A Contextual History of Accounting in UK Hospitals 1880 -1974

A thesis submitted for the degree of Doctor of Philosophy Cardiff University

by Neil Robson

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Personal Note

The author worked in various financial roles within the National Health Service (NHS) for nine years. This research was partly motivated by what he perceived as a lack of knowledge, among both practicing accountants within the NHS and accounting academics, of previous accounting practice within the service. The opportunity to 'learn from the past' represents his small contribution to the often controversial topic of accounting and health.

Dedication

With many thanks to Joy, Jennie and Oliver.

Abstract

This thesis explores accounting change in UK hospitals, from 1880 to 1974. Using a processual approach (Porter, 1981; Pettigrew, 1987; Bhimani, 1993; Dawson, 2003) to historical investigation the focus is on three accounting 'events': the introduction of Burdett's uniform system of accounts in 1893; the introduction of annual departmental costing in 1956, and the introduction of functional budgeting in 1974. There is a duality to the research which explores both the role of *change agents* and the contextual environment within which change takes place.

For the first event, contextual factors such as the growth in hospital care, early 'managerialism' and moral concerns are first explored. These are identified as important in stimulating interest in accounting change, from both internal and external groups and institutions, but it is internal groups that take control of accounting reform. It is argued that economic, professional and technological forces were crucial in the spread of these accounts.

The second event takes place after the nationalisation of voluntary hospitals in 1948 with an emphasis on the process of change after nationalisation. The interaction of dominant individuals, groups and institutions, as well as political and economic forces are all explored in an effort to explain the *how* and *why* of change. The role of the medical profession in the departmentalisation debate is discussed, together with possible explanations for the reluctance to adopt new management accounting techniques.

The final event was preceded by a renewed interest in the concept of efficiency (Klein, 1995) and the thesis examines a number of managerial initiatives between 1956 and 1974. It suggests that there was a cautious approach to change among both accounting practitioners and civil servants and this, together with a disappointing response to previous accounting reform, combines to prevent more radical accounting change.

The thesis adds to the limited information on public sector accounting and suggests that the controversies surrounding the introduction, and use, of 'new' accounting technologies are part of a long process which can be traced back to the pre-nationalised voluntary hospitals and constitute a recurring theme throughout the life of the NHS.

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Glossary

AHA	Area Health Authority
CIPFA	Chartered Institute of Public Finance and Accountancy
COS	Charity Organisation Society
DHA	District Health Authority
DHSS	Department of Health and Social Security
HFMA	Healthcare Financial Management Association
HMC	Hospital Management Committee
ICAEW	Institute of Chartered Accountants in England and Wales
MB	Management Budgeting
NAHAT	National Association of Health Authorities and Trusts
NAPSS	National Association for the Promotion of Social Sciences
NHS	National Health Service
NHSME	National Health Service Management Executive
NPM	New Public Management
PRO	Public Record Office
RHA	Regional Health Authority
RM	Resource Management
SHSC	Scottish Health Services Council
SSA	Social Science Association

A Contextual History of Accounting in UK Hospitals 1880 -1974

Chapter 1 ~ Introduction

1.1 Background

This research provides a historical analysis of accounting change in UK hospitals, exploring the contextual factors driving change and tracking its process. The roles of leading opinion formers, including individuals, groups and institutions, are analysed within the context of broader social, technological and economic forces, and conceptual developments in medicine, management and accounting.

This multi-faceted approach to examining accounting change is broadly located within the processual school of change, (Porter, 1981; Pettigrew, 1987; Bhimani, 1993; Dawson, 2003) and aims at limiting criticism of traditional accounting histories by avoiding an over-concentration on technical aspects of accounting change (Hopwood, 1987).

The focus of the thesis is on three accounting events in UK hospitals, spanning the period 1880 to 1974, and covering:

- The uniform system of accounts in 1893,
- Annual departmental costing information in 1956, and
- Functional budgeting in 1974.

These events embrace a period of both voluntary and State control of hospitals and the thesis, drawing on a vast array of evidence and material, provides historical insights on the complex path, and contingent nature, of accounting policy change and implementation.

1.2 Previous Research

There is an extensive literature on accounting change in UK hospitals after 1979, associated particularly with the introduction of the internal market for healthcare in 1989. These *quasi*-market reforms are seen as the driver of extensive changes to accounting practice and, indeed, organisational culture based around competition, accounting controls and performance measurement systems (Ellwood, 1990; Broadbent *et al.* 1991; Gray and Jenkins, 1993; Chua and Preston, 1994).

These healthcare market reforms were associated with wider changes in public sector management, generally referred to as '*new public management*' (Hood, 1991; 1995). The impression given by academic work on these reforms is that they heralded a '*new paradigm*' in public sector management and accounting, but few researchers trace the history, or make any attempt to map antecedents.

A number of authors, (Parker, 1993; Carnegie and Napier, 1996) suggest that public sector accounting history is relatively neglected, compared to the enormous volume of research relating to private sector enterprises. Carnegie and Napier (1996) suggest two possible reasons for this '*historical imbalance*' (p.26), and consider it '*may reflect the bias towards financial reporting and the activities of professional accountancy ...*', while, in addition, they argue 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 and idea*'(p.26), and this 'driver' is obviously missing within the public sector.

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 these 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 associated with the mobilisation of accounting information, which can be seen as an economic-rationalist justification for accounting change.

This thesis aims to add to the limited information on public sector accounting, and suggests that the controversies surrounding the introduction, and use, of 'new' accounting technologies are part of a long process of accounting change which can be traced back to the pre-nationalised voluntary hospitals, and which are certainly a recurring theme throughout the life of the NHS. Other authors have noted that pressure for accounting change in the public sector can be traced to earlier periods. For example, Humphrey (1991) suggests that attempts to '*influence the management of public sector resources need to be placed in their evolutionary context and not be simply regarded as the product of the post 1979 revolution of Thatcherism*' (p.169).

McSweeney (1994), in the context of the British Civil Service, maintains that a change to *'management by accounting'* predates the 'New Right' governments, associated with Thatcherism, and Kirkham and Loft draw similar conclusions on Direct Labour Organisations in Local Government (2000).

The research, to date, underlines that there is an area for the accounting historian to explore, namely what accounting information existed before the 1970s, and how, and why, accounting developed as it did? While interesting in itself, this will also help place in historical context, the changes in hospital accounting associated with the later decades of the 20th Century (Preston *et al.* 1992).

1.3 Pre-1979 Hospital Accounting

There are a limited number of historical studies on hospital accounting. Mellett (1992) explores the origins of depreciation accounting in the NHS from 1948 to 1991, and Jones and Mellett (2000) track the interaction of organisational and accounting change from 1800 to 1989, using the social order model. In the USA Preston (1992) traces the '*emergence and transformations of discourses on costs and practices of accounting in US hospitals*'.

These works are examined in more detailed in Chapter 3, but it is possible to draw a number of conclusions, and assertions, from work primarily relating to later periods,

on pre-1974 hospital accounting. These may be regarded as conventional wisdom and can be broadly summarised as follows:

- New Public Management introduced a new paradigm to hospital accounting information that was substantially different from previous initiatives and was primarily promoted by '*external agency in attempts to colonize*' (Broadbent, Laughlin and Read, 1991. p.18).
- Prior to 1979 accounting information within the hospital sector [and indeed the public sector generally] was primarily concerned with its treasury function rather than 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 technologies were predominately promoted by government initiatives rather than practitioners within the service (Lapsley, 1991).
- Accounting technologies tended to be inadequate for large modern organisations (Bourn and Ezzamel, 1986; Perrin, 1988). This was particularly evident in relation to costing and budgetary control information and 'poor' information relating to clinical activity.

This thesis, in exploring accounting change, will also assess the validity of these assertions.

1.4 Processual Change

The focus of this research is accounting change at the macro policy level rather than the micro-level of the individual hospital. To this extent the research concentrates on debates, between influential individuals, groups and institutions, advocating, and driving, change.

The approach used is analogous to the accounting scholars label 'contextual' (Hopwood, 1983, 1987; Napier, 1989) and more recently 'processual' (Guthrie, 1994; Burns, 2000). Hopwood (1986; 1987) suggests that a limitation on the number of accounting histories centred on the tendency to see accounting change as a logical response to the technical, and economic, needs of organisations. Whereas, contextualised history has developed '*new ways of posing questions about the past*'

(Miller, Hopper and Laughlin: 1991. p.395) and Bhimani argues that, in contextual studies, '*accounting is a social practice subject to being influenced by a wide array of forces and itself effecting social changes of its own account*' (Bhimani, 1993. p.3).

There is extensive and wide-ranging literature on accounting change in its context (Burchell *et al.* 1985; Loft, 1986; Hopwood, 1987), and it is increasingly recognised that examining accounting change over a longer timeframe, with a detailed analysis of the decision-making processes, can provide a fuller understanding of how accounting practice is devised and implemented (Hopwood, 1983; Bhimani, 1993; Guthrie, 1994; 1998; Ryan, 1999; Burns, 2000; Scott *et al.* 2003). The contextual and processual methodologies are examined in more detail in Chapter 2.

1.5 Time Frame

The events examined in this study take place over an extended timeframe and embrace a period of both voluntary control and 'nationalisation' of the hospital service. Where possible the study broadly tracks the three accounting changes in chronological sequence over the following time periods:

- 1880 -1920 [Introduction of the uniform system of accounts]
- 1920 -1956 [Emergence of departmental costing]
- 1956 -1974 [Introduction of functional budgets]

[For a summary of the key features of each accounting system see table 1.1, page7]
The first two changes are difficult to locate squarely within either of the normally accepted fields of financial and management accounting. The uniform accounts were essentially concerned with external reporting, but the additional performance data required by these accounts, was more closely associated with management accounting. Departmental costing which aggregated information for each individual hospital, was published annually but was little used internally to compare hospital performance, even though national and regional data comparisons were published (Montacute, 1962). Functional accounting was, essentially, a budgetary control system and would, therefore, be located within the management accounting field. The next Section provides a brief outline of the three events.

1.6 Uniform Accounts ~ 1893

Before nationalisation in 1948 financial reporting and external accounting information within the voluntary hospital sector was based on the uniform system of accounts, first set out in Burdett's 1893 publication (Jones and Mellett, 2000). This was an early attempt to introduce uniformity in financial accounting information for the majority of voluntary hospitals in the UK, and, indeed, to provide basic cost-per-bed performance data.

The aim, in this thesis, is to explore potential antecedent contextual factors influencing this accounting transformation; including changes in the nature and growth of hospital care, and the effects of emerging concepts, such as managerialism and efficiency. In addition there are a number of powerful individuals, internal and external groups and institutions, promoting accounting change and their interplay, and conflict, over an extended time period is a key focus for the study.

The spread of the uniform accounts is examined, paying particular attention to the roles of groups and institutions after the 'creation' of the accounts, and their use of economic, professional and technological forces to extend uniformity.

1.7 Departmental Costing Information

The second accounting event examined is the development of departmental costing, introduced in all large acute hospitals in 1956. The aim of this part of the study is to track the origins of departmentalisation in the pre-nationalised service, and, in particular, the role of influential individuals in hospital management, such as Captain J. E. Stone (Stone, 1924; Prochaska, 1992; Jones and Mellett, 2000). In addition, both why, and how, change occurred is explored by analysing the roles of dominant groups and institutions, and the political and economic forces that interacted with those advocating accounting change.

The author argues that the process of change had a significant impact on the accounting technology adopted; with departmental budgeting discarded in favour of annual costing information. This was not a solution proposed by any of the original

groups associated with departmental accounting. It is also suggested that accounting practitioners were influential in preventing more radical accounting change, and that this set the scene for the early years of the NHS.

Table 1.1: Key features of each accounting device

Uniform accounts	Departmental costing	Functional budgets
Presented annual summarized information for an individual hospital.	Aimed to trace costs to individual departments within a hospital. Produced annually.	Budgets based on hospital professions or functions.
The key to these accounts was an Income and Expenditure Account that presented information by type of expenditure, for example: *Meat* *Eggs* *Drugs and Dressing* *Medical salaries* *Nursing salaries* This was known as the subjective analysis of expenditure.	This information was presented (annually) as if each department was a cost centre. For example, the Radiologist departmental statement, including the headings: *Radiologist salaries* *X-Ray films* *Cleaning materials* *Renewal and repairs.* Detailed information was provided on how this data was to be prepared and therefore this **continued the concept of uniformity** of information. (Note: budgetary control information was still produced for hospitals, rather than departments and this information was based on the subjective headings).	Monthly budgetary control information presented for every hospital function. For example, Nursing, Professional and Technical, Catering, Finance etc. Hierarchical structure based on professions. This was the first attempt (within all hospitals) to delegate/devolve budgets and responsibility for budgets to a large number of hospital managers. Prior to this reform, the hospital budget was controlled by the treasurer, via hospital management committees.
The uniform accounts also required the collection of statistical data on a hospital – such as the average number of hospital beds. This lead to the publication of comparative data on hospital performance, such as: average cost per bed occupied for provision costs	Departmental costing also required departments to collect non-financial information and therefore produce departmental performance measures, on an annual basis. This resulted in cost per unit data for each department, e.g. cost per x-ray.	Functional budgeting was the high water mark for management by hospital professions. They now had titles such as District Nursing Officers and District Administrators. These officers managed their profession, and the corresponding budgets, for all the hospitals in their geographic area.

1.8 Functional Budgeting

In 1974 the NHS saw its first major reorganisation with the creation of an additional tier of governance, the Area Health Authority, within the service, sometimes seen as the '*high water mark*' for '*statism*' and '*planning*' (Klein, 1995; Jones and Mellett, 2000). This reorganisation brought with it the necessity of introducing budgets at a level lower than the individual hospital.

The aims of the Section covering this topic are to trace the early roots of this decision and to explore extensive efforts, by the NHS bureaucracy, to use 'managerial tools and techniques' to control the service between 1958 and 1974 (Klein, 1995; Webster, 1998).

This period sees an early challenge to the usefulness of accounting data, particularly annual cost information, introduced in 1956, both from managers within the service and academics attempting to use the accounting information generated. This Section also explores the perceived limitations of the costing information produced after 1956, and the effect of this on future accounting developments within the NHS.

1.9 Scope of Research

Although the first event, uniform accounting, occurs in 1893, the antecedents of this are also explored and the commencement of the research can be traced to around 1880, or certainly the late 1880s. While the final event is the introduction of functional budgeting in 1974, it is not the intention of the thesis to provide a chronological history of accounting in this long period but to examine three significant change events in UK hospital accounting between 1880 and 1974.

The research is only interested in hospitals, and, while the organisational structure of the NHS includes GP and community care, the events examined in this thesis are hospital specific. In the pre-NHS period the research deals with the voluntary hospital movement, and not those hospitals owned by Municipal Authorities or governed by Poor Law statutes. There are a number of reasons for the concentration

on voluntary hospitals in the pre NHS world. First, most of the debates around costing, and, to smaller extent, budgeting in the NHS, are concentrated on hospitals that treat patients for acute care, rather than long term care, such as mental illness. Prior to 1948 it was the voluntary hospitals that were responsible for the vast majority of this acute care and therefore this work attempts to provide continuity by tracing accounting to similar hospitals, prior to 1948. In addition, given the time-frame covered in this research, there was also a limitation of time and space preventing an exploration of another system, prior to 1948.

1.10 Synopsis

An introduction to the three events that are the focus of the thesis has been provided in Chapter 1. The following Chapter 2 outlines the methodological debate between 'traditional school' and 'new' accounting histories, and also provides an outline of the processual methodology adopted for this research, concentrating on the work of researchers examining strategic management change (Pettigrew, 1987; Dawson, 2003), and the framework for processual historical studies suggested by Porter in his text EMERGENCE OF THE PAST: A THEORY OF HISTORICAL EXPLANATION (1981).

Chapter 3 examines the literature on hospital accounting and, more generally, on hospital organisation and management. The Chapter outlines academic work and more recent accounting changes, broadly referred to as New Public Management (Hood, 1991; 1995), from researchers associated with the 'critical' perspective and those with a more technical focus. This Chapter also, specifically, considers academic work on hospital accounting history, particularly by Jones and Mellett in the UK (2000) and Preston (1992) in the USA, and examines a diverse range of secondary sources on the political, social and economic history of hospitals.

This is followed in Chapters 4-6 with an exploration of the three accounting change events identified above with each Chapter concentrating on an individual event, and building on the antecedent conditions. Chapter 7 draws on the *'explanatory narrative'* (Porter, 1981) in the preceding Chapters to present conclusions on the how and why of change in UK hospital accounting.

Chapter 2 ~ Accounting History and Processual Methodology

2.1 Introduction

This Chapter explores the types of approach in studying accounting history, and outlines the main methodological features associated with contextual and processual research. The Chapter begins with an explanation of the purpose of accounting history, followed by an outline of the 'traditional' and 'critical' schools, together with an exploration of the main approaches adopted by both schools. This is followed by an analysis of the change methodologies suggested by Porter (1981), Pettigrew (1987) and Dawson (2003), and a summary of the main features of the processual approach is presented. An outline of the sources used in the thesis is given and the Chapter ends with concluding comments.

2.2 Approaches

In their 1990 paper Previts *et al.* consider the case for the 'relevance' of accounting history, and note that:

> *History supports contemporary research in policy-making and practice and in standard setting. It acquaints accountants with the individuals, ideas, experiments and lessons that constitute our heritage. It informs us about how we reached a particular present-day convention ...also encourages the thoughtful scholar to consider the interdisciplinary view of accounting and its environmental context* (p.3).

In addition, quoting from an earlier paper, they suggest *'that an intuitive justification for the study of history exists by relating what 'was' (the historical state) to what 'is' (the positive state) to what 'ought to be' (the normative state)'* (1990. p.3).

Carnegie and Napier, reviewing previous accounting work, identify three 'roles' for accounting history: *'enhancing the status of accountants, using accounting's past to put the present into context and as a data bank of solutions to current problems'* (1996. p.17).

There is little dispute about the rationale for historical investigations and Carnegie and Napier (1996) identify the 1990s, and Miller *et al.* (1991) the 1980s, as a period characterised by an 'explosion' of academic interest in accounting history. This '*manifested itself not just in the number of publications but in the topics examined, research approaches adopted, and range of theoretical perspectives applied to the study of accounting through its history*' (Carnegie and Napier, 1996. p.7).

These authors even suggest that an indicator of the '*maturity*' of accounting history, as an accounting discipline, is the appearance of a variety of different historiographies, such as '*traditionalist, antiquarian, post-modern, Marxist, post-modernist, Foucauldian and critical*' (p.7). These theoretical perspectives are broadly divided into two schools: '*traditional*' and the '*critical or contextualisers*' (Napier, 1989; Anderson, 1994; Fleishman and Radcliffe, 2000).

2.3 The Traditional School

Attempts to describe traditional accounting histories tend to concentrate on two defining characteristics; their approach and their commitment to economic-rationalism.

Historians associated with the traditional school make extensive use of original documents to reach a view on accounting history. For example, Anderson (1994) states that:

> *In order to understand the past, there is a need to discover the events of the past. The discovery stage must involve a comprehensive study of original accounting records, accounting treatises and contemporary documents, which provide material relating to the usage of accounting* (p.68).

In addition the traditional school is associated with an economic-rationalist explanation for accounting change. For example, Fleischman and Radcliffe (2000) argue that:

> *most accounting historians who bear the 'traditionalist' label subscribe to the economic-rationalist, cost beneficial paradigm wherein accounting developments are explained in terms of rational, cost-beneficial decisions*

on the part of entrepreneurs within the context of a neoclassical, transactions-based theory of the firm (p.13).

The economic-rationalist perspective [traditional school] tends to argue that accounting change is associated with technological and economic forces, particularly demands for increased efficiency. In addition the long term development of accounting practice is often summarised as one of '*continuity and change*' (Edwards *et al.* 1995). For example, in their study of British cost accounting (1838-1900) they conclude that:

> *we find a system of cost accounting, broadly defined, in operation throughout the period, a large measure of continuity concerning its basic features, and innovations made from time to time presumably designed to improve its usefulness* (1995. p.1).

Some critics, for example, Hopwood (1987) and Stewart (1992), suggest that in 'traditional' accounting histories there is an over-concentration on '*economic*' and '*technical*' perspectives, with the assumption, often implicit, that accounting is continuously being enhanced:

> *The view of accounting theory and practice assumed in these histories is that accounting is autonomous and has progressed in an evolutionary way - accounting is constantly improving* (Stewart, 1992).

Napier (1989) identifies another problem with this approach, namely, that

> *...accounts of the past are too often judged using the criteria of today... indeed, we are tantalised by apparent early examples of modern techniques and concepts, and are tempted to identify early anticipations of these. But are we viewing our raw material through the blinkers of the present, and simply failing to see what is there because it does not fit with our preconception* (p.241).

Stewart (1992) describes this as an *'ahistorical'* approach and argues, like Napier, that these critics suggest that

> *...accounting is abstracted from its historical context and is judged apart from this context. A second criticism has stated that some traditional history is antiquarian in nature. The essence of this criticism seems to be that in some extant accounting history there is an excessive concern with the facts. The accumulation of facts will not, of itself, provide adequate explanations of how and why accounting practices have developed in a particular manner* (p.58).

In addition to these theoretical issues there are a number of practical problems associated with this type of archival research undertaken by the traditional accounting historian. This includes its time-consuming nature and a tendency to an over-reliance on surviving records (Anderson, 1994). Anderson cautions researchers on *'generalising'* from surviving company records, which may not be representative of the whole.

Related to this is the concern that many groups within organisations, particularly workers, are unlikely to leave archival evidence for future generations. Fleishman (2000) suggests that critical historians are wary of the traditionalists' reliance on archival information because:

> *There are the numerous categories of people who because of economic or social position have no access to an historical accounting archive. Consequently, the voices of the past speaking to us through primary sources are severely limited* (p.14).

In part, as a response to these concerns, 'new' accounting histories have increasingly challenged many assumptions associated with traditional histories, and have attempted to broaden the context of accounting histories, with many introducing new 'theory' to accounting history.

2.4 'New' Accounting History

Miller *et al.* (1991) suggest that in the 1980s accounting history was transformed by a *'pluralization of methodologies'* probing the conventional wisdoms about accounting history and challenging *'received notions such as progress and evolution'*, investigating instead *'broader transformations in accounting knowledge. New ways of posing questions about the past of accounting have become possible as a result* (1991. p.395).

An early promoter of this school was Hopwood (1983) and his paper ON TRYING TO STUDY ACCOUNTING IN THE CONTEXT IN WHICH IT OPERATES is normally identified as a turning point in accounting history methodology. Hopwood argues that

> *...we have very limited understanding of the forces that either influence accounting change or help shape the different forms that the accounting craft can take. Although a great deal of work has been done on the history of accounting, many studies that are available have adopted a rather*

technical perspective, seeking not only to emphasise the developments that have occurred rather than also probing into rationales for them.... Only rarely seeking to relate their insights to broader understandings of the development of the corporate form, its social and economic setting, and the roles which organizational accounts might have played in the emergence of both the organization as we know it now and the relationships which it has to other bodies and interest (1983. p.289).

Stewart suggests that '*by placing accounting in its organizational, social and historical contexts, the study of accounting history is liberated from the constraints of the present*' (p.58) and that '*these 'new' histories have broadened the context within which the history of accounting has traditionally been situated*' (p.58).

However there is a debate among accounting historians on the criticism that *'traditional'* histories lack context. For example Carnegie and Napier (1996) argue that 'traditional' histories were '*aware of the importance of context and the environment, it was natural for the traditional accounting historians to judge historical accounting records in terms of their ability to provide information useful for decision making*' (p.15). Carnegie and Napier suggest therefore that the appeal to consider context '*is not necessarily a distinctive feature of new accounting history*' (p.16) rather the distinctiveness stems from their '*focus more on the structure and uses of accounting information for control and even coercion*' (p.16).

Fleishman and Radcliffe (2000) [and others] argue that this focus is represented by the two major *'research paradigms'* or *'worldviews'* (p.21), the Marxist/Labour Process and the Foucauldian.

According to Fleishman and Radcliffe (2000): '*Marxist historians have actively fostered an agenda to communicate to academics the partisan nature of accounting records and the methodologies through which accounting practices can be deployed to suppress classes of people*' (p.28).

A good, and often quoted, example of the Marxist approach is Hopper and Armstrong's paper: COST ACCOUNTING, CONTROLLING LABOUR AND THE RISE OF THE CONGLOMERATES (1991), which argues that accounting changes in corporations

> *...are better understood through a 'labour process' approach to economic and industrial history... the core presupposition of this perspective is that social and economic conflicts arising from the modes of control which characterise particular phases of capitalistic development stimulate the creation of new forms of control intended to eliminate or accommodate resistance and to solve the associated problems of profitability* (p.406).

Hopper and Armstrong suggest that this labour process approach contradicts, and challenges, many of the assumption and conclusions of economic rationalists, and these authors suggest that the creation of new accounting controls could not be explained by '*economic or technological imperative, but rather were rooted in struggles as firms attempted to control labour processes*' (p.405).

Another methodological approach, widely associated with new accounting history, is that influenced by the work of Foucault (1972; 1977; 1981). Stewart (1992) argues that *'Foucault's work has been divided into two chronological stages. The first phase of his work comprises a series of primarily historical case studies which he called archaeologies'* (p.62) This type of investigation is described by Preston (1992) as an analysis of the '*emergence, functioning and conceptual features of various discourses which may be implicated in the shaping of and in turn shaped by, accounting thought and practice*' (p.65).

The second phase is referred to as *Genealogy* and here *'he emphasized the constitutive role which power plays in knowledge'* (Stewart, 1992).

For Fleishman and Radcliffe (2000)

> *...one of Foucault's major contributions to the philosophy of history has been his analysis of the interconnections between power and knowledge...* (p.25) *the Foucauldian view of power differs from a more traditional definition of power as an agency of subjugation. Instead, power is construed as an 'omnipresent web of relations'* (p.25).

Stewart adds to the explanation of the power/knowledge relationship by noting that a key device was '*surveillance*' and '*power is exercised by watching*' (p.62) and argues further that

> *...the role of accounting in surveillance monitoring, often in an unintended way (see Hopwood, 1987) over production in the workplace has been*

> *usefully highlighted by Hoskin and Macve (1986, 1988), Loft (1986) and Miller and O'Leary (1987)* (Stewart, 1992. p.62).

Fleishman and Radcliffe argue that the '*philosophical differences*' between traditional or old and new historians can be summarized as follows:

> *Whereas the old attempts to make the past understandable, new narratives try to make 'the familiar strange' (Funnell, 1998:144; Merino, 1998:606). Old school historians privilege the written archive of the past (Chua, 1998:619), while the new are wary of primary sources, in part because of the silenced voices, and suggest an expanded view of what can constitute archival evidence (Chua, 1998:618; Carnegie and Napier, 1996:8). The new accounting history provides new forms of historical discourse, different lenses for viewing the past (Gaffikin, 1998. p. 632)* (2000. p.32).

However, Fleischman and Radcliffe (2000) suggest that the gulf between 'old' and 'new' is not as wide as the above analysis may suggest, and, like Carnegie and Napier, argue that it is '*more of degree than kind*' (p.8). Further, using Funnel's (1996; 1998) work they suggest that '*neither side is itself homogeneous so that discourse tends not to be so doctrinaire'* and *both new and old historians, even the most radical postmodernist, use narrative form as a primary tool*' (p.32). In addition Fleishman and Radcliffe (2000) argue that '*traditional accounting historians could claim 'new' history status with a widening of perspectives and perhaps a more questioning view of historical objectivity and facticity*' (2000. p.33).

The next Section examines an approach, to the analysis of change and historical investigation, which attempts to widen the contextual parameters of traditional histories while tracking the detailed and complex process over time.

2.5 The Processual Approach

The demand for more contextualisation in accounting studies is closely associated with the work of Hopwood (1983; 1987) but strategic organisation change scholars (Pettigrew, 1987; Dawson, 2003) also argue that to understand change we need to examine the long term process through which change is instigated and negotiated by 'change agents' [particularly individuals and groups]. This focus on both context and the change process is defined as *the processual approach.*

Pettigrew (1987) argues that a manager's ability to achieve strategic change is dependant on '*three related areas: the content of a chosen strategy, the process of change and the contexts in which it operates*' (Pettigrew, 1987). The content of change includes exploring the: '*frames of thought... source of the strategy ... and extent to which strategy anticipates the means of implementation*' (1987. p.18).

While the context of [strategic] change can be explored at 'inner and outer' levels, Pettigrew considers that:

> *The inner context consists largely of the structure, culture and politics of an organization... the outer context may be conveniently divided into four areas: the economic, business, political and societal formations in which firms must operate* (1987. p.18).

The processual 'dimension' examines

> *...the long term pattern of events by which strategies are conceived and their competitive purposes put into operation. We need to ascertain, therefore, who champions and manages new strategies; what decision arenas and processes they emerge from'; what models of change govern the conception and implementation; and how appropriate they are to the contexts in which the firm operates* (1987. p.19).

Pettigrew's approach emphasises the role of agents of change in both responding to the external environment and using this to pursue their own change agenda, as

> *...managers perceive and construct their own versions of the competitive environments together with their personal visions of how to re-order their business to meet those perceived challenges* (1987. p. 19).

Another work examining management change in organisations, and very much in the tradition of Pettigrew's work, is Dawson's RESHAPING CHANGE: A PROCESSUAL PERSPECTIVE (2003). This work outlines three main fundamental aspects to the processual approach to examining change: '*politics, context and substance*' (p.7). While there is no definition of the term 'politics' he does give examples and suggests that 'political' actions may emanate from both within and outside the organisation. Outside influence 'may involve: senior business leaders or industry groups lobbying governments' while inside the organisation

> *...political activity can be in the form of shop-floor negotiations between trade union representatives and management... These individuals or*

> *groups can influence decision-making and the setting of agendas at critical junctures during the process of organizational change* (p.9).

Dawson suggests that '*the more covert forms of political process may be evident in the legitimization of certain norms and values that, while often remaining implicit, nevertheless serve to influence individual and group response to change*' (p.9).

The second aspect identified by Dawson is the context of change, referring '*to the past and present external and internal operating environments as well as the influence of future projections and expectations on current operating practice*' (p.10). Like Pettigrew there are external and internal contextual 'factors'. Examples of external factors include '*government legislation, changing social expectations, technological innovations*' while internal factors include '*Leavitt''s (1964) classification ... human resources, administrative structures, technology, and product or service, as well as an additional category labelled the history and culture of an organisation*' (Dawson, 2003. p.10).

In Dawson's final aspect, the '*substance of change*' he lists four dimensions: including its '*scale and scope*', '*timeframe*', '*perceived centrality of change*' and the '*defining characteristics of change – this refers to labels attached to change projects and the actual content of the change in question*' (p.11).

The central ideas that change takes place over time, rather than being static, and is multi-dimensional, with internal and external pressures on individuals and groups, who negotiate responses to these pressures in unpredictable ways, is also stressed in history literature, in particular Porter's work: EMERGENCE OF THE PAST: A THEORY OF HISTORICAL EXPLANATION (1981).

Porter proposes that any historical event can be investigated using six *elements*. The first element is at the level of the *individual*. This, for Porter, is '*biography*' and provides important information on the role and aspirations of key individuals; their views, visions and behaviour, as well as their relationships with other elements, particularly groups and institutions. Porter recognises that, at this individual level, there is a possibility of bias.

The next two levels are *groups* and *institutions* and although it is not always obvious whether a group is '*large enough, permanent enough, structured enough or associated closely enough with certain physical structures or symbols to be called an institution*' (Porter, 1981. p.92), both, for Porter, can be analysed by probing, and exploring, relationships between other groups and other elements. In his work on the creation of the Thames Embankment, Porter suggests that an:

> *Analysis of the competing groups, the meanings they attributed to the Embankment, and the process through which these meanings were negotiated, stabilized, and elaborated provides a running commentary on the metamorphosis of the project* (Porter, 1998. p.9).

Porter also notes that a group can be mobilised, perhaps from existing groups and institutions, for a specific purpose, but without formalising themselves as a group.

The next three elements can be regarded as the more contextual elements; Porter uses the term *'abstract'*. The first is *conceptual* and is defined as '*the ideas, principles and doctrines that serve as foci for patterns of meaning that involve many other elements*' (Porter, 1981. p.92). For Porter, concepts often motivate individuals and groups into action, with particular concepts often being championed and promoted by different individuals and groups.

Porter's final two elements are *forces* and *universals.* Forces are *'traditionally used by historians to indicate their field of enquiry'*, with examples including *'economic, political, technological, religious*' (Porter, 1981. p.94) and, of course, these forces are not mutually exclusive. An explanation of most events will require an awareness of the part played by these forces in the process of change.

Universals is the most abstract element, and Porter uses '*enlightenment*' and '*romanticism*' as examples, and suggests that they are often described using a single word. In addition Porter suggests that when a universal is related to a more focussed research area it may be regarded as a conceptual element. For example he suggests, in relation to the study of the history of art, romanticism would become romantic art. With regards to health-care, as a universal, a '*scientific*' revolution may become scientific medicine or even scientific management.

2.6 Processual Approach and Accounting

Within accounting literature there are a number of studies using a processual approach to examining change, for example: Bhimani, (1993); Guthrie, (1994); Burns (2000); Scott *et al.* (2003).

Bhimani's examination of accounting change in Renault (1898-1938) concludes that:

> *Rather than suggest that accounting evolved as a reaction to organisational needs and that it accords with notions of essentialism, this essay has posited the existence of distant antecedents conditioning accounting practices at Renault* (1993. p.36).

