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*Costing, Funding and Budgetary Control in UK Hospitals:
An Historical Reflection*

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An Historical Reflection**

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Costing, Funding and Budgetary Control in UK Hospitals: An Historical Reflection

Abstract

This historical reflection traces the changes in accounting practice in UK hospitals, focussing on costing, funding and budgetary control. The paper finds that, contrary to many implicit assumptions in academic accounting studies, our accounting ancestors promoted, and sometimes used, accounting data in pursuit of similar objectives to those advocated in the 21st century. For example, cost comparison information, often prepared with the aim of rewarding 'efficient' hospitals, is a particular feature of accounting practice throughout the last hundred years. This cost information 'evolved', within its historical context, although the process of establishing standard costs was slow and controversial, and the use of such information for funding hospital activity was avoided. The paper also argues that information for control, particularly budgetary control, was central to the nationalised service, and achieved its primary aim of limiting expenditure (Lapsley, 2001a). Finally it is suggested that the devolution of financial control to lower level managers, was a slow but significant process often overlooked in the accounting literature.

Key Words: hospital history, accounting change, costing, budgeting.

Introduction

This paper provides a historical overview of the provision of accounting information in UK hospitals from 1893-2003, exploring the changing role and nature of accounting practice, particularly for control, costing and funding. The aim is to provide a historical reflection that 'supports contemporary research in policy-making and practice' and to 'acquaint accountants with the ideas, experiments and lessons that constitute our heritage' (Previts *et al.* 1990. p.3).

A number of authors argue that public sector accounting history is limited, certainly when compared to our knowledge of private sector enterprises (Parker, 1993; Carnegie and Napier, 1996). Within UK Local Authorities or Municipal Corporations this neglect has been partly filled by the work of Jones (1992) and Coombs and Edwards (1993; 1994; 1995). In UK healthcare there have been histories tracking the origins of depreciation accounting (Mellett, 1992), the wider societal drivers of accounting change (Jones and Mellett, (2007) and the move to departmental costing in the early NHS (Robson, 2003). In US hospitals, Preston (1992) traced the '*emergence and transformations of discourses on costs and practices of accounting*' and Scott et al (2003) explored the rotation between cash and accrual accounting in Australian hospitals.

Carnegie and Napier (1996) suggest two possible reasons for the 'historical imbalance' (p. 26)' between private and public sector accounting research. Firstly, it 'may reflect the bias towards financial reporting and the activities of professional accountancy ...', (p.26) and secondly, that accounting history is dominated by the use of 'economic models of decision making based on notions of profit maximization...to explain the emergence and development of accounting methods' (p.26). While the absence of the profit motive may indeed explain why public sector accounting histories are relatively rare, it is possible to take issue with the suggestion that public sector institutions do not utilise economic models to drive decision-making, and, indeed, accounting change. For example the numerous calls to improve 'efficiency' in the public sector are often accompanied by the mobilisation of accounting information, which could be interpreted as an 'economic-rationalist' justification for change (Hopwood, 1984; Perrin, 1988).

A number of authors argue that the creation of the 'internal market' for healthcare in the 1990s was a driver of accounting change (Ellwood, 1990; Broadbent *et al.* 1991; Gray and

Jenkins, 1993; Chua and Preston, 1994). However, it could be argued that the accounting changes associated with the internal market were part of a long history of the development of accounting practice, and the impression that these reforms heralded a 'quantum leap' is an over-simplification. The paper seeks to assess this claim and to challenge a number of other assertions, or 'conventional wisdoms', about hospital accounting practices. These can be broadly summarised:

- Prior to 1979 accounting within the hospital sector was primarily concerned with its treasury function rather than the provision of information for managerial decision-making (Hopwood, 1984; Perrin, 1988; Broadbent and Guthrie, 1992).
- The NHS was a slow adopter of new accounting technologies (Mellett, 1992).
- Accounting tended to be inadequate for the large modern (i.e. post 1960) hospital (Bourn and Ezzamel, 1986; Perrin, 1988).

The paper first undertakes a chronological examination of accounting change from the introduction of uniform accounts in 1893 to the costing of Healthcare Related Groups [HRGs] in the late 1990s. It draws from the accounting academic literature which is supplemented by reference to government publications, accounting practitioner journals and public records. A wide ranging discussion follows and the paper then presents some conclusions.

The Uniform System of Accounts ~ from 1893

Before the 'nationalisation' of UK hospitals in 1948 most UK acute hospitals were part of the voluntary sector, with each hospital a separate legal entity, governed by a local board elected from subscribers (Stone, 1924; 1936; 1953) and funded from a variety of sources. In the 1890s these sources were predominately donations and subscriptions, although a small amount, around 9 % of total income (Burdett, 1901), was received from what was referred to as hospital funding institutions, charities set up to fund hospitals. Waddington (1995; 1996) refers to this as 'indirect philanthropy'.

In 1893 the *Uniform System of Accounts* was published by Sir Henry Burdett (Burdett, 1893; 1916; Rivet, 1986). Similar accounting systems were also advocated by other charitable reformers, most notably the Charity Organisation Society (Robson, 2006). Burdett's uniform accounts itemized expenditure by type, e.g. provision costs [food and drink], drugs and nurses wages and this was later described as the; *subjective analysis* of expenditure. In the

1916 edition of Burdett's accounts, there were over 50 classifications of expenditure and hospitals were required to produce statistical tables detailing information on the number of beds available, and number of in- and out-patients.

This financial and statistical data was combined to provide unit-cost information, most importantly 'average cost-per-bed occupied' and was published annually by the Kings Fund [for hospitals in London], and for most large hospitals in the UK in the publication *Burdett's Hospitals and Charities* (Burdett,1901; Rivett, 1986; Prochaska, 1992; Robson, 2006). This was a major source of information, including data on income sources, expenditure and cost-per-bed. In recognition of the different cost characteristics associated with institutions they were grouped by hospital type, for example, London hospitals, with and without medical schools, and provincial hospitals, with and without medical schools. Indeed the extensive performance measurement information collected and presented would not be out of place in the league table culture of the 21st Century.

