of their beds allocated to tuberculosis (both respiratory and non-respiratory) or diseases of the chest (including thoracic surgery) or both.
6	Geriatric	Hospitals with 90 per cent or more of their beds allocated to that one function.	16	Tuberculosis and Chest and Isolation	Hospitals with 90 per cent or more of their beds allocated to tuberculosis (both respiratory and non-respiratory) or diseases of the chest (including thoracic surgery) or both, and infectious diseases.
7	Preconvalescent	Hospitals with 90 per cent or more of their beds allocated to patients who have already received elsewhere the most intensive part of their treatment but who still require active nursing care and medical oversight.	17	Children's (Acute)	Hospitals with 90 per cent or more of their beds allocated as in Type 1 but for children only.
8	Convalescent	Hospitals with 90 per cent or more of their beds allocated to patients recovering from a disability who no longer require active medical supervision or nursing care in bed though they may need such simple nursing procedures as renewal of dressings or the administration of medicines.	18	Eye	Hospitals with 90 per cent or more of their beds allocated to that one function.
9	Rehabilitation	Hospitals with 90 per cent or more of their beds allocated to patients who no longer require nursing care in bed and who, with or without the aid of appliances, can get about and attend to their own needs with occasional assistance but who require remedial and re-educative treatment with a view to their attaining the maximum degree of recovery of use of functions.	19	Other Hospitals	This group covers a variety of hospitals not clearly falling into any of the foregoing types and average costs are not calculated.
			20	Day Hospitals	Hospitals with no residential facilities.
			30	Hospital Clinics	Hospital-based clinics with no facilities for resident or day case patients.
10	Isolation	Hospitals with 90 per cent or more of their beds allocated to infectious diseases.			

Notes 1. "Excluded departments" referred to in the above definitions are those used for mental illness, child psychiatry, adolescent psychiatry, mental handicap, diseases of the chest, units for younger disabled and convalescence (including rehabilitation but not pre-convalescence).

2. In the tables that follow, acute hospitals have for greater accuracy been sub-divided into 4 size bands, viz: Over 300 beds, 101-300 beds, 51-100 beds and 1-50 beds.