In addition Renault was not insulated from the influence of external '*rationalities*' and these were crucial in altering the '*conceptualisation of legitimate organisational action*' (p.36). However these external influences alone did not provide an adequate explanation for change, as there were also '*circumstances particular to the firm*' (p.36). This included the influence of dominant individuals, and a degree of happenstance, and Bhimani argues that accounting was

> *...to an extent...shaped by incidents that were unanticipated and unplanned but which nonetheless affected and altered organisational possibilities over a protracted period of time* (p.37).

The conclusion that change is multi-faceted, partly conditioned by external environment, dominant individuals or '*actors*' and '*circumstance*', is echoed in the work of Porter (1981), Pettigrew (1987) and Dawson (2003). It is possible to derive a number of conclusions from these researchers on processual change.

There is general recognition of the importance of '*change agents in orchestrating the change process*' and of investigating the '*power plays and manoeuvrings of individuals and groups during the change*' (Dawson: 2003. p.26).

Porter (1981) argues that:

> *The pattern of relationships between a specific group and other elements in any event may be analyzed so as to clarify the significance of the other elements... analyses of other groups' viewpoint would supplement and*

> *refine the first, until one had constructed a multiperspective description of each element in the event's configuration* (p.91).

All stress the importance of '*context*', both internally, and, more widely, outside the organisation, as an important component in understanding change. These contextual factors may include economic or technological factors [Porter - forces] as well as wider societal norms, beliefs and practices [Porter - concepts]. Both Dawson and Pettigrew refer to organisational culture which '*includes the beliefs, meanings and rationales used to legitimate action, together with the languages, codes and rules that inform those actions*' (Pettigrew, 1987. p.18).

In addition historic context is important and Dawson argues that '*an historical perspective on both the internal and external organizational context is central to understanding the opportunities, constraints, and organizationally defined routes to change*' (Kelly and Amburgey, 1991:610, quoted in Dawson, 2003. p.10). Dawson does note that the contextual and historical dimension can promote certain options and devalue others (Dawson, 2003. p.10). But there is a general understanding that predicting events from either antecedent conditions or from contextual factors is almost impossible, partly because of the interaction between these. Porter argues that:

> *Like a DNA molecule inherited from one's parents, a historical event is definitively coded with respect to its antecedents. But this code is merely conditional with respect to its future transformations. The potential configurations that may emerge from its interaction with other molecules within the organic environment are almost unlimited, though some configurations obviously have more potential than others* (1981. p.52, see also Allan's (1983) review of Porter's book).

This view is echoed by Bhimani (1993) who asserts that '*accounting change is neither an inevitable consequence of a universal force of logic nor a predictable outcome reflective transcending contextual elements'* (p.37).

Any investigation that attempts to analyse change in context, while also tracking the complex process of change and the interaction of leading change agents, will require extensive sources and these are discussed in the next Section.

2.7 Sources

Historical research into the development of UK hospitals is extensive, and is discussed in more detail in the next Chapter. Secondary sources range from numerous individual hospital histories (Granshaw, 1985, Clarke, 2001) to work concentrating on the social, economic and political development of hospitals and, more generally, medicine (Abel-Smith, 1964; Rivett, 1986; Granshaw, 1993; Klein, 1995; Webster, 1988, 1996, 1998; Porter, 1999). Particular exhaustive are Webster's two volumes: THE HEALTH SERVICES SINCE THE WAR (1988; 1996) giving a detailed account of the history of the service using primary sources and privileged access to health department records.

There are also a number of studies on specific groups and institutions, such as the Kings Fund, and Saturday and Sunday Funds, which were closely associated with hospitals especially in the pre-NHS world (Prochaska, 1992; Waddington, 1995). In addition there is limited research on specific aspects of hospital organisation, for example hospital funding (Cherry, 1993, 1997, 2000; Berry, 1997; Mohan and Gorsky, 2001). Some of this work provides extensive references to accounting (Rivett, 1986; Prochaska, 1992; Webster, 1988, 1998) as do a number of texts (Stone, 1956; Montacute, 1962; Forte, 1986) and official reports, such as that produced by Guillebaud (1956). All provide brief summaries of hospital accounting history, particularly on the introduction of departmental accounting in 1956 (Guillebaud 1956; Montacute, 1962; Forte, 1986). In addition, particularly after 1948, there are a vast number of official, and government sponsored, publications on hospital organisation and management, and these provide invaluable insights into the wider social and economic forces influential in accounting policy change.

Other important documentary sources include accounting and hospital management journals. The accounting journals include; *THE ACCOUNTANT* and *HEALTH SERVICE FINANCE*. *THE ACCOUNTANT* is particularly informative on the pre-nationalisation period and the debate on accounting information for charitable organisation from 1880-1895. *HEALTH SERVICE FINANCE,* the journal of the Association of Hospital Treasurers, provides coverage of conferences and practitioner articles relating to hospital finance between 1958 and 1974.

THE HOSPITAL is another important source that spans the total timeframe of this study and deals specifically with hospital administration and management. This journal owed its origin to a key individual in hospital management, Sir Henry Burdett and dates back to the late 19th Century. It was [usually] published weekly and is an invaluable resource on the policy and conceptual debates in hospital management for the whole period of this research. Evidence has also been drawn, but less frequently, from the main UK general medical journals: the *BRITISH MEDICAL JOURNAL* and *THE LANCET.*

This research project also consults a number of archives. Most importantly the national archive at Kew, particularly after State control in 1948, which provides access to many original documents; minutes of meetings, unpublished reports and internal correspondence on hospital accounting and management. These provide a valuable insight into the policy-making process at the higher levels of government. In addition other smaller archives relating to key individuals and groups, such as Sir Henry Burdett and the Sunday and Kings Fund have been consulted. These sources are more fully explored in Chapter 3.

The reliance on different sources also changes for each of the three accounting events. The first event makes extensive use of three primary sources; professional journals, the House of Lords report and Burdett's yearbooks. The second event makes more use of the PRO at Kew and government papers on accounting policy development, in addition to the professional journal the hospital. By the third event there more use was made of secondary information and government, or government sponsored, reports. In addition use was made of the specialist journal: *Hospital service Finance.*

Tracking down the above sources proved a complex task as hospital accounting history is relatively unexplored. However, future researchers may be interested in the following information. There are a number of key specialist libraries. The Kings Fund Library has a complete run (up to 1974) of *Hospital Service Finance* and extensive secondary material. The Wellcome Library also has a large collection of secondary data, a huge number of hospital annual accounting reports and there is a

complete run of the journal the *Hospital* at the Royal London Hospital library. There are also a number of archives. Burdett's papers are at the Bodleian Library, records relating to the Kings Fund are at the London Metropolitan Archive and the Sunday Fund records are at the Corporation of London. Obviously many of the records relating to the NHS are held at the PRO but there are extensive archives for many hospitals held at local record offices, a list of these can be obtained via the PRO website. I made use of some of these at the Gloucester and Bristol Record offices.

2.8 Conclusions

After outlining the purpose of accounting history this Chapter discusses the two paradigms, or schools, associated with the writing of accounting history; the *'traditional'* and the *'contextualisers'*. The dominant historical perspectives, including economic-rationalist, labour process and Foucauldian, associated with these schools are outlined and the '*philosophical differences*' and, indeed, similarities are explored.

A summary of the processual approach adopted in this study is given, concentrating on the methodologies suggested by other processual researchers (Porter, 1981; Pettigrew, 1987; Dawson, 2003). This processual framework provides structure to the subsequent search for historical evidence in this thesis and helps guide the narrative account. This chapter also identified the primary and secondary sources used in this study. The next chapter will provide a detailed review of these secondary sources and provide a summary of existing research on the history of hospital accounting.

Chapter 3 ~ Literature Review

3.1 Introduction

This research covers the period 1880-1974, a period of both voluntary and State control of UK hospitals, and the purpose of this Chapter is to summarise existing literature on both hospital accounting and, to a lesser extent, hospital management, together with broader academic work relating to UK hospitals. This provides an insight into other research, within the boundaries of hospital accounting, and also identifies important documentary sources. Secondary sources include management, political and social, as well as institutional histories, and primary sources are largely government publications, practitioner journals and archive material on accounting and managerial policy available at the Public Record Office.

Hospital Accounting Literature and New Public Management in Section 3.2 provides an overview of the huge volume of research on hospital accounting practices after the introduction of the internal market in 1989. The purpose of this section is twofold. To explore the significant contextual factors identified in the more recent debates on hospital accounting reform and also to assess what awareness this literature has of antecedent conditions. ***Accounting History in the UK Public Sector*** in Section 3.3 examines historical accounting work on municipal or local authority accounting and provides interesting contrast with hospital accounting and also important insights into universal changes affecting public sector accounting practice. This is followed by a consideration of the work of accounting historians in the hospital sector, in Section 3.4: ***Hospital Accounting History***, which provides an important starting point for this research.

As the purpose of the research is to provide a contextualised history, Sections 3.5 and 3.6 widen the research area beyond hospital accounting history. In 3.5: ***Political and Social History of Hospitals*** the author examines secondary hospital literature, from the late 19th Century to nationalisation in 1948, concentrating on changes in medical care, the role of funding institutions, the development of hospital records and

hospital management texts. ***Political and Social Policy in the NHS ~ 1948 -1974***, in Section 3.6, is a brief review of the political and social policy literature for this period.

In Section 3.7: ***Government-sponsored Reports and Sources ~ After 1948*** the author concentrates on the increasing number of government policy documents on accounting and management after 1948, and draws on the work of other groups and institutions, a number of which are sponsored by the NHS bureaucracy. This Chapter ends with a brief summary of literature leading to the 1974 reorganisation in Section 3.8: ***Hospital Management and Accounting Studies and the NHS***, while Section 3.9 concludes the Chapter.

3.2 New Public Management

During the 1980s and 1990s there was a huge growth in the literature on hospital accounting, and, more broadly, what has subsequently been described as *'new public management'*, (NPM) (Hood, 1991; 1995). This intensified after the publication of the 1989 White Paper (Department of Health), which introduced the concept of the purchaser/provider split [widely referred to as the 'internal market'], as well as introducing self-governing trusts, capital charges and contract pricing. The key theme of much of the hospital accounting research after 1989 was the effect of the market reforms on the nature of public sector organizations and the managerial culture being created, or certainly extended and cemented within the NHS. There is a vast amount of research after 1990 and the author divides this into two; work with a predominately contextual focus and that from a more technical perspective.

3.2.1 – Contextual Papers

Broadbent and Guthrie (1992), in their paper: CHANGES IN THE PUBLIC SECTOR: A REVIEW OF RECENT 'ALTERNATIVE' ACCOUNTING RESEARCH, suggest that the transformation of the organisation and management of the public sector has been substantial, and that accounting has been at the heart of the process of change. Summarising Hood (1991) and Pollitt (1990) they argue that:

> *The previous central focus of accountancy and auditing in this sector (the public sector) has been with probity, compliance and control. A movement*

away from this situation has emerged, and the emphasis now is on changing the character of the discourse and technologies to promote what is characterized as efficiency, effectiveness, cost saving and streamlining – managerialism in the public sector (Broadbent and Guthrie, 1992).

Their review of literature is broader than the NHS and embraces three, what they refer to as, 'orientations': *technical accounting, technical contextual accounting* and *contextually technical accounting.* Using these different research approaches they examine the 'critical' literature on central and local government, and on other public sector bodies, such as the NHS and public corporations. They conclude that

> *...more and more attention has been given to investigating how the forms that accounting takes and the ways in which it functions are influenced and influence the wider functioning of organizations, institutional and social settings', and also that the lack of research in the 'alternative' mode in the public sector at present means that unevaluated reforms are being implemented with impunity and using the name of accounting as legitimation* (p.26).

In an earlier work, concentrating on the NHS, rather than the public sector in general, and a ten year timeframe after 1979, Broadbent, Laughlin and Read (1991) use a *'model derived from Habermas' critical theory'* to *'evaluate the different steering mechanisms issued by the Department of Health of the British Government to mould the behaviour of the National Health Service'* (p.25). They track the initiatives of successive UK governments in the NHS, and suggest that:

> *Three areas of concern can be identified: the management, organization and financing of the service, the issues of value for money, and finally the need to generate data and information* (p.13).

On *management, organisation and finance* they identify four reports, PATIENTS FIRST (DHSS, 1979), CARE IN ACTION (DHSS, 1981), GRIFFITHS REPORT (DHSS, 1983) and WORKING FOR PATIENTS (Department of Health, 1989) and suggest, particularly on the last report on the market reforms, that *'the discourse around the White Paper throws into stark relief the differences between the lifeworld which informs those who work within the NHS and that which informs the external steering medium'* (p.14). They use the opposition of the BMA to the changes proposed in the WORKING FOR PATIENTS white paper as an illustration of this conflict.

On *Value for Money* they identify the 1979 Rayner Scrutinies, cash limits, competitive tendering, cost improvement programmes the publication of performance indicators and early attempts at medical audit, as examples of *'steering mechanisms'*. These reports and initiatives

> *...provided a discourse in which ideas and theories which might not have been produced by the internal steering mechanisms can be proposed by external agency in attempts to colonize. It could be argued that the different reports show increasingly intensive efforts to colonize in that they have been less and less amenable to substantive justification by the average individual. This can be demonstrated by the increasing level of debate as each one has been published* (p.18).

In a later paper, Humphrey, Miller and Scapens (1993) also connect accounting and managerial change and suggest that in the 1980s *'there erupted a concern within public sector organizations with notions of 'accountable management'* (p.7). This is illustrated by a collection of techniques used in public sector organisations, including

> *...efficiency scrutinies, value-for-money audits, performance indicators, resource management initiatives, computerized financial information systems, cash limits, delegated budgets and internal markets all became central to notions of a 'new public sector management'* (p.93).

They make the bold statement that *'organizations with little prior experience or demonstrated need for financial-based record keeping and control systems began to question how they had managed to function without such systems'* (p.7).

This wide ranging paper analyses the influence of the 'neo-liberalist' agenda on the actions of the State and, using the Thatcher governmental reforms as examples, suggest that the degree of change is consistently overstated, and that *'the greatest 'miracle' of the Thatcher years was that rhetoric triumphed over reality for so long'* (p.11).

The theme of 'rhetoric' being a long way from the 'reality' of change is continued in their discussion on the impact of *'accountable management'*, as

> *...in many situations it has almost seemed that the reforms have been made up, or fabricated, as they have been implemented, with problems in the pilot stages seldom leading to a significantly different approach* (p.22).

Even though they suggest that there was a degree of fabrication they still maintain that a *'cultural clash'* (p.18) has developed between professionals and managers, and there has been a transfer of authority from doctors to managers. For example, using the work of Rose and Miller (1992) and Preston (1992), they state:

> *It is managers rather than clinicians who are becoming increasingly powerful – as the terms of calculation and performance measurement shift from medical to the financial. Where clinicians were once trusted, faith is now being placed in the capacity of managers, aided by accountable management systems, to ensure that public services are delivered economically and efficiently* (p.19).

Humphrey *et al.* (1993) also identify a number of other drivers of change in addition to the 'neo-liberalist' agenda, in particular new computer systems, the implementation of which was often the responsibility of the accounting department, which in turn increased the influence of accountants. The paper concludes that:

> *Perhaps the clearest point which emerges from the above reflections is the mobilizing power of appeals to accountable management, coupled with the congenitally failing nature of the reforms carried out in its name* (p.24).

The importance of this paper is that it recognises that, while reforms have been instigated with the aim of improved accountability, increased efficiency and more focus on what has broadly be described as 'managerialism', they have had substantially less impact than the 'spin' surrounding their introduction. The question not posed, in the paper, is whether these observations could be applied to similar initiatives in earlier periods.

Another paper by Chua and Preston (1994) also suggests that from the mid-1970s there is an emphasis, within health care rhetoric, on cost consciousness in a number of countries, but particularly in the United States, the UK and New Zealand. For example they argue that:

> *Prior to 1980 there was little of the cost and economics of health care in medical journals. However, during the 1980s articles concerned with health care costs and their control become regular features in these journals, including the prestigious New England Journal of Medicine in the USA* (p.5).

They also suggest, perhaps radically, that accounting has also influenced medical practice and patient care. For example they conclude:

> *Accounting-led initiatives, however, are not merely techniques to control costs and promote efficiency, as proponents argue; they have a profound constitutive role to play in shaping medical practice, the provision of healthcare and the experience of the patient as well as circumscribing the ground on which we are able to talk about health care* (p.15).

Chua and Preston (1994) further claim that there is very little evidence relating to the benefits of accounting systems in a health care context, stating

> *...these initiatives are constituted within the rhetorics of rationality, efficiency and 'free market' economics with very little evidence of their ability to achieve these goals* (p.15).

However the focus of the paper is on more recent reforms and there is little historical perspective and, although they acknowledge that accounting in healthcare [certainly in the UK] existed prior to the 1970's, like Broadbent *et al.* (1991), they argue that in the UK 'old' accounting was *'concerned with its treasury and reporting role'* (p.4).

This conclusion appears to ignore a number of attempts to introduce and implement costing and budgeting techniques into the NHS between 1948 and 1974 and will be challenged later in this thesis. In addition Chua and Preston (1994) perhaps 'overplay' the significance of the reforms in respect to their impact on medical practice in the UK, particularly given, as Humphrey *et al.* (1993) suggest, their *'failing nature'* (p.24).

3.2.2 – Technical Issues and Focus

In addition to wide ranging papers on the consequences of the market reforms there have also been a number of papers narrower in scope. These papers often focus on one issue, such as depreciation accounting or contract pricing within the NHS. For example, the accounting requirements around internal contracts, between purchasers and providers, within the *quasi*-market reforms and the concept that contract price should equal cost (National Health Service Management Executive, 1990), stimulated renewed interest in hospital costing techniques.

Ellwood (1990; 1992; 1995; 1996) examines the development of costing methods in one NHS region and concludes that the information was inadequate for the purpose of pricing contracts. In a slightly later paper she concludes that there was little

'incentive' to ensure contracts were *'consistent, meaningful and comparable'* (1995. p.47).

Bates and Brignall's (1993) paper evaluates the costing and pricing systems introduced as a result of the internal market and, like Ellwood (1992), question the notion that increased cost information would improve efficiency. In addition, they suggest that the focus on cost information would inevitable impact on traditional relationships in hospitals, particularly between managers and clinicians, concluding that *'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) but the introduction of contracting will *'superimpose other considerations'* (p.33). These other considerations will, they suggest, result in a *'re-orientation'* of the organisational culture away from, what they, and earlier studies refer to as a *'clan'* culture towards a more traditional managerial one.

Another 'technical' issue that received increased attention, from both accounting academics and practitioners, following the creation of the internal market, was depreciation accounting, introduced in hospitals in 1990. The aim of the reform, like many others, was the more *'efficient'* use of capital assets and to help comparison of performance, both within the NHS and with private sector providers (Hodges and Mellett, 1998; Mellett, 1992). This 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 (1989), at the Ministry of Health (Mellett, 1992). However there had been a debate, both at practitioner and academic level, prior to the market reforms, about the merits of capital charging, and this history of depreciation charges within UK hospitals is fully explored by Mellett (1992).

In addition there is a substantial volume of literature on the rationale for the introduction of the charges and their accounting characteristics (Lapsley, 1986; Mayston, 1989; Mellett, 1992; NAHAT, 1990). Subsequent research attempts to assess the effect of capital charges on the management of assets within the NHS (Heald and Scott, 1996), and Shaoul (1998) challenges the assumption that there was inefficient use of capital resources prior to capital charging.

There are various papers on the effect of accounting reforms, and their impact on doctors, obviously a key hospital professional group. Jones and Dewing (1997) used a longitudinal study to assess how new accounting control systems changed managerial relationships in hospitals, with particular regard to the work of clinicians, and they conclude that the new systems appear to support central control.

In a later paper, DEVELOPING FINANCIAL ACCOUNTABILITY IN BRITISH ACUTE HOSPITALS (1999), Jones outlines the development of Healthcare Resource Groups (HRGs) in UK hospitals, from the publication of the Griffiths report in 1983 (DHSS) to their use for benchmarking performance after 1997. These HRGs are essentially standard costs of care based on *'patients who consume broadly similar resources into clinically meaningful groups'* (p.3). Jones suggests that *'the compilation of a national database of costs for HRGs is intended to enable comparisons to be made between provider units'* (p.11).

Jones acknowledges that this attempt to introduce accounting systems is not new and that 'the NHS has a legacy of management and cost information systems which have been criticised as inadequate in identifying the costs of operation and procedures' (1999, p.16). However his overall conclusion was that the HRG exercise, perhaps because of the increased involvement/interest of clinicians, had met with a degree of achievement. This is in marked contrast to earlier efforts to introduce clinical information systems, in particular; Management Budgeting and Resource Management. For example, Rea's 1994 study concluded that these initiatives, were costly and of limited value in providing improved information to clinical and non-clinical managers.

3.2.3 – NPM and Historical Research

Within the context of 'New Public Management' (NPM) research, there is, however, recognition that the use of accounting devices in the public sector, for control and indeed policy advancement, can be traced to earlier origins than the early 1980's. McSweeney (1994), in the context of the British Civil Service, maintains that a change to *'management by accounting'* predates the election of the Thatcher

Administration in 1979, and Kirkham and Loft draw similar conclusions in relation to Direct Labour Organisations (DLOs) in Local Government (2000).

Kirkham and Loft identify the 'efficiency' agenda, pursued by both Conservative and Labour governments in the 1970s as a key conceptual justification for accounting change in DLOs and also implicate the professional accounting institutes [in this case CIPFA], in the promotion of accounting technologies:

> *In the UK accounting mechanisms have been very influential not in the least due to the power and influence of the institutions behind them, the professional accountancy associations which have successfully 'colonised' administrative structures in organisations* (p.44).

This idea that NPM management may have its antecedents in earlier reforms is also alluded to by Humphrey (1991), who argues that attempts to *'influence the management of public sector resources need to be placed in their evolutionary context and not be simply regarded as the product of the post 1979 revolution of Thatcherism' (p.169).*

Therefore, while the creation of the 'internal market' in 1989 stimulated extensive research on UK hospital accounting this is, perhaps, part of a long tradition of attempted 'accountingisation'. This aspect is one of the main questions in this thesis, but previous accounting history research in the public sector will first be explored.

3.3 Accounting History in the Public Sector

While accounting histories in the public sector are relatively limited (Parker, 1993; Carnegie and Napier, 1996); within Local Authorities or Municipal Corporations this neglect has been partly filled by the work of Jones (1992) and Coombs and Edwards (1993; 1994; 1995).

Coombs and Edwards' research has a financial accounting or external reporting focus and they are also interested in the nature and context of change. For example they suggest that allegations in the 1830s of *'maladministration led to state-organized inquiries and the creation of the initial statutory framework, including regulations*

for accountability' (1993. p.28). In addition the growth of municipal trading activity, particularly water supply, transport and utilities *'rendered existing statutory regulations and prevailing reporting practices inadequate'* (1993. p.47).

This change in the scope of the municipal corporation together with the creation of a professional accounting class, in the form of the Corporate Treasurers and Accountants Institute (CTAI) (later the Chartered Institute of Public Finance and Accountancy), led to what they describe as a *'gradual improvement of financial reporting practices'* (1993. p.41) and to increased efforts to *'standardize financial reporting practices'* (1993. p.41).

Coombs and Edwards' further suggest that one factor motivating the profession towards reform of accounting practices was

> *...stinging criticism of contemporary practices from Burdett's Official Intelligence, published each year on behalf of the London Stock Exchange, and in the columns of The Accountant* (p.41).

This is interesting in itself but also, as we shall see later, Burdett had an important influence on early hospital accounting and the introduction of a system of uniform accounting for hospitals in 1893. Indeed the quest for uniform accounting information seems to be an important *'concept'* (Porter, 1981) in accounting reform in both Hospitals and the Municipal corporations.

Coombs and Edwards, (1993) note that the CTAI was advocating uniformity and that this was also proposed by the joint Select Committee on Municipal Trading in 1903 (p.42). In Chapter 4 there is also a distinct similarity between the role of the State in accounting reforms in Hospitals and in Municipal corporations. For example the Select Committee of the House of Lords on hospital reform (BPP, 1893) refused to intervene in hospital affairs and recommend a system of uniform accounts, which mirrors the reluctance from the Select Committee on Municipal Trading. Coombs and Edwards (1993) state that:

> *Its report favoured the principle of uniform accounts, but was doubtful whether it would be possible to prescribe a standard form for all municipal and other local authorities, having regard to the varying conditions existing in different districts (Macmilan et al. 1934:26 quoted in* Coombs and Edwards, 1993. p42).

This aversion to State prescription in the later part of the 19th Century appears to be what Porter (1981) would describe as a universal element. This evidence from Municipal Corporations suggests that the State was comfortable leaving accounting policy to institutions and groups rather than direct intervention. For example '*it was left to municipal officials to develop improved procedures with encouragement from the CTAI'* (Coombs and Edwards, 1993. p.47).

Jones' (1992) work on THE HISTORY OF THE FINANCIAL CONTROL FUNCTION OF LOCAL GOVERNMENT ACCOUNTING IN THE UK traces accounting practice in local government from the Middle Ages to the early 20th Century. It includes an explanation of the technique of charge/discharge accounting and *'why double-entry eventually held sway over charge/discharge'* (p.43).

Like Coombs and Edwards (1993) Jones identifies the drive for 'uniformity' as the *'one significant theme running through the work done by committees of enquiry during this Edwardian period'* (p.91). Jones concurs with the work of Coombs and Edwards arguing *'that there was no political will to achieve this'* (p.117) but also suggests that this was partly from their realisation of the substantial problems associated with trying to 'standardise' accounts from numerous and heterogeneous corporations.

Within the central government, of the UK, papers on accounting history are even more limited. However, recently Edwards *et al.* (2005) explored how double entry booking was resisted by civil servants. They find that *'while a growing respect for business practices was sufficient to convince the government of the need to adopt the mercantile method of accounting [double entry], ...there remained effective and successful resistance at the operational level'* (p.656) particularly from civil servants, preventing accounting change.

This resistance, with the backing of accounting practitioners, was also prominent in early accounting reform in the NHS, and features in the process of change in Chapters 5 and 6.

3.4 Hospital Accounting History

Academic interest in pre-1974 hospital accounting regimes is limited (Lapsley, 1991), and most recent studies on accounting practices, and their impact on UK hospitals, fail to make more than a passing reference to the historical context (Jones and Mellett, 2000). There are, however, a few notable exceptions: Mellett (1992), and Jones and Mellett (2000) in the UK, and Preston (1992) on hospital accounting in the USA. These papers are discussed in detail below together with a summary of other research by Berry (1997), Lapsley (1991) and historical work written by accounting practitioners working within the NHS.

3.4.1 – Mellett and Jones and Mellett

Mellett (1992) explores the origins of depreciation accounting in the NHS, from 1948 to 1991. He suggests there is a long history of attempted reform since the creation of the NHS, but that, until the introduction of the *quasi*-market in 1989, the

> *...stimulus necessary for depreciation's full adoption was not apparent, but the revised funding arrangements significantly changed the nature of the fixed assets. They are no longer simply causes of cash outflows, 'facilities' in Mautz's (1988) terminology, but have become income generators'* (p.176).

Mellett concludes that the introduction of conditions similar to profit-making organisations is the central factor in the adoption of depreciation accounting in the service.

This paper is also interesting as it outlines the major accounting reports produced after the introduction of the NHS in 1948, including the Kings Fund (1952) and Nuffield Reports (1952) on departmental costing and budgeting, and early work on patient costing, that began to develop in the early 1970s (Feldstein, 1973; Russell, 1974; Perry, 1975). This literature is further discussed in Section 3.8.

In another history paper on UK hospitals Jones and Mellett (2000), using a social order model, track the interaction of organisational and accounting change in UK hospitals from 1800 to 1989 and propose that the health service [although they concentrate on hospitals] provides

... a good example of a current major British institution which has evolved slowly over time from a situation where communitarian principles have been dominant, through to the dominance of etatist principles, and, finally, to a situation where market principles have made great inroads (p.2).

The three periods identified above [*communitarian, etatist* and *market*] are placed in the approximate time frames of; communitarian 1800-1948, etatist 1948-1989, and market 1989-present. In the first period Jones and Mellett (2000) argue that:

Two discernable trends are evident in the accounting procedures of voluntary hospitals. First, a move away from cash to accruals accounting, albeit only for items of a revenue nature and, second, the increasing degree of uniformity between hospitals (p.12).

They also identify the creation of the uniform system of accounts as a crucial event in hospital accounting history, and suggest further that the Kings Fund played a leading role in the adoption, and dissemination, of these accounts (p.28).

In the second period Jones and Mellett note that

...progress towards governmental objectives, such as economy, efficiency and effectiveness, was facilitated by the development of performance indicators based on accounting data. The visibility, which cost analysis encouraged, necessitated increasing attention to costs. In turn, this uncovered new areas of costing and comparison (2000. p.28-29).

In the 1980s, Jones and Mellett consider that accounting was beginning to spread to clinical areas and that the

...transformation to a market-driven health service in which normal, commercial, full accruals accounting was adopted for external reporting. Patient costing, a prerequisite for pricing, was instituted. In addition, accounting provides the data which drives the purchaser-provider split (2000. p.29).

This work suggests that efforts to improve the *visibility* of accounting information were part of the debate in UK hospitals in a much earlier period than the internal market. Indeed this quest can be traced to the uniform accounts of 1893.

3.4.2 – Preston ~ the Emergence of Hospital Accounting in the USA

In addition to the work on UK hospitals there is some accounting academic work outside the UK using a historical perspective. Most notably Preston in his paper: THE

BIRTH OF CLINICAL ACCOUNTING: A STUDY OF THE EMERGENCE AND TRANSFORMATIONS OF DISCOURSES ON COSTS AND PRACTICES OF ACCOUNTING IN US HOSPITALS (1992). Using the theoretical framework devised by Foucault (1972; 1977; 1981) Preston argues that investigations into accounting change benefit from recognising

> *...their social and historical perspective, to illustrate both the intertwining of accounting and the social, and the linkages between the past and present* (p.64).

Preston further identifies the changes in US medical care over two centuries and their organisation and function. Using Foucault's concepts of 'genealogy' and 'discourse' he notes that:

> *Transformations in accounting practice within hospitals at the turn of the century and, indeed, throughout the twentieth century, are not seen as the result of strategic intent nor as a response to societal needs, nor indeed as a process of continuing technical elaboration. Rather, the transformations are seen as the outcome of the interplay of various socially and historically situated discourses and practices which may have had, and may continue to have, unforeseen and unintended consequences*
> (Rajchman, 1985, quoted in Preston, 1992. p.65).

In his extensive exploration of the origins of these discourses Preston also suggests that they were influenced by professional practice and indeed technological change. For example he argues that in the early 20th Century hospital accounting was *'informed by contemporaneous developments in the commercial world and in the manufacturing industries'* (p.73) and, partly due to changes, or *'advances'*, in medical techniques, this was also a period characterised by *'expressions of concern over increased operating costs'* (p.73).

Preston uses Chapman (1921), and Curtis (1924), as early illustrations of the advocacy of department accounting and suggests that: *'Another form of accounting to emerge in the 1920s concerned with the control of hospital costs was the use of budgeting' which was 'couched in terms of business practice'* (p.74).

Preston also notes that it is around this time that *'discourses on efficiency'* (p.74), for example, Harris and West (1925) stating that

> *...the gross cost per patient in a given institution throws very little light upon the activities and the cost of these activities, but we get the facts capable of comparison that tell the story vividly and accurately, when the*

units of cost are explicit and are based upon the following: Maintenance of patients, per bed, X-ray, per examination; (Quoted in Preston 1992. p.74)

Preston (1992) concludes:

> *We can see that notions of responsibility, departmentalization and the analysis of performance and efficiency based on a system of cost accounting and budgeting, begin to emerge as central themes in discourses on hospital accounting in the first quarter of the 20th century* (p.74).

Preston identifies a number of developments taking place in the US which were, undoubtedly, very similar to those in the UK and indeed around the same time period. Particularly the work of Stone (1924; 1936; 1953), an early promoter of hospital departmental costing in the UK, appears to be very similar to hospital accounting texts identified by Preston in the USA. This is discussed in Chapter 5 where the drivers of accounting change from a UK perspective are explored.

3.4.3 – Berry, Accounting Practitioners and Lapsley

In a paper examining UK hospital funding and decision-making for three voluntary hospitals, up to 1815, Berry (1997) briefly examines accounting information provided in annual reports. She concludes that the volume of information was extensive, and was stimulated by the need to

> *...assure their benefactors that their donations were being put to good use. Their format is broadly similar. All carry an annual report on the performance of the institution and appeals for additional financial support. They list the names of subscribers and benefactors and the sums of money given each year, incorporate an account of the financial state of the hospital, enumerate the patients treated each year and note the outcome of their treatment* (p.4).

While Berry's paper is only up to 1815 it certainly suggests that attempts at *'corporate governance'* were evident early in the life of voluntary hospitals and that the accounts *'were essential tools for appealing for additional funds'* (p.6). This is a claim also made by a number of other authors, (Rivett, 1986; Jones and Mellett, 2000), and by a number of witnesses giving evidence to the House of Lords enquiry in 1893. Berry, to a large extent, rejects many of the criticisms of the accounts, such as their failure to distinguish between capital and revenue expenditure (Pinker, 1964), arguing that, although the accounts were *'Receipt and disbursement'* (p.6),

> *...secretaries, in both the eighteenth and the nineteenth century, were clearly aware that some items of expenditure, such as new boilers, were 'extraordinary' rather than recurrent items, and correctly saw that it was necessary to detail these items* (p.8).