It is difficult to assess how this information was used and what effect it may have had on hospital performance. Social reformers, such as Burdett and some of the funding institutions, saw the accounts as a means of 'judging' performance and rewarding 'efficient' hospitals with increased grant income (Rivett, 1986; Prochaska, 1992), although the author has not seen any evidence to confirm that the 'threat' was implemented. Certainly cost-per-bed data represented an early attempt to use a standard cost unit to compare hospital performance and reward those institutions considered efficient by increased funding. During World War II cost-per-bed information was used by the Government to fund voluntary hospitals for treating casualties (Titmuss, 1950; Abel-Smith, 1964); a development which represented a direct link between the use of cost information and hospital funding (PRO: MH 137/13).

Subjective Budgets and Control ~ from 1950

After hospital 'nationalisation' in 1948 and the creation of the NHS, the UK was divided into 19 Regional Health Boards [RHBs], and, within each, there were a number of Hospital Management Groups [HMGs] reporting directly to their respective RHB. Hospitals with undergraduate medical schools [teaching hospitals] were managerially responsible to the Ministry of Health and not to the RHB (Acton Society Trust, 1955). The scale of the change

was obviously enormous and is illustrated by the fact that, in England and Wales, 2,800 hospitals were brought under control of the State (Acton Society Trust, 1955).

The groups consisted of a number of hospitals in a geographic area, and the formal decision-making body at this level was a board of management, referred to as the Hospital Management Committee [HMC]. This organisational structure, Bevan [Minister of Health] argued, would give local bodies ‘substantial executive powers, subject to broad financial control, and so prevent rigidity’ (PRO: CAB 129/3, quoted in Klein, 1995. p.18). The production of detailed costing information was a high priority and Bevan ‘proposed to introduce a system of comparative costing which would in their view, be one of the most effective ways of checking extravagance’ (PRO: CAB 128/5. p.22).

Indeed the early years of the NHS, 1948-1950, were characterised by controversies concerning overspending (Guillebaud, 1956; Klein, 1995; Webster, 1998) and the lack of financial control. In 1950 Sir Cyril Jones (see Klein 1995. p.44; PRO CAB 134/518), a senior civil servant, conducted an *‘inquiry into the financial workings of the service’*. The subsequent report provides useful insights into budget setting and control, and the use of costing information during the first two years of the service. Jones was critical of budgetary controls, which relied on annual estimates, submitted by hospitals to Regional Health Boards, and then aggregated for submission to the Ministry. Budgets, at hospital level ‘...emerge showing considerable increases under all or most heads of account and are then forwarded to regional boards’ (PRO CAB 134/518, p.7). While at regional level Jones argued that differences in checks on the estimates varied between the ‘widest possible extremes’ (p.7).

Following these concerns about financial administration the Ministry issued a circular (Ministry of Health, RHB 50-16) which stated that budgets for 1950/51 were to be tightly controlled, with hospital management committees required to send monthly returns to the Regional Hospital Board and the Ministry, highlighting expenditure against budget (Hospital, June 1950). This internal budgetary control device was referred to as the: *AGD 303, Comparison of Expenditure with Approved Budget* and compared cumulative expenditure [for each Hospital Group] with the proportionate part of the budget to date, using the subjective headings [similar to the uniform accounts]: salaries and wages, provisions, staff uniforms and drugs and dressings (Rigden, 1983). This allowed an element of control via the Department of Health over the Regional Health Authorities and Hospital Management Committees. In

addition to cementing vertical command (Klein, 1995) this also provided a form of budgetary control for each Hospital Management Committee.

Departmental costs ~ from 1958

While the AGD 303 used a subjective analysis to achieve budgetary control there was also an extensive debate, stretching from 1948 to 1956, on the possibility of introducing budget and costing data, based on hospital departments (Guillebaud, 1956; Forte, 1986). The drivers of the move to departmental information were examined by Robson (2003) and can be traced to the influence of changes in accounting practice in the US (Preston, 1992) and to the advocacy of a pressure groups outside the service, particular the Nuffield Trust (1952) and Kings Fund (1952). Although these pressure groups advocated the introduction of departmental budgets this was rejected by finance managers within the service (Ministry of Health, 1955; Robson, 2003). Instead of monthly departmental budgetary control information, annual departmental costing was introduced on a full costing basis, with comparative information produced for each RHB.

Two studies attempted to evaluate the costing scheme; one by a hospital finance director (Montacute, 1962) and the other by a civil servant (Walker, PRO T227/1545). These were generally supportive of the scheme although both suggested that very little use was made of the information by the Department of Health. In addition, practitioner journals, *The Hospital* for managers, and *Hospital Service Finance* for finance officers, suggested that the costs produced were difficult to compare, due to reallocation processes and differences in case-mix which made 'like for like' comparison difficult (Feldstein see PRO, MH 148/38).

In the 1960s, and the planning explosion (Barnard, 1974) associated with the Plowden Report (Treasury, 1961), there was a renewed attempt to find a more 'rational' basis for agreeing hospital budgets, based on the concept of a standard departmental cost. A working party on revenue allocation, set up in 1961, attempted to establish departmental norms or standards, although the use of cost norms for resource allocation did not materialize. Instead the annual departmental cost performance data introduced in 1958 was eventually streamlined in 1966 (Ministry of Health, 1965), with a simplified method of overhead reapportionment and the use of direct, rather than full, departmental costs (Brinley-Codd, 1974).

In this period, 1958-1974, there was also extensive discussion on the need to improve and demonstrate 'efficiency', particularly through the use of Organisation and Methods and improved building design (Harrison, 1988; Klein, 1995; Webster, 1998). However accounting relied on departmental annual costs and the subjective monthly budgets introduced in the early 1950s. Although discussion on standard costs and monthly departmental budgets took place, it was not until the first major reorganisation in 1974 that new accounting technologies were eventually introduced.

Functional Budgetary Control ~ from 1974

The 1974 reorganisation is often seen as the 'high water mark' for 'statism' and 'planning' (Klein, 1995; Jones and Mellett, 2007) which brought with it the necessity of introducing budgets at lower operational levels. The organisational structure created three tiers of management, Regional Health Authorities [RHA] Area Health Authorities [AHA] and Health Districts. The function of the AHA was:

To review and challenge objectives, plans and budgets submitted to it by the Area Team of Officers and the District Management Teams; resolve competing claims for resources between Districts; and agree a plan and budget for each District against which District performance will be assessed.

(Department of Health and Social Security, DHSS, 1972. p.21)

This structure was devoid of any form of general management and was instead 'based on unified management within the hierarchically-organised professions, on representative systems within the non-hierarchically-organised medical and dental professions, and on co-ordination between professions' (DHSS, 1972. p.15).

In addition there was to be a new budgeting system based on hospital functions with functional heads largely corresponding to hospital professions, for example, nursing, pathology and catering. The 'span of control' of these functional heads normally extended beyond individual hospitals and these budgets were therefore not quite the same as the departmental budgets proposed by early accounting reformers, such as the Nuffield Trust (1952) and Kings Fund (1952).

The need to mimic private sector techniques is also evident and Levitt (1976) noted that:

Budgets serve three main functions in commercial organisations - planning, controlling and costing. In the NHS these functions have until recently had low

priority, but with the reorganisation there will be close parallels between commercial organisations and the operation of the NHS (p.183).

The functional budgeting system had its roots in the 1960s. There was a major hospital building programme, which continued the expansion of specialist technical departments and this, in turn, saw the growth in status of the healthcare functionalist (Crossley-Sunderland, 1977). Argent (1969. p.355) notes that between 1948 and 1968, hospital managerial responsibility was transferred from hospital administrators to functional service heads. The movement away from hospital to function-based control was one later commentators found baffling. For example, Bourn and Ezzamel, quoting Drucker, state that ‘functional decentralisation is universally applicable to the organisation of management. But it is the second choice for any but the small enterprise’ (1986. p.57).

After the 1974 reorganisation academic accountants began to take an interest in NHS accounting (Lapsley, 1991) and developed a number of criticisms of what they found. These included the lack of involvement of clinicians in resource allocation, poor ‘responsibility accounting’ processes and inadequate cost information systems (Bevan *et al.* 1980). They suggested that while functional budgets were good for control (Perrin *et al.* 1978; Bourn and Ezzamel, 1986; Lapsley 1991), they ‘were of limited use in contributing to management’s effective use of resources’ (Lapsley 1991. p.336).

RAWP and funding reform ~ from 1976

In the 1970s there was also an attempt to provide more equal healthcare funding throughout the UK with the introduction of the Resource Allocation Working Party [RAWP] formula to distribute additional [growth monies] funds to Regional Health Authorities (Department of Health and Social Security, DHSS, 1976). Each region had a revenue target based on its population, weighted for a number of factors, such as age, sex and mortality rates. Incremental growth monies were to be distributed to those Regions poorest in terms of their resource allocation target.

Prior to RAWP hospitals’ funding was based on their historical claim for resources, although to conclude that this meant 28 years of incremental funding is over-simplistic. Firstly, there was a major hospital building and closure programme in the 1960s. The revenue consequences of these capital schemes was a major issue at this time and the new hospitals

appear to have received their revenue funds according to a formula based on average costs rather than incremental information. Also, between 1948 and 1976 the process of incremental hospital change had the effect of making hospital funding radically different. Many hospitals were rebuilt or closed, there were new medical techniques and with them new departments and staff with different management structures.

Although RAWP attempted to find a formula that would allocate funds more equitably to regions, and ultimately local hospitals, it also introduced a further complication for finance managers. Growth monies were to be based on the 'distance from their RAWP targets' rather than other possible criteria such as efficiency of service provision (Bevan and Brazier, 1985). This may have had the effect of reducing the search for improved accounting data, when all important additional resources were, in fact, reliant on the funding formula. Certainly this change was to further politicise the funding process (Bevan and Brazier, 1985).

It is interesting to note that funding was not based on accounting information but instead statistically adjusted population. Thus, despite a number of suggestions that cost-per-bed, or cost-per-departmental-unit, could be used as a standard cost for resource allocation; the use of accounting for hospital funding was again side-stepped (DHSS, 1976).

General Management and Budgeting ~ from 1983

The emphasis on planning, functional budgeting and equity in resource allocation was superseded in the 1980s by a new general management and cost performance culture. The pivotal event was the publication of the Griffiths Report in 1983 (DHSS, 1983). This report (*NHS Management Enquiry*) strongly advocated the introduction of hospital [or unit] general managers, devolution of responsibilities and more involvement of clinicians in the decision-making process. As with most other reforms within the service, similar ideas on general management had been mooted in the past (Harrison, 1988), for example the 1966 Farquharson-Lang Report (Scottish Health Service Council, SHSC, 1966) recommended the introduction of general managers, but was ignored. The Griffiths Report had political backing and resulted in a proliferation of Unit Managers and further devolution of budgetary control within the organisation to front line managers. Although the District Health Authority [DHA] remained the legal entity it was increasingly Unit General Managers [UGMs], based around hospitals, who were responsible for most operational decisions.

Griffiths also advocated the introduction of management budgets (DHSS, HM(86)34, 1986) to 'involve the clinicians more closely in the management process, consistent with clinical freedom for clinical practice... and a fully developed management budgeting approach' (quoted in Brookes, 1986. p.20). Some saw this as a means to make clinicians 'accountable', although, again, this was a view that had been brewing a while. For example, the Kings Fund's Accounting for Health Report (1973) argue that there was a need 'to devise management procedures for determining and controlling medical policies without impinging on the clinical freedom of the doctor' (Kings Fund, 1973. p.16). Following the Griffiths report a number of pilot hospitals attempted to introduce management budgeting, but, despite a huge amount of spending on IT systems and associated staff costs, the experiment was widely regarded as a failure (Preston *et al.* 1992).