Interestingly Berry argues that the accounts were already similar to those later *'produced'* and advocated by Burdett, stating *'items were classified on similar lines to the classifications in the income and expenditure accounts proposed by Henry Burdett in 1893 in his uniform system of accounts'* (p.8). The evolution of these 1893 accounts is explored in Chapter 5.

A small number of accounting practitioners have tried to place more recent accounting changes in a historical perspective, providing brief summaries of previous accounting techniques in UK hospitals. Forte (1986), a member of the Department of Health and Social Security (DHSS) operational research department, gives a three page summary of the development of the costing in a collection of work on MANAGEMENT BUDGETING IN THE NHS (1986). He concludes that the costing system introduced in 1957 [departmental accounting]:

> *Was not working out as expected and still not serving management's information requirements... Insufficient distinction between treatment and non-treatment costs and no integration of cost information with budgeting information meant that enthusiasm for costing as a management tool was waning* (p.57).

Forte further suggests that interest in hospital costing at the local level was further reduced by the introduction of the Hospital Plan in 1961 and the emphasis on *'capital planning'* (p.57). This is a theme the author returns to in Chapter 6.

Hurst (1978), an economic advisor at the DHSS, in an earlier summary of hospital costing regimes, provides a brief summary of costing in hospitals up to 1977 with more focus than Forte, on costing for the clinician. He quotes from Burdett's 1916 uniform system of accounts, to illustrate attempts to introduce costing systems for comparing clinicians' spending, as Burdett (1918) claims that at the Edinburgh Royal Infirmary a system existed for comparing patient costs by clinician.

In a review of accounting research in the NHS, Lapsley (1991) suggests that until 1978, with the Warwick Report [see Perrin 1978] produced for the 1979 Royal Commission on the NHS (Royal Commission, 1979), there is little academic interest in NHS accounting. Therefore he concentrates on the period after 1979 but does make reference to the earlier reports on hospital costing by the Kings Fund (1952) Nuffield Trust (1952) and the Guillebaud Report of 1956.

Later in this study, in Chapter 5, the author notes that the Kings and Nuffield Funds both produced substantial reports on hospital accounting in the mid-1950s, and the controversy over the introduction of departmental accounting in the first eight years of the service (1948-56) is significant in the context of accounting practice of the period.

3.5 Political and Social History of Hospitals

While hospital accounting history is a relatively limited field there is an extensive literature on the social history of hospitals. Granshaw argues that the study of hospitals *'used to be the preserve of practitioners from the institutions themselves, who tended to emphasize the role of doctors and the uniqueness of the institution'* (1993. p.1180), whereas social historians have *'looked beyond the doctors to the governors, administrators, nurses, technicians, and the patients, who seldom feature in the older histories'* (1993. p.1180).

Perhaps the most important work in this area (Craig, 1991) relates to the USA and the work of Charles Rosenberg (1979), particularly; INWARD VISION AND OUTWARD GLANCE: THE SHAPING OF THE AMERICAN HOSPITAL, 1880-1914, where he identifies this period as providing a huge change in the number of hospitals and the number and social class of patient admitted:

> *Not only had the hospital become more widely distributed throughout the United States, it had become a potential recourse for a much larger proportion of Americans; the respectable and prosperous as well as the indigent might be treated in hospitals, frequently by their regular physicians. The hospital had become an institution easily recognizable to late twentieth-century eyes* (p.347).

The work of Abel-Smith (1964), Cherry (1992), Granshaw (1993), Maggs (1993) and Porter (1999), all identify similar trends in the UK in the late 1880s and early 1900s. This includes the professionalisation of medical and nursing staff (Maggs, 1993), changes in the social class of patients and the public/patient perception of hospitals (Porter, 1999), the growth in number and type of hospital, and their increasing technical sophistication (Abel-Smith, 1964; Granshaw, 1993).

3.5.1 – Abel-Smith and Pinker

One of the earliest contributions in the UK was by Abel-Smith (1964), with his study on the development of Hospitals in England Wales from 1800-1948. Using professional journals; the *BRITISH MEDICAL JOURNAL*, *THE HOSPITAL*, *HOSPITAL GAZETTE* and *THE LANCET*, and a chronological approach to historical analysis, Abel-Smith identifies the main changes in the organisation of hospital medical care over an extended time period. These changes, stimulated by medical advances, included the growth in the number of hospitals, including the voluntary hospital, and 'pauper' hospitals, supported by the poor law. He chronicles the changes in funding regimes associated with the voluntary hospitals; from large individual donors, to funding institutions and, later, voluntary insurance and patient payments.

Abel-Smith also tracks the slow process of government involvement in hospitals. This ranges from increased support, following World War I, followed by increased state hospital funding, and Government concern, throughout the early 20th Century, with the lack of planning and the perceived *ad hoc* hospital development. In addition he collected a large volume of statistical data, published in Pinker's work ENGLISH HOSPITAL STATISTICS (1964).

Pinker uses Burdett's Yearbook, but also, after 1920, Ministry of Health annual reports as data sources, and provides details of bed numbers, occupancy levels, cost-per-bed, average length of stay, source of funds and an analysis of revenue expenditure. Pinker (1964) provides early criticism of the reliability of accounting data, stating:

> *There were many devices by which hospital accounting could be used to further the raising of money. The most intractable mystery remains of distinguishing clearly between Current and Capital account. It was not*

unknown for secretaries to list major items, such as new boilers, under 'extraordinary expenditure'. This had the effect of reducing the 'average cost per bed', thus giving such a hospital the reputation for economy in administration. Similarly an Income account could be modified by listing some 'donations for special purposes' under extraordinary income instead of income on maintenance account (143).

3.5.2 – Rivett and Craig

Another, more recent, work covering much of the same period, 1823-1982, is Rivett's THE DEVELOPMENT OF THE LONDON HOSPITAL SYSTEM (1986). Again this work is chronological and maps the history of the London hospitals, concentrating on changes in medical care, the organisation and management of London hospitals and the financial, political and economic factors leading to changes in the provision of care. Rivett uses medical and management journals, government reports, archives of individual hospitals and important institutions, like the King's Fund, and documents early attempts to *'manage'* the voluntary sector.

Rivett's work is particularly useful on the role of early groups, institutions and governmental organisations and their attempted reform of hospital administration and organisation. Examples include the role of the Charity Organisation Society, Hospital Reform Association and the Kings Fund. Many of these reforming groups had direct, or indirect, influence on accounting and management reform and tracking their activities is an important part of the approach adopted by the author in the following Chapters.

As part of the changing nature of the hospital we also see changes in how hospitals managed themselves and Craig (1991) suggests that in this period *'administrative functions developed beyond the simple institutional arrangements needed to dispense relief to the sick'* (p.76) and, using UK and Canadian hospitals, argues that

> *...hospital records were affected by growth and standardization and record-keeping practices by the development of more complex record offices* (p.383).

and that

> *...after about 1880, printed forms produced by commercial suppliers were widely used by hospitals to achieve regularity and uniformity in the recording and presentation of information. Hospital registers, financial ledgers, personnel files, and clinical files were particularly affected* (p.384).

Craig (1991) finds that the increased number of records is also linked to the development of more and more formal hospital administrative departments, and to the availability of the *'new technologies'* of the day; the typewriter, mechanical copying and duplicating. The role of these records in maintaining a 'visibility' in the hospital and a more managerial approach to their organisation is also alluded to:

> *The elaboration of administrative duties and responsibilities in larger and more complex hospitals was achieved by a delegation of authority which was controlled by records. Records provided strong links in an evolving chain of command and ensured that customary hierarchical control was maintained* (p.385).

This increase in record keeping was accompanied by the 'birth' of the professional administrator. In the UK the Hospital Association was created in 1886, and in the US the Association of Hospital Superintendents first met in 1899. The creation of this profession, hospital administration, has been documented in the US (Vogel, 1989), but even though there is some evidence to suggest that the US followed the UK the creation and development of the UK profession has only been briefly explored in academic literature.

3.5.3 – Hospital Management, Groups and Institutions

Chaplin (Health Services Management, April 1989) provides a brief history of hospital management and in particular the journal, *THE HOSPITAL*. Abel-Smith, Rivett and Maggs (1993) make reference to the *'administrative'* function in the context of their research on hospital and nursing change, and Moore (1999) tracks the early development of the hospital administrative function in relation to the influence of Burdett. However, the growth, development and influence of this profession certainly appears to be an under-researched area in UK hospitals.

There were a number of groups and institutions interested in the organisation and management of the voluntary hospitals, and in accounting change (Rivett, 1986; Prochaska, 1992; Waddington, 1995; Jones and Mellett, 2000). The most significant of these were the Kings, Sunday and Saturday Funds, normally referred to as the funding institutions. There are several histories of the Kings Fund, (Long, 1942; Prochaska, 1992), and Waddington's work (1995) on the Sunday Fund suggests that this type of benevolent fund created a new *'reference framework'*, where he states:

By creating a mass subscribing public through the popularisation and centralisation of philanthropic collections, the benevolent fund aimed to meet the metropolitan hospitals' pressing financial problems. Simultaneously the benevolent fund hoped to utilise economic incentives to remodel the hospitals' internal management and organisation (p.152).

And suggests that the Fund's

...most significant achievement was the encouragement it gave to uniform accounting procedures (p.157).

Another major work by Prochaska (1992) is PHILANTHROPY AND THE HOSPITALS OF LONDON, THE KINGS FUND, 1897-1990. He contends that, particularly in the first decade of the 20th Century, the Fund was crucial in promoting accounting and other managerial techniques to improve the performance of the voluntary hospitals, as:

The fund sought to create a new generation of capable, well-paid professionals who would revamp hospital management....with its enthusiasm for innovative administrative practices, based on the science of accountancy and social statistics, the Fund contributed to the growth of a 'managerial class' which was an increasingly visible feature of British society in the early twentieth century (p.70).

Prochaska (1992) also suggests that the fund promoted accounting and managerial practice in the following ways:

- The preparation of an *'annual statistical report'* (p.72) that used basic performance measures to compare hospital costs, such as cost-per-bed.
- *'The systematic compilation of statistics; one of the principal means by which the Fund gained power over institutions'* (p.73).
- Employing accountants to update Burdett's uniform accounts (p.71).

In addition to these institutional histories there are other institutions and groups that, while not directly associated with hospitals, were significant in influencing, or attempting to influence, voluntary hospital management before the advent of State control. The most noteworthy of these, certainly in relation to the development of accounting and management practices, were the Charity Organisation Society and the Social Science Association, (Owen, 1965; Rivett, 1986; Moore, 1999) and their influence is examined in chapter 4.

3.5.4 – Hospital Funding

Perhaps stimulated partly by problems in NHS funding, and organisation, in the late 20th Century, and more recently New Labour's interest in Foundation Hospitals, funding of UK hospitals, prior to nationalisation in 1948, is receiving renewed attention. Mohan and Gorsky (2001) explore charitable funding, both before, and after, the creation of the NHS and include a *'spatial analysis'* of hospital provision within the UK, finding that the lack of planning and coordination of voluntary hospitals resulted in an inequitable distribution of care, as

> *...well-provisioned areas included London, parts of the south west and south east and the Midlands... and poorly provisioned areas like Wales, Cornwall, Lincolnshire and parts of Scotland, and also some of the Home Counties* (p.58).

Like Pinker (1964), they use Burdett's hospitals and charities annual and its successor, the hospitals yearbook, to create trend lines of hospital income and expenditure from the early 1900s up to 1948. Their expenditure trends identify the changing nature of healthcare, as expressed in accounts, and particularly noticeable is the transfer from provision costs to staff costs as the technical nature of healthcare, with its resultant requirement for specialist staff, developed. On the funding of voluntary institutions, between the wars, Mohan and Gorsky (2001) conclude that:

> *From the mid 1930s annual deficits were becoming more common, with large hospitals exhausting their capital reserves and becoming reliant upon borrowing. The problem of rising debt became more acute as publicly funded municipal hospitals undermined philanthropy* (p.90).

Mohan and Gorsky's summary of changes in funding from 1900-1948 was that:

- *'Total annual income of British voluntary hospitals more than quadrupled in real terms.*
- *Outside London the proportion of funding coming from charitable sources (including subscription) declined from over 70% of voluntary hospitals income to around a quarter.*
- *There was also a proportionate decline in charitable funding of voluntary hospitals in London, but a more gradual one.*
- *Greatly increased direct payments by patients and income from mass contributory schemes made up the difference in both cases.*
- *But costs also increased rapidly, particularly staffing costs.*
- *In the decade before the Second World War growing numbers of voluntary hospitals were in financial deficit: more than one third of them by 1939. This situation was eased only with the onset of the state-financed wartime emergency scheme'* (p.53).

However, generalising about the financial strength of voluntary hospitals in the first half of the 20th Century is not an easy task, partly because of differences geographically and between decades. Certainly Prochaska (1992) rejects the conventional wisdom of impending doom:

> *Contrary to received opinion, the voluntary hospitals were not in perpetual crisis, let alone terminal decline, in the inter-war years, or only salvaged by patients' payments. It is facile to say that in the 1920s the finances of the voluntary hospitals were rescued largely by patients or that 'by 1924 no distinguishing characteristics of a voluntary hospital could be found' (Abel-Smith, 1964:327)* (Prochaska, 1992, p.104).

Cherry (2000) examines the role of Hospital Saturday, and other, workplace collection schemes, in the funding of late 19th Century voluntary hospitals, and suggests that the feature of this period was the growth of contributory schemes and that these schemes were important in promoting the expansion of hospital services and facilities in the inter-war years. He argues that the schemes promoted a *quasi-*insurance basis for hospital activity and that, while these schemes promoted a degree of co-ordination of hospitals, they were able to remain independent institutions. While he acknowledges that funds raised from these sources were only a small portion of total hospital income, they were significant in providing another source of revenue when hospital spending was under pressure.

Taking an even earlier period, 1765-1815, Berry (1997) uses annual hospital accounts to analyse hospital funding, and economic problems, over a fifty year period to *'explore the interaction between the financial position of a sample of three hospitals and policy making'* (p.4). Berry suggests that subscriptions and donations were the main sources of income, with investment income increasing in importance as the period progressed. Indeed *'examination of balance sheets built up from information in the hospitals accounts showed a gradual accumulation of nominal wealth, common to all three hospitals'* (p.15).

After 1948 the, previously voluntary, hospitals were effectively nationalised and therefore funded, predominately, from general taxation. Throughout the first 26 years of the service (1948-74) there were periodic debates on alternative sources of funding. This was particularly the case during the early years of the service, when the

cost was far higher than originally envisaged (Webster, 1988; Klein, 1995). This led to a committee of enquiry, later referred to as the Guillebaud Report (1956), into the cost and organisation of the service. This report was generally supportive of existing funding arrangements and neither of the two governing political parties have since seriously considered any alternative to general taxation, as the major source of funding.

3.5.5 – Early 'Text Books' ~ Burdett and Stone

Other important documentary evidence on the operation, and management, of the voluntary hospitals are texts and yearbooks. Two hospital management pioneers, both closely associated with the Kings Fund, Sir Henry Burdett and Capt. J.E. Stone produced the most important, and perhaps influential, texts on hospital management before 1948. For example Burdett's three-volume work, HOSPITALS AND ASYLUMS OF THE WORLD: THEIR ORIGIN, HISTORY, CONSTRUCTION, ADMINISTRATION, MANAGEMENT AND LEGISLATION (1893) is a brief history of the origins of hospitals. In addition there is a chapter on hospital revenues and the main sources of hospital funding, with a similar chapter on hospital expenditure and economy, with the average cost-per-bed calculated using ten expenditure classifications.

Most significantly for accounting historians Burdett published the first accounting manual the UNIFORM SYSTEM OF ACCOUNTS (1893), subject to a number of revisions, up to 1948, by the Kings Fund and the emergence and spread of uniformity is discussed in chapter 4.

Stone also published a text: HOSPITAL ACCOUNTS AND FINANCIAL ADMINISTRATION in 1924. Stone's work was aimed at hospital administrators, and dealt with hospital bookkeeping and record-keeping systems, the role and function of the various staff, hospital organisational structures and law. In addition Stone used his work to criticise existing accounting systems in voluntary UK hospitals, particularly the traditional subjective analysis of expenditure, and the problems associated with cost-per-bed data generated. [The subjective analysis of expenditure was a classification by subject or type. There were around 60 expenditure subjects, including ten categories of provision costs, e.g. meat, fish, butter and malt liquors were all itemised and appeared in the Income and Expenditure account]. Instead he advocated the use of

departmental accounting information, and the emergence of departmentalisation is further discussed in Chapter 5.

After 1898 Burdett begun to compile a hospital yearbook: HOSPITALS AND CHARITIES: THE YEAR BOOK OF PHILANTHROPY and the HOSPITAL ANNUAL. These books published a huge amount of data on hospital costs and income and have been extensively used by later academics to compile information on pre-1948 hospitals (see Pinker, 1964). In addition they provide a useful summary of the main issues [as identified by Burdett] affecting hospitals during the year.

3.6 Political and Social Policy in the NHS

Hospital history in the UK, after 1948, is inextricably linked to the NHS, as all voluntary and municipal hospitals were nationalised in 1948 and there are a number of writers examining policy change, after the birth of the new service. Klein's THE NEW POLITICS OF THE NHS (1995) and Webster's (1998) POLITICAL HISTORY both suggest that in the first fifty years of the service a number of policy paradigms can be identified. The first is *creation and consolidation* [Klein], and literature on this period concentrates on the origins of the service and the much-debated conflict between Bevan [Minister of Health] and the British Medical Association (BMA). Foot (1962), Bevan's biographer, provides a detailed account of both the process of the conflict, as well as insights into Bevan's background and political ideology.

Foot suggests that the nationalisation of the service, and the organisational form created in 1948, were very much Bevan's ideas. Whereas Pater (1981), who was a senior civil servant at the time of nationalisation, and wrote the MAKING OF THE NATIONAL HEALTH SERVICE contends that the Chief Medical Officer first suggested nationalisation in 1939, and that Sir John Hawton was responsible for suggesting nationalisation. While Webster (1998) concludes that Bevan decided to nationalise the service, even though it was opposed within the Ministry of Health.

The *consolidation* phase (Klein, 1995) deals with the financial crisis in the early years of the service and what is referred to as the political acceptance of the post-war

consensus on the organisation, and funding, of the service. Klein believes that in the 1950s the Department of Health was demoted in relation to the ministerial and civil service hierarchy, and that the period is characterised as *'keeping the machinery running, on care and maintenance rather than innovation and change'* (p.40). Klein also identifies, perhaps the central problem of all large organisations and bureaucracies; *centre-periphery relations,* arguing that

> *...from the centre came pressure on the Ministry of Health to exercise stricter control.... ...from the periphery, however, there came complaints that the Ministry of Health was interfering too much* (43).

This is a recurring theme in the NHS and Bates and Brignall (1993) describe the NHS structural organisation in the 1990s, as similar to a company organised into divisions, with the added complication of political interference. In Chapters 5 and 6 this thesis explores the appeal of accounting tools in solving this centralisation or decentralisation dichotomy.

The second stage in the policy-making history of the NHS, according to Webster, (1998), is characterised by *Planning and Reorganization*, whereas Klein describes this phase as the *Politics of Technocratic Change*. This is, approximately, the period from the early 1960s to the mid 1970s, which comprised both Labour and Conservative governments, and Webster argues that

> *...in an attempt to improve the performance of spending departments, the Heath administration (1970) imported business advisers, and shared their enthusiasm for planning, programming, budgeting systems and techniques such as cost-benefit analysis* (p.79).

Klein (1995), similarly, suggests that the main features of the period are *efficiency*, and later *planning* and that this was the:

> *Heyday of technocratic politics in the NHS. It is the emphasis on efficiency and rationality in the use of resources which marked this period...there were efficiency drives in the early 1950s, just as there were efficiency campaigns in the late 1970s. But what marks out the period in between is the development of an ideology of efficiency* (p.57-58).

Like Webster (1998), Klein (1995) identifies techniques, such as cost-benefit analysis and Planning, Programming and Budgeting (PPB) as evidence of a change in ideology, which he refers to as changing from the *'paternalism'* of the 1950's to

one based on *'rationalism'* in the 1960s. In Chapter 6 the author takes issue with Klein on the significance of PPB, particularly at the hospital level.

In addition to his POLITICAL HISTORY (1998) Webster also produced two very detailed volumes on the history of the service (1988; 1996). Webster had privileged access to civil service departmental records and his work provides a detailed account of all important events, and policy debates, up to 1979. His vast and detailed work embraces the whole service, not just hospitals [normally referred to as secondary care], but also primary and preventative services. He focuses particularly, at the macro level, on the changing health policies of the major governing parties, organisational reform in the period, and the economic and social forces affecting healthcare policy. He provides an insight into policy-making, and the relationship between senior civil servants and the various Ministers of Health, during this period. This includes a detailed description and analysis of the; reorganisation of the service in 1974, the debates on financing the service, particularly in the early 1970s, and the origins and rationale for the first Hospital Plan in 1962. In addition Webster provides essential insights and information on managerial change [or attempted change] in the period.

Another general source on the early decades of the NHS is Rivett (1997) who tracks medical and nursing developments and changes in organisational and managerial practice over the first fifty years. He uses academic journals, particularly the BMJ, government publications and policy statements, and a vast array of secondary sources.

There are a number of other academic studies in the social policy area, some with a historical perspective. Chris Ham completed, in 1981, a history of the Leeds Regional Health Board from 1947-1974 and summarises his two research questions as:

> *What does the experience of the Leeds Board tell us about the dynamics of public policy? And, Secondly, what does the experience of the Leeds Board tell as about the evolution of the NHS* (p.4).

Ham is broadly supportive of the Regional Health Authority (RHA) and argues that the region was able to aid the planning process and improve healthcare strategy.

Ham's evidence further suggests that *planning* was a dominant concept from the mid 1960s and confirms Barnard's view (1974) that it was the new managerial '*panacea*'.

An earlier and wide-ranging review of the NHS was completed by Lindsey in 1961. Using secondary data, largely Government publications, and interviews with those working in the service, he provides a brief history, and assessment, of the opening years of the service. His review of the first thirteen years is very supportive of the structure, financing and operation of the service, indeed some of the tone of his writing may be considered almost party political forty years on. For example:

> *Prudent spending and careful management have produced a service of incalculable value. The program is paying tremendous dividends in a healthier nation. As one observer put it 'The Health Service was not a money-consuming service; it was a wealth-producing service'* (p.472).

Lindsey's support extends from NHS financing to more detailed questions on the managerial organisation of the service, for example, on the promotion of efficiency and departmental accounting, he states:

> *One cannot avoid being impressed with the constant effort to promote more economy and better performance. While there has been no obvious waste, it is clear that new improved techniques save both time and money. Introducing departmental accounting was a major step. Under this system, expenditures are broken down by departments and services, and ward costs are even classified on the basis of the various specialties. From such information, comparative studies suggest where inquiries most appropriately can be made to reduce expenses* (p.462-463).

However Lindsey provides little evidence to substantiate his conclusions, which appear to be based on central bureaucracy hopes for their initiatives, rather than their outcomes. Much of this work on the NHS obviously makes use of the extensive reports prepared on behalf of the government after 1948 and the next Section provides a brief summary of these.

3.7 Government Publications

As early as 1950 Sir Cyril Jones (PRO CAB 134/518), a senior civil servant, conducted an inquiry into the financial workings of the service. This is used by Klein (1995. p.44) to illustrate the centralised/decentralised debate, and also the lack of

appropriate decision-making information generated within the service. The report provides useful insights into budget setting and control, and the use of costing information during the first two years of the service.

Jones suggests that the NHS had an inherent problem in the control of expenditure as

> *...old compulsions in favour of financial responsibility as now disappeared, viz., the limit of public generosity and the odium of rate increase... something is needed to take their place if the situation is not to get completely out of hand* (p.6).

Jones is particularly critical of budgetary controls which relied on annual estimates submitted by hospitals to Regional Health Boards, and, in turn, their aggregation and submission to the Ministry. According to Jones budgets, at hospital level

> *...emerge showing considerable increases under all or most heads of account and are then forwarded to regional board.... Figures for 'cost per patient-week' of groups of hospitals of similar type and of all hospitals under each Management Committee are given, but, as they are calculated by dividing gross annual expenditure (including extraordinary expenditure) by one seventh of the annual patient days, thus disregarding the all important factor of the bed occupancy rate, they are valueless for purposes of comparison* (p.7).

At regional level the differences in checks on the estimates varied between the *'widest possible extremes'* (p.7) and:

> *The fact is that the Ministry possesses very limited information regarding the financial administration of the hospitals of the country on the basis of which or the procedure by which the estimates are framed; has no costing yardstick at its disposal by which to judge the relative efficiency or extravagance of administration of the various hospitals, and hence has no alternative but either to accept the estimates wholesale as submitted without amendment, or to apply overall cuts to the total budgets in a more or less indiscriminate manner* (p.9).

This led Jones to speculate on the use of departmental costing but he regarded such a hospital financial information system as *'a dream of the remote future'* (p.10).

His main conclusion was that estimates/budgets should be controlled directly by the Ministry and that Regional Hospital Boards should cease to be directly concerned with hospital administration and management. This proposal, to strengthen central

direction, was rejected by the Minister of Health but the idea was a recurring one within the service (Klein, 1995).

A wide ranging investigation was set up in 1953, reporting in 1956; the Guillebaud Report (Ministry of Health, 1956). The objectives of this committee of enquiry were:

> *To review the present and prospective cost of the NHS; to suggest means, whether by modifications in organisation or otherwise, of ensuring the most effective control and efficient use of such exchequer funds as may be made available* (p.1).

The chairman of the committee was a Cambridge economist, C W Guillebaud, and the committee was appointed by the Conservative government. Its conclusions, unlike the Jones Report above, were very supportive of the existing organisation, and its funding through taxation. Indeed it concludes that there was little evidence of inefficiency and overspending within the service in real terms, for example, stating

> *... no major change is needed in the general administrative structure of the NHS, we have sought to ascertain where, if anywhere, there is opportunity for effecting substantial savings in expenditure, or for attracting new sources of income, within the existing structure of the Service; but we have found no opportunity for making recommendations which would produce new sources of income or reduce in a substantial degree the annual cost of the service* (p.268)

and continued:

> *The rising cost of the Service in real terms during the years 1948-56 was kept within narrow bounds; while many of the services provided were substantially expanded and improved during the period. Any charge that there has been widespread extravagance in the National Health Service, whether in respect of money or the use of manpower, is not borne out by our evidence* (p.269).

In addition the report includes a section on accounting within the service, and describes the, then, current system of financial reporting [often referred to as the subjective analysis of expenditure] as *'unsatisfactory'*, and also provides a brief history of the development of departmental accounting. It concludes that a good case had been made for its introduction and that budgetary control should be introduced at the departmental level, stating:

> *As soon as practicable, hospital departments should forecast annually how they propose to spend with maximum efficiency the money allocated to them, and should be required to account for any considerable discrepancies at the end of the financial year* (p.251).

Guillebaud also raises the idea of data collection and statistical analysis, and suggests the introduction of a research and statistics branch [within the department], which would:

- *Devote the whole of its time to statistical investigation and operational research in general, and would consider what information is now lacking as to the working of the NHS and how this information might best be produced* (p.267)

and

> *This Department would act as the intelligence branch of the health department, working in close co-operation with the Departments' administrative and medical staff* (p.267).

This report is often referred to as 'influential', and certainly appeared to help quell any opposition, from inside, or outside, the service, to its basic structure and funding, with its conclusion that the NHS was basically a success, but could be improved by incremental change.

In the 1960s one begins to see a proliferation of interest from the government and Ministry of Health on organisation and management (Klein, 1995) and, therefore, a significant increase in official reports. Indeed Barnard (1974) suggests that the *'government caught the bug of managerialism'* (p.117) in the 1960s.

In 1962 the first Hospital Plan was completed for England and Wales, which announced a huge new hospital building programme (Ministry of Health, 1962). In addition to the physical construction of new hospitals the effect of this report, and the building programme, was to introduce the concept of the large District General Hospital (Webster, 1996).

There were also a number of studies on the organisation of medical work in hospitals, later published and referred to as the Cogwheel Reports. The first, published in 1967, suggests that the work of medical staff should be organised around specialities, stating that

> *...taking the district general hospital complex as the basic unit it is suggested that the grouping together of specialities would allow an organised approach to many problems which medical staff should be facing and so establish effective medical administration in hospitals* (p.15).

In addition to the Cogwheel report on medical staff organisation, there is a report on the Function of the District General Hospital and numerous reports on specialist staff within personnel. This includes the organisation of nursing (Ministry of Health, 1966, Salmon Report), administrative and clerical staff and hospital, scientific and technical staff (DHSS, 1968). There is also a report on hospital management, the Farquharson-Lang Report (Scottish Health Service Council, SHSC, 1966), which is the first to recommend the introduction of general managers, and is, generally, critical of the management function in the hospital service; in particular, the unclear definitions of the roles of officers and members, the time spent by senior staff on relatively minor matters and the lack of strategic direction.

THE HOSPITAL PLAN of 1962 (Ministry of Health) and the later report, THE FUNCTIONS OF THE DISTRICT GENERAL HOSPITAL (DHSS,1969) consolidated the belief that the optimum healthcare structure was based on the District General Hospital (DGH), stating:

> *Not merely can supporting services be more economically provided at one central site, but the patient who may be suffering from a combination of different conditions should not have to be referred from one hospital to another: he should ideally be able to obtain whatever hospital treatment he requires from a team of consultants working together in one district general hospital* (p.3).

In addition to these official reports there are a number of studies completed by individuals, groups and institutions after 1948, and this literature is explored in the following Section.

3.8 Individuals, Groups and Institution ~ after 1948

One of the objectives of this research is to use a multi-faceted approach in the search for historical explanations, and to assess the role of individuals, groups and institutions, which Porter (1981) refers to as *'elements'*, in the process of accounting change. A number of these individuals, groups and institutions published accounting studies after 1948, and these are important data sources, which provide valuable insights into accounting practice in this period, and to their thoughts and aspirations. In addition there are a number of government reports, and government-sponsored

reports, on accounting between 1948 and 1974. Up to the late 1960s these revolve around the issue of departmental accounting, whereas, after this date, patient costing information begins to emerge.

3.8.1 – Departmental Costing

The Nuffield Trust Report (1952) on departmental accounting appears to have been largely written by a Miss Livock and states that *'a system of departmental costing had been instituted at the Radcliffe Infirmary, Oxford in 1937'* (1952. p.10). One of the objectives of the experiment was to assess the possibility of introducing standard costing into the hospital environment, and it is suggested that it would be possible to adopt a standard patient cost, which could be used as a basis for resource allocation and performance measurement. For example:

> *An attempt could be made to build up a standard cost by adding to the basic patient-maintenance cost the estimated expenditure on the special departments based on the unit cost of normal output. ... This standard should give to HMCs, RHB, and the Ministry a basis on which they would be able to judge the financial position of the hospitals under their control and to make global allocations to meet the expenditure of those hospitals* (p.11).

There were nine hospital groups associated with the study, and a total of 44 hospitals, and although the report concludes that *'standard costs can be used in hospitals as the basis of the preparation of the estimates'* (p.53), there are also some qualifications to this initial optimism, arguing *'that departmental standards can be evolved which, by their modification to meet local conditions, would provide a valuable aid in the allocation of funds... but before this can be done much more needs to be known of the factors affecting cost'* (p.52).

This Report is one of a series on departmental costing and budgeting produced in the early 1950s. The others are the Kings Fund (1952) and a report prepared by practitioners within the service, the Regional Treasurers (Committee of Regional Treasurers, 1952).

In addition the Ministry put together a working party made up of representatives from the various institutions, a number of senior civil servants, and leading hospital

treasurers, who produced a joint report on hospital departmental costing in 1955 (Ministry of Health, 1955). This report eventually resulted in the introduction of departmental costing in the larger hospitals. A detailed analysis of the process of change, and influence of the various groups, and institutions, is given in Chapter 5.

Montacute (1962) a Treasurer sponsored by the Nuffield Trust, carried out questionnaire research on costing in the service, focussing on the effect of the departmental costing scheme introduced in 1958. This work provides an insight into the views of hospital treasurers and other senior managers, on the possible function of costing and accounting information, and is drawn upon in Chapter 6. In an earlier article Montacute (1962) discusses the possibility of introducing a national standard cost for various parts of the service and measuring performance against these standards, arguing that:

> *The present practice of comparing crude costs would therefore be replaced by comparison with national standards adjusted for local factors, and national and regional averages would cease to have any significance. One would not need to wait for the Ministry's annual cost publication before knowing how one's costs stood, for comparison could be made at once with one's adjusted target* (p.254).

Montacute acknowledges that any monetary standard would need to consider the quality of the service actually provided. In addition he appears to be influenced by efforts in the United States to monitor and assess hospital and clinical performance, particularly a scheme of accreditation of hospitals, based around medical audit and the recording of clinical data.

3.8.2 – Treasury Reports on Departmental Costing

Government archives reveal that a civil servant was seconded, from the Treasury to the Ministry of Health, to investigate the use of the costing information produced after 1958 (PRO: T227/1545). This report, considered in Chapter 6, concludes that, while there had been some benefits from the costing scheme, it was generally critical of the Ministry and their use of the data produced.

3.8.3 – Early Research on Patient Costing

Feldstein (Hospital Service Finance, January 1965) examined hospital costs, in the five year period after the introduction of hospital departmental costing in 1958 (Hospital Service Finance, 1965, MH148/38, 1964-6), and identifies that hospital *'case mix'* is a significant driver of *'hospital costliness'*. Using the coefficient of variation for 177 hospitals, he concludes that the variation in cost between hospitals over the five year period stayed broadly the same (Feldstein work is discussed further in chapter 6).

After Feldstein's critical appraisal of existing costing regimes, and the use, or misuse, of *'crude'* costs, in the early 1970s, there is an increasing interest in establishing, and comparing, the cost of specific medical episodes. This is variously referred to as disease costing (Babson, Hospital, 1971; 1973), patient costing and case-mix costing (Feldstein, Hospital, 1965). This later develops into specialty costs (Magee *et. al,* 1974) and Diagnostic Related Groups (Preston, 1992) in the USA, and Healthcare Related Groups in the UK (Department of Health, 1997; Llewellyn and Northcott, 2005).

Babson was an early pioneer in the UK of disease costing. This research was associated with the Department of Social Administration, University of Manchester, and a continuation of the work of Professor Chester on hospital efficiency (See Farndale Ed., 1964). Babson identifies a number of potential benefits associated with disease costing (MH 1971, 166/466), including the ability to *'identify areas of inefficiencies, as a means of allocating funds to individual hospitals and once sufficient disease costing data becomes available, 'standard costs' could be established for each diagnosis or group of diagnoses'* (p.13).

There are a number of other studies with a similar theme. Perry, in her 1973 study of disease costing at Northwick Park HMC, identifies work by Piachaud and Weddell (1972) Weir, Russell and Harper (1973) and Magee, Edwards, Connies-Laing and Richards (1973). Another report, for the Scottish Home and Health Department, by Russell (1974), suggests that existing hospital costing statements and data could be adapted to provide useful patient/cost information. The study makes the, perhaps

obvious, point [in retrospect] that there is a close relationship between length of stay and cost, and concludes that their costing system offers three potential benefits:

> *For the clinician, it would indicate the costs of the type of care he wished to provide; for the planners, it would allow estimates of cost alternative policies and priorities; and for the administrators it would permit comparison of production costs of particular services and would identify the extent to which defined components contribute to them* (p.32).

Another study on 'patient costing' was completed by the Kings Fund in 1973. This report ACCOUNTING FOR HEALTH with the sub-title THE APPLICATION OF ECONOMIC PRINCIPLES TO HEALTH SERVICE MANAGEMENT was prepared by a working party, including Abel-Smith of the LSE, and Walter Holland of the department of clinical epidemiology at St Thomas's Hospital medical school. The Report broadly supports the integration of the Health Service associated with the 1974 reorganisation. However it points out that, while the Green Paper [leading to the 1974 reorganisation] emphasises good management and performance measurement,

> *...it is only possible to decide if resources are used well or badly if there are ways of measuring what is obtained for these resources – and what might be obtained by alternative use of these same resources* (p.16).

It also candidly suggests that

> *...not the least of the difficulties to be overcome in improving standards of management and evaluating performance, is that it has for so long been tacitly accepted within the NHS that the activities of the medical profession lie outside management control* (p.16).

This Kings Fund report (1973) quickly establishes that the key to controlling the activities of medical professionals were improvements in information systems, particular costing systems, and they describe the aim of the report to

> *...devise management processes for determining and controlling medical policies without impinging on the clinical freedom of the doctor to treat each individual patient as he thinks fit and that the main obstacles to achieving this aim were the defects of present information systems... and the inappropriateness of existing methods of cost accounting* (p.17).

The costing system proposed in the Report is interesting in itself, but also because of its closeness, both in rhetoric and design, to Cooper and Kaplan's (1988, 1991) ACTIVITY BASED COSTING. A chapter title, for example, is COSTING THE ACTIVITY

UNITS and they appear to suggest the two-stage approach advocated by Cooper and Kaplan. Firstly the report suggests:

> *It will be necessary to define for each main area of the health service ... the elements of service to be costed, the activities within each to which costs can readily be ascribed, and the appropriate unit or units of cost*

and continues

> *Costs can then be ascribed to individual cases by allocating the appropriate number of costed units. Cases costed in this way from each source of care or accommodation can be grouped by reference to the doctor in charge of the case* (Kings Fund, 1973, p.49).

The Report argues that current costing systems are inadequate and recommends that costs be collected by diagnostic groups, and that only this *'has real value for comparative purposes'* (p.50).

While this interest in patient costing stems from the early 1970s, it was not introduced in the first major reorganisation of the service in 1974. Instead, as noted below, functional budgets, allied to extensive planning mechanisms, were recommended and implemented.

The earliest attempt to introduce some form of case-mix costing throughout the hospital service; was the Körner initiative of 1984. This required hospitals to prepare an annual financial return outlining the cost of each speciality treated. In the 1990s hospitals were encouraged to publish Healthcare Related Costs, similar to Diagnostic Related Costs. While the Körner report, and subsequent HRG (Departmental of Health, 1997) initiatives, are outside the time period of this research it again illustrates the slow pace of change within the NHS bureaucracy, as illustrated by Mellett (1992) in relation to depreciation accounting. While there was an interesting debate taking place, both academically and via research commissioned by the Department of Health, on possible patient costing systems, these ideas were either too radical, or the practicality of introducing such change within the NHS, delayed change.

3.8.4 – Hospital Management and Reorganisation

In the 1960s the Ministry of Health began to promote a number of hospital studies on management and efficiency. This included work by the London School of Economics by Rosemary Stewart, and later by Brunel University, led by Professor Jacques (MH 166/251). Brunel University later set up a management investigation team called the Brunel Health Services Organisational Research Unit, active from 1966 to 1980. There were, at least, two published studies of their work, HOSPITAL ORGANIZATION (Rowbottom, 1973) and HEALTH SERVICES (Jacques, 1978), which suggests their ideas were influential in the reorganisation of the service in 1974.

Changes in the structure of the service have, historically, resulted in a heightened interest from academic researchers in the hospital service. This is evident, particularly from work on the effects of the internal market on healthcare provision, but can also be identified with other organisational changes; normally referred to as *reorganisations*.

An example of this is Levitt's (1976) work on the 1974 structural changes, which provides a historical narrative of the evolution of the reforms, and briefly considers the effects on financing and budgetary control. Similarly to previous work in relation to departmental accounting (Stone, 1924; 1936; 1953) and subsequent research (Broadbent *et al.* 1991) on the internal market, Levitt claims that the 1974 reforms resulted in an increase in commercial accounting techniques. For example, she states:

> *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).

Levitt suggests that pre-reorganisation the budgetary control systems were inadequate:

> *Since budgeting and planning were generally so poorly used in the pre-1974 NHS, they failed to provide the comprehensive and efficient scheme of care that was originally envisaged* (p.183).

In a summary of accounting and reporting in the NHS, Perrin (Henley *et al.* 1983) identifies the 1974 reorganization as an influential event in the history of hospital accounting. For example, he states:

> *Following the 1974 reorganization, with its emphasis upon managerial authority and accountability based upon the local head of function (i.e. profession) concerned with staff and services, the NHS financial accounting (and costing and budgeting) became more disaggregated and more closely related to the actual management process. At about the same time came increased use of computers for payroll and general ledger, although these were located at RHAs with DHAs often in some difficulty over obtaining information outputs promptly in a form useful for management as distinct from discharging routine financial accountability and reporting requirements. This newer system, known as functional accounting and budgeting, continues in use* (p.221).

The government publication, just before the reorganization, MANAGEMENT ARRANGEMENTS FOR THE REORGANISED NATIONAL HEALTH SERVICE (1972), also argues that functional budgets are central to planning and control within the new service. This change to functional budgets is recognised by both Rigden (1983) and later academic authors, Bourn and Ezzamel, (1986), as the main form of financial control within hospitals after 1974, and this change the author regards as the third 'event' in the historical review of costing change.

3.9 Summary and Conclusions

This Chapter identifies a number of papers associated with the debate around the impact of 'new public management' (NPM) (Hood, 1991; 1995), and which, intrinsically linked to the concept of managerialism, suggest that accounting is central to the promotion of these concepts. Indeed Broadbent *et al.* (1991), perhaps more boldly, states that accounting was part of a *'colonisation'* process. For these researchers the role of accounting itself changed from *'probity compliance and control'* to *'technologies to promote what is characterised as efficiency, effectiveness, cost saving and streamlining - managerialism in the public sector'* (Broadbent and Guthrie, 1992). While many of these papers were written before the election of New Labour, in 1997, the moves towards a more managerial organisation environment, identified with Conservative governments, appears to have broadly continued.

In other research, Chua and Preston (1994), suggest that the challenge posed to the traditional ascendancy of the professions, particularly in this case the medical profession, is what differentiates NPM from previous reforms. Humphrey *et al.* (1993) identify an enormous difference between the 'rhetoric' and 'reality', finding that many of the reforms can be defined by their 'failure'. Other papers (McSweeney, 1994; Kirkham and Loft, 2000) question the timing of these changes arguing that 'management by accounting' can be identified in the public sector before the election of the 1979 Thatcher administration.

If these reforms can be identified in earlier periods this leaves two key questions: Is this part of the long process of change, or is there something different about these changes, compared to other periods? In particular is it that these reforms, as suggested by Chua and Preston (1994), were the first to challenge the dominance of the medical profession? The author suggests, in the next Chapter, that both these questions will benefit from a historical, and procedural, analysis of accounting change (Hopwood, 1987; Preston, 1992).

There have been two important papers, from a historical perspective, on the development of accounting practice, one in the USA (Preston, 1992) and the other in the UK (Jones and Mellett, 2000). Both examine a similar time-frame to this author's study, but use different models to provide a broad review of the forces influential in hospital accounting change over a century.

Jones and Mellett (2000) use the revised social order model to explore changes in UK hospital accounting and Preston (1992), using Foucault's framework, outlines a number of 'discourses' evident in US hospital accounting. Many of the changes in US healthcare are also evident in the UK, for example, the; development of modern medicine, the changing role of the hospital in the late 19th and early 20th Century, and the interest in departmental accounting in the 1920s (Jones and Mellett, 2000).

This research project builds on this previous work of Preston (1992), and Jones and Mellett (2000), but, using Porter's (1981) framework, the focus is on the process of change and the interface between individuals, groups and institutions over time, their

impact on accounting change and, in particular, three 'events' identified in literature as significant:

- Uniform accounting in 1893.
- Departmental costing in 1956.
- Functional budgeting in 1974.

There is a recognition that this take place within the context of wider changes in *'discourses'* (Preston, 1992) and *'societal'* forces (Jones and Mellett, 2000) and these can be regarded as analogous to *'concepts'* and *'universals'* in Porter's model of historical investigation.

The reason for choosing three specific events, is that, in addition to Jones and Mellett (2000), a number of practitioners, obviously with the benefit of hindsight, or what Porter refers to as '*retrodiction*', identify one, or all, of these developments as the major change events in hospital accounting before 1974 (Perrin, 1983; Brinley-Codd 1974; Bourn and Ezzamel 1984; Forte, 1986; Prochaska, 1992).

This Chapter demonstrates that, while there is a relative lack of research on the history of hospital accounting in the UK, the volume of secondary material, for the contextual historian to excavate, is enormous. Pre-nationalization this includes the political and social development of the hospital over an extended period (Abel-Smith, 1964; Pinker, 1964; Rivett, 1984; Maggs, 1993; Porter, 1999) and the role of key individuals, and funding institutions, on hospital operation and management (Cherry, 1992; Prochaska, 1992; Waddington, 1995, 1996). This work represents a vast volume of secondary research, and most identify Burdett's uniform accounts as a significant event in attempts to reform/regulate the disparate voluntary institutions.

After 1948 there are several substantial historical works on the NHS, mainly by Klein, Rivett and Webster and there is general agreement in this literature around the various phases in the organisation of the service from 1948-1974; '*creation* and *consolidation'* followed by *'planning* and *reorganisation'*.

The most debated accounting change is departmental accounting, introduced in 1956, but the evolution of this technology embraces both the creation and consolidation phase, while its impact begins to be questioned in the planning age associated with the mid-1960s. Throughout these phases government interest in the management and organisation of the service expands, with a proliferation of reports on: the relationship between managers [officers] and members; the role of medical staff in hospital management and other occupational functions; hospital planning and the development of District General Hospitals.

There are a number of groups, and institutions, in the early years of the NHS, particularly the Nuffield Trust and the Kings Fund, contributing to the *discourse* on accounting. Although by the 1960s the influence of these institutions appears to be in decline and one begins to see an increasing literature from university departments, much of which is sponsored by the Ministry of Health.

Feldstein's early work (1965) begins a new debate around the practicality, and usefulness, of patient costing information and provides implicit criticism of previous costing practice. As with earlier accounting reforms, implementation appears to be a slow process, and, instead, functional budgets are introduced in 1974, along with more formalised planning and control mechanisms.

Before returning to Feldstein's work in chapter 6 the next chapter investigates an earlier attempt to provide comparative cost information based on uniform accounting data and associated with Sir Henry Burdett.

Chapter 4 ~ The Road to Uniformity

Introduction of Burdett's Uniform Accounts (1893)

4.1 Introduction

This Chapter explores a pre-nationalisation attempt to develop unit costs based on uniform accounting data, and examines the emergence, and spread, of these accounts in the UK voluntary hospital sector in the period 1880 to 1920. This has parallels with the early part of the 21st Century and another attempt, in the UK, to compare hospital performance, using unit cost information (NHS, 2001; Llewellyn and Northcott, 2005), based on a classification known as Healthcare Related Groups (Jones, 1999).

The uniform accounts surfaced within the context of the changing nature, and funding, of hospital care, increasing professionalisation and early managerialism (Sturdy and Cooter, 1998). These elements led to an intensive debate on the organisation and management of voluntary hospitals, and external groups mobilised a variety of forces, and concepts, such as inadequate governance and inefficiency, and also raised the possibility of political intervention, to help generate change.

Partly in response to this, internal institutions took responsibility for accounting reform by introducing Burdett's uniform system of accounts of 1893, and largely succeeded in excluding external institutions from hospital management and accounting. A number of authors attribute the origin of the uniform accounts to Sir Henry Burdett (Abel-Smith, 1964; Maggs, 1983; Rivett, 1984; Jones and Mellett, 2000) but while Burdett was crucial in the change process, and, subsequently, for the spread of the uniform system, his role as initiator is debatable.

The drive towards uniformity in company accounts can be traced to 1849 in UK railway, with legislation eventually introduced in 1868 (Parker, 1984). This was followed by *'prescribed formats'* for life assurance (1870) and gas companies (1871), but attempts, at this time to extend uniformity, did not find favour with

legislators (Parker, 1984). In addition Coombs and Edwards (1993) and Jones (1992) (see Chapter 3) both suggest that uniformity was a central debate within local government in the later part of the 19th Century.

Within voluntary hospitals there were a number of uniform accounting schemes proposed in the late 1880's and early 1890's. The Institute of Chartered Accountants in England and Wales (ICAEW), working with the Charity Organisation Society (COS), proposed a uniform accounting format in 1890. These accounts were not adopted but were usurped, in 1893, by THE UNIFORM SYSTEM OF ACCOUNTS FOR HOSPITALS AND PUBLIC INSTITUTIONS, ORPHANAGES, MISSIONARY SOCIETIES, HOMES, CO-OPERATIONS, AND ALL CLASSES OF INSTITUTIONS (Burdett, 1893). Often referred to as Burdett's uniform accounts, these were subsequently adopted by a majority of the UK voluntary hospitals.

The main objective of this Chapter is to explore the contextual factors driving change, and to track the process of change and the spread of uniform accounts. At each stage the role of leading opinion formers – individuals, groups and institutions – are analysed, within the context of broader social, economic and technological concepts and forces. Of particular interest is the manner in which internal groups, associated with the voluntary hospital movement, resisted 'interference' from outside groups and institutions. Voluntarism established uniformity of information and disseminated comparative hospital data, with limited intervention from the State or the accounting profession.

In Section 4.2 the antecedent contextual conditions are explored, particularly the growth in hospital numbers, changes in funding and early concerns with 'efficiency' and the emergence of key groups and institutions. This is followed in Section 4.3 by an analysis of group and institutional conflict as the process of accounting change unfolds. In Section 4.4 the author reviews and compares the different types of accounts proposed by the various change agents and finds a large degree of homogeneity. Section 4.5 provides a detailed analysis of the spread of the Burdett's uniform accounts and tracks the influence of new groups and the demand for professional conformity. The spread of the accounts beyond the UK is briefly outlined in Section 4.6, and the Chapter ends with conclusions.

4.2 Antecedent Contextual Conditions

4.2.1 – Growth in Hospital Care

A number of authors note that in the latter half of the 19th and early 20th Century there was an enormous growth in the voluntary hospital movement and this is often illustrated by the substantial increase in bed numbers, as shown in Table 4.1 (Abel-Smith, 1964; Pinker, 1964; Cherry, 2000).

Table 4.1: Number and Type of Beds in Voluntary Hospitals

	1861	1891	1911	1921
Teaching	5,291	7,228	8,284	9,548
General	6,658	15,184	21,651	27,443
Infectious Diseases	238	443	160	178
Tuberculosis	288	1,075	4,200	7,015
Maternity	139	210	311	462
Other Special	2,008	4,701	6,495	9,521
Chronic	150	679	2,120	2,347
Total	**14,772**	**29,520**	**43,221**	**56,514**

(Pinker, 1964:61)

Hospital historians identify a combination of factors contributing to this growth, including: improvements in medical science; the creation of a professional medical association; industrialisation and subsequent urbanisation (Rosen, 1979; Granshaw, 1997). These changes led to a shift in the type of care, and the period is often characterised as one *transforming* the role of the hospital (Abel-Smith, 1964; Maggs, 1993; Granshaw, 1997; Porter, 1999). The social historian Porter argues that:

> *Many developments – notably new surgical possibilities thanks to anaesthetics and Listerism and the humanizing role of nurses – were transforming the hospital from a charitable refuge for the sick poor into an all-purpose medical institution... Teaching and research were increasingly based on hospital sites* (1999. p.380).

Porter quotes an American doctor, in 1930, reflecting on 50 years of medicine, to illustrate:

> *One of the very greatest changes that I have observed in the past fifty years has been in the attitude of the public towards hospitals. Dread of them was general and well founded before the days of antiseptic surgery. But with its widespread adoption, fear faded rapidly from the lay mind.*
> (Robert Morris, quoted in Porter, 1999. p.380)

4.2.2 – Hospital Governance

Hospitals were numerous, but were not a homogeneous group, varying in size, funding, age and medical specialty (Abel-Smith, 1964). They were often divided into three types: general, teaching and specialist hospitals, and while, as independent institutions, it is difficult to generalise on their governance, Stone (1927) identifies a number of common features: independently funded, unpaid senior medical staff and managed by a board of governors.

Hospital funding was linked to their governance as Subscribers who paid an agreed annual amount became, or were entitled to become, hospital governors and able to attend meetings and play a role in hospital management (Abel-Smith, 1964). At the annual meeting, the governors appointed a *committee of management,* or house committee, which met on a weekly, sometimes monthly, basis and, certainly by the late 19th Century, appointed a 'secretary' who was largely responsible for management of the hospital, although [in most cases] not directly the medical and nursing staff (Abel-Smith, 1964).

Another 'corporate governance' device, used by some hospitals, was the quarterly 'open court', open to all governors, where they could ask questions and examine hospital minutes of meetings (BPP, House of Lords, Ryan 1893, para. 14401). In addition many hospitals had a series of sub-committees, with finance and medical committees particularly common, which generally met each month (Abel-Smith, 1964).

The role of the finance committee varied, but there was some sort of expenditure analysis and the monitoring of income sources, which was of key concern, particularly as hospital financing became more complex (Cherry, 1992; BPP, House of Lords, Ryan, 1893). Most hospitals had a significant income from long-term assets, and investment decisions were, therefore, important, which would also have been the responsibility of the finance committee (Berry, 1997). Exact managerial relationships within hospitals are difficult to establish and were likely to vary between hospitals. In general, doctors appeared to have overall control of patient care

issues, matrons had responsibility for nursing staff, with the hospital secretary, through the governors, responsible for all other managerial tasks (Abel-Smith, 1964).

4.2.3 – Funding and the Growth of New Institutions

The increasing size and number of hospitals placed increased pressure on their ability to fund their activities which led to new funding sources being sought (Burdett, 1881; Berry, 1997; Cherry, 1992; 2000). Table 4.2 gives a 'snap-shot' of fund sources for 1899. The main source was income from investments, at close on 25% overall, but as high as 37% for London medical schools. Attracting and maintaining funds for investment was a crucial task and was linked to success in attracting legacies. Indeed legacies and other large one-off donations, accounted for 36.2% of total income, while annual subscriptions and donations were surprisingly limited at 22.7% of total income. Therefore, when taken together, the percentage of total income directly donated to hospitals was 58.9%.

By the 1880s one sees the development of another important source of income: *hospital funding institutions* (Cherry 1992; 2000; Waddington, 1995, 1996).

Table 4.2: Sources of Income for Hospitals – 1899

	Medical Schools		General Hospitals		Total
	London	Provincial	London	Provincial	
			Percentages		
Annual Subscriptions	7.2	24.0	7.0	22.8	13.7
Donations	7.0	9.6	9.2	11.5	9.0
Boxes	0.2	0.3	0.5	0.3	0.3
Prince of Wales Fund (Kings)	3.6	0.0	1.7	0.0	1.8
Hospital Sunday Fund	3.6	5.5	2.4	5.1	4.1
Hospital Saturday Fund	0.7	3.6	0.6	5.7	2.4
Contributions from Workplace	0.4	8.3	0.1	9.9	3.9
Invested Property	37.4	24.8	4.5	20.8	24.9
Private Nursing Institutions	0.7	1.0	0.5	1.7	1.0
Nurses/Probationers' Fees	0.7	1.2	0.1	0.9	0.7
Patient Payments	1.2	2.1	1.2	1.9	1.5
Miscellaneous Receipts	0.4	1.2	0.1	0.6	0.5
Total Ordinary Income	63.1	81.6	27.9	81.2	63.8
Donations for Special Purposes	7.8	3.4	60.1	5.5	16.6
Legacies	29.1	15.0	12.0	13.3	19.6
Total Income	100.0	100.0	100.0	100.0	100.0

(Burdett's Hospitals and Charities, 1901)

There were three main Funds, Sunday, Saturday and later the Kings Fund, which Waddington views as a *'new departure in hospital funding – a form of indirect philanthropy'* (1996. p.186) as they collected money on behalf of hospitals in general and made allocations to those hospitals they considered worthy. In addition, workplace contributions, normally deductions from workers wages, often by large local employers, also played an important role in hospital funding (Cherry, 2000). As shown in Table 4.2 there was a significant difference between London and the provinces in the extent of income from these last four sources; they provided almost 21% of total income for general hospitals in the provinces while only 4.8% for general hospitals in London (Cherry, 2000).

4.2.4 – Professions and the Concept of Efficiency

In addition to changes in the sources of income, the period after 1850, and particularly after 1880, saw the creation of professional organisations (Sturdy and Cooter, 1998), with the Medical Act, 1858, introducing Doctor registration, which, in turn, led to the formation of the General Medical Council (Gelfand, 1993).

Moves towards a more professionalized nursing service followed, partly stimulated by more complex care regimes in hospitals and this was illustrated by the increasing numbers employed (Maggs, 1987). Burdett (1901, p. 76) estimates at the London Hospital in 1878 there were 590 beds and 152 nurses, or 0.25 nurses per bed but by 1900 there were 656 beds and 302 nurses, or 0.46 nurses per bed.

Sturdy and Cooter argue that *'efficiency became an abiding concern within the voluntary hospitals from the last third of the nineteenth century'* (1998. p.424), and this reflected wider changes in society, and, in particular, the development of a managerial culture (Searle, 1971; Miller and O'Leary, 1987; Perkin, 1989).

Further evidence of this, for Sturdy and Cooter, was; *'the greater ordering and segregation of patients by new forms of architecture which literally restructured hospitals in the interests of efficient moral management'* (1998. p.424). There was increasing emphasis on administration, the introduction of managers from outside the

hospital environment and the growth of funding institutions. This increased concern over 'management' also spread to hospital medical staff and they note that doctors:

> *Began to look for ways of improving the efficiency and productivity of their practices... it had become common practice for senior hospital surgeons to marshal the junior doctors training under them into formal hierarchies, among whom they divided responsibility for different aspects of the clinical work. The term adopted for this form of organisation – 'the firm' – carried clear overtones of business management* (Sturdy and Cooter, 1998. p.425).

Another indicator of the development of more formal management was the increasing use, and importance, of the Hospital Secretary, who reported directly to the House Committee of Governors, (Sturdy and Cooter, 1998), and, in London, was often the highest paid employee (House of Lords' Enquiry: BPP, 1890-93).

One of the main performance tools used to evaluate hospital efficiency, in the latter decades of the 19th Century, was the use of cost-per-bed data and this eventually led to calls for hospitals to use similar or uniform methods to calculate this key indicator (BPP: House of Lords, 1893; Jones and Mellett, 2000). Attempts to compare hospital performance has a long history (Moore, 1999), for example, in 1857 the Statistical Society published a report highlighting the significant cost differences between 'ancient' hospitals, like Bart's, Guy's and St Thomas', compared to the 'modern' hospitals such as the Royal Free and University College (Lancet, 1858. p.634; Rivett, 1986. p.113). In 1863 Fleetwood Buckle's book, VITAL AND ECONOMICAL STATISTICS OF THE HOSPITALS, INFIRMARIES OF ENGLAND AND WALES, provided data on 117 hospitals including percentage mortality rates, average number of beds per medical officer, as well as the average cost-per-bed and cost-per-in-patient.

4.2.5 – Mobilisation of External Policy Groups

Another development in the early 1880s was that a key external policy institution began to take an interest in the organisation and management of the voluntary hospitals: the National Association for the Promotion of Social Sciences (NAPSS) (Millman, 1974; Rivett, 1984; Moore, 1999).

NAPSS, referred to as the Social Science Association (SSA), was an example of an early institution providing a *'focal point for those who sought a better way of delivering medical services through a well-organized hospital system'* (Millman, 1974. p.122). The SSA was *'a potent political force'* (Millman, 1974. p.123), with their influential annual conferences helping promote public policy debates and its members were *'practically oriented and deeply involved in carrying out the business of the Empire'* (p.123).

In 1881 the SSA set up a special committee to 'enquire' into hospital administration and in 1883 organised, with Burdett, a conference for hospital managers (Rivett, 1984). Millman notes that:

> *Men like Henry C Burdett, Timothy Holmes and T Gilbart-Smith examined the organization, financing and delivery of hospital services. The result of these studies led to agitation for hospital reform in the 1880s. The Social Science Association provided a focus for this agitation by sponsoring Britain's first Hospital Administration Conference* (1974. p.124).

Burdett presented a paper: THE PRESENT FINANCIAL DIFFICULTIES OF THE METROPOLITAN HOSPITALS: THEIR CAUSE AND PROBABLE RESULTS. HOSPITAL FINANCE AND AUDIT (SSA, 1883). This used data collected from 67 hospitals to illustrate financial problems faced by hospitals, outlining a number of weaknesses in accounting practices including a paucity of information and, by implication, the manipulation of accounts:

> *In but a few instances is a balance sheet presented at all. Frequently all that is forthcoming is a statement of the receipts and payments for the previous 12 months, but from which statement are sometimes excluded the receipts from legacies, the amount of stock sold or purchased. At another general hospital the accounts are made to show an excess of income of, say, £3000, and this excess appears year after year* (SSA, 1883. p.88).

While this paper makes no reference to the need for uniform accounting, this is implied in the narrative:

> *I therefore hope, in the interests of the hospitals, that as one result of this Conference, we may get an agreement as to the best and completest system of keeping hospital accounts, and that the best and most carefully conducted charities will decide to adopt it* (SSA, 1883. p.90).

From this conference the Hospital Association, made up of hospital secretaries, was created to *'facilitate discussion of hospital management'* (Millman, 1974; Rivett, 1984. p.126).

This new group was to prove an important advocate of performance measurement, efficiency and the 'best practice' agenda. Its aim was described as *'... bringing together for conference and mutual help accredited representations of the voluntary hospitals both from London and the country'* (Hospital, 1893. p.25). Key institutional symbols, such as a weekly journal and an annual conference, were quickly established and by 1890 the Association had begun to publish books and articles on hospital administration: HOSPITAL EXTRAVAGANCE AND EXPENDITURE (Michelli, 1890); SIXTEEN YEARS OF HOSPITAL SUNDAY (Waterlow, 1890); and CONTRIBUTIONS BY PATIENTS IN RELATION TO THE FINANCIAL CONDITION OF THE LONDON HOSPITALS (Burdett-Coutts, 1890).

4.2.6 – The Role of Burdett

Sir Henry Burdett, a key promoter of the Hospital Association, was perhaps the most influential individual in the early moves towards a more managerial, or formalised, organisational culture in hospitals, and an increasing number of authors identify his role, in promoting hospital management (Millman, 1974; Rivett, 1984; Moore, 1999; Cook, 2001), the creation of the Kings Fund (Prochaska, 1992) and a pension fund for nurses (Maggs, 1987). Indeed as an author on hospital management, owner and editor of hospital journals and with his high level contacts in the philanthropic world; his influence permeates much of the debate in this period.

Burdett began his career in banking, at what appears to be a fairly low level, and then became hospital secretary at Queen's Hospital, Birmingham (Hospital, May 8th 1920). At 26 Burdett started medical studies but did not take his final examinations (Rivett, 1984); instead returning to hospital administration, significantly perhaps, in London, becoming House Governor to the Seaman's Hospital, Greenwich (Prochaska, 1992).

Seven years later, in 1881, he became Secretary to the Share and Loan Department of the Stock Exchange, and, in 1882, produced BURDETT'S OFFICIAL INTELLIGENCE, later

to become the Stock Exchange Yearbook (Morgan and Thomas, 1969). How he was able to transfer from hospital secretary to this lucrative post at the stock exchange is unknown, but certainly he appears to have had good contacts within the establishment, and these were to further aid his philanthropic aspirations (Hospital, May 8th 1920).

Burdett owned the Scientific Press and started the weekly professional association journals, *THE HOSPITAL* and *THE NURSING MIRROR* together with the annual publication BURDETT'S HOSPITAL AND CHARITIES YEARBOOK, using these publications to promote his views on hospital management and, more importantly, to publish hospital performance data, in particular, promoting the rate, or cost, per occupied bed as a key measure, as *'by the rate per occupied bed one judges whether or not an institution is being arranged economically'* (Burdett Papers, MS ENG d.2887:50). He also appears to have had a close relationship with the Prince of Wales (Prochaska, 1992) and this, together with his City contacts, was a critical factor in the creation of the Kings Fund, indeed, Prochaska claims that *'Burdett and the Prince wielded unrivalled power in the hospital world'* (1992. p.18).

4.3 Groups and Institutional Conflict

The changing nature of hospital care and funding, together with the advent of professions and a more managerial focus provided the context for accounting reform; driven by new hospital groups and by a key individual, Burdett. While the process of change is continuous this Section concentrates on the activities of competing groups and institutions, and begins with the entry of two 'external' groups/institutions, the Charity Organisation Society (COS) and the Institute of Chartered Accountants in England and Wales (ICAEW), extending to the eventual publication of Burdett's uniform system of accounts in 1893. The ensuing debate on accounting reform is complex, with competing groups and institutions using a variety of tools to promote accounting, and organisational, change.

4.3.1 – The Intervention of External Institutions: COS and ICAEW

The Charity Organisation Society (COS), created in 1869, was concerned that *'ill considered and unsystematic philanthropy'* (Owen, 1965. p.221) discouraged individual responsibility. The society was organised around local committees with the aim of *'bringing together the applicant and the voluntary agency best equipped to assist him'* (Owen, 1965. p.222).

Whelan argues the COS *'epitomised, from the start, the view that alms carelessly given are worse than no alms at all. It urged people to think before giving money to those requesting assistance, and it instigated a rigorous policy of enquiring into the backgrounds of applicants'* (2001. p.2).

COS efforts to control, and monitor, both charitable institutions and those seeking assistance from them, led to demands for changes in their organisation and, with this, improved accounting information. This applied particularly to the largest and most numerous of the charities: voluntary hospitals (Owen, 1965; Bosanquet, 1973).

The major reason for the interest of COS in hospitals was the 'abuse' [or what was referred to as abuse] of hospital out-patient departments (Abel-Smith, 1964; Owen, 1965). These departments caused much controversy in the last decades of the 19th century and Owen (1965) suggests that they were challenged from two perspectives. Patients seen by a hospital doctor, at out-patient departments, had free treatment, and many GPs believed this reduced their income from patient fees, and charity reformers, particularly COS, believed it provided a disincentive for patients to organise care for themselves (Abel-Smith, 1964; Rivett, 1986).

This out-patient issue drew COS into other hospital issues (Owen, 1965) and they demanded that some sort of central hospital regulator be set up to oversee healthcare in London. Bosanquet states that:

> *The aim of the Society was neither to make any investigation itself, nor to take part in the actual management of the hospitals; but merely to facilitate the institution of a central Board of Management, representative of the hospitals themselves, and working out a definite system of medical relief* (1973. p.215).

COS set up a committee, within their organisation, to examine healthcare and began a campaign for an *enquiry* into the operation of voluntary hospitals in London and they managed to achieve this with a House of Lords committee of enquiry set up in 1890 (Owen, 1965; Bosanquet, 1973; Rivett, 1986). Their evidence highlighted their concern that hospitals manipulated or indeed fabricated their accounts as a fund-raising device, for example Montefiore, Organising Secretary of the Medical Committee of the COS, stated to the 1893 Lords enquiry:

> *The most general effect that seems to be striven for is to manufacture a deficiency where there is not one. The object of this is to make the accounts look as if the charity were in debt, and this is done in order that a piteous, but lying, appeal may be made to a sympathising but critical public. This is the reason we frequently find so many accounts in one report* (BPP, 1893, Montefiore's evidence, para.171).