Nevertheless there was, after Griffiths, a reorientation of hospital management towards unit general managers and more involvement of clinicians and 'front line' staff in managerial decision-making (Bloomfield and Coombs, 1992). Many hospitals moved to clinical directorate organisational structures and Pollitt *et al.* (1988) found that budgets were increasingly being delegated within the hospital hierarchy, particularly to Unit General Managers. This was coupled with increased delegation to lower level managers, such as ward sisters (Pollitt *et al.* 1988. p.225) and the transfer of finance personnel from central departments to hospital units.

While much of the academic debate was on management budgeting and, later, resource management, most managerial, financial, medical and nursing staff were focussed on devolving budgets, using existing information systems. This was a simple, and largely neglected, change, which perhaps had longer term significance than the high profile resource management initiative. Lapsley (2001b), in his study of Scottish hospitals argues that although management budgeting and resource management initiatives were largely unsuccessful:

There is evidence that a variant of the initial reform – management budgeting – has succeeded. The specific variant which has succeeded is the use of clinical directors with responsibility for management budgets [i.e. essentially finance-driven, financial information for the management of a directorate]. The evidence of its use is compelling (p.101).

Specialty Costing ~ from 1988

While Griffiths was preparing his report, a *Steering Group on Health Services Information* (DHSS, Körner Report, 1983) was investigating the information needs of the service (Brooks, 1986) and there was a renewed interest in clinical cost information. This steering group, chaired by Edith Körner, recommended new “information sets” for the service and the most important requirement, certainly as far as hospital accountants were concerned, was the introduction of a *Specialty Cost* statement.

Again this was not a new idea; as early as 1965 an economist working for the Ministry of Health (Feldstein, 1965 and PRO, MH148/38) questioned the usefulness of departmental costing data, arguing that it took no account of hospital case-mix and therefore its use for comparison was severely restricted. In the early 1970s Babson experimented with disease costing data and, in a report to the Department of Health, outlined the familiar roles for such information in giving ‘an opportunity to identify areas of inefficiency’ (PRO: MH 166/466, 1971. p.12), and proposed using this ‘standard cost’ information to reward ‘efficient’ hospitals with increased funding (PRO: MH 166/466, 1971. p.13). Academic interest in specialty or case-mix costing (Hurst, 1978) continued in the 1970s with a number of studies on a similar theme (Magee *et al.* 1973; Perry, 1975; Weir *et al.* 1973).

The specialty cost statement implemented in 1987/88 was subsequently produced on an annual basis for each Health District, rather than hospital, and only included patient treatment costs with the number of specialties limited to 19. The subsequent costing data was not published by the Department of Health; rather it was the CIPFA [Chartered Institute of Public Finance and Accountancy] and the HFMA [Healthcare Financial Management Association] who were left to produce a database of comparative information. Interestingly the CIPFA/HFMA publication was at pains to point out the limitations of the data. For example:

The first year’s figures illustrate that there are many teething troubles in the preparation of the district statements. These relate mainly to different interpretation of definitions. The variation in costs produced is too extensive for the figures to be used for valid comparisons. (CIPFA, 1987. p.30)

Wise (1991) examined the data for 1989/90 [the following year] and argues that there were ‘wide variations in costs between authorities’ due to ‘length of stay... accuracy of diagnostic

coding... artificial distinction between the same procedures carried out as an out-patient or as a day case' (p.17-18). In addition Wise identified the difficulty hospitals had in allocating costs to each speciality, caused by poor information systems, and he concludes that 'the allocation of costs between patient type is largely a once-a-year exercise to complete the financial returns, often requiring a large degree of estimation' (p.18).

On the eve of the most discussed reforms, the internal market, hospital management accounting information consisted of unit budgets prepared along functional lines, with some hospitals adopting a clinical directorate structure, and annual information in the form of subjective, departmental and specialty costs.

Costing for Contracting and Capital Accounting ~ from 1990

The introduction of the internal market, with the creation of purchasers and providers, in 1990, has rightly been identified as a time of significant change in the organisation and accounting for healthcare in the UK (Ellwood, 1990; Broadbent *et al.* 1991; Bates and Brignall, 1993; Gray and Jenkins, 1993; Chua and Preston, 1994). The split between purchasers, District Health Authorities and GP Fund Holders (GPFH), and providers [Hospitals and GPFH] was accompanied by the creation of Self Governing Trusts. For accounting the most important changes were the introduction of capital charges and contract pricing (National Health Service Management Executive, 1990; Department of Health, 1991). Contract prices were based on *full cost* including a capital charge, depreciation plus an interest element based on annual revaluations, and these prices were offered to purchasers as part of their contract negotiation.

Ellwood, in a number of studies, examines the effect of 'cost-based pricing' (1990, 1992, 1995, 1996, 2000) on the operation of the 'market' and concludes that 'the nature of the market [most providers locked into contracts with a small number of major purchasers] made sophisticated costing and pricing unnecessary' (2000. p.26). Bates and Brignall (1993), like Ellwood, questioned the notion that increased cost information would improve efficiency and, in addition, suggested that the focus on cost information would impact on traditional relationships in hospitals, particularly between managers and clinicians. They concluded that although 'historically the NHS's organisational culture, underpinned by medical ethics, has

held that providing good quality patient care is paramount and cost is secondary' (p.29) the introduction of contracting will 'superimpose other considerations' (p.33).

In addition to the cost/pricing regime another significant change was the introduction of capital charges. The aims of the reform, like many others, were more 'efficient' use of capital assets and to aid comparison of performance, both within the NHS and with private sector providers (Mellett, 1992). It was partly stimulated by long-standing criticisms of the management of the NHS estate and, perhaps, by the appointment of a keen advocate [Sheila Masters], at the Ministry of Health (Mellett, 1992).

Although it is possible to debate the merits of contract pricing and capital charging, there appears to be little argument that they stimulated renewed interest and indeed investment, via new staff and information systems, in the accounting function in hospitals. However, the difficulties of establishing full, and meaningful, contract costs soon became apparent. This led to renewed interest in establishing appropriate, or more valid, units of measurement or standard costs, and in the 1990s we see a renewed effort to cost clinical activity, using Healthcare Related Groups (HRGs).

Healthcare Related Groups and Reference Costs ~ from 2000

Healthcare Related Groups are treatments that can be grouped together because they are clinically alike and have similar costs (Department of Health, 2000; Jones, 2001). The groups are derived from the International Classification of Diseases and the Office of Population Censuses and Surveys (Jones, 1999; Jones, 2001). Disquiet about the information and costing systems in the early 1990s led to further investment in clinical costing and a new emphasis on HRGs (Jones, 1999). The NHS Management Executive believed a database of comparable HRG costing data would ensure; 'a standardised currency for the acute sector... a more refined language for interaction between clinicians and administrators; and a 'currency' for monitoring contract performance' (Jones, 1999. p.6).

Jones (1999) concludes that, overall, the HRG exercise, perhaps because of the increased involvement/interest of clinicians, had met with a 'measure of initial success' (1999. p.18). Progress in the production of HRG information was slow, with hospitals only producing HRGs for one specialty in 1994/5, but by 1997 the information 'had become more robust and

comprehensive' (Jones, 1999. p.8). However there were still questions as to whether the HRG costs were accurate enough to be used for comparison, as the 'complexity of cost allocations and behavioural overtones associated with costs, may militate against cost transparency' (Jones, 1999. p.11).

The need for an HRG standard cost continued after the election of New Labour in 1997 (Department of Health, 1997). Llewellyn and Northcott (2005) argue that 'the government emphasised 'comparison' rather than 'competition' (p.558) and attempted to use comparative cost data in the form of reference costs that were, effectively, standard HRG costs [referred to as tariffs] as the primary method of 'benchmarking'. In addition they argue that 'the HRG simultaneously creates standardization in hospitals and imposes it' (p.561). Their examination of HRG data suggests that hospitals were pulled 'toward the average' (p.578) and that 'there is... some prima facie calculative evidence that standardisation of clinical practices has played a major part in the trend to the average cost' (p.579). They identified other potential problems in using the HRG [reference costs] data, including the fact that 'it may deter clinicians from meeting the very expensive care needs of particular patient...and constrain innovation through reducing providers' propensity to take risks' (2005. p.580).

Discussion and Reflection

Perhaps the most prominent issue debated within hospital accounting has been: 'what should the cost-unit be? It started as cost-per-bed, and was followed by department, speciality and HRG. Perhaps, as Preston (1992) and Robson (2003) allude to, each cost-unit seemed suitable within its historical context. Cost-per-bed data was appropriate where the majority of hospital costs were of a residential hotel-like nature (Preston, 1992), whereas with high-tech hospital care, and its related costs, one sees the search for more sophisticated costing units, culminating in the HRG. This suggests a gradual evolution of cost information, an increasing numbers of cost-units and more intricate allocation processes. However there was a reluctance to drop previous costing information on the adoption of new data, resulting in a multi-layered approach, for example cost-per-day continued when departmental data was created and departmental information continued after specialty costing data and HRG. *'Continuity and change'* (Edwards *et al.* 1995) appears to be just as prevalent in hospital accounting as in the commercial sector.

Another debate on cost information that stems the long history of the NHS was whether to use full or direct cost information and this again mirrors the wider accounting community (Dugdale and Jones 2004). Cost-per-bed data was prepared using full cost and departmental information started out as full cost but changed to direct. Specialty costs were prepared using direct patient treatment costs, whereas contract prices and HRGs used full costs. Related to this debate was how to account for full costs, Absorption or Activity Based Costing [ABC]. Unlike the academic and accounting professional communities, very little attention appears to have been devoted to this issue within hospital accounting. Perhaps this was because the ABC debate coincided with the internal market changes and ‘change overload’ was already gripping NHS managers, or, more likely in the author’s view, because finance managers already used a multiple cost drivers approach.

Another recurring theme associated with each costing reform was criticism of the accuracy and appropriateness of the previous system. Stone (1924) was critical of the use of cost-per-bed data, and Montacute (1962) and Walker (PRO, T227/1545) draw attention to difficulty in using the enormous volume of information generated by departmental costing in 1958. Wise (1987) questions the use of ‘specialty’ as a cost-unit and its accuracy, while similar criticisms were levelled at contract costing and HRGs (Ellwood, 2000; Llewellyn and Northcott, 2005).

It is important to recognise that hospitals were not introducing simple costing systems and, indeed, the complexity and variety of data produced perhaps caused its own problems. For example, the number of different cost-units or departmental ‘cost drivers’ for 1956 were extensive, and, by the standards of the time, a vast volume of information was produced, although senior managers were unsure of its validity or usefulness (Montacute, 1962).

A frequent ‘rallying cry’ was the demand for ‘standard costs’. This was evident from the proposed use of cost-per-bed information to drive ‘efficiency’ and reward hospitals in the pre-nationalised service. The Nuffield Trust (1952) report on department costs argues that these could be used as a benchmark to compare performance. Babson (see PRO, MH 166/466), in the 1970s, suggested that disease costs could provide standard data and, more recently, costing for contracting and HRG reference costs were promoted as ‘a standardised currency for the acute sector’ (Jones, 1999. p.6). But even into the 21st Century questions still remain about the validity, and indeed the benefits, of using standard cost information in the hospital

sector (Llewellyn and Northcott, 2005). Perhaps the best summary of the problem is provided by Enoch Powell, a former Minister of Health:

Enormous efforts have been lavished during the twenty years of the NHS on the collection of statistics of hospital activity, and on the search among them for the means of making valid comparisons, within the service itself and between services and other systems. It is a search I myself engaged in with the freshness and hopefulness of inexperience, only to be driven into recognising reluctantly that the search itself was inherently futile. The most carefully constructed parallels between one hospital or hospital group and another dissolved on closer examination into a baffling complex of dissimilarities. Every attempt to apply a common standard had the effect of disclosing a deeper level of individual differences and immeasurables (Powell, 1966. p.52).