Their disquiet about hospital accounting, and, indeed, the accounts of all charitable institutions, led to COS setting up a close alliance with the Institute of Chartered Accountants in England and Wales (ICAEW) and an editorial in the *ACCOUNTANT* suggests that the two organisations agreed on more than just accounting reform, with their views on charity and charitable organisations being remarkably similar:

> *The Charity Organisation Society has from time to time endured a great deal of unmerited obloquy, but it has managed to outlive its principal detractors. In our opinion this institution is founded upon the truest principles of practical benevolence as opposed to indiscriminate and ill-bestowed almsgiving, which generally aggravates the very evils it is intended to ameliorate* (Accountant, 1890. p.207).

THE ACCOUNTANT published three articles on the accounts of charities in September, 1888. Why the journal chose to discuss *charitable accounting* at this time is not revealed, nor is the author identified. Three months later Gerard Van De Linde delivered a paper to the COS Council; THE PREPARATION AND AUDIT OF THE ACCOUNTS OF INCOME AND EXPENDITURE RELATING TO CHARITABLE INSTITUTIONS (Van De Linde, 1888), which outlined pro-forma statements of accounts for hospitals and led to the formation of a committee, with membership including E. Cooper (Cooper Brothers and Co.) and G.W. Knox (Knox, Burbridge, Cropper and Co.), to *'report on the best form of accounts for charitable institutions of different types'* (Accountant, March, 1890. p.161).

4.3.2 – Internal Group Resistance

COS and the ICAEW immediately came into conflict with hospital managers and Burdett's journal *THE HOSPITAL*. For example, when the (COS/ICAEW) Report was discussed at a London meeting of COS and hospital managers appeared less than impressed. Michelli, Secretary at the Seaman's Hospital, stated that '*... many of the recommendations were made from the actuarial or auditor's point of view'*. In addition he questioned the usefulness of the accounts to the hospital secretary and argued that the form of accounts *'was not new'* (Charity Organisation Review, 1890. p.173). Ryan, Secretary at St Mary's Hospital, was even more critical, stating:

> *The report from the point of view of general hospitals was purely and absolutely superfluous. The report recommended what had long ago been done by the general hospitals. The difficulty of uniformity of accounts was very much a question of uniformity in detail, not in style or principle; and these difficulties of detail were not practically dealt with in the form of accounts in the report* (Charity Organisation Review, 1890. p.173).

Burdett used his editorship of the journal *THE HOSPITAL* to make a further attack on COS and specifically on outside intervention:

> *The report of the COS on hospital accounts is remarkable in more ways than one. It proves to demonstrate that gentlemen who have no technical knowledge of the special requirements of particular fields of work should refrain from expressing opinions thereon, and specially from formulating definite proposals and forms which reveal an ignorance of technique as amusing as it is instructive* (Hospital, 1890. p.405).

This evidence suggests that leading figures within the hospital movement had great difficulty in accepting incursions by COS and the ICAEW, but these exogenous institutions did succeed in raising the profile of hospital accounting and management and, in 1890, were successful in their attempts to establish some form of government investigation, with a committee of the House of Lords beginning a 'hospital enquiry' in 1890 (Owen, 1965).

Burdett had suggested a government enquiry in his address to the Social Science Association in 1881 (Moore, 1999) but COS success, in this task, appears to have been assisted by the medical profession in the form of a petition and assistance from the professional press (Charity Organisation Review, 1890; Bosanquet, 1973; Rivett. 1986). Bosanquet states that:

This petition was backed by an extraordinary support from the medical profession. It was signed by about 1,000 members, drawn from all grades and sections of the profession, and was supported also by the Lancet and other medical papers (Bosanquet, 1973. p.21).

Again there was resistance from Burdett and the internal hospital institutions. For example, in an editorial, in his journal *THE HOSPITAL,* with the title, A HOSPITAL INQUISITION, he rejects the need for a hospital enquiry and takes the opportunity to attack COS and its intervention:

We cannot afford to allow these splendid institutions, built up by the efforts and sacrifices of a noble philanthropy, to be despoiled or discredited at the bidding of an irresponsible society with a craze for meddling ... (1890. p.42).

continuing:

There is no doubt whatever that in sympathy with hospitals and in practical acquaintance with everything that appertains to their management, the Hospital Association is as superior to the Charity Organisation Society as the latter body is to a second-rate detective in ferreting out the delinquencies of a begging letter impostor (1890. p.43).

4.3.3 – House of Lords Intervention

The House of Lords committee, set up in 1890, collected extensive evidence from hospital practitioners on the operation and management of voluntary hospitals in London and this data collection process appears to have been the catalyst for accounting change (BPP, 1890-93; Rivett, 1986).

The enquiry was wide ranging and considered the effect of free out-patient provision, the possibility of introducing some sort of monitoring organisation or central board, to license or approve new hospitals, as well as accounting and audit arrangements (BPP, 1890-93). Though limited to London hospitals it provides a detailed record of hospital organisation and management from leading and influential figures within the hospital movement and there was almost unanimous agreement that a uniform system of accounts should be introduced. For example the final report states:

Under the existing arrangements, each hospital making out its own financial statement after its own fashion, it is found impossible to form anything approaching a trustworthy estimate of the comparative cost of management and maintenance as between different hospitals. The estimated annual cost of a bed, which is the ordinary standard of

comparison, is calculated after so many different methods, producing such widely different results, as to be altogether fallacious
(BPP, 1893. Final Report, para.242).

This emphasis on the need for cost-per-bed comparisons was central to the demand for uniform accounting, and it was argued that, only after such reform could this *'assist hospitals themselves in checking their own extravagance, and the subscribers in judging how the money was spent'* (BPP, 1893, Final Report, para. 242).

The Lords' report also drew attention to difficulties associated with cost-per-bed comparisons, such as, adjusting for the cost of out-patients treated in the hospital. They also appeared to be wary of recommending an accounting system that could be interpreted as a challenge to the concept of voluntary control, stating:

Objection was taken to any attempt being made to forcing all the hospitals into an exact method; this, it was thought, savoured too much of State control, and would tend to destroy individuality (BPP, 1893. para.251).

With the Lords' Enquiry taking three years to complete their Report and their obvious reluctance to intervene, this allowed internal individuals and groups to step into the void and take control of the accounting change agenda. In particular, the Sunday Fund used their economic power, and their social status, to drive accounting change in London hospitals (Rivett, 1986, Waddington, 1995).

4.3.4 – Sunday Fund and Hospital Managers

The Sunday Fund was closely associated with the Church where collections on a specific Sunday [Hospital Sunday] were used for the benefit of local voluntary hospitals (Waddington, 1995). Waddington states:

It was envisaged that a fund would remove abuse and encourage reform, as distribution was to be placed in the hands of a scrutinising committee which would identify any problems and penalise hospitals accordingly. Hospitals, it was hoped, would reform, if only to improve the size of their awards (1995. p.153).

The London Sunday Fund was run *'...on strict commercial grounds as the committee was made up from London's leading financiers, businessmen, politicians and philanthropists'* (Waddington, 1995. p.154). The Fund required hospitals to submit

cost and patient activity information before they would award grants and produced a table of statistics for each hospital based on this data. In December 1890 a special meeting of the Distribution Committee was convened to *'consider the possibility of assigning some uniform system of accounts to be presented to their subscribers'* (Metropolitan Sunday Fund, MS 30587/5).

This meeting of hospital managers, in 1891, produced a layout of accounts that they recommended for adoption. This included an income and expenditure account, similar to, but not exactly the same as, the one Burdett had presented to the Lords' enquiry. Subsequently a detailed index of classification of expenditure was agreed after which the council of the Sunday Fund sent out a recommended *'form of accounts'* to all hospitals requesting grants (Burdett, 1916; Rivett, 1986). These accounts were published in 1893 as 'BURDETT'S' UNIFORM SYSTEM OF ACCOUNTS FOR HOSPITALS, CHARITIES, MISSIONS, AND PUBLIC INSTITUTIONS (1893).

The speed with which the Sunday Fund produced the uniform accounts suggests that the internal institutions wanted to retain control of the administrative apparatus of the hospitals and were not prepared to surrender accounting policy to external bodies.

However, the extent to which uniform accounts can be attributed to Burdett, as has been subsequently claimed, is unclear. Burdett states that the system *'originated at the Queen's Hospital, Birmingham, nearly half a century ago (1869) and was devised by Mr. (now Sir) Henry C. Burdett, with the co-operation of an eminent Birmingham accountant, the late Mr William Laundy'* (1916. p.1). Burdett was secretary at Queen's Hospital for over five years but unfortunately the hospital's archive [at Birmingham Library] is very limited, while Burdett's papers, in the Bodleian Library, also provide little further information on the uniform accounts; Burdett's assertions cannot therefore be confirmed.

However, between 1881 and 1893 Burdett delivered a number of papers on hospital management and accounting but made no reference to the uniform system of accounts, supposedly devised for the Queens Hospital in 1869. For example his papers; HOSPITALS AND THE STATE (Burdett, 1881) and THE PRESENT FINANCIAL

DIFFICULTIES OF THE METROPOLITAN HOSPITALS: THEIR CAUSE AND PROBABLE RESULTS. HOSPITAL FINANCE AND AUDIT (SSA, 1883) while discussing accounting and audit, make no reference to the Birmingham system and neither did his evidence to the House of Lords enquiry (BPP, 1893). Burdett's uniform accounts were very similar to those already in use, and Berry notes that in the 18th and early 19th Century, *'items were classified on similar lines to the classifications in the income and expenditure accounts proposed by Henry Burdett in 1893'* (1997. p.8). It could be that Burdett did take the accounts in existence at Birmingham in 1869 and use these as the basis for the 1893 accounts, particularly as the Income and Expenditure account was, as Berry (1997) states, similar to that already in use. Although the distinguishing feature of Burdett's accounts, the *'index of classification'*, was, according to Burdett's own account, created by Michelli (Burdett, 1916).

The uniform accounts were formalised in the early 1890s, at the instigation of the Sunday Fund (Hospital, 1892; Hospital, 1893) and the part played by Burdett, and a number of London-based hospital managers, in this process are unclear. However Burdett was in an advantageous position, stemming from his ownership of The Scientific Press, which allowed rapid publication of the proposed uniform accounts and also from his reputation, which helped legitimate the accounts within the voluntary hospital sector.

The 'hospital' institutions, the Sunday Fund and the Hospital Association, were able, aided by Burdett, to pre-empt the findings of the House of Lords committee, and exclude the external institutions, COS and ICAEW, from hospital financial reporting, by producing their 'own' accounts, using Burdett's name in 1893. Although COS/ICAEW played an important campaigning role in promoting accounting reform they were unable to usurp the institutions of the hospital world in the design, and later, the implementation of uniform accounting.

4.4 Competing Accounts

The preceding Sections set out the conditions that led to the creation, and eventual standardisation, of hospital accounting in the 1890s. Broad social changes, emphasised managerialism and professionalism, and increased funding, from a variety of sources, meant wider interest in the public accountability of hospitals.

Campaigning bodies, such as COS, had an ideological agenda of; 'self help', case enquiry, rather than blanket provision, and better organised philanthropy. This appeared to gel with the views of the accounting professional association, the ICAEW, who argued that the COS was "founded on the truest principles of practical benevolence" (see quote from Accountant on page 78 of this work). Both COS and ICAEW clashed with the vested interest of the recently formed Hospital Association but it was COS who were able to generate interest politically, via the House of Lords. Although the need for uniformity was supported by all groups and institutions it was not clear which of the various proposals would actually be adopted and this Section provides an overview of the alternatives on offer.

At a narrow technical level one can compare the proposals according to their merits in dealing with various categories of revenue and expense, and with assets and liabilities, through their presentation in receipt/payment, income/expense and balance sheet statements. However, this would be to misunderstand what was at stake. The newly founded Hospital Association wanted control of a key element of the reporting and control structure, and hardly wished to concede that an external professional body, such as the ICAEW, could lay down better processes and procedures than hospital professionals with long experience. Thus the battle, though ostensibly over narrow technical issues, actually had much wider consequences and the following Sections need to be read with this in mind.

There was general agreement on the need for uniformity and the accounting treatment of most items of income and expenditure and this was no longer an issue for debate. However the internal and external institutions could find a key point of difference in the weight given to the objectives of the uniform accounts. COS/ICAEW emphasised the production of accounting information for external accountability whereas internal institutions were far more concerned with detailed comparative costing data for management purposes. The four main schemes for charitable/hospital accounting reform, proposed by the main groups and institutions, are analysed in the next Section.

4.4.1 – ICAEW, Van de Linde and COS/ICAEW

The Accountant ran a series of articles on charitable accounting in September 1888, and though they refer to charitable institutions in general, the examples used are all from hospitals. The articles begin with a description of how *'straightforward'* accounting for a charity is and recommended an income and expenditure account with two separate statements, one for provision costs and another for dispensary and surgery expenses. A balance sheet, which included land, buildings and equipment, was also recommended, but without depreciation, stating *'it is not usual to charge depreciation in these accounts; this matter is not of such importance here as with commercial concerns'* (Accountant, 1888. p.1615). All legacies and donations over £50 were taken to the Balance Sheet rather than to the Income and Expenditure account.

In 1888 Van De Linde presented a paper to the COS on charity accounts. These were similar to those suggested in *The Accountant* with key differences being the treatment of legacies and depreciation. Van De Linde recommended that all legacies be taken to the Income and Expenditure account, and that hospital fittings be depreciated. Shortly after this paper the COS commissioned the ICAEW to produce a report for the COS on charity accounts.

This report recommended that charitable institutions should produce different types of accounting statements depending on the *'extent of their operations'* (Accountant, March, 1890. p.161). This ranged from a simple receipts and payments account to a trading, and income and expenditure, account, and a balance sheet for larger charities with investments. The report implies that most general hospitals would be required to complete an income and expenditure account and a balance sheet. Figure 4.1 shows the COS/ICAEW recommended income and expenditure account.

Figure 4.1: Income and Expenditure Account ~ COS/ICAEW

176 THE ACCOUNTANT. April 5, 1890.

FORM II.—(B).

CHARITABLE INSTITUTIONS HAVING PROPERTY BUT NOT CARRYING ON TRADING OPERATIONS.

(B)—LARGE INSTITUTIONS HAVING CURRENT LIABILITIES AT THE CLOSE OF THE PERIOD.

THE GENERAL HOSPITAL.

Dr. *Income and Expenditure Account for the year ended December* 31, 1888. *Cr.*

Expenditure.		£ s. d.	£ s. d.
To General Expenses:			
Provisions:			
Meat	£700 9 6		
Bread, flour, &c.	790 15 0		
Milk	439 5 0		
&c. &c. (detail other a/cs)..	800 1 6		
		2,730 11 0	
Washing		114 2 0	
Fire, lighting and gas (give details)		121 7 0	
Rent, rates, taxes, and fire insurance (give details) ..		221 3 0	
Officers' salaries (give details)		602 5 0	
Wages (give sub-heads and details)		850 2 0	
Medical & Surgical Expenses:			
Instruments and repairs .	£430 2 2		
Drugs	650 0 2		
&c. &c. (detail other a/cs)..	820 2 1		
		1,900 4 5	
Funerals		50 2 0	
Hire of ambulances		20 1 6	
Repairs and renewals (give details)		200 0 0	
			6,809 17 11
To Secretary's Office:			
Salaries of secretary and clerks (give sub-heads) ..		300 0 0	
Stationery and printing ..		86 3 6	
Postages and telegrams ..		31 14 0	
Expenses of special appeal..		37 10 0	
Advertising		32 2 6	
Collector's poundage.. ..		15 0 6	
Travelling expenses		12 10 0	
Petty expenses		5 1 6	
			470 2 0
To Depreciation Account:			
Amount written off cost of fittings of the hospital ..		—	100 2 6
To Balance, being excess of income over expenditure for the year ended December 31, 1888, carried to capital account, *see* balance sheet		—	130 0 1

Income.	£ s. d.	£ s. d.
By Subscriptions:		
Annual (as detailed)	1,800 0 0	
Life (as detailed)	400 0 0	
		2,200 0 0
By Donations (as detailed) ..	—	2,100 0 0
By Dividends on investments .. (Income tax returned on the same)	—	600 0 0
By rents of real property ..	—	400 0 0
By Collections after Sermons:		
St. Stephen's, Walbrook ..	73 2 6	
St. Mary's, Hornsey	70 1 0	
St. Michael's, Highgate ..	69 3 0	
St. John's, Upper Holloway .	68 15 9	
St. George's, Hanover Square	68 5 3	
		349 7 6
By Grants from other Institutions or Funds:		
Sunday Hospital Fund ..	292 10 6	
Saturday Hospital Fund ..	207 9 6	
Cancer Hospital Trust ..	200 12 6	
St. Margaret's Nursing Fund	150 0 0	
		850 12 6
By Legacies:		
Miss Emma Burns ..	300 0 0	
Sir George Coram .. .	250 0 0	
Lady Thurnstead	200 0 0	
The Duchess of Winchester . (All free of legacy duty)	150 0 0	
		900 0 0
By Collections in almsboxes ..	—	54 0 0
By Proceeds of Sundry Sales:		
Kitchen stuff	23 2 6	
Rags and waste paper ..	22 17 0	
		45 19 6
By Patients' payments	—	10 2 6

4.4.2 – Burdett's Uniform System of Accounts ~ 1893

This system proposed that hospitals should publish four main statements: an *income and expenditure* account, *a balance sheet,* an *invested property* account and a *special appeal* account. Burdett only includes an example of the Income and Expenditure account in the 1893 (1st) edition and this statement was effectively a receipts and payments account, with 'income' and 'receipt' being used interchangeably within the text. There was no attempt to recognise changes in stock or to depreciate assets, although a distinction was drawn between revenue and capital expenditure. The '*income and expenditure'* account provided a detailed breakdown of sources of income and a classification of expenditure by similar subject, or type, as shown in Figure 4.2 overleaf.

Even though Burdett suggests that hospitals may consider an *invested property* account, listing the securities held and their income, he provides no pro-forma statement of such an account. Nor is there a *balance sheet*, and, instead, he states '*... this may be prepared under the direction of the auditors in such a form as may seem to lend itself best to the circumstances of each institution'* (Burdett, 1893). This appears to accord with Burdett's views to the House of Lords enquiry where he states

> *...as to balance sheets and other forms in connection with the accounts of hospitals, I myself, do not attach much importance to them per se*

and adds that

> *...what we really want to get is some simple system which staff include the same things under the same heads, and give the details of income and expenditure on the same lines*
>
> (BPP, 1893. Burdett's evidence, para. 25880).

The accounts also included a recommended classification of expenditure index. This was a 25 page list of expenditure items, ranging from bacon and ham to surgical boots, put together by Burdett's close ally Michelli, secretary at the Seaman's Hospital (Burdett, 1916).

Figure 4.2: Income and Expenditure Account ~ Uniform System of Accounts

Dr. INCOME AND EXPENDITURE

INCOME.	£	s.	d.	£	s.	d.	£	s.	d.
A. ORDINARY.									
I. Annual Subscriptions . . . (*see page*)									
II. Donations . . . . . (*see page*)									
Boxes . . . . . . (*see page*)									
III. King Edward's Hospital Fund for London .									
IV. Hospital Sunday Fund									
V. Hospital Saturday Fund									
VI. Congregational Collections (apart from Hospital Sunday Fund)									
VII. Workmen's Collections (apart from Hospital Saturday Fund)									
VIII. Entertainments (*the gross proceeds of Festivals, Bazaars, Dinners or other Entertainments for general purposes to be separately shown here*).									
IX. Invested Property, &c.									
Dividends									
Rents									
Income Tax Returned									
Interest on Deposit or Current Account .									
X. Nursing Institution.									
Private Nurses									
Nurses' and Probationers' Fees . . .									
XI. Patients' Payments.									
In-Patients									
Out-Patients									
XII. Receipts under the National Insurance Act . *This heading is for sums received by the Hospital quâ Hospital as the result of an arrangement with any insurance authority, &c., under the Act. Sums received by the Hospital as employer or paid voluntarily by patients are not here included.*									
XIII. Other Receipts.									
Total Ordinary Income									

Hospital or Dispensary 19

ACCOUNT *for the Year ending the 31st December, 19—* **Cr.**

EXPENDITURE.	£	s.	d.	£	s.	d.	£	s.	d.
A. MAINTENANCE.									
I. Provisions.									
1. Meat									
2. Fish, Poultry, &c.									
3. Butter, Bacon, &c.									
4. Eggs									
5. Milk									
6. Bread, Flour, &c.									
7. Grocery									
8. Vegetables and Fruit									
9. Malt Liquors									
10. Aërated Water and Ice									
II. Surgery and Dispensary.									
1. Drugs, Chemicals, Disinfectants, &c. . .									
2. Dressings, Bandages, &c.									
3. Instruments and Appliances									
4. Wines and Spirits									
5. Sundries									
III. Domestic.									
1. Renewal and repair of Furniture . . .									
2. " " Bedding and Linen .									
3. " " Hardware, Crockery, Brushes, &c. .									
4. Washing done off Hospital premises (average weekly number of articles) .									
5. Cleaning and Chandlery									
6. Water									
7. Fuel and Lighting—									
(*a*) Coal									
(*b*) Gas									
(*c*) Electric Current									
(*d*) Oil, Wood, &c.									
8. Uniforms (Nurses', Porters', &c.) . . .									
9. Sundries									
IV. Establishment.									
1. Insurance									
2. Renewals and Repairs									
3. Annual Cleaning									
4. Garden									
V. Salaries, Wages, &c.									
1. Medical									
2. Dispensing									
3. Nursing									
4. Other Officers									
5. Mechanics, &c.									
6. Porters									
7. Domestic Servants									
8. Scrubbers									
9. Pensions									

4.4.3 – Homogeneity and Contention

These efforts to introduce uniformity in the accounting arrangements of charitable institutions, and, with it, the voluntary hospitals, raise interesting differences in the treatment of key items of income and expenditure and in the presentation of accounting information. All the accounts appear to be obsessed with identifying the cost of provisions [food and drink] which is not surprising given the greater relative importance of these costs in the 1890s, (and before 1890, see Berry, 1997) as in Table 4.3.

Table 4.3: Expenditure on Provisions and Salaries and Wages

	1891	1921	1938	1958
	Percentage of Total Cost			
Provisions (food and drink)	31.3	21.6	16.2	8.4
Salaries and Wages	25.7	32.8	38.1	64.7

(1891, 1921, and 1938 - Pinker, 1964. p.157; 1958 - Hospital Service Finance, 1959. p.19)

In 1891 almost a third of total cost related to provisions and all the Income and Expenditure accounts give a detailed list of provision items. For example, Van De Linde's statements had 16 headings (1888), while Burdett had 10 headings and the ICAEW Report (Accountant, 1888) recommended the completion of a separate statement for provision costs.

A summary of the controversial issues is given in Table 4.4. A number of accounting reformers [e.g. Burdett (1883) and Montefiore of COS (BPP, 1893, House of Lords)] identified the treatment of legacies as open to manipulation and after 1888 a consensus view developed around their accounting treatment. *THE ACCOUNTANT* article of 1888 recommends that amounts of £50 and above should be capitalised, while the other reports suggest that all income, including legacies, should be credited to the income and expenditure account.

Burdett's 1893 cash-based uniform accounts did not include a balance sheet while Van De Linde and the COS/ICAEW Reports both recommend a balance sheet and the depreciation of fittings. No reference is made to depreciation in Burdett's uniform accounts, which was not systematically recognised in UK hospital accounts until the introduction of the 'internal market' in 1989 (Mellett, 1992).

Table 4.4: Accounting Statements and Treatment

	ICAEW	Van De Linde	COS/ICAEW	Burdett
Year Published	**1888**	**1888**	**1890**	**1893**
Income and Expenditure Account	✓	✓	✓	**Q** (More like a Receipts and Payments Account)
Balance Sheet	✓	✓	✓ (Depending on size)	**Q** ("may be prepared under direction of auditors", see page 87) Note: no form included
Depreciation	**X**	✓ (Fittings only)	✓ (Fittings only)	**X**
Legacies in: **a.** Income and Expenditure Account **b.** Balance Sheet	✓	✓	✓	✓ (Extraordinary Income)

The differences between Burdett's accounts and those proposed by the ICAEW were that Burdett's did not specify a Balance Sheet but did include a detailed index classifying expenditure by type. It is possible to argue that Burdett's accounts reflected a lack of accounting knowledge but a more generous interpretation would be that Burdett, and the hospital managers, were more concerned about creating appropriate comparative cost information, which was only possible with this index of classification. Michelli's and Burdett's comments on COS accounts, previously mentioned, support this view. The classification of expenditure index provided detailed information as to which sub-heading, within the Income and Expenditure account, each item should be charged. In addition statistical tables provided data on the number of available beds, number of days each in-patient was resident and similar out-patient information. Burdett, and the funding institutions, sought to use the information for expenditure analysis, combining it with statistical data to produce performance measurement information, such as average cost-per-occupied bed, both in total, and under subject headings.

4.5 The Spread of the Uniform Accounts after 1893

After their success in the creation of the uniform accounts, the internal groups and institutions were still faced with the difficult task of convincing a diverse group of

independent voluntary hospitals, to introduce the new system. Table 4.5 suggests that by 1912, 90% of the larger voluntary hospitals in the UK had introduced Burdett's uniform system. They were quickly adopted in London (100% by 1899) with a somewhat slower process in the 'provinces'.

BURDETT'S ANNUAL does not include smaller cottage hospitals and the data is from Burdett's own publication and may therefore be biased, but, even so, progress towards uniformity is striking. This Section explores possible reasons.

Table 4.5: Hospitals Adopting the Uniform System of Accounts

Year	1899	1903	1907	1912
Number of Hospitals	152	163	166	165
London Hospitals Percentage	50 from 50 100%	59 from 59 100%	60 from 61 98%	61 from 61 100%
Provincial Hospitals Percentage	14 from 102 13.7%	30 from 104 28.8%	66 from 105 62.8%	88 from 104 84.6%

Burdett's Hospitals and Charities (1901, 1905, 1909, 1914)

4.5.1 – Institutions: Inspections and Statistics

Prochaska (1992), and Jones and Mellett (2000) suggest that the funding institutions [Saturday Fund, Sunday Fund and Kings Fund] used their economic power to drive accounting change. For example, by 1896, the rules of the London Sunday Fund stated that:

Those hospitals and dispensaries only, which are managed by a committee duly constituted, and which produce their printed reports with Balance Sheets duly audited for three years, by a Public Accountant, and in accordance with the uniform system of accounts agreed upon, shall be allowed to participate in the Fund

(Metropolitan Hospital Sunday Fund, MS 30586/3, 1896).

A governing 'Council' ran the Fund and monies were allocated to hospitals on the recommendations of a distribution committee (Waddington, 1995). This committee, according to a description given at the time, calculated their award in two stages, first what they regarded as the *'needs of the hospital'* and this

...is raised or lowered at the discretion of the committee, as soon as they have determined the merits of a particular institution. The task of arriving

at the merits is no doubt more difficult than determining the financial needs and rests to a greater extent on the discretion of the committee. Detailed information, including the number of beds, the average number occupied daily ... the average cost of each in-patient per week...is all laid before the committee (Hospital, 1897. p.105).

In addition to this analysis, hospital secretaries were often expected to attend special meetings, called '*deputations*', where there were asked questions on matters considered to be of an *'unsatisfactory character'*. A number of these deputations required hospitals to complete Burdett's uniform accounts as a condition for receiving a grant (Metropolitan Hospital Sunday Fund, MS 30586/3, 1896).

Outside London the Hospital Saturday Fund was of greater importance and was an early attempt to attract funds from 'working class' donors often from public collections or from more regular contributions deducted from wages (Abel-Smith, 1964; Cherry, 1997, 2000). The Saturday Funds appeared to have been governed by a committee of men drawn from the workplace and by the 1890s they became increasingly interested in hospital management, for example, awarding marks, out of fifteen, for their assessment of hospital 'efficiency' (Hospital, November 6th 1897). This assessment made less use of performance measurement information than the Sunday Fund, relying instead on answers to a series of questions. These questions were more qualitative in approach, than the Sunday Fund, and perhaps reflected their interest in gaining access to hospital care for its members and more control over hospital governance rather than using accounting numbers to assess hospital performance (Hospital, November 6th 1897).

In 1897 another significant hospital funding charity was created: the Kings Fund. This began life as 'the Prince of Wales's Hospital Fund for London to Commemorate the Sixtieth Year of the Queen's Reign' (Prochaska, 1992), later becoming the Kings Fund. In 1898 the Fund set up a system of hospital visits or inspections, of both medical and managerial practices. The medical visitors *'were a closely-knit group at the top of their profession'* and the lay visitors were *'leading businessmen and philanthropic aristocrats'* (Prochaska, 1992. p.60). Prochaska states that:

The earliest of the Fund's visiting forms asked specifically about a hospital's records and accounts, the fabric of the building, the condition of the wards....

And

> *Though it recognised that hospitals of different types used their beds in different ways, the cost-per-bed-occupied became a major test of hospital efficiency to the fund* (1992. p.62).

Hospitals requesting funding were required, as for the Sunday Fund, to produce accounts and statistical information and this was used to produce an Annual Statistical Report, starting in 1903 (Prochaska, 1992), eventually made publicly available, which can be regarded as an early attempt to use accounting information to make hospital performance 'visible' (Jones and Mellett, 2000). In addition Prochaska suggests that *'the Fund sought to create a new generation of capable, well-paid professionals who would revamp hospital management'* (1992. p.70) and that this was part of a wider universal trend in the period (Perkin, 1989).

4.5.2 – COS and the Spread of the Accounts

The other main institution, the Charity Organisation Society (COS), promoting accounting change, before the 'creation' of Burdett's uniform accounts in 1893, appeared far less interested in its implementation. Immediately after 1893 there is little reference to the accounts in *'the official organ of the Charity Organisation Society'*, the *CHARITY ORGANISATION REVIEW*.

One possible reason was the introduction of hospital almoners. At some hospitals, particularly in London, a process of 'enquiry' into the background of patients, and their ability to pay for treatment, began to take place and this resulted in the creation of hospital almoners, the first in 1894, charged with the task of this enquiry (Owen, 1965; Bosanquet, 1973). These staff were often trained, and partly paid for, by COS (Bosanquet, 1973) and this development may have moderated criticism of hospitals by COS. In addition COS was not primarily concerned with hospital organisation and was relatively ill-equipped to challenge the Hospital Association in their attempts to reform managerial and accounting practice in the voluntary hospitals.

4.5.3 – The Hospital Association: Professional Conformity

Membership of the Hospital Association was largely made up of hospital secretaries, and used two key publications to promote their professional concepts to their

members, *THE HOSPITAL* and BURDETT'S HOSPITALS AND CHARITIES: THE YEAR BOOK OF PHILANTHROPY AND HOSPITAL ANNUAL. *THE HOSPITAL*, published fortnightly, described itself as *'a journal of the medical sciences and hospital administration'*. It dealt with a wide range of topics including medical treatments, hospital administration and nursing issues.

Importantly for the spread of the uniform accounts, they also ran a regular feature called 'Institutional Workshop' which was a summary of an inspection/visit made by a reporter, normally Burdett, to a hospital. A personal visit by the powerful Burdett, with the prospect of a report on the management of the hospital in his journal, is likely to have strongly influenced how these key hospital secretaries undertook their activities, and no doubt this fact was used to promote the uniform accounts.

THE HOSPITAL ANNUAL or YEARBOOK was also significant in endorsing both the uniform accounts and more generally the concept of *managerialism*. The preparation of the Yearbook was a massive task, with information, supplied by a large number of hospitals throughout the world, arranged by country and type of hospital, for example, medical schools, general, children or special hospitals, with tables supplying the average cost-per-bed for each hospital. Those hospitals with the highest cost were identified in what appears to be an early 'naming and shaming' strategy. [While similar tables continued up to 1948 for London hospitals (Prochaska, 1992), Burdett's Yearbook appears to have discontinued this practice by the 1920s. Perhaps the cost of collecting this information was prohibitive or, as we shall see with subsequent reforms, was the value and accuracy of the information questionable?]

This promotion of *'professional good practice'* by the Hospital Association may have been aided by the early use of *pro-forma* accounting documents. Craig identifies the period 1890-1940 as one of *'standardisation'* and *'unprecedented growth in the extent of the records kept'* (1991. p.383) and confirms that:

> *After about 1880, printed forms produced by commercial suppliers were widely used by hospitals to achieve regularity and uniformity in the recording and presentation of information. Hospital registers, financial ledgers, personnel files, and clinical files were particularly affected*
> (1991. p.384).

The entrepreneurial Burdett, who owned the Scientific Press, appears to have been quick to exploit the demand for printed forms. He *'designed in accordance with the uniform system of accounts'* what he describes *'as a complete set of account books'* (Burdett, 1916. p.4), a 350-page analysis journal, a 300-page cash book and various other printed registers. Very few hospital secretaries would have had a background in accounting and are likely, therefore, to have welcomed account books, or what could be regarded as early 'accounting packages', specifically relating to hospitals, which may have been crucial to the spread of the accounts.