Closely related to the search for standard costing data is the question of resource allocation or hospital funding. Prior to the creation of the NHS there is some evidence to suggest that hospital reformers wanted to use standard cost comparison data, in the form of cost-per-bed information, when deciding how to allocate funds. In the early years of the NHS, the Nuffield Trust (1952) and Kings Fund (1952) both suggested that a standardised unit departmental cost could eventually provide the basis for revenue allocations to hospitals. By the 1960s the government was promoting *'forward looks'* which were longer term plans suggested by the influential Plowden Report (Treasury, 1961) and a Working Party on Revenue Allocations in 1961, suggests that funding *'norms'* could be established. However, progress on establishing such norms were, at best, *'patchy'*. It was the mid-1970s before hospital funding was to again appear on the political agenda when RAWP attempted to provide more equal funding across Regions. However, the formula for distributing additional funds was based on weighted population, rather than standard cost, and this may have had the effect of reducing efforts to produce and use accounting data as a basis for resource allocation.

While accounting information was by-passed for hospital funding, hospital budgets did prove to be the primary control device and indeed it is reasonable to argue that they dominated the hospital accounting agenda. In addition it would appear that budgetary control was, to use a contemporary phrase, *'fit for purpose'*; certainly in fulfilling the limited aspiration of controlling expenditure. The AGD 303, introduced in the early 1950s survived for over 20

years, being replaced by functional budgeting in 1974 and both methods were successful in controlling costs (Bourn and Ezzamel, 1986; Lapsley, 1991).

More sophisticated control devices that were tried, such as resource management, were however, widely regarded as failures. Attempts to provide information systems with multiple objectives, such as providing information for clinicians, signalling the efficiency of processes and financial control, were beset with difficulties, including problems with IT systems, and limited commitment from both clinicians and finance staff. Nevertheless it is important that these ‘failures’ do not obscure some success in devolving more financial control to lower levels within the organisational hierarchy and moving decision-making closer to those more directly involved with patient care, particularly through the creation of clinical directorates (Lapsley, 2001b).

There were a number of attempts to align budgetary control with the organisational structure of the service, individual hospital, departments, functions and directorates were all, at some stage, the focus for budgetary control information. It is not clear whether the, somewhat slow, devolution of financial control was due to resistance from clinicians or a disinclination on the part of managers and finance officers. Montacute’s (1962) early study of the 1958 costing system found only limited support among finance managers for budgetary devolution and most efforts to increase manager’s financial autonomy were motivated by official reports, such as that by Griffiths (Department of Health, 1983).

Conclusions

In the introduction to this paper reference was made to a number of assertions or ‘conventional wisdoms’ regarding accounting for hospitals. Firstly, the assertion that the introduction of the internal market introduced accounting reforms substantially different from previous initiatives is questionable. In the late 1890s hospital reformers, like Burdett and the funding institutions, had attempted to gather data that would allow them to ‘judge’ the performance of hospitals. While in the early years of the NHS (1948-1954) there was intense interest in departmental accounting. There was a change in the 1960s and early 1970s to a more ‘steady state’ but accounting change was firmly back on the agenda after 1974.

The idea that pre-1979 accounting information was primarily concerned with the treasury function, (Hopwood 1984; Perrin, 1988) tends to ignore the previous reforms that introduced performance measurement and control information. The departmental costing scheme used unit-cost information to compare hospital performance, and the debate on the introduction of departmental budgets also illustrates that a number of groups were advocating financial devices to control hospital entities. While the functional budgeting system introduced in 1974 recognised the new power structures within hospitals, and the increasing dominance of these managers.

There is evidence to suggest that hospitals were 'slow to change' and certainly the gestation periods for accounting reform tended to be long and complex. For example, demands for departmental information began in the mid 1920s, was intensified after 1946 but was only introduced in 1956, with a partial victory for accounting reformers as departmental budgets were not introduced. Budgeting at local functional level took another eighteen years and the reorganisation of 1974.

The idea that accounting technologies were predominately promoted by government is partly borne out by evidence from 1948 onwards. Both accounting practitioners and civil servants were 'lukewarm' in their support for departmentalisation and this remained even after the production of early departmental information in the early 1960s. Indeed accounting practitioners appear throughout to have been cautious, conservative and incremental change reformers.

The final contention that accounting information systems were inadequate for a large scale organisation is debatable. Certainly, early in the life of the NHS, Hospital Management Committees seemed to operate relatively well with simple information systems based around the AGD 303 form for budgetary control. Overspends were contained and healthcare was largely left to medical professionals, with political debate on healthcare change limited. Hospitals historically were smaller, more numerous and local than those introduced with the development of the District General Hospital and therefore perhaps complex costing and control systems were not required.

Institutions funding hospitals, both voluntary and later Government, have always looked towards accounting to fulfil the three functions of measuring financial performance, allocating resources and controlling expenditure. This review suggests that the first two were often

beyond the capability of accounting. However, even though this data may have been 'flawed', it was often all there was, and therefore seen as 'better than nothing'. Financial information for control established itself, after nationalisation in 1948, as the primary task of hospital accountants and the relatively simple systems adopted appear to have served their purpose.

References

- Abel-Smith B. (1964) *The Hospitals 1800-1948 A Study in Social Administration in England and Wales*, Massachusetts: Harvard University Press.
- Acton Society Trust (1955) *Hospitals and the State: hospital organization and administration under the National Health Service*, Vols.1-6, London: Acton Society Trust:
- Argent, A. J. (1969) Is functional management the answer? *Hospital*: October, pp. 354-356.
- Bates K. and Brignall T. J. (1993) 'Rationality, politics and healthcare costing', *Financial Accountability and Management*, Vol. 9, No. 1.
- Barnard K. (1974) 'Health planning – the last of the panaceas, in *NHS Reorganisation, Issues and Prospects*, Barnard and Lees (eds), Leeds: Nuffield Centre for Health Services Studies.
- Bevan G. and Brazier J. (1985) 'Equity and efficiency: clarifying confusion for English acute hospitals' *Financial Accountability and Management*, Vol. 1, No. 2: 173-189.
- Bourn M. and Ezzamel M. (1986) 'Costing and budgeting in the national health service', *Financial Accountability and Management*, Vol. 2, No. 1:53:71.
- Brinley-Codd. R. (1974) 'Costing and efficiency in the health service', *Public Finance and Accountancy*, Vol.1, No. 8: 244-251.
- Broadbent J., Laughlin R. and Read S. (1991) 'Recent financial and administrative changes in the NHS: a critical theory analysis', *Critical Perspectives on Accounting*, Vol. 2: 1-29.
- Broadbent J. and Guthrie J. (1992) 'Changes in the Public Sector: A review of recent 'alternative' accounting research, *Accounting, Auditing and Accountability Journal*, Vol. 5, No.2: 3-31.
- Brooks R. (1986) *An Introduction to Management Budgeting*, in *Management Budgeting in the NHS*, Health Services Manpower Review: Keel: University of Keel.
- Burdett H. C. (1893, 1916) *The uniform system of accounts for Hospitals, Charities, Missions and Public Institutions*, London: Scientific Press.
- Burdett H. C. (1901) *Burdett's Hospitals and Charities, the yearbook of philanthropy*, London: Scientific Press.
- Carnegie G. D. and Napier J. N. (1996) 'Critical and interpretive histories: insights into accounting's present and future through its past', *Accounting, Auditing and Accountability Journal*, Vol. 9, No.3:7-39.
- Coombs H. M. and Edwards J. R. (1993) 'The accountability of municipal corporations', *Abacus*, Vol. 29, No. 1: 27-51.

- Coombs H. M. and Edwards J. R. (1994) 'Record keeping in municipal corporations: a triumph for double entry bookkeeping, *Accounting, Business and Financial History*, Vol.4, No.1:164-180.
- Coombs H. M. and Edwards J. R. (1995) 'The financial reporting practices of British municipal corporations 1835-1933: A study in accounting innovation', *Accounting and Business Research*, Vol. 25, No.98: 93-105.
- Crossley-Sunderland (1977) 'Health administration and the jaundice of reorganisation', in *Conflicts in the National Health Service*, Ed. K Barnard and Kenneth Lee, London: Croom Helm.
- Department of Health (1991) *Costing and pricing*: London: HMSO.
- Department of Health (1997) *The New NHS: modern, dependable*, Cm 3807: London: The Stationery Office.
- Department of Health (2000) *Reference Costs 2000*, Leeds: NHS Executive.
- Department of Health and Social Security (1972) *Management Arrangements for the Reorganised National Health Service*, London: HMSO.
- Department of Health and Social Security (1976) *Sharing Resources for Health in England*, Report of the Resource Allocation Working Party, London: HMSO.
- Department of Health and Social Security (1983), *NHS Management Enquiry* (The Griffiths Report), London: HMSO.
- Department of Health and Social Security (1984) *Steering group on health services information: Sixth Report to the Secretary of State*, report chairman, Körner E, London: HMSO.
- Dugdale D. and Jones C. (2003) 'Battles in the costing war: UK debates, 1950-1975, *Accounting, Business and Financial History*, Vol. 13, November: 305:338.
- Edwards J. R., Boyns T. and Anderson M. (1995) 'British cost accounting development: continuity and change', *The Accounting Historians Journal*, Vol. 22, No.2: 1-41.
- Ellwood S. (1990) 'The role of cost information under managed competition', *Management Accounting*, London: CIMA.
- Ellwood S. (1992) *Cost Methods for NHS Health Care Contracts*. CIMA: London.
- Ellwood S. (1995) 'NHS costing for contracting', *Public Money and Management*, April-June: 41-47.
- Ellwood S. (1996) 'Pricing services in the UK national health service', *Financial Accountability and Management*, Vol. 12, No. 4: 281-301.
- Ellwood S. (2000) 'The NHS financial manager in 2010' *Public Money and Management*, Vol.20, No.1, January-March: 23-30.

- Feldstein, M. S. (1965) Studying hospital costliness, *Hospital Service Finance*, January, pp. 3-17.
- Forte P. (1986) 'The development of accounting systems in the NHS', in *Management Budgeting in the NHS*, edited by Ray Brooks, Health Services Manpower Review, Keel, Staffs: University of Keel.
- Gray A. and Jenkins B. (1993) 'Codes of accountability in the new public sector', *Accounting, Auditing and Accountability Journal*: 52-67.
- Guillebaud C. W. (1956) *Report of the Committee of Enquiry into the Cost of the National Health Service*, Cmnd.9663, London: HMSO.
- Harrison, S. (1988) *Managing the National Health Service, Shifting the frontier*, London: Chapman and Hall.
- Hopwood A.G. (1984). 'Accounting and the pursuit of efficiency', in *Issues in Public Sector Accounting*, Edited by Hopwood A. G. and Tomkins C., London: Philip Allan Publishers.
- Hospital, The (1950) 'Annual conference: opening by the Minister', June: 429.
- Hurst J. (1978) 'A review of costing', in *Hospital Costing and the Clinician*, London: Department of Health and Social Security.
- Jones C. S. (1999) 'Developing Financial Accountability in British Acute Hospitals', *Financial Accountability and Management*, Vol. 15, No. 1: 1-20.
- Jones M. and Mellett H. (2007) 'Determinants of changes in accounting practice: Accounting and the UK health service', *Critical Perspectives on Accounting*, Vol. 18, Issue 1: 91-121.
- Jones R. (1992) *The history of the financial control function of local government accounting in the UK*, New York and London: Garland Publishing.
- Jones T. (2001) *Developing Reference Costs*, London: Certified Accountants Educational Trust.
- King Edwards Hospital Fund (1952) *Report on Costing Investigations for the Ministry of Health*, London: Kings Fund.
- Kings Fund (1973) *Accounting for Health, Report of a King's Fund Working Party on the application of economic principles to health service management*: London: King Fund.
- Klein R. (1995) *The New Politics of the NHS*, Third edition: London: Longman.
- Lapsley I. (1991) 'Accounting Research in the National Health Service', *Financial Accountability and Management*, Vol. 7: No.1: 1-14.
- Lapsley I. (2001a) 'Accounting, Modernity and Health Care Policy', *Financial Accountability and Management*, Vol. 17, No. 4: 331-350.
- Lapsley I. (2001b) 'The Accounting- Clinical Interface- Implementing Budgets for Hospital Doctors', *Abacus*, Vol.37, No.1: 79-109.