4.5.4 – Spread Beyond the UK

The search for uniformity in hospital accounts and with it the increased interest in 'efficiency' measures, is also apparent in the United States (Allen, 1906; 1907). The time lag between the USA hospitals and the UK suggests that their moves towards uniformity followed the UK. Allen argues that in the USA *'hospital reports lacked uniformity and clearness as to receipts and payments'* (1906. p.299) and as a result, in 1905, a committee of:

> *Hospital officers, contributors, finance experts, worked for fifteen months; studied the hospital experience of American and European cities... recommended unanimously but one remedy for deficits, extravagance, obsolete methods, or lack of public interest - more light.*

and

> *Many managers looked askance at the proposed remedy – viz. uniform, up-to-date system of accounts and reports* (Allen 1906. p.300).

In 1906 some hospitals in New York agreed a common *'form of recording and publishing important facts as to efficiency and needs'* (Allen, 1906. p.307). While the proposed accounts are different, to those required under Burdett's system, the influence of the UK is also evident from the proposed creation of a US Hospital Annual. The National Association of Hospital Superintendents (Secretaries in the UK) advocated the production of *'an annual digest of hospital data such as that which has helped the British hospitals so much during the past ten years'* (Allen, 1906. p.311), indeed Allen refers to this as an *'American Burdett'* (p.311).

Another similarity and possible managerial transfer from the UK to the USA was the idea of a professional association for managers. In the UK the Hospital Association, was created in 1884 and Burdett stated [six years later] the objectives of the Association were

> *...to raise the standard of efficiency of the administration of hospitals and kindred charities ... and the means; the promotion of co-operation among those connected with and interested in these institutions. The provision of facilities for the consideration and discussion of matters connected with hospital management and the furtherance of the decisions arrived at*
> (Burdett, 1890. p.35).

While Vogel's (1989) history of the American Hospital Association suggests that this Association dates from 1899 and at their meetings *'formal papers, scheduled discussions, and face to face contact allowed superintendents to share the specialized knowledge of their craft and to seek guidance on subjects they found puzzling'* (Vogel, 1989. p.246). These moves towards accounting uniformity and the creation of a professional association could have been coincidence but a case can also be made for the transference of the 'best practice' from the UK.

4.6 Conclusions

This Chapter examines a specific event, the introduction of 'Burdett's' uniform system of accounts (1893), that provided the foundation for hospital accounting information until State control in 1948. Using Porter's elements it suggests that a number of individuals, groups and institutions, initially stimulated by wider social forces, both from within and outside the hospital, generated initial interest in accounting reform. For example, an increasing interest in the role of charitable and other social institutions within society, and concerns about the 'efficiency' of healthcare providers, led reform groups, such as the Social Science Association, to take a keen interest in hospital organisation. However it was another external institution; the Charity Organisation Society (COS), that was to prove the catalyst for accounting change.

The conceptual stimulus for COS was concerns that hospitals were helping to create a dependency culture, (Rosen, 1976) through free access to out-patients departments,

and also manipulating accounts to show deficits to aid hospital funding initiatives. Their trenchant criticism of the free provision of out-patient care led, as a by-product, to their probing of hospital organisation and accounting, and ignited interest in hospital reform from another two institutions, The Institute of Chartered Accountants in England and Wales (ICAEW) and later the House of Lords. The ICAEW provided essential technical expertise as well as professional legitimacy. The possibility of State intervention, in the form of the Lords Enquiry, appears to have been decisive in mobilising internal hospital institutions into defending the organisation of voluntary hospitals, and provoked a reaction to accounting reform (Rivett, 1986).

A detailed examination of the process of change from 1888 -1893 illustrates how *internal* individuals, groups or institutions, in the form of the Sunday Fund, Hospital Association, Burdett and other leading figures within the London Hospitals, were able to control hospital accounting policy and effectively exclude external institutions.

Although there was a degree of similarity between all proposed accounts, 'Burdett's' were, in many respects, the least sophisticated of the possibilities on offer, therefore, rationality is not the key to understanding why these accounts were those eventually adopted. Other possible reasons are complex and inevitably subjective. The concept of voluntarism appeared to be a universal embraced by all groups and institutions and this indirectly provided support for Burdett and the internal groups. The House of Lords report, for example, while supporting uniform accounting was reluctant to recommend any State intervention in the internal organisation of the hospitals and this fitted well with the self-governing principles of the hospitals.

There may have also been a far more practical explanation. While COS and ICAEW were able to denounce hospital accounting practice, it was not, for either institution, a main-stream concern, and, given the reluctance of the State to intervene, it appears that both COS and ICAEW were either unwilling, or unable, to convert 'criticism' into action. This contrasts markedly with the internal individuals, groups and institutions; particularly Burdett, the Sunday Fund and the Hospital Association. These internal groups, certainly within London, were controlled by a small elite

group of individuals, many of whom were close to Burdett, and who appear to have been prepared to devote time and energy, and use their resources, to pursuing accounting reform.

The role played by the ubiquitous Burdett was also crucial in the process of change. His influence and power stemmed from his ownership and editorship of *THE HOSPITAL* journal, his high level contacts within the hospital institutions and his personal friendships with hospital secretaries, such as the hospital treasurer Michelli. Indeed it can be argued that these contacts enabled Burdett to create a group, of like-minded individuals, committed to accounting reform and able to use the internal institutions to accomplish such reform. Burdett was also in the fortuitous position, as owner of the Scientific Press, to be able to publish quickly and to present 'Burdett's' uniform accounts as a *fait accompli*, even before the final publication of the House of Lords Report.

The 'victory' of the internal groups had far-reaching implications for hospital accounting information and control; extending the principal of uniformity from accounting stewardship to performance measurement, by the inclusion of a detailed index of classification of costs and other statistical information, such as number of in-patients, out-patients and occupancy levels. For the next 50 years one sees attempts, particularly by the Kings Fund, to use this data to compare hospital performance and to drive resource-allocation decisions.

Central to the spread of uniform accounts is the influence of Burdett and his publications, the economic power of the funding institutions and, perhaps, the demand for professional homogeneity (DiMaggio and Powell, 1983), encouraged by the Hospital Association. It is this combination of individual advocacy, institution power and professional conceptual conformity that appears to have achieved change so completely. Whether one element would have achieved change is questionable. For example, the economic power, of the funding institutions, can be overplayed (Cherry, 2000), as all three of the main funding institutions only accounted for around 8% of total hospital income in 1899. However they contributed towards professional conformity, in the preparation of accounting information, and by their

influence via hospital visits and inspections. A hospital secretary, faced with a visit from these powerful, and often rich, individuals, was more likely to conform to their expectations than to challenge them.

In the absence of State involvement this was a potent external pressure. With the creation of the Hospital Association, one sees the beginnings of a professional network influencing the behavioural norms of hospital secretaries. This was reinforced by the journals *THE HOSPITAL* and BURDETT'S HOSPITAL ANNUAL. In addition Burdett's Scientific Press was quick to respond, or perhaps exploit, the demand for uniformity by producing standard printed account books. There is limited, but interesting, evidence to suggest that accounting uniformity spread beyond the UK to the USA.

The development and diffusion of hospital uniform accounting suggests that the attempted use of accounting to measure and influence hospital performance and organisation has a long history and was a much earlier phenomenon than those associated with 'New Public Management' (Hood, 1991). This research implies that a multi-level explanation for accounting change avoids the over-reliance that can be placed on a single element, such as government intervention or economic forces, when exploring a complex event.

While external contextual influences on accounting policy formulation are important in stimulating change, the outcome [certainly in this case] is also intrinsically linked to the actions of individuals, groups and institutions. It suggests that, at the time, well-organised and connected internal groups were able to resist incursions from the accounting profession and prevent them controlling hospital accounting information. This may partly explain why hospital, and indeed, charity accounting has received limited attention from the profession until the more recent past.

Chapter 5 ~ The Emergence of Departmental Costing

5.0 Introduction

This Chapter examines the emergence of *departmental costing*; the second major change event to be explored in this study. The first Section tracks the changes in governance of hospitals in the early 20th century. The concept of voluntarism and self control continues but we begin to see a gradual interest from the State in hospital care but limited intervention.

This is followed in Section 5.2 with a discussion on the concept of departmental accounting, while the early contextual drivers of change in the UK are debated, and compared with research on hospital accounting change in the USA (Preston, 1992) in Section 5.3.

Section 5.4 analyses the major change in funding and organisation, brought about by 'nationalisation', in 1948. Paying particular attention to the central role envisaged for accounting and the political desire to find an accounting technique to measure performance and maintain control after the nationalisation of the hospitals.

This is followed in Section 5.5 with a detailed examination of the process of accounting change, from 1948 to the eventual introduction of departmental costing in 1956. The debate, and conflict, among key individuals, groups and institutions is discussed and it is suggested that this process of change had a significant impact on the accounting technique adopted, with *departmental budgeting* being relinquished. In this period we see the decline of pre-nationalisation institutions, like the Kings Fund, and the emergence of new internal groups.

The role of the medical profession in the departmentalisation debate is reviewed and possible explanations for the reluctance to adopt new management accounting techniques are given. The Chapter ends with conclusions.

5.1 Early 20th Century Contextual Elements

In the first half of the 20th Century there was a mounting debate on the role of the State in hospitals, but no significant changes in their organisation. This increasing interest from the State is evident from the number of official reports and limited financial support (Abel-Smith, 1964). For example, the Ministry of Health, created in 1919, commissioned two Reports into the provision of medical care and hospital finances; the Dawson (Ministry of Health, 1920) and Cave Committee Report (Ministry of Health, 1921). The more important and extensive being that from the Cave committee. This report defended the voluntary hospitals, but made a series of suggestions regarding their organisation and funding (Stone, 1927; Abel-Smith, 1964).

This included the creation of a Hospital Commission to allocate a £1 million grant to the voluntary hospitals, although the amount actually allocated was reduced to £500,000 (Prochaska, 1992). It also recommended that local authorities be allowed to contribute to the costs of voluntary hospitals and that Local Voluntary Hospital Committees be formed. These committees were established, and, among their aims, they were to:

- *'act as local advisors to the commission*
- *create and further co-operation between hospitals*
- *advise as to the adoption of the uniform system of accounts'*

(Stone, 1927. p.50)

However Stone points out that these committees would not challenge the traditional voluntary ethos:

> *It was not contemplated that these committees would, nor do they, control the hospitals in any way, the voluntary principle being adhered to*
> (1927. p.50).

In addition the Hospital Commission played its part in promoting uniform accounts. For example, in an attempt to ensure *'proper administration'* (PRO: MH 58/186) they set up a sub-committee to recommend an accounting system for smaller hospitals, and concluded that the simplified version of the uniform accounts,

produced by the Kings Fund, should be adopted. In addition the Commission helped enforce accounting uniformity by, like the voluntary funding institutions before them, only funding those institutions using the uniform accounts (PRO: MH 58/186; Prochaska, 1992).

The Voluntary Hospital commission also produced guidance on 'good practice', such as their, NOTES ON HOSPITAL MANAGEMENT (1922). These notes reinforced the business orientation previously associated with the Kings Fund:

> *There is nothing in the management of a hospital which sets it apart from any commercial undertaking. Hence what is primarily required of the Committee of Management is the application of sound business principles not only in the larger questions of raising and investing funds, and expenditure on larger items such as buildings, but also more particularly in the supervision of the routine expenses*
> (MH 58/186: Voluntary Hospitals Commission, 1922. p.3).

The Report continued with recommendations on control of expenditure, suggesting:

> *Every hospital should prepare an annual budget... if the cost of any department exceeds the sum allocated to it, the causes of the excess should be carefully investigated. For this purpose a quarterly comparison between estimated and actual expenditure is desirable*
> (MH 58/186: Voluntary Hospitals Commission, 1922. p.4).

Together with a creeping interest from the State and continued calls for improved management another significant change was in the financing of voluntary hospitals; with them becoming increasing reliant, for funds, on contributory schemes and patients' payments (Abel-Smith, 1964; Cherry, 1992). Cherry notes:

> *The growth of hospital contributory schemes enabled renewed hospital expansion to occur and established a quasi-insurance basis to hospital activity in place of the earlier, largely philanthropic approach. The schemes also involved additional market mechanisms and promoted reorganization, including a degree of co-ordination of hospital services, felt at the local level before the growth of policy making bodies on a national scale and largely independent of central or local government*
> (1992. p.455).

Another development, in the first half of the 20th Century, was the municipal hospital (Abel-Smith, 1964, Rivett, 1986). These were quite often former Poor Law institutions or hospitals used for particular types of care, for example, infectious diseases or for mental health patients (Stone, 1954) but the 1929 Local Government

Act allowed local authorities to undertake a wider role in hospital care previously associated with the voluntary hospitals (Stone, 1954). However Abel-Smith notes that *'while some authorities were attempting to provide a service to the public, there were others who made little progress in the health services'* (Abel-Smith, 1964. p.383).

The restricted role played by the State, in the eyes of the 21st Century reader, needs to be seen in the context of the universal values of the period. There appears to have been little support, certainly among the voluntary hospitals, for state intervention and there appears to be unwillingness from Governments to finance hospital care (Cherry, 1992; Prochaska, 1992). Prochaska further argues that *'most people, still deeply imbued with Victorian values, did not wish to make a decisive break with a familiar liberal society in which localism and selectivity were deeply ingrained'* (Prochaska, 1992. p.91).

There were, however, increasing demands from state-sponsored reports – Dawson Report, Cave Report, and later the Sankey Report, 1937 – for more 'co-ordination' of medical care and for more organised 'planning' of the hospital service, with this concept of regional planning to become central to the organisation of hospitals after nationalisation in 1948 (Titmuss, 1950; Abel-Smith, 1964; Rivett, 1986; Webster, 1998). While in the inter-war years there were the beginnings of interest from the State in hospital care, direct intervention was limited. However this period did see the emergence of a new concept: departmental accounting.

5.2 Concept: Departmental Accounting

Throughout the first half of the 20th Century there were a number of revisions [1903, 1910, 1916.] to the uniform system of accounts introduced in 1893. The 1916 edition of the uniform accounts notes that revisions had been made

> *...by John Griffiths, F.C.A., in 1905, and that a committee of hospital secretaries and the representatives of the Kings Fund were engaged in a further revision of the system. The revised system which resulted was completed in November, 1906, adopted by the three funds – the Kings Fund, the Hospital Sunday, and Hospital Saturday Funds – and came into force on January 1, 1907* (Burdett, 1916. p.2).

The main change appears to be the addition of a Balance Sheet which was not included in the first edition of 1893.

However, by the 1920's, the uniform system of accounts was beginning to come under attack from advocates of *departmental costing and budgeting* and the debate about the need for this type of information dominated hospital accounting for the next thirty years (Prochaska, 1992; Jones and Mellett, 2000).

The leading advocate of change was Captain J. E Stone and a major theme of his text HOSPITAL ACCOUNTS AND FINANCIAL ADMINISTRATION (1924), was the introduction of departmental information and budgets. Stone argued that, with the increased size, and the complexity of medical care, employment and expenditure within hospitals was increasingly based around departments (see also Preston, 1992 for similar comments in the US). While the number of departments varied with the size of the hospital they typically included wards, out-patient departments, operating theatres, x-ray, laboratories, catering, laundry, portering, cleaning and administration. He recommended that accounting information should reflect this organisational structure, with departmental budgets for planning and control, and the use of departmental unit costs as comparative performance measures.

This departmental template was later to be taken up by pressure groups within the healthcare sector, such as the Nuffield Trust (1952) and the Kings Fund (1952). A good example of a departmental statement was produced by the Nuffield Trust and is reproduced as Figure 5.1. A departmental system normally required:

- An account for each department, within the hospital, with costs split into pay and other expenditure. The number of departmental accounts recommended by the Nuffield Trust (1952) was more than ninety, and included wards divided by specialty as well as numerous other patient, and non-patient, care departments.
- Departmental unit costs, such as cost per in-patient day for wards and cost-per-item for the laundry.
- The introduction of a budget for each department, and a comparison to actual expenditure.

Figure 5.1: Departmental Cost Statement

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TABLE III

SAMPLES OF DEPARTMENTAL COST STATEMENT

Departmental Cost Statement for Period 1.10.51 to 31.12.51

Group F — *Department*: Radiology
Hospital H — *Unit of cost*: Weighted points value of examinations

Total number of units 10,527
Total number of examinations as counted for S.H. 3 . . 5,554

Expenditure headings	*Sub-total* £ s. d.	*Main total* £ s. d.	*Unit cost* £ s. d.
Salaries and Wages			
Radiologists . . .	1,231 0 0	..	2 4¼
Radiographers . . .	1,113 14 6	..	2 1¼
Nursing . . .	152 18 3	..	3½
Other	62 7 3	..	1½
		2,560 0 0	4 10½
Stores Issues and Direct Purchases			
X-ray films . . .	..	581 2 8	1 1
*Instruments and equipment	..	528 19 3	1 0
Printing and stationery .	..	107 15 5	2½
Cleaning materials . .	3 11	..	..
Bedding and linen . .	9 1 7	..	..
Hardware and crockery .	1 0 4	..	..
Renewals and repairs to equipment . . .	4 2 0	..	..
Uniforms and clothing .	71 4 7	..	2
		85 12 5	
Total . . .		£3,863 9 9	7 4

Note: If a training school please state number of students.
* Includes purchase and fitting of Anode tube £300 (approx.).

The departmental statements can be regarded as a move away from the hospital as the accounting entity, to its division into departmental units, with each department effectively becoming a separate reporting entity. This was a substantial change from the measurement of overall total hospital performance based on cost-per-bed data [a subjective analysis] to unit cost information for department performance.

It was envisaged that this departmental information would provide a tool for hospital managers, both for the evaluation of managers via unit cost comparisons and for the control of expenditure through departmental budgets. Indeed some advocates proposed that average departmental unit cost data, for a number of hospitals, would

provide standard cost data and could be used as a basis for resource allocation to departments, or indeed to hospitals (Nuffield, 1952).

Departmental budgets were also an early attempt to introduce devolved budgets within hospitals. They were to be at a much lower level in the organisational hierarchy than the later functional budgets introduced in the 1974 reorganisation of the NHS, which were largely professional, or discipline, based (Perrin, 1988). Nursing budgets provide a good illustration – after 1974 the District Nursing Officer was often the only budget holder for nursing, whereas Stone's departmental information proposals advocated that nursing costs be managed via individual ward budgets. Interestingly later reforms, particularly after the Griffiths Report, 1984, encouraged hospitals to establish budgets for units, normally hospitals, and within these, for departments.

5.3 Early Drivers of Change

5.3.1 – The Early Influence of Stone

Stone appears to have been the leading advocate of departmental budgeting and costing (Prochaska, 1992; Jones and Mellett, 2000); he had been the Treasurer at St Thomas's Hospital, and extensively promoted departmental accounting information in the period 1924-1956, through his connections with hospital groups and his texts (Stone, 1924, 1936, 1956).

While there was no direct connection with Burdett, who died in 1920, Stone was regarded as a *'formidable figure in the history of hospital administration, a man in the tradition of Henry Burdett'* (Prochaska, 1992. p.143). Stone argued that the uniform system of accounts and, in particular, the use of cost-per-bed comparisons to *'judge'* hospital performance was misleading and did not recognise the differences in cost of more complex treatments, making the measure a *'largely absurd'* comparison. (1936. p. 6)

Stone uses an economic rationalist explanation for accounting change, in particular, the increase in the technology and complexity of medical care, since the publication of the uniform accounts in 1893 (Stone, 1924; 1936; 1956). There is some support for this view in the changing cost structure of hospitals, with, as Stone argues, their

increased reliance on x-ray, pathology laboratories and operating theatres, which, in turn, increased the number of hospital departments and specialist staff. For example, in 1891 provisions [food and drink] and salaries represented 31% and 25% respectively of total cost; by 1938 these percentages had changed to 16% and 38%, as in Table 5.1.

Table 5.1: Changes in Cost Structure

Percentage of Total Cost	1891	1921	1938
Provisions (food and drink)	31.3	21.6	16.2
Salaries and Wages	25.7	32.8	38.1
Surgery and Dispensary	12.4	11.3	12.9
Domestic Expenses	16.5	19.4	16.3
Other Expenditure	14.1	14.9	16.5
Total	100.0	100.0	100.0

Source: Pinker (1964. p.157)

5.3.2 – Techniques from Commercial Sector

UK hospitals were not alone in this drive towards departmentalism as similar changes were also underway in the USA in the mid 1920s (Preston, 1992). Preston suggests that in the USA departmentalism was an early attempt to introduce commercial practice into the hospital environment and identifies, as Stone does in the UK, changes in medical practice as having a major impact on cost structure and therefore accounting information within hospitals. For example, by 1925, he notes

> *...that the accounting portion of the annual report of Boston City Hospital had undergone a significant transformation. Reflecting contemporary medical discourse and practice expenditure was increasingly categorised according to departmental heads* (Preston, 1992. p.75).

Whether the UK led, or followed, the USA has not been explored, but Curtis (Preston, 1992) in the USA wrote BETTER MANAGEMENT OF HOSPITAL THROUGH BUDGET CONTROL in 1924, the same year that Stone's text proposed the introduction of departmental accounts. Their views were remarkably similar; for example:

> *Good accounting involves accounts arranged to reflect precisely the departmental organisation of the institution, so that the costs of operation may be kept by departments*
> ([Curtis, 1924:332], quoted in Preston, 1992. p.73).

and

> *The organisation of the costing system is commenced by dividing the hospital into sections and these sections into wards and departments, for each of which separate records will require to be kept* (Stone, 1924. p.97).

In addition to the convergence of ideas, between USA and UK hospitals, on departmental accounting, there is also evidence that in the UK, as in the USA (Preston, 1992), interest in departmental information was also stimulated by a perceived need to follow commercial practice. Stone (1924) in a section headed *'Applicability of cost accounts to hospitals'* states that:

> *There is nothing in the management of a large hospital which sets it apart from that of a commercial undertaking and to those who are responsible for the efficient and economical management of hospitals it is obviously more satisfactory to have the accounting records on such a system*
> (Stone, 1924. p. 95).

[Note: Stone's views are very similar to those, sometimes the exact words, (see section 5.1 above) expressed by the Voluntary Hospital Commission; perhaps Stone was involved in the writing of Commission's Report].

Stone reproduces a diagram from Hawkins' 1921 text COST ACCOUNTS: AN EXPLANATION OF PRINCIPLES AND A GUIDE TO PRACTICE to illustrate the double entry principles of cost accounts, and how hospital departmental accounts could replace the job account in the manufacturing environment.

There is also some evidence of Stone establishing relationships with USA hospitals and the fact that similar ideas on hospital accounting were beginning to emerge at around this period in both the UK and USA may be linked to the flow of information, via academic texts, exchange visits and the establishment of the International Hospital Federation. Stone was, for example, Honorary Secretary and Treasurer of the International Hospital Federation, Honorary Member of the American Hospital Association and Honorary Fellow of the American College of Hospital Administrators (Stone, 1956).

In addition there was an increased interest in the preparation of departmental accounting information in the management accounting literature for the period 1920-1950. Vollmers analysis of US academic accounting texts suggests that the

'foundation of the costing procedures of the first half of the 20th Century was the department' (1996:187). She uses, as an example, the financial reports used by Jordan and Harris in their 1921 text which are *'highly detailed statements and schedules that break down information by cost department'* (Vollmers, 1996. p.185).

The extent to which departmentalisation was practice rather than theory is, however, debatable. Certainly within the USA, the Anglo American Council on Productivity (AACP, 1950) report on management accounting suggests that departmentalisation was the dominant practice in USA organisations:

> *Certain points of practice are common to all companies investigated regardless of the type of system used. The classification of expenses follows departmental lines, and is carefully coded according to a 'chart of accounts'. Great stress is laid on the use of departmental accounts, because it enables reports to be prepared to show managers or foremen how the expenditure under their control is going. This is the accountant's contribution to the policy of decentralisation of responsibility which appears to be a general tendency in American industry*
>
> (AACP 1950. p.39).

But

> *...the principles and methods which American management applies are well known in this country [the UK] but are practised much more universally and vigorously in American* (AACP, 1950. p.14).

It is not the author's purpose to explore the possible transference of accounting techniques between the two countries, or to compare their accounting adoption rates, but the take up of departmental accounting in the USA does appear to support the view that the UK lagged behind the USA in hospital accounting practice identified by Preston (1992). There does appear to be similarities between the two countries, certainly in the literature of the leading campaigners for departmental accounting but, despite Stone's efforts from around the mid-1920s, adoption was to prove a very slow process in the UK.

5.3.3 – Historiographic Paradigms

This evidence suggests that the move to departmentalisation can be analysed from a number of perspectives. It could be seen as merely mimicking business *'best practice'*, as hospital departmental accounting appears to be similar to accounting theory, and possibly practice, in the manufacturing sector. In addition hospital

accounting was certainly not insulated from conceptual developments in the management accounting field (Vollmers, 1996), and what DiMaggio and Powell refer to as the remarkable *'homogeneity of organisation forms and practices'* (1983. p.148) is evident in the move towards the departmentalisation of accounting information.

Another driver of moves to departmentalisation could be, as suggested by Stone and Preston (1992) in relation to the USA, as an *'economically rational'* response to the changing complexity and organisation of hospital care, resulting from medical and technological innovations. However, even this interpretation, although with a degree of obvious logic attached, can be questioned. For example, the overall difference in hospital cost structures (see Table 5.1) between the late 1880 and the early 1920s is not hugely significant. Salaries and wages as a percentage of total costs have only increased by 6% over a 40 year period and provision costs are still 21% of all costs. It can also be argued that the changing medical complexity preceded the 1920s, when the debate on departmentalisation emerged, in both the UK and the USA.

Another interpretation draws on Foucaudian perspective and the use of accounting for 'surveillance'. Changes in healthcare resulted in the introduction of skilled and specialist staff in anaesthetics, pathology, and radiology, and this increased the proportion of manpower costs in relation to total costs. The non-specialist administrator would have had increasing difficulty in understanding and managing the increasingly complex hospital organisation. New accounting techniques might therefore have been employed to combat increasing complexity, attempting to ensure that departments and their specialist staff were accountable and, in a sense, *'visible'* (Loft, 1986; Jones and Mellett, 2000).

This multiplicity of possible drivers of accounting change suggests, as in more recent academic work in relation to Taylorism, it is possible to interpret departmentalisation within more than one historiographic paradigm (Fleishman, 2000). Indeed it may be more likely that all these drivers contributed to the advocacy of this new accounting direction. Within UK hospitals, departmental information did not replace Burdett's subjective analysis, and this illustrates the reluctance of practitioners to abandon

'tried and tested' systems, or, indeed, to invest in new unproven accounting techniques. [The subjective analysis of expenditure was used, by Stone and others, to describe the system of accounting adopted in Burdett's Uniform System of accounts of itemising expenditure only by subject or type, rather than also associating expenditure with a department, as advocated by Stone]. These changes, first suggested by Stone in 1924, would have to wait for another 24 years, to re-emerge after hospital nationalisation.

5.4 War and Nationalisation

During the Second World War an Emergency Medical Service was established and the country was divided into healthcare regions (Webster, 1998. p.6). The hospitals in each region were classified accorded to facilities offered, and the government began to fund capital schemes to upgrade hospitals and also agreed a recharging scheme for hospitals treating war casualties (Abel-Smith, 1964; Titmuss, 1950; Rivett, 1986; Prochaska, 1992). Therefore, although the hospitals, certainly in their internal management, were not under direct state control, the War did establish a role for the State in a form of 'co-ordination' and, increasingly, in the funding of both revenue and capital expenditure (Titmuss, 1950; Webster, 1998).

The voluntary hospitals were reimbursed for the cost of War casualties by the government and made a return to central government, 'Statement of Expenditure and Income' as in Figure 5.2, to claim this reimbursement. The statement broadly followed the headings given in the uniform accounts and may have helped establish a familiarity with the uniform system within government departments, as, certainly after the creation of the service in 1948, it was broadly this type of accounting information that was adopted (PRO: MH 137/13).

Figure 5.2: Statement of Expenditure and Income

STATEMENT OF EXPENDITURE AND INCOME

PART I.—EXPENDITURE TO BE APPORTIONED ON BED COMPLEMENT, i.e. the amounts shown in Col. 2 of this page allocated to the Emergency Hospital Scheme in Col. 3 of this page in the proportion of fraction $\frac{\text{Col. 5(c)}}{\text{Col. 6}}$ on Page 1. Heading I.

Item (1)	Expenditure (2)			Amount apportioned to E.H.S. (3)		
	£	s.	d.	£	s.	d.
The notes in parentheses refer to the appropriate para. in Memo. 243 A.G.						
1. Salaries, Wages and Uniforms (including employee's contribution to Superannuation Fund and Employer's equivalent contribution*; Employer's and Employee's contributions for Health, Pensions and Unemployment Insurance).						
(i) Medical (See Note 4 (a))...						
(ii) Nursing‡ (See Note 4 (b))						
(iii) Other Officers and Employees (e.g. Domestics, Mechanics, Porters, Stretcher Bearers, Laundry Workers, etc.)						
(iv) Additional staff whole time for E.H.S. (Particulars should be given in a separate statement)						
2. Provisions for Staff (See Note 4 (c)) (i) Actual Cost or						
(ii) Calculated Cost						
3. Fuel, Light and Water						
3 (a). Staff Laundry (See Note 4 (d)) (i) Actual Cost or						
(ii) Calculated Cost						
3 (b). Patients' Laundry if done in hospital†						
4. Rates, Taxes and Insurance						
5. Internal Repairs and Decorations						
6. Miscellaneous (Printing, Stationery, Postages, Telephones, Travelling Expenses of Staff, etc.)						
7. Expenditure on Farm and Garden (where separate account is kept, excluding value of supplies to Hospital included under Items 2 and 8) ...						
TOTAL EXPENDITURE PART I						
Less **General Income** (See Note (e))						
Farm and Garden (sale of produce excluding value of supplies to Hospital)						
50% See Note 4 (e): Deductions from Salaries and Wages in respect of Board, Laundry, etc.						
50% See Note 4 (e): Miscellaneous sales of waste, etc.						
TOTAL INCOME PART I						
NET EXPENDITURE PART I						

* This may be shewn as a separate item (v) in respect of all staff if preferred.

† Net amount should be inserted here if there are credits in respect of laundry done for other institutions.

‡ NOTE.—Enter the NET amount after deducting the sum of £..........received by way of State Grant in respect of increases in Nurses' Salaries.

THIS FORM SHOULD BE PREPARED ON

The needs of War and in particular the increased State planning and incursions into many aspects of everyday life (Titmuss, 1950; Webster, 1998. p.8), may have led to a new attitude towards State control of hospitals and the possible advantages associated with a centralised service. Although there was a degree of resistance to

nationalisation from the voluntary hospitals, this appears to have been muted, and all were eventually 'nationalised' with the creation of the National Health Service in 1948 (Webster, 1998).

The prelude to nationalisation is thoroughly examined elsewhere [e.g. Lindsey, 1962; Pater, 1981; Webster, 1988; Klein, 1995] and Webster states that the Minister of Health, Bevan:

> *Gave up the attempt to reconcile the two rival hospital systems, deciding instead to merge all hospitals as the 'direct responsibility of the Minister and financed wholly from the exchequer*

And that:

> *The recently adopted regional advisory machinery could be readily modified to take on a more general administrative function as the agent of the Minister* (1988. p.82).

Webster suggests the idea of a regional-based hospital structure was not new and that '*although slow to gain acceptance in official circles, hospital regionalisation of one kind or another had been a dominant theme for nearly ten years* (1988. p.82). In addition avoiding municipal control, by nationalisation, was actually welcomed by both the medical profession and the voluntary hospitals and the major opposition to the scheme, within the Labour government, came from Morrison, Lord President of the Council, who was concerned the scheme would *'weaken local government'* (Klein, 1995. p.17; Webster, 1998).

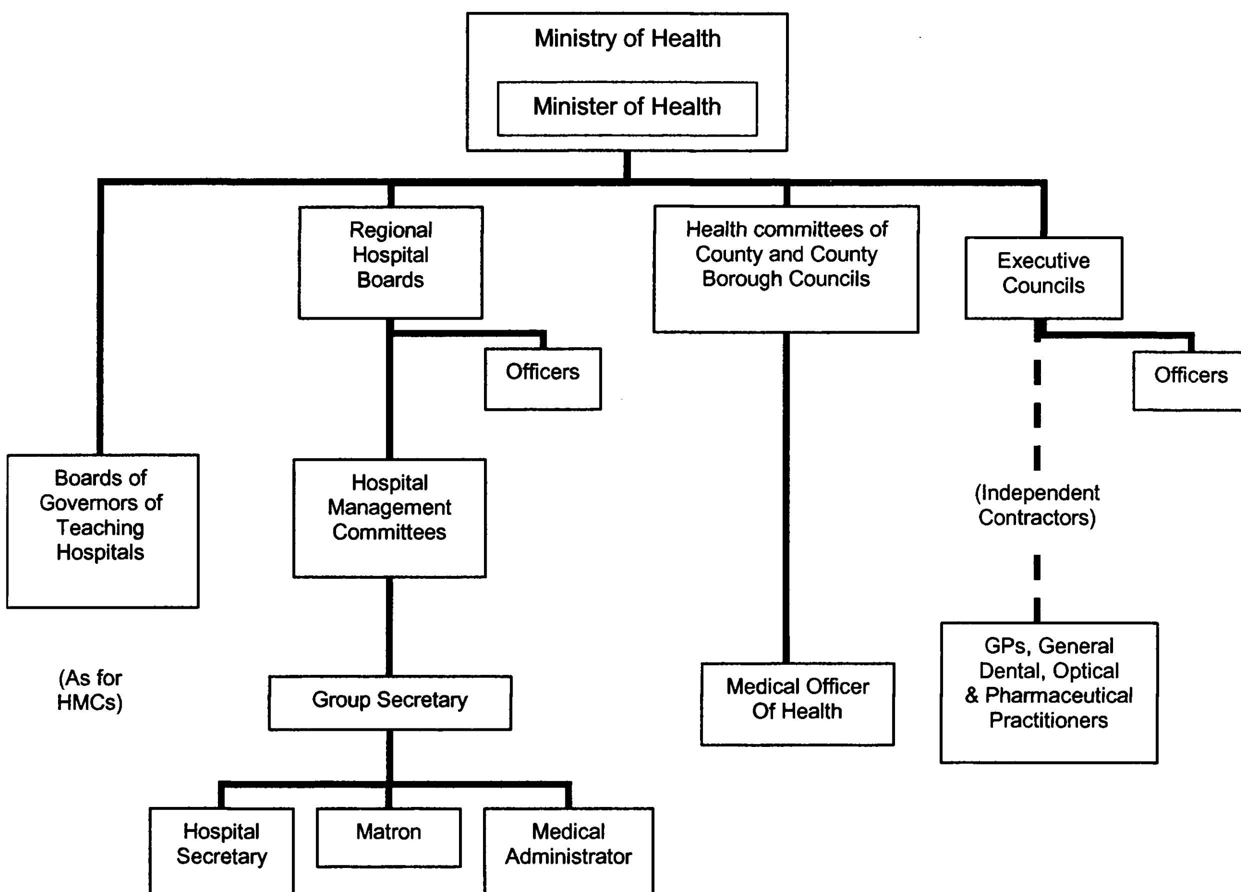
Bevan was eventually successful in the nationalisation, and regionalisation, project and *'the new health service arguably constituted the single biggest organizational change and greatest improvement in healthcare ever experienced in a nation's history'* (Webster, 1998. p.2). The scale of the change is illustrated by the fact that, in England and Wales, 2,800 hospitals were taken under central State control (Acton Society Trust, 1955).

5.4.1 – Organisation of the NHS

The organisational structure of the hospital service established in 1948 is outlined in Figure 5.3. The NHS was divided into 19 Regional Health Boards (RHB), and, within each, there were a number of hospital groups reporting directly to the RHB, while

hospitals with undergraduate medical schools [teaching hospitals] were responsible to the Ministry of Health and not to the RHB (Acton Society Trust, 1955).

Figure 5.3: Structure of the NHS ~ 1948



(Harrison, 1988:10)

The hospital groups consisted of a number of hospitals in a geographic area, and the formal decision-making body, at this group level, was a board of management, referred to as the Hospital Management Committee (HMC). This organisational structure, Bevan, the first 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 membership of the hospital management committee (HMC) was part-time and unpaid, with appointments made by regional boards, while the HMC were 'supported' by a number of officers, normally with the titles: medical officer, matron

and secretary, with this internal management arrangement often described as *'tripartite'* (Bradbeer, 1954; Harrison, 1988, p.10). At the hospital level there was a degree of confusion surrounding decision-making and the respective functions of officers and members in hospital groups. As early as 1954 the government-sponsored Bradbeer Report, on the internal administration of hospitals, stated:

> *The relationships between officers and their governing body and between the officers themselves, which once presented few problems, now raise all sorts of questions which we believe have been prevented from developing into serious stumbling-blocks only by the genuine desire of officers throughout the service to make the service work*
>
> (Ministry of Health, 1954. p1).

The recommendations of the Bradbeer Report did little to clarify roles and merely concluded that *'the development of the hospital service must be organic development, and its administrative pattern must remain flexible'* (1954: Para. 245). Who managed, or who should manage, the hospital group was the topic of much debate after nationalisation, and the author returns to this debate in the next Chapter (Harrison, 1988).

Within this organisational structure accounting information was provided at the group, rather than at individual hospital level, and was normally produced by a small team of finance staff, headed by a treasurer who was a qualified accountant.

The provision of detailed accounting, particularly costing information was a high priority from the inception of the service in 1948. Indeed there is evidence to suggest that the centrality of accounting information, to promote efficiency, helped suppress opposition from the Treasury to the NHS (Klein, 1995). Bevan, in Cabinet, stated that they *'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 128/5:22).

At a later Cabinet meeting Bevan also outlined his belief in local decision-making, but with costing information being used to 'educate' and bring 'order' to local hospitals, stating:

> *Decentralisation to local bodies, a minimum of itemised central approval, and the exercise of financial control through global budgets,*

relying for economy not so much on a tight and detailed Department grip but on the education of the bodies concerned by the development of comparative costing, central supply and similar gradual methods of introducing efficiency and order among the heterogeneous mass of units (PRO: CAB 134/518:1).

This is an early illustration in the life of the welfare state of the proposed use of accounting data to record *'economic visibility'* and provides an important insight into the high expectations politicians have for accounting information. Though it would appear that the way was open for accounting change the process was to prove complex and problematic, with competing interpretations of the role, type and purpose of accounting information. The following Section tracks this complex process of change.

5.5 The Process of Accounting Change

This Section examines how accounting change unfolded in the eight years before the introduction of departmental information in 1956. Central to the narrative is the role of individuals, institutions and the central NHS bureaucracy in the debate, and sometimes conflict, surrounding accounting change. Important environmental disturbances, such as major budget overspend, and their triggering effects on accounting policy, are considered. The Section begins with a brief consideration of the work and influence of a key individual, Captain J.E. Stone.

5.5.1 – Individual Champion: Captain J. E. Stone

Stone was the leading advocate of departmental budgeting and costing (Prochaska, 1992). Significantly, in 1939, the Kings Fund employed him as an advisor on hospital finance and his links with the Fund were consolidated after 1948 when he became Director of the Kings Fund Division of Hospital Facilities; effectively an independent advisory unit on hospital management (Hospital, December 1948).

Stone wrote extensively, with substantial texts on both hospital administration and accounting, and was able, like Burdett before him, to use the institutional power of the Kings Fund to promote new accounting techniques to replace those established more than 50 years earlier. In addition to his post with the Kings Fund Stone also

appears to have had close allies in the professional press; in particular the hospital administrators/managers journal, *THE HOSPITAL*, and also at *THE ACCOUNTANT*.

His high status continued in the early years of the NHS and the Civil Service co-opted Stone to its committee on hospital accounting (PRO: MH 137/2). Although his views on accounting change were too radical for the newly-created bureaucracy, his work appears to have set the agenda for the controversy surrounding departmental information that dominated the early years of the NHS.

5.5.2 – Institutional Lobbying and the Rise of Internal Groups

The first groups to promote departmental accounting in the new climate created by nationalisation were the professional accounting associations and the well established Institute of Hospital Administrators. However, these powerful professional bodies were unable to impose accounting reform and were prevented by a powerful alliance between the accounting practitioners [the regional treasurers and the civil servants].

The Institute of Chartered Accountants in England and Wales (ICAEW) and the Institute of Hospital Administrators used their respective journals to promote departmental accounting (Accountant, August 1946 and August 1949; March and April, 1950; see also Hospital, July 1948, and Webster, 1988. p.297). The Institute of Hospital Administrators set up a working party, the *Joint Committee on Hospital Accounts,* in co-operation with the ICAEW and the Institute of Cost and Works Accountants (ICWA) (Accountant, October 1952). This working party report (Institute of Hospital Administration, 1948) recommended a departmental system of accounts, broadly in line with that advocated by Stone.

In parallel with the activities of the hospital administrators and the accounting associations the Ministry of Health set up an advisory committee on hospital accounts in June 1947 (PRO: MH 137/2). The membership of this committee is revealing. The only accounting association represented was the Institute of Municipal Treasurers [now CIPFA]. All other members were county council based, or civil servants, except for Capt. Stone, representing the Kings Fund. The ICAEW and

ICWA, even though showing an interest in this area, via the joint working party, were not represented on the advisory committee. In addition many hospital treasurers were members of the ICAEW (Sidebottom, Hospital, 1962, p.583). This suggests that quite early on in the NHS, there was an effort to seek public sector solutions to public sector accounting problems.

This was a symbolic triumph for public sector management and reflects the confidence, in public sector institutions, of the newly created central bureaucracy. At the second meeting of the committee, both Stone and Lees Read, of the Institute of Hospital Administration, presented papers advocating the introduction of departmental accounting. However, these proposals were rejected on the grounds that it was *'impractical'* to introduce because of limited time and, and in any case, the *'primary accounting aim was to correlate and unify rather than to elaborate'* (PRO: MH 137/2, Memo. dated 24/7/47).

Given the enormous task of creating a new service, particularly so soon after War and with limited access to finance (Foot, 1962; Campbell, 1987), accounting change was perhaps not seen as a priority by civil servants, however, even if it had been, ministerial records suggest that there was a more deeply ingrained and fundamental opposition to accounting techniques within the public sector. Riddle's memo, a civil servant at the Ministry of Health, is a good illustration:

> *I doubt whether the information they provide would be such as Parliament requires. The professional accountant is always inclined to regard hospitals as a business undertaking, and attempts to apply to them costing systems which provide a mass of technical information, forgetting that the hospitals exist for the treatment of the sick, that they vary considerable in their functions and lay-out, in the age of the buildings, and in the technique of their medical staffs* (PRO: MH 137/2 dated 16/4/48).

The civil service were aware of the agitation for change from outside the service, in the form of Stone and the accounting profession (MH 137/2), but they questioned both the usefulness and practicality of introducing a departmental system:

> *It is so elaborate that it could only be worked in a large hospital having a very highly trained accounting staff. Quite apart from the fact that it is doubtful whether such elaboration could ever be justified or would serve any useful purpose, we are satisfied that the system could not be adopted generally* (PRO: MH 137/2. minute sheet, 28/4/1948).

In addition Webster (1988) suggests that even the Treasury provided little support for departmental costing information:

> *The long drawn out deliberations of the Ministry of Health on cost accounting were accompanied by increasing scepticism on the part of the Treasury. It was suspected that cost accounting would become an expensive investment which was unlikely to bear fruit in either economies or more efficient reallocation of resources* (Webster, 1988. p.298).

[Edwards *et al.* (2005) work on accounting reform in central government departments, although relating to an earlier period, also suggested that civil servants were resistant to accounting change].

The accounts recommended by the advisory committee and adopted; (Ministry of Health, 1948), were based on Burdett's subjective analysis with a simplified balance sheet that excluded fixed assets.

The survival of Burdett's system and the rejection of departmental accounting can be interpreted as indicative of the declining power of the Kings Fund, the limited influence of the accounting profession and the new dominance of the civil service over hospital accounting practice. Certainly it is an illustration of the enormous difficulty faced by accounting reformers when attempting to change embedded accounting methods. However economic and political forces soon intervened to re-ignite interest in accounting concepts to control the new service, and give new impetus to the process of change.

5.5.3 - The Search for New Accounting Techniques

Expenditure control within the hospital service after 1948 relied on the submission of estimates/budgets by Hospital Management Committees to Regional Hospital Boards. These budgets were divided into subjective headings, such as central expenses, salaries and wages, provisions, drugs and dressings and fuel/light/power, and were identical to those required for the annual accounts, representing a continuation of Burdett's uniform system.

Within a year the new service suffered a serious financial shortfall when the cost of the NHS exceeded the original estimates produced by the Ministry of Health and supplementary monies were needed to fund the service in both 1948/49 and 1949/50, as in Table 5.2 (Webster, 1998). This resulted in much controversy (Land *et al.*, 1992) regarding the perceived lack of control of financial resources and there followed demands for increased investment in *'economic calculation'* via accounting techniques.

Table 5.2: NHS Budget Revisions ~ 1948-1951

Estimate/Budget	1948/49 (9 months)	1949/50	1950/51
	£ million	£ million	£ million
Original Budget	198.4	352.3	464.5
Final Budget	275.9	449.2	465.0
% Increase	39%	28%	0.01%

The National Health Service in Great Britain, Ross (1952. p.15). Reprinted in Webster (1998)

It is clear from Table 5.2 that there were enormous problems, initially at least, in achieving the original budget targets. Whether this was inefficiency or inadequate funding is a matter of historical debate, but within the government these overspends received a high profile and a special Prime Ministerial Committee was set up to monitor expenditure (PRO: PREM 8/1486; Campbell, 1987; Webster, 1996; 1998; Land *et al.*, 1992; Klein, 1995). In March 1950 the Ministry issued a circular (Ministry of Health, RHB (50) 16) and 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 showing budget and expenditure by subjective headings (Hospital, June 1950). The Public Accounts Committee and the Select Committee on Estimates both wrote reports critical of the quality of financial information and the debate on departmental hospital accounting was re-awakened (MH 137/2).

Bevan's 1950 speech to the Institute of Health Service Administrators stated that very shortly a system of *'comparative costing would be introduced'* and that the Kings Fund and the Nuffield Trust would investigate possible improvements to hospital costing (Hospital, June 1950a. p.432). There is little doubt that Bevan was

keen to use costing information for, what he referred to as *'self examination'* (Hospital, June 1950a. p.432), to achieve economies in the provision of care and limit hospital expenditure.

In addition he created teams of 'expert' officials from the Ministry who were to visit hospitals and examine staffing levels. The success of the teams, while difficult to judge, appears to have been limited and in 1953 *'most of them were unobtrusively wound up'* (Webster, 1988. p.301). The investigation into hospital accounting did continue with both the Kings Fund and the Nuffield Trust reporting in 1952, but in 1950, before the production of the two reports, the Regional Hospital Treasurers produce their own report on hospital costing and began to emerge as a new policy group.

5.5.4 – Budgetary control and internal groups

Following the economic problems associated with the first two years of the service, Regional Health Boards were given increased power to control the financial affairs of the local hospitals. Indeed, in retrospect, perhaps the most significant accounting change was that estimates (budgets), from 1950, were to be regarded as a fixed budget and monitored on a monthly basis (Guillebaud Report, 1956). These monitoring forms, the AGD 303 (see figure 5.4), became the mainstay of financial control within the hospital service for nearly 25 years.

They used Burdett's subjective headings for budget and expenditure comparisons and any overspend, or saving, was to be reported direct to the RHB and, from there, to the Ministry (Guillebaud Report, 1956). The AGD 303 was the only budgetary control device used before 1974. It was at the level of the hospital rather than individual departments demanded by accounting reformers, like Stone. Therefore subjective budgets were used to consolidate central financial control, rather than departmental budgets and performance measures to evaluate performance (Klein, 1995). While the AGD 303 had its critics, it appeared to be effective. Spending was controlled within estimates after 1952 and this may well, indirectly, have had the effect of reducing the need for departmental information (Webster, 1998).

Figure 5.4 Comparison of Expenditure with approved Budget: Form AGD 303

HOSPITAL SERVICE FINANCE 29

NATIONAL HEALTH SERVICE, SHEFFIELD REGION — Form AGD 303 (4/66)

.... **Hospital Management Committee**

Comparison of Expenditure with Approved Budget — 1st April to ....

(1)	Proportion of Budget (see over) (2) £	Cumulative Expenditure in period (3) £	Net Over-spending (4) £	Net Under spending (5) £	Staff Nos. (WTE) (6)	Comments on significant variations (including action being taken to correct) — Refer to covering letter if necessary (7)
I HOSPITAL MAINTENANCE (Table B):—						
1. Pay :—						
(a) Medical						
(b) Nursing						
(c) Building and Engineering						
(d) Administrative and Clerical						
(e) Professional and Technical						
(f) Other						
Basis of staff numbers— † month-end / average for month SUB-TOTALS						
2. Provisions						
3. Uniforms and Clothing						
4. Drugs						
5. (a) Dressings						
(b) Medical and Surgical Appliances and Equipment						
(c) Patients' Appliances						
6. (a) Fuel, Light, Power and Water						
(b) Laundry and Cleaning Materials						
7. Building and Engineering Services and Grounds						
8. Domestic Repairs, Renewals and Replacements						
9. (a) User Agreements						
(b) Other Hospital Expenditure						
10. (a) Services received from other Hospital Authorities						
SUB-TOTALS			*			
(b) LESS Services provided to other Hospital Authorities						
11. TOTALS			*			
12. LESS Direct Credits :—						
(a) User Agreements						
(b) Staff : Rent, Board, etc.						
(c) Trading Services						
(d) Miscellaneous						
(e) TOTAL DIRECT CREDITS			*			
13. TOTAL HOSPITAL MAINTENANCE						
II CENTRAL ADMINISTRATION (Table A)						
III OTHER EXPENDITURE (Table C)						
GRAND TOTAL FOR H.M.C.			*			

* Show only one figure at each total (i.e. the net difference at that point).
† Delete as appropriate.

The Regional Hospital Treasurers appeared to have had a significant influence on accounting change. They were far more cynical, or realistic, than other policy groups on the benefits of departmental information, and more apprehensive, perhaps unsurprisingly so, given their positions, about the *'practicalities'* of introducing major accounting reform within this enormous new service. Their 1950 Interim Report on hospital costing states that departmental costing was *'far too elaborate for wholesale introduction into the very large number of hospitals'* (Copy of report in Hospital, June 1950. p.462).

In contrast to Stone's (1924) appeal to mimic commercial practice, the Regional Treasurers argued that the accounting requirements of hospitals were in fact different and that following manufacturing techniques was inappropriate, stating that hospital patients couldn't be

> *...regarded as units of cost comparable with articles produced by a manufacturing process. We also consider that the criticisms made have ignored a most important factor, namely, the varying levels of basic financial organization obtaining throughout the country at the appointed day* (MH 137/13, copy of report para. 2).

The feasibility of its introduction particularly in the large number of hospitals within the NHS was also an important part of their case against departmental information in 1950. For example they state

> *...it is apparent that there are considerable difficulties in extending cost accounting in this form throughout the national hospital service. As an essential preliminary to any such system, it would be necessary to ensure that complete stores accounts providing for the departmental allocation of all issues exist in each hospital... In general we think that the introduction of functional, or objective, cost accounting should proceed with caution; that the time and labour spent would be largely wasted unless the results obtained by costing were accepted and used by those responsible for spending* (MH 137/13, copy of report para. 5).

The Treasurers had powerful allies within the Civil Service, for example, H C Chatterton, a civil servant within the Ministry of Health in a minute, dated 26/01/1950, was very supportive of the Regional Treasurers Report of 1950. He describes the report as follows:

> *This is a valuable report on what is immediately practicable in the field of hospital costing... the policy differs from those advocated by the Hospital Administrators, Kings Fund, and Nuffield... they (the Regional*

> *Treasurers) have the great merit that they are based on the financial accounts prescribed in the regulations* (PRO: Memo., MH 137/13).

Another civil servant, states that the Regional Treasurers report is a *'reasonable approach to the problem by practical men.... I think the Minister would have an adequate answer to critics of the present accounting methods'* (PRO: MH 137/13).

This archival evidence suggests that senior civil servants within the Ministry of Health were not supporters of departmental costing and budgeting. These civil servants, like the Regional Treasurers, appeared to be more concerned about the practicalities of producing and dealing with the volume of information produced. Indeed Chatterton even questioned the need for an 'experiment' into departmental accounting:

> *I am doubtful about the wisdom of adopting the additional proposal for an experiment in departmental costing and suggest that we should not formally adopt this part but tell the Boards that we should be glad to see the experiment tried in suitable hospitals by agreement with the Management Committees* (PRO: MH137/13, minute dated 26/1/1950).

As was noted above, the civil servants were also concerned to ensure that any costing information should be based on the financial accounts.

The interim report also makes reference to an article in *THE ACCOUNTANT* (5th November 1949), which suggests that hospital accounting was also influenced [again] by the debate on marginal costing taking place within the wider accounting community. Dugdale and Jones (2003) suggest that 1950-1975 was *'a lively period in the long running debates between proponents of absorption and marginal costing'* (305). Lawrence and Humphries wrote a text on marginal costing published in 1947 and according to Dugdale and Jones *'they set out to explain what marginal costs were, i.e. variable costs, and to show the advantages of a marginal profit and loss account over its absorption counterpart'* (2003. p.313).

In a *THE ACCOUNTANT* article 'u*nit costing for hospitals'* (1949) the author suggests that hospital costs need to be divided into three categories:

> *...those varying directly and proportionately with the patient occupancy rate.....at the other end of the range we have expenditure of the overhead*

> *type... and between these two extremes...hospital expenditure, on which the influence of the patient occupancy rate is undoubtedly strong but not proportionate* (p.489).

It concludes with forthright criticism of existing costing systems, *'so called 'costing' on the lines adopted before the war for both voluntary and local authority hospitals is obsolete and useless'* (p.500). The article argues that comparing hospitals using cost-per-bed data is very difficult due to the different occupancy levels at each hospital.

This evidence suggests that ideas concerning hospital accounting were influenced by conceptual developments within the wider accounting community, but the Regional Treasurers and civil servants appear to have been worried about the complexity of accounting systems suggested for the new service and were therefore cautious regarding change. However, the political pressure on Bevan in 1949/50 to respond to the budgetary control issues appears to have instigated a process of accounting change that could not be halted. The Kings Fund and Nuffield Trust continued with the preparation of their Reports and before their publication one sees changing political and economic forces.

There was no overspending of overall government estimates (Webster, 1998), Bevan leaves the Ministry of Health in January 1951 and in October of that year a Conservative government is elected. This change in political control had little impact on the management of the service as there were few political differences between the two main political parties on the structure or funding of the service created by Bevan (Klein, 1995). It was within this context of policy stability, with hospital spending controlled within government estimates that reports, on departmental accounting, commissioned by Bevan, were presented to the Conservative Administration (Webster, 1998).

Departmental accounting information was still on the agenda and the following Sections provide a close examination of the three reports in 1952 on departmental accounting information. There was some commonality to the reports in that they all

recommended some form of departmental accounting, along the lines previously proposed by Stone (1924; 1937).

There was broad agreement that hospitals should be divided into departmental units for the collection of cost information. In addition, they all agreed on the need for uniformity of information and the combination of cost information with units of work measurement, producing unit cost information for each department, such as cost per x-ray, cost per item laundered. However, a close examination of the reports also highlights stark differences between the accounting *practitioners* within the service, in the form of the Regional Treasurers, and the *independent institutions,* in the form of the Kings Fund and the Nuffield Trust.

5.6 Conceptual Conflicts

The King's Fund and the Nuffield Trust both strongly recommended the introduction of departmental budgets: The Kings Fund, for example, states:

> *It is essential that the hospital budget, like the accounting system, should be based on the department composing the organisation of the hospital, so that the results may be compared periodically with the department budget* (Kings Fund, 1952. p.19).

Similarly the Nuffield Trust states:

> *If estimates (budget) are prepared departmentally an estimate in this form would be drawn up for each department and discussed with the department head concerned, who would then be able to compare actual with estimated expenditure* (Nuffield, 1952. p.40).

This emphasis on departmental budgeting, and, with it, responsibility accounting, was central to both reports and was a continuation of Stone's earlier work of 1924 and 1936 [Note that Stone was responsible for the completion of the Kings Fund Report, therefore some similarity with his other work might be expected. It also illustrates that Stone was in a dominant position at the Fund, certainly in relation to accounting reform]. Both Reports also recommended that the subjective analysis be discontinued. This directly conflicted with the Regional Treasurers who want to keep this well 'tried and tested' system and this reluctance to abandon accounting practices is a feature of the period and contrasts markedly with those proposing

reforms, normally with little responsibility for its subsequent introduction. As in the next Chapter once accounting practices were established, accountants (practitioners) working within the service, preferred to adapt these or provide additional information, rather than start with a 'clean slate'. In fact the subjective analysis was to survive until the late 20th Century.

Nevertheless, there were a number of fundamental management accounting conceptual conflicts between the two institutions (Kings Fund and Nuffield Trust). The Nuffield Report was directed towards the needs of the operational departmental managers, and the use of departmental information for budgeting and cost comparison, or benchmarking.

In addition to avoid the possible *'distorting/arbitrary influence of overhead allocation'*, the Nuffield Trust recommended the use of *prime* cost for each department, while the Kings Fund argued that a *full* cost of each department was essential, and that accurate comparisons could only be made if general service expenses were included (Forte, 1986). Again, this dispute between prime cost and full cost has echoes of the marginal cost/absorption cost debate identified by Dugdale and Jones (2003).

Another conflict centred on the possible use of standard costing in hospitals (Nuffield, 1952; Forte, 1986). The central conclusion of the Nuffield Report was that standard costing could be used as the basis for resource allocation and budgetary control with the use of flexible budgets for each department. The Kings Fund regarded the use of standard costs as problematic and suggested they were only appropriate for *'non-patient care departments'*, such as kitchens and laundries. For direct patient care departments the Kings Fund regarded standard costing as requiring a *'blueprint precision'* which was not possible in a hospital environment. This difference over the possible role of standard costing appears to have prevented the two Institutions from collaborating and producing a joint report (PRO: MH 137/15).

However, both these reports from the independent institutions agreed on the need for departmental budgets, and the discontinuation of subjective analysis. Accounting

practitioners were more guarded in their advocacy of departmental accounting, and rejected the main conclusions of the Kings Fund and Nuffield Trust; the introduction of departmental budgeting and abandonment of subjective analysis.

5.7 Group Conflict

The central theme of the Regional Treasurers' Report (Committee of Regional Treasurers, 1952) was the need for annual cost information. There is no discussion on budgeting; only the possibility that comparative annual hospital cost information could provide information for statistical analysis and measures of performance. For them the calculation of full in-patient/out-patient cost data via departmental costs and this represented a fundamental move away from the departmental budgeting and cost control agenda, proposed by the Kings Fund and the Nuffield Trust, to annual aggregated cost comparison data.

The Treasurers' were far more cautious, than the other two reports, on the usefulness of departmental information, arguing that departmental costing was a step in the direction of more accurate patient costing. They rejected the proposition that departmental information could be used for resource allocation and were unable to support the abandonment of the subjective analysis of expenditure.

The Minister, faced with no clear agreement on the way forward, from these three reports, set up another Working Party to: *'devise a system of costing the departments and services of a hospital, within the framework of a subjective accounting system'* (Ministry of Health, 1955. p.5). The terms of reference of this working party, particularly its insistence on the continuation of the subjective analysis is an illustration that the practitioners, namely the Regional Treasurers, were able to influence the accounting reform agenda.

The Treasurers were aided in their, arguably reactionary, project by changes in personnel at the Nuffield Trust. By 1955 the Nuffield was represented on the Working Party by G. McLauchlan, whose views were close to those of the Regional Treasurers. Miss D.M. Livock, who authored the Nuffield Report, no longer

represented the Trust and was later to enter academic life. McLauchlan rejected the idea of using departmental standards stating: *'The difficulty of finding suitable units, which are capable of application to all hospitals and not open to question, is almost insurmountable'* (Accountant, October 1952, p.411; Hospital, September 1952, p. 626). The absence of Livock, and her replacement by McLauchlan, together with the dominance of practitioners on the Working Party, with only Stone not in the service, made it unsurprising that the views of the Treasurers had ascendancy.

The Working Party Report was eventually published in 1955. The subjective analysis of expenditure was to continue as the basis for the annual financial accounts. Additional annual costing statements were recommended, based on departmental information on a full cost basis, excluding depreciation, and there was to be a 'two-tier' costing scheme that allowed smaller hospitals to produce limited departmental information (Forte, 1986).

There is no suggestion in the report that budgetary control information should be based on departments, although hospitals could, if they wanted, produce interim cost statements. The maintenance of the subjective analysis and the rejection of departmental budgets was a victory for the Treasurers and the Working Party Report formed the basis of the departmental costing system introduced in 1956 (Ministry of Health, Circular (56) 77). Budgets, similar to those advocated by Stone, the Kings Fund and the Nuffield Trust were not introduced until a reorganisation of the service in 1974 (Perrin, 1988).

5.8 Opposition from the medical profession?

A key group missing from the preceding analysis is the medical profession, particularly surprising as several studies (Rea, 1994; Laughlin and Broadbent, 1992) of accounting change in later periods of the NHS have suggested that the doctors resisted accounting change. There is little doubt that the medical profession was [and remains] a powerful group within the service and Klein suggests that, during this period, they *'permeated the decision-making machinery of the NHS at every level and achieved an effective right of veto over the policy agenda'* (1995. p.49). Klein uses their dominance

of Regional Hospital Boards (RHB) and Hospital Management Committees (HMC) to advance his case identifying them as the largest group represented.

The Bradbeer Report on the Internal Administration of Hospitals (Ministry of Health, 1954) confirmed the Ministry's view, that only medical officers of a hospital could be represented on the management committee and rejected this being extended to other professions within the service. However, the privileged status of the medical profession in hospital management did not appear to hinder moves to departmental accounting. Indeed the BRITISH MEDICAL JOURNAL (BMJ) stated in an editorial:

> *With the bill for wages, equipment, and food still rising the Minister of Health is going to find it difficult to reduce hospital expenditure, and it is essential for this purpose that the present inadequate accounting arrangements in hospitals should be brought up to date* (1952. p.1247).

The article continued with a summary of the three reports on costing, concluding:

> *An accountancy or costing system can measure cost only in terms of work done. It can never by itself disclose whether costs are due to inefficiency or are an indication of better quality. What it can do is to provide information that will help the person responsible for any service to judge whether he is providing that service at the lowest possible cost consonant with its efficient and humanitarian discharge* (1952. p.1249).

By 1955, the BMJ questioned the *cost of costing* and managed to combine this with the issue of over-centralised control of hospitals, stating:

> *Until management committees are much more masters in their own house than they are at present, costing may add to hospital costs without saving the public a penny* (1955. p.372).

The foregoing suggests a degree of scepticism; but there is little evidence of resistance to accounting change from senior members of the medical profession. It is impossible to discount more organised opposition within hospitals but it is unlikely that doctors opposed accounting change even at this local level, as:

- Firstly, departmental cost centres were unlikely to threaten their clinical freedom. While departmental information could have provided performance data on operational departments it did not facilitate clinical comparison of medical professionals, as medical practices were excluded from external visibility and their total clinical autonomy remained sacrosanct.

- Secondly, although members of the medical profession had wide-ranging professional power, they had less direct responsibility for hospital administration. Indeed this led to later criticisms that doctors were able to *'direct the use of costly resources with varying, but often considerable, degree of autonomy'* (Levitt, 1976).

5.9 Why was budgeting not introduced?

Why departmental budgets were not adopted in 1956, and why the accounting practitioners were opposed to their introduction, remain questions of interest.

A possible explanation is suggested by Klein (1995), namely the organisation and reward structure of the hospital service. A Hospital Management Committee (HMC) controlled each hospital or small group of hospitals. These HMCs were, in some respects, small divisions within a large multi-divisional organisation, but administrators were more likely to see the individual hospital as the focus for their career aspirations, rather than the Regional Health Board or the Ministry of Health (Klein, 1995). Klein notes that most senior officers, at hospital level, had been recruited from the previously independent hospitals and were more interested in *'accommodating local pressures, rather than implementing central government exhortation'* (Klein, 1995. p.41).

Indeed there would appear to be little benefit, for these key local managers, in improving the visibility of activities via improved management accounting information. This would have involved new systems; more work and could have led to greater accountability and central pressure.

Even after the introduction of departmental costing in 1957, the first year of operation, most senior finance officers within the service remained unconvinced of the need for departmental budgets, for example, Montacute (1962) found in a survey of hospitals [in 1958] that only 30% of finance managers were definitely in favour of departmental budgeting. Their major objection, like that of the civil servants, was that hospital budgets should replicate the format of the annual accounts, which were

prepared on a subjective basis. This reinforces Johnson and Kaplan's (1987) views on the dominance of financial accounting, and therefore the lack of change in management accounting after the 1920s. The dominance of financial accounting is also evident from the earlier comments of senior civil servants.

Other objections, by the finance officers, included the reluctance to trust departmental managers with budgets and the difficulty of establishing the level of budgets within specific hospitals (Montacute, 1962). This reluctance to trust managers, together with the sharp differences between accounting practitioners and the independent institutions, may suggest that it was finance managers themselves, rather than departmental managers, who delayed the introduction of budgets.

This guarded attitude towards accounting change is interesting, and research on later reforms within the NHS, on Resource Management (RM) or Management Budgeting (MB) for example, supports the view that finance officers were very *'cautious'* regarding devolution of budgets to front-line staff (Pollitt *et al.* 1988. p.224). For example Pollitt *et al.* illustrate this with a quote from a regional accountant, stating that management budgeting:

> *Was far more complicated than Griffiths ever thought' and then went on to add: 'I've got a reservation about RM – will it deliver the goods?' There was very widespread scepticism about suggestions emanating from Whitehall that RM would spread rapidly so that many of or most districts would have it working by the early 1990s* (p.225).

This accountant was to prove correct about the spread of RM, with most pilot sites being abandoned in the 1990s. Perhaps experience of previous reforms or an innate understanding of the practical difficulties surrounding accounting change makes practitioners wary of solutions advocated by those outside the service.

After 1952 the economic driver for accounting change had lessened, as there were no substantial overspends within the service between 1950 and 1955, and this had been achieved by using the subjective analysis of expenditure for monthly hospital budgetary control information (Klein, 1995; Webster, 1998). A major report on the cost and organisation of the service in 1956 also concluded that the cost of the service was not excessive (Guillebaud Report, Ministry of Health, 1956). Although

Guillebaud added his voice in support of department costing and budgeting, he was also very supportive of the existing NHS structure and organization, stating there was little scope for significantly reducing costs within the service and rejecting the idea that major *'inefficiencies'* were evident (Webster, 1998). The Treasury was upset with these conclusions (Webster, 1998), for example, a minute written before the publication of the report states:

> *From a treasury point of view this is a highly disappointing and indeed unsatisfactory document. The committee were asked to suggest means of ensuring the most effective control and efficient use of such Exchequer funds as may be made available; to advise how, in view of the burdens on the Exchequer a rising charge upon it can be avoided while providing for the maintenance of an adequate service. The committee's conclusion on the last part of its terms of reference is negative and indeed a minus quantity* (PRO: T227/424, dated 22/11/1955).

After this report, justifying investment in accounting techniques may, perhaps, have been more difficult.

5.10 Conclusions

This Chapter again challenges the assumption, implicit in many studies, that the consideration and use of accounting techniques for performance measurement, control and resource allocation within the hospital sector is a recent phenomenon, associated with the internal market or the benchmarking agenda of New Labour (Department of Health, 1997). The high profile accorded to departmental information, at the birth of the NHS, provides further evidence of an earlier attempt at improving accounting.

Attempts to introduce new accounting techniques, certainly within massive public sector bureaucracies, are complex, and the protean contextual and processual nature of accounting change is the underlying theme of the author's work. Technological forces, such as developments in medical techniques and the introduction of specialist departments, continued the swing in the balance of hospital expenditure towards specialist departments. This was a slow process and one that can be said to have started before the 1920s. Economic rationalism would suggest that accounting systems change to reflect this and provides a rationale for the increasing

preoccupation with departmental analysis. However even if one accepts this perspective it fails to explain the time lag between the conception of departmental accounting in 1924, and its part-implementation in 1956.

Another driver of accounting change appears to be the increasing interest in *departmentalisation* as an accounting concept. Both in the UK and the USA (Preston, 1992), the departmental information promoted by Stone and other groups and institutions within the hospital world mimics the conventional wisdom of accounting texts and perhaps practice, certainly in the USA. This *'isomorphism'* (DiMaggio and Powell, 1983) continued after the nationalisation of the hospitals in 1948 and appears to have been an important factor driving Stone to advocate its adoption.

The NHS attempted to combine central control with local decision-making (Klein,1995) and this provided fertile ground for departmental accounting, allowing the technique to germinate as a tool to control the vast number of hospitals brought under state control. However, policy makers were vague as to which accounting techniques were to be used preferring to use the general language of accounting such as *'comparative costing'* and *'global budgets'* to provide legitimacy for the new organisational form. Therefore, while the move towards departmentalisation can be interpreted from a number of historical paradigms, it was certainly, as in the USA (Preston, 1992), a much earlier attempt to mimic private sector practice than the new right agenda of the 1980's.

While these drivers for change were important in promoting departmental accounting the process of change was complex, with both internal and external environmental factors influencing events, which led to the rejection of departmental budgeting in favour of annual departmental information and the continuation of the subjective analysis for internal budgetary control. An explanation for the rejection of departmental budgets and the introduction of the annual departmental information compromise, as a first step towards a new accounting technique, is aided by the detailed analysis of the interaction between Porter's (1981) three elements, individuals, groups and institutions.

Stone is identified as an important individual in the promotion of the departmental accounting technique (Prochaska, 1992). The various groups and institutions [professional accounting associations, the Institute of Health Service Administrators, Kings Fund, Nuffield Trust and Regional Treasurers] all had competing interpretations of the type, and nature, of departmental information. Porter's conceptual element is particularly evident in the conflict, between the Kings Fund and the Nuffield Trust, over the use of standard costing, and full, or direct, cost information for departmental accounting. This may have contributed to preventing the most powerful, pre-nationalisation, institution, the Kings Fund, from dominating accounting developments after nationalisation.

The accounting practitioners within the hospital service, with the aid of the civil servants, eventually succeed in preventing the more radical changes to departmental budgets proposed by the other institutions. This 'success' could not have been predicted given the broadly-favourable circumstances for departmental analysis, and was contingent on changes in other elements, such as the change from adverse economic forces. Initially overspending within the service was to drive change (Webster, 1988) but stable budgets after 1952 was, perhaps, a barrier to radical accounting reform.

The 'success' of the accounting practitioners within the service also illustrates how this internal group were able to moderate the demands from the accounting profession and the newly established Institute of Administrators. The Institute of Administrators set up a joint working party with ICAEW and the Institute of Cost and Works Accountants (Institute of Hospital Administration, 1948) but were unable to control the accounting agenda. This may have set the tone for the next twenty years within the NHS as the professional accounting associations appear marginalised.

In tracking the process of accounting change this thesis provides historical insights for policy makers on the uncertain, and contingent, nature of accounting policy implementation (Bhimani, 1993). Actual change is slow and there is a reluctance to replace established accounting methods, such as the subjective analysis of

expenditure but the process of change eventually influenced the outcome, with annual departmental information a compromise, not originally advocated by any of the groups or institutions. The *'actions, reactions and interactions of the various interested parties'* (Pettigrew *et al.* 1992. p.7) had, over time, a fundamental influence on the policy adopted.

This indicates that accounting practitioners are much more cautious than 'advisors' or 'independent institutions' when implementing new accounting techniques and that accounting historians need to be careful in confusing the 'theory', or indeed 'discourses', with the actual 'practice' of institutions. While departmental accounting existed from the mid-1920s it was to take at least 30 years to become practice and then only in a modified form. This point is echoed by other researchers investigating accounting change in the NHS, with Humphrey *et al.* (1993) noting that the difference between the *'rhetoric'* and the *'reality'* of change, in relation to later managerial changes, is often quite marked.

The focus of the author's research is at the policy level, and further archival research is required at the level of the hospital to map the process of change at this lower level, with, no doubt, other individuals, groups and institutions influencing accounting implementation. A brief re-examination of the past by policy makers may be an appropriate starting point for those contemplating the future of hospital accounting information, as the process of emergence has fundamental consequences for the adoption of accounting techniques.

Chapter 6 ~ Adapting not adopting: towards functional budgets

6.0 Introduction

This Chapter explores managerial change and accounting from 1957 up to the first major reorganisation in 1974, including the third major accounting change in this study; *functional budgeting*. The period is often characterised as one of organisational stability, but the author argues that it encompassed various attempts by the NHS bureaucracy, largely failed, to manage the service, using a number of 'managerial tools and techniques', starting in the late 1950s with the re-emergence of the concept of 'efficiency' (Klein, 1995; Webster, 1998), the introduction of Work Study and the creation of an Advisory Council on Management Efficiency [within the Department of Health]. From the mid 1960s the efficiency concept is mostly superseded by the concept of 'management', intrinsically linked to budgeting and planning from 1970 (Forte, 1986; Harrison, 1988).

The Chapter also examines the response to the introduction of departmental accounting, outlined in Chapter 5, particularly from the local managers' perspective and that of the central civil service. Proposed changes to accounting information are investigated, in particular, the debate surrounding the possible use of cost norms, or standards, and early attempts to introduce and use patient costing data.

The focus is the interaction between the central NHS bureaucracy and groups, or institutions, representing hospital administrators at a local level, and their attempts to manage the service. There are a number of dominant concepts, such as efficiency, early managerialism and technological forces, particularly the growth of large District General Hospitals, influential in generating proposals for accounting change. As with later NHS reforms, for example the introduction of internal markets and resource management, the 'reality' of managerial and accounting change did not match the 'rhetoric', and the conservatism of both NHS bureaucracy and local

administrators, when bolstered by medical influence was a potent mix that limited major reform.

Section 6.1 provides a brief introduction to academic studies on this period and outlines accounting techniques in use at this time, in particular, departmental annual cost information and the subjective analysis of expenditure and budgetary control. According to Klein (1995) this period is notable for 'technocratic' developments to generate 'efficiency', and Section 6.2 outlines three of these developments: planning, work study and costing.

Section 6.3, using published, and unpublished, secondary data, assesses the impact of the departmental information first produced in 1959. This is followed by Section 6.4, exploring the managerial debates taking place after 1965 and general 'discontent' with existing decision-making structures within the service. In Section 6.5 the developments in accounting practice are explored, together with new accounting technologies, associated with patient costing, and Section 6.6 examines how functional management becomes the dominant organisational form after 1974. The Chapter ends with concluding comments in Section 6.6.

6.1 Early Accounting Practice

The late 1950s until 1974 has been described, by NHS scholars, although exact dates differ, as the second 'period' in the history of the service (Klein, 1995; Webster, 1998). Klein suggests (1995) that by 1958 there was little major political difference between the political parties on the merits of nationalisation. This organisational form was universally accepted, and, instead, the '*debate was about the instruments rather than the ideologies, about means rather than ends*' (1995. p.57). There are, however, a limited number of academic studies on hospital accounting in this period, although later studies tend to make two basic assertions. Firstly, accounting change was government-inspired rather than academic, or practitioner, led (Lapsley, 1991), and, perhaps more damaging, that accounting practices were of little value and anachronistic. For example, one early accounting academic paper, COSTING AND BUDGETING IN THE NHS, examining the late 1970s to the early 1980s, would not

have made pleasant reading for accountants working in the service during this period, where it concludes:

> *Past hospital costing practice provides little information that is useful for short term control of activities and resources. It is of little assistance in determining longer-run funding and resource allocation. There is as yet little need for pricing or inventory valuation, but past costing practice would be of little help in approaching these issues either.*
>
> (Bourn and Ezzamel, 1986. p.66)

On budgeting Bourn and Ezzamel point out that, at that time, budgets were allocated to functional office-holders, and, quoting Drucker, argue that:

> *Functional decentralisation is universally applicable to the organisation of management. But it is the second choice for any but the small enterprise.... Federal decentralisation has been widely adopted in manufacturing industry, and increasingly in service industries. It is only now beginning to emerge into the thinking about the hospital service in the form of discussion about the devolution of budgets to clinicians.*
>
> (1986. p. 57)

While early academic accounting studies are critical of the functional budgets and costing information produced after 1974 there is little knowledge of how these techniques came to be embedded in the NHS. This Chapter explore this question, beginning with accounting information produced at the outset of this period.

6.1.1 – Accounting Information in 1958

By 1958, and indeed throughout the period [1958-1974], there were three main types of accounting information produced by NHS hospitals: annual financial statements, monthly budgetary control information and annual departmental costs.

The annual financial accounts included a *Hospital Revenue Expenditure Statement* which detailed expenditure by 'subjective' cost headings, such as wages, provisions, medical supplies, and rent and rates (Montacute, 1962; 1969). This type of information was very similar to information used in the uniform system of accounts, which dated back to 1893 (Burdett, 1893; 1916). There was also a *Hospital Revenue Income Statement* that identified income sources, such as sale of patient appliances,

and a summary *Expenditure and Income Statement* by hospital type, e.g. acute and long stay. These statements, primarily, had a probity, or stewardship, function with Hospital Management Committees recording how cash disbursements from the Department of Health were spent (Montacute, 1969). It was difficult to compare hospital performance using this information as fixed assets were not recognised and the statements were aggregated by hospital group.

Internal budgetary control relied on the form **AGD 303, Comparison of Expenditure with Approved Budget**, shown in Figure 5.4, page 122, which was introduced in 1950 in an attempt to control escalating costs in the first two years of the service. The AGD 303 compared cumulative expenditure with the proportionate part of the budget to date, under the subjective headings: salaries and wages, provisions, staff uniforms, and drugs and dressings. The AGD 303 used the same subjective headings as the Income and Expenditure Statement in the annual financial statements, and was produced monthly for each Hospital Management Committee (HMC) and forwarded to the Regional Health Authority (RHA) (Hospital Service Finance, March 1967 and May 1968).

This subjective budget, often referred to as an estimate, was agreed, line by line, between the HMC and RHA before commencement of the financial year. The budgets were, effectively, prepared on an incremental basis for each HMC, and there was therefore a degree of historical bias to the process (PRO, CAB 134/518, Jones Report). By 1958 this form was well established in the service and was used for accountability upwards to the Health Authority, and for internal management control within each Management Committee.

From 1958, as discussed in Chapter 5, larger hospitals were required to produce annual departmental costing information, including wards, x-ray, pathology, laundry and catering. Each department had a different work measure, for example, number of patients, tests or items laundered, and there was a unit cost for each department in every hospital. This data was compared by different types of hospitals, for example, acute, mainly acute and long stay, for all hospitals within each Region. The use made

of this information at both Department of Health and local hospital level is discussed further in Section 6.3. This national comparative cost information was one '*tool of management*' embraced to drive the concept of *efficiency* (Klein, 1995) and could be regarded as the first, or certainly an early, attempt, by policy-makers and civil servants to take a more formal centralised control of the hospital service.

6.2 Efficiency

Klein (1995. p.57) suggests that the period from around 1960 to 1975 was the '*heyday of technocratic politics in the NHS*' and that the key feature of the period '*was the emphasis on efficiency and rationality in the use of resources*'. Webster concurs with this view and argues that:

> *The NHS authorities themselves wanted more decisive leadership, and were indeed prepared to accept major changes, but these were precluded 'by the inertia of established ideas in the rest of the Ministry'. In response to criticism of this kind, the Ministry of Health undertook various leadership initiatives. In 1959 an advisory council on management efficiency was set up* (1996. p.39).

Webster also argues that the creation of a research and statistics section, a hospital design section and work study units at the Department of Health all provide evidence of this new leadership style from the central bureaucracy.

This promotion of the concept of efficiency needs to be placed in the context of governmental change and particularly the publication of the 1961 Plowden Report (Treasury, 1961; Klein, 1995). This Treasury Report advocated the use of long term plans and the adoption of what it referred to as '*tools of management*' for the public sector:

> *As our investigation proceeded, we became increasingly conscious of the importance of management. In this we include the preparation of material on which decisions are taken; the technical efficiency with which large operations of administration are carried out; the cost-consciousness of staff at all levels; the provision of special skills and services (scientific, statistical, accountancy, O & M, etc.) for handling problems ... these are the real substance of management, and it is upon them that the effective control of expenditure and value for money must in the last resort depend.* (Treasury, 1961. p.16)

For the hospital service the Report urges the Department of Health to provide more help in providing management services and states:

> *Much is being done to develop work study, O & M, costing, the formulation of standards, etc. But the surface is hardly scratched yet, and there is tremendous work still ahead, above all in disseminating knowledge of these services and encouraging their use throughout the whole hospital service.* (Treasury, 1961. p.19)

But even before the Plowden Report (1961) there was a sustained effort, by the Ministry of Health, to promote the *efficiency* concept to hospital operational managers, *via* various professional groups within the service and, in 1959, their hospital conferences [Chief Financial Officers, International Hospital Congress and the Royal College of Nursing] all had *'efficiency'* or *'management efficiency'* as their theme. The Chief Financial Officers conference was addressed by the Under-Secretary for Finance for the Ministry of Health, and a correspondent for *THE HOSPITAL* (1960. p.987) journal protested that *'efficiency is in danger of becoming one of the most over-worked words in the health service'.*

By 1961, in an editorial titled; '*Economics and efficiency*', *THE HOSPITAL* concludes that the Ministry had started to take initiatives that suggested an increased interest in how the vast bureaucracy was to be managed. This was demonstrated by the use of work study, the *'development of a long term building programme'* (p.736), the preparation of forward estimates, and the new attitude was

> *...symbolised in the establishment of the Advisory Council on Management Efficiency, which is associated with the increased appreciation of the use of work study and other tools of management. Other aspects are the intention to use the Ministry as a clearing house for information on efficiency, and an attempt to increase standardisation.* (1961. p.737)

However while these initiatives appear to have been introduced with the best of intentions there has been limited (see Harrison, 1988) subsequent work on their impact and archival evidence suggests that the reality of these reforms was far different from the clear cut objectives stated by their promoters. In practice, the Ministry of Health was cautious in using these efficiency tools, and apprehensive about dictating to, or usurping, local hospital managers. This is illustrated by the operation of the advisory council on management efficiency (ACME).

6.2.1 – Advisory Council on Management Efficiency (ACME)

The Council was made up of representatives from industry, trade unions and universities. The chair was Sir Ewart-Smith from ICI, and members included C Bartlett, later chairman of the TUC, and T. E. Chester, Professor of Social Policy at Manchester University (MH 137/370). It was organised around three committees: management efficiency techniques; financial and statistical data; and requirements and layout of hospitals (MH 137/370). Surprisingly, given the nature of the work of ACME, there was no accountant on the Council and this was questioned by Regional Hospital Board Treasurers who wrote to ACME objecting to *'the non-inclusion in the Councils membership of someone with an accountancy qualification and practical experience in the hospital service'* (Letter in file: MH 137/370).

However, even before the creation of ACME, the Ministry was keen to ensure that 'Council' adopted a conciliatory 'advisory' approach and this is evident from their deliberations on appointing Ewart-Smith, a senior manager with ICI, as the chair of the Council. His appointment was not wholeheartedly supported, and senior civil servants appear to have been concerned that his managerial style could provoke 'resistance' from hospital management committees. A good example is their response to a letter from Ewart-Smith, before his appointment, on work study:

> *Judging by the letter alone the danger seems to be that he is so set on the programme he has already drawn up in his mind that he will create so many resistances as to make further progress with this subject in the hospital service very difficult. The alternatives seem to be: For the Minister to see Sir Ewart Smith again and explain to him – a) that there is still a lot of 'selling' of the idea of work study, etc., to be done in the hospital service, and b) that, as there is not a chain of command like there is in business, our success will depend on persuasion as we are not in a position to give orders.* (PRO: MH 137/338)

Early evidence from the deliberations of ACME suggests that the Council did in fact adopt this cautious, conciliatory role, supporting hospital authorities rather than a more interventionist or managerial approach. For example, on the use of management consultants within hospitals, ACME concluded that they should be used only under *'carefully controlled conditions, and in those parts of the service most*

nearly analogous to industrial and commercial experience... the ultimate aim should be self help' (Minute Sheet MH 137-428).

While the creation of ACME was certainly part of a drive towards a reorientation of the service towards a more managerialist agenda (Harrison, 1988) it also demonstrates the dilemma around central/local [*centre-periphery relations* (Klein, 1995)] control/autonomy which Klein regards as the central issue for the management of the service in that period. The evidence, from the role adopted by ACME, suggests that the Ministry was determined to be seen as supporting local hospital control, rather than one more analogous to a large divisionalised company, with a dominant Head Office, that Bates and Brignall (1991) suggest existed after 1974.

6.2.2 – Hospital Building Programme

While ACME represented part of the attempt to refocus the management of the service, another significant event overshadowing the hospital service in the 1960s was the publication of the HOSPITAL PLAN FOR ENGLAND AND WALES (1962). This led to the start of a major building programme, with almost 100 hospitals being built, together with extensive improvements and additions to existing hospitals (Ham, 1981). Ham notes that, in addition to the building programme:

> *A new framework had been created within which these works were to be carried out. At the centre of this framework was the district general hospital (DGH), a hospital of between 600-800 beds serving a population of 100,000-150,000, and providing all services.... It was a natural corollary of the development of a network of DGHs' that many small hospitals would become redundant.* (Ham, 1981. p.61)

Webster argues that *'without any particular coherent justification, the district general hospital had emerged by consensus as the guiding feature of planning arrangements, but this proposal was not particularly well-worked out'* (1996. p.105), while Klein suggests the hospital plan was: *'A marriage between professional aspirations and the new faith in planning: between what might be called medical expertise and administrative technology. It was designed to promote both efficiency and equity: to bring about uniform standards throughout the NHS'* (1995. p.67).

A speech to the Hospital Management Committee (HMC) group secretaries, by the Chief Medical Officer [Dr G E Godber] appears to confirm Klein's view. Godber considered the old hospital buildings hindered the operation of the service, and states:

> *The first priority was concentration on efficiency and its greatest obstacle was the structurally sound small unit, incapable of providing fully effective service, but very dear to someone and dangerously likely to be put to some diversionary use even when its functions were taken over by a new area general hospital* (Hospital, 1961. p.460).

This idea that new hospitals could create efficiency, echoes ideas from the past and the building programme of almost a hundred years earlier, where Sturdy and Cooter (1998. p.424) suggest that hospital reformers introduced *'new forms of architecture which literally restructured hospitals in the interests of efficient moral management'*.

The creation of the 'new general hospital' appears to have been a powerful weapon in attempts to improve efficiency and the standard of healthcare. But the building programme would take time to materialise, and the NHS bureaucracy was also keen to utilise management techniques, perhaps transferred from the private or commercial sector; in particular, Organisation and Methods (O & M) (Hospital, December 1961).

6.2.3 – Organisation and Methods

A civil servant's paper, on the first use of O & M in UK government, suggests this could be traced back to 1941, *'when the Treasury's Investigating Section was renamed the Organisation and Methods Division'* (MH 137/425). This paper notes that the Ministry of Health used Treasury staff to consider the possible use of O & M in 1954 and that, in 1958, Walker-Smith, Minister of Health, created an O & M team at the Ministry of Health (MH 137/416; MH 137/425). This was followed by the appointment of O & M and Work Study staff at regional level.

By the early 1960s the Ministry was generally content with the progress on O & M and while there appears to be no evaluation of the technique, the Ministry appeared pleased with the number of officers involved in O & M and the savings made. For example the Ministry states that

> *...by the end of 1961 all these arrangements had resulted in the appointment by hospital authorities of over a 100 officers to work full-time on efficiency studies and these were achieving excellent results in improving the services to patients, in cutting waste of time and money and in helping to make the best use of available resources.*
> (MH 137/425)

The introduction of O & M does not appear to have been solely a centrally-driven policy as several hospital authorities, for example, Manchester and Oxford Regional Health Boards, ran trials using O & M or Work Study teams in the late 1950s (MH 137/425). Other groups associated with professional associations were also exploring the role of O & M, most notably, the Royal College of Nursing, who organised a conference on *'work study and the hospital service'* in 1957 (MH 137/425). Speakers included Iain Macleod [Minister of Labour and National Service] and a number of advocates from Imperial Chemical Industries (MH 137/338). The O & M concept also appears to have provided an opportunity for the Kings Fund to continue their interest in efficiency, for example, by establishing an O & M training school and appointing staff from ICI to run it (MH 137/425).

In addition to the interest of professional and pressure groups, from within and outside the service, Watts argues that interest in O & M in the NHS was partly generated

> *...by Imperial Chemical Industries Ltd., and particularly by the then head of that firm's work study department, in assisting and encouraging the early efforts of hospital authorities to establish their own work study departments.* (1969. p.433)

This evidence suggests that O & M, like many developments in NHS accounting, was driven by professional forces, and norms of good practice, transferred from the commercial world.

Certainly by the mid-1960s O & M was well established within the service, with Watts estimating that 150 O & M posts had been created by 1963, and this continued after health circular HM (68)23 (Ministry of Health, 1968) notes a further substantial increase in their numbers. Unfortunately there appears to have been very little academic interest (discussed briefly by Webster (1996) and Watts, (1969)) in the development, or indeed in the decline, of O & M in the service, but several features are noteworthy.

O & M tended to be used to establish productivity and bonus schemes, rather than as managerial tools to question managerial efficiency, as first envisaged. In addition investigations tended to ignore professional and medical work within hospitals, concentrating instead on manual occupations. There is also evidence to suggest that the central bureaucracy (MH 137/416) was keen to avoid O & M being seen, at hospital level, as a centralised tool to generate improved performance, advocating instead devolution to Regions, with the civil service acting as reluctant, cautious advocates, rather than command and control leaders. Indeed A. W. France, Permanent Secretary at the Ministry of Health, in a paper to the conference of Hospital Administrators in 1965, describes the Ministry's job:

> *To act as a centre for the collection and distribution of information on how management efficiency can be improved as demonstrated by efficiency studies carried out by hospital authorities, and to conduct studies of national value or of a kind which can best be done centrally.*
> (Hospital, July 1965. p.375)

This reluctance to impose solutions on hospital and management committees, combined with a respect for their independence, resulted in long lead times for reforms, and a degree of frustration, at both central and local level. However, there seems little doubt among NHS history academics (Klein, 1995; Webster, 1996) that the late 1950s and early 1960s saw, perhaps, the first attempt by the NHS bureaucracy, in their continued search for efficiency, to shape the NHS along a more managerial perspective.

The role of accounting techniques in the promotion of these managerialism and efficiency concepts was limited. The regional treasurers were excluded from ACME and there appears to be little accounting input into O & M either at the national or local level. There are a number of possible reasons for this, including the limited number of accountants employed by the Service and, perhaps, the general disappointment with departmental costing information introduced in 1958.

6.3 Early Assessments of Departmental Costing

This Section outlines how departmental costing information was received by key staff within the service, and uses secondary reports to assess its impact at local hospital level and within the central bureaucracy at the Ministry of Health. The previous Chapter traces the long incubation period for the departmental scheme, eventually introduced [first year of operation] in 1958 (Ministry of Health, 1956, (HM (56)77)). This scheme, for large acute and mainly acute hospitals, aimed to provide unit costs for hospital departments. Departments were divided into three groups, patient departments [wards, out-patients and casualty], medical service departments and general services. It used full costing principles and there was extensive re-charging of indirect costs to the various departments (Brinley-Codd, 1974; Stone, 1956). Costs were first charged to each department, or a clearing account, and then a re-allocation process was undertaken to re-apportion costs to medical services and patient service departments. Finally, these departmental costs were apportioned, to in-patients and out-patients, to give a total unit cost for these 'outputs' (Stone, 1956).

Any retrospective attempt to assess the departmental scheme is obviously difficult and the analysis below draws on a number of sources. First, anecdotal evidence from the journals, *THE HOSPITAL* and *HOSPITAL SERVICE FINANCE,* is used to assess the semi-public debate following the publication of early departmental costing data. Secondly, a number of studies of the scheme, one by ACME, which seems to be based on interviews with Regional and Hospital Boards, and others, by well-placed individuals within the service; a study largely based on questionnaires by Montacute [Hospital Treasurer] and interview research by Walker [Treasury civil servant].

6.3.1 – Public Criticism from Operational Managers

After a few years in operation, the earlier doubts of the civil service, identified in Chapter 5, on the usefulness of the costing data, was soon echoed by operational managers. Both management journals, *THE HOSPITAL* and *HOSPITAL SERVICE FINANCE*,

ran a number of critical articles, with hospital administrators particularly scathing, for example:

- *'I find it impossible to wade through the welter of detailed statistics and figures of the departmental cost statements without the feeling of utter gloom and despondency. Just think of all those hundreds and hundreds of cost clerks throughout the country assiduously totting up thousands and thousands of little-comprehended figures. It is a relatively easy matter to single out those departments which appear to offer the most profitable scope for enquiry. It is a vastly more difficult matter properly and fairly to investigate and judge them and, if need for improvement is found, to secure it. A real danger exists that the annual 'critical' examination of the cost statements tends to be a glorious exercise in whitewashing'.* (Hospital, 1961. p.342)

- *'Officers who are responsible for spending have to be trusted to do their job without all this slide rule calculation which goes on to produce these quite useless and valueless figures'.*

  (Hospital Service Finance, 1961. p.3)

- *'The optimistic note of the Guillebaud Report had come down and down the scale... and owing to the unreliability in his opinion, of the prime statistics used, he suspected the whole of the figures which were produced'.* (Hospital Service Finance, 1961. p.3)

While it is difficult to judge how representative this evidence is, additional studies, identified below, tend to confirm the two central criticisms above: the difficulty in using this data to compare hospital performance, and the unreliability of some of the information.

6.3.2 – Report by Advisory Council on Management Efficiency (ACME)

The first attempt to assess the departmental scheme was, as part of a larger operating brief on statistical and financial information, undertaken by the Advisory Council on Management Efficiency. ACME set up a sub-committee *The Statistical and Financial Comparison Committee*, with the brief to assess 't*he usefulness and aptness of statistical and financial detail handled at various levels in the hospital service* (PRO: MH137/350. p.1). In their report of March 1961 they conclude that *'at the present stage of evolution we are not surprised or disappointed to meet some*

sceptism about costs and statistics at different levels' (MH137/350. p.4), and that hospital managers had great difficulty in comparing hospital performance:

> *Over and over again we have comments from Regional Hospital Boards, the Central Statistics Branch, from a Hospital Management Committee, to the effect that the real reason for the observed difference can only be found by intensive examination.* (MH137/350 p.4)

The Report fails to outline the number, or type of staff, interviewed, but given the centrality of ACME to the early efficiency drive in the 1960s it is likely to have been senior officers at Regional level or perhaps Regional Board chairmen.

6.3.3 – Studies on Departmental Costing

In addition to the above, largely anecdotal, evidence, there were also, in the early 1960s, two detailed studies attempting to evaluate the costing scheme, which both tend to confirm its limited impact. The first, partly funded by the Nuffield Trust, 'COSTING AND EFFICIENCY IN HOSPITALS: A CRITICAL SURVEY OF COSTING AS AN AID TO THE MANAGEMENT OF HOSPITALS' (Montacute, 1962). The second, an unpublished study by Martin Walker, a Treasury civil servant, seconded to the Ministry of Health (PRO: T227, 1545). Both reports, while supporting the costing scheme, suggest that operational managers believed the data was of limited value and that little use was made of it at the Ministry of Health.

Montacute (1962) was a hospital group treasurer, and active within the Hospital Treasurer's Association. His study used a questionnaire, distributed to 144 hospital group finance officers, followed by interviews with senior administrators at local level and at the Ministry of Health. He concludes with the following question to finance officers: *To what extent can you visualize costing making a worthwhile contribution to the more efficient use of resources in the service, and, in particular, in your hospital?*

Table 6.1: Questionnaire on departmental accounting

Response	Percentage
Of definite value	26
Of no value	-
Of potential value	51
Of only limited value	12
Of very doubtful value	6
No reply	5

(Montacute, 1962, Table 37, p.168)

With only 26 % of respondents in Table 6.1 believing completion of their returns to be 'of definite value', Montacute concludes:

> *It might be thought that finance officers as a body would naturally be more disposed towards the effectiveness of costing than other officers. Any such tendency is, however, likely to be offset by the lack of enthusiasm which some of them have found in making use of costs when produced... In some quarters, including the Ministry of Health, I encountered the feeling that costing was at a cross roads. Whilst something had clearly been achieved, precisely how much was not known. The original enthusiasm had waned and views about [the] role of costing and its possible development were blurred and uncertain.*
>
> (1962. p.168)

However Montacute's large study concludes that *'the short term impact has been appreciable'* (p.265) and, in the long term, he holds that *'the potentialities of costing can hardly be disputed and indeed were accepted by the majority of a wide range of members and officers questioned during the survey'* (p.265). But, he adds, making further progress with departmental costing *'will depend upon the success of the efforts to refine the costing system, and, in particular, to rationalize the factors which lead to variations in cost'* (p.265).

Walker, like Montacute, believes the costing scheme was *'basically a sound system and...it has enabled many lessons to be learned'* (PRO: T227/1545. p.48) and his study provides useful insights into the attitude of Ministry officials to the data. It suggests there was little time or effort devoted at the Ministry to the evaluation or assessment of the enormous amount of information produced by the hospitals. As an insider, albeit from the Treasury, Walker's study was very critical of the Ministry of Health, and he criticised their leadership, noting they are reluctant to use the information produced. Several comments from his report stand out:

- *the attitude of the Ministry towards costing in the service did not impress me as dynamic... it seems to be that in the hospital service is the need for a strong lead from the Ministry on the subject of costing as an aid to management, something more than a rather detached advisory service. It is possible that the introduction of a new system may provide a good opportunity for this.* (T227/1545. p.45)
- *I suggest that central government, which provides the funds, has a management function to perform; it is therefore the duty of central government to ensure that the best possible management tools are used right down the line.* (T227/1545. p.49)

These studies suggest there were very real concerns about the benefit of the departmental costing scheme, and that commitment from senior staff at the Ministry of Health was limited. There were difficulties comparing hospitals with different characteristics, problems dealing with the physical amount of information produced and concerns about the use made of information produced.

These reports were quickly followed by an analysis of the departmental costing information produced, this time by an economist, who specifically tried to adjust hospital costs to reflect variations in case-mix. This was to lead to the emergence of a new concept: case-mix costing and is explored further in the next Section.

6.3.4 – Case-mix Costing

In 1964 Professor Feldstein suggests that case-mix [type of patient treated] was a significant driver of *'hospital costliness'* (MH 148/38; Hospital, 1964, pp.707-709; Hospital Service Finance, January 1965. p.6) and argues that the departmental costing scheme [in its first five years of operation] had little impact on *'cost variation'* between hospitals. Feldstein was engaged on a research project, at Nuffield College, on hospital costing and the findings were presented to the statistics branch of the Ministry of Health, as well as to Regional Treasurers and ACME. A summary of his report, by the statistics branch, states '... *the first Section shows the existence of substantial variation and indicates that there was little reduction in variation during the first five years of the departmental costing scheme* (MH 148/38, Feldstein Report, p.1).

In a presentation to Hospital Treasurers Feldstein suggests the following reasons:

> *Much of the variation may be due to factors outside management control such as the hospital's casemix. The second reason is dependent on the first. To the extent that administrators and medical people believe that casemix differences make crude cost figures inappropriate, the behaviour of these people will not be influenced by cost information. And rightly so.*
> (Hospital Service Finance, January 1965. p.6)

His work was possibly the first to attempt to statistically adjust for the case-mix factor when comparing hospital performance and highlighted a major deficiency of the departmental costing scheme, for example, he argues:

> *The usual process of comparing hospital costs with national averages indicates a tacit assumption that casemix differences are either not substantial or have little influence on costs. We shall see that neither assumption is justified.* (Hospital Service Finance, Jan, 1965. p.6)

Feldstein's work provided quantitative support for those administrators who instinctively suggested that the mass of information created by the departmental costing scheme was not appropriate for hospital comparisons.

The late 1950s and early 1960s were characterised by attempts to improve hospital operational efficiency, through the use of a number of managerial techniques, such as O & M and costing. The success of these 'tools of management' is, at the very least, questionable and the way they were introduced, and used, suggests that the Ministry of