- Levitt R. (1976) *The Reorganised National Health Service*, First edition, London: Croom Helm.
- Llewellyn S. and Northcott D. (2005) 'The average hospital', *Accounting Organizations and Society*, Vol. 30: 555-583.
- Magee, C. C., Edwards J. R., Connies-Lang P. and Richards M. (1974) *Report on Costing Cervical Cytology*, Cardiff: University College.
- Mellett H. (1992) 'The application of depreciation accounting to the National Health Service', *Accounting, Business and Financial History*, Vol. 2, No. 2: 161-179.
- Ministry of Health (1950) *Hospital Circular RHB (50)16*, London: HMSO
- Ministry of Health (1955) *Report of the Working Party on Hospital costing*, London: HMSO.
- Ministry of Health (1956) *Hospital Costing, Circular (56)77*, London: HMSO.
- Ministry of Health (1965) *Hospital Costing*, H.M. (65)90, London: HMSO.
- Montacute C. (1962) *A critical Survey of costing as an aid to the management of hospitals. Nuffield Provincial hospital trust*: Oxford: Oxford University Trust.
- National Health Service Management Executive (NHSME) (1990), *Costing and pricing contracts: Cost allocation principles*, London: HMSO.
- Nuffield Provisional Hospital Trust (1952) *Report of the Experiment in Hospital Costing*, Oxford: University Press
- Parker R. H. (1993) 'The scope of accounting history: a note', *Abacus*, Vol. 29, No.1: 106-110.
- Perrin J. (1988) *Resource Management in the NHS*, London: Van Nostrand Reinhold (UK).
- Perry J. A. (1975) *Disease Costing: Report of a study of methods of costing the hospital treatment of individual diseases*, sponsored by the DHSS and undertaken at Northwick Park HMC.
- Pollitt C., Harrison S., Hunter D. and Marnoch G. (1988) 'The Reluctant Managers: clinicians and Budgets in the NHS', *Financial Accountability and Management*, Vol. 4, No. 3, Autumn, 213: 233.
- Powell J. E. (1966) *Medicine and Politics*, London: Pitman Medical Publishing.
- Preston A. M. (1992) 'The birth of clinical accounting: a study of the emergence and transformations of discourses on costs and practices of accounting in U.S. hospitals', *Accounting, Organisations and Society*, Vol.17, No1: 63-100.
- Preston A.M., Cooper D. J. and Coombs R. W. (1992) 'Fabricating budgets: A study of the production of management budgets in the NHS'. *Accounting, Organisations and Society*, Vol. 17, No. 6: 561-593.

Previts G. J., Parker L. D. and Coffman E. N. (1990) 'Accounting history: definition and relevance'. *Abacus*, Vol. 26, No1.

Prochaska F. K. (1992) *Philanthropy and the Hospitals of London, The Kings Fund, 1897-1990*, Oxford: Clarendon Press.

Public Record Office:

CAB 128/5 1946, Cabinet Conclusions: 1(46) – 62(46) and CAB 129/3 1945, Paper Nos.:- 201(45) – 250(45).

CAB 134/518, 1950, Committee on the National Health Service: Meetings 1-6; Papers 1-33, The Jones Report.

MH 137/13, 1949-1952, Interim and Second Report of the Costing Sub-committee. Appointed by the Committee of Regional Hospital Board Treasurers.

MH 148/38, 1964-1965, Research project on hospital costing by Martin S Feldstein, Nuffield College, Oxford.

MH 166/466, 1967-1972, Hospital costing: Department of Social Administration, University of Manchester, studies and reports.

T227/1545, 1965, Costing of hospital current expenditure in England and Wales (Mr Walker's report).

Rigden M. S. (1983) *Health Service Finance and Accounting*, London: Heinemann.

Rivett G. (1986) *The Development of the London Hospital System 1823-1982*, King Edwards Hospital Fund for London: London.

Robson N. (2003) 'From voluntary to state control and the emergence of the department in UK hospital accounting', *Accounting, Business and Financial History*, Vol. 13: No.2: 99-123.

Robson N. (2006) 'The road to uniformity: accounting change in UK voluntary hospitals 1880-1920', *Accounting and Business Research*, Vol. 36, Issue 4: 271-288.

Scott J. E. M., McKinnon J. L. and Harrison L. (2003) 'Cash to accrual and cash to accrual, A case study of financial reporting in two NSW hospitals 1857 to post-1975', *Accounting, Auditing and Accountability Journal*, Vol. 16, No.1: 104-140.

Stone J.E. (1924, 1936, 1953) *Hospital Accounts and Financial Administration*, London, Faber and Faber.

Titmuss R. M. (1950) *Problems of Social Policy*, London: HMSO.

Treasury (1961) Chancellor of the Exchequer, Control of Public Expenditure, London: HMSO, Cmnd.1432.

- Waddington K. (1995) 'Bastard Benevolence: Centralisation, voluntarism and the Sunday Fund 1873-1898', *London Journal*, Vol19, No.2: 151-167.
- Waddington K. (1996) 'Grasping Gratitude': charity and hospital finance in late-Victorian London', in M. Daunton (edited), *Charity, Self-interest and welfare in the English past*, London: UCL.
- Webster C. (1998) *The National Health Service, A Political History*, Oxford University Press.
- Weir R. D., Russell E.M. and Harper D. R. (1973) *Patient Costing Study*, Department of Social Medicine, Aberdeen: University of Aberdeen.
- Wise J. (1991) 'Specialty costs: reading between the lines', *Public Finance and Accountancy*, 1st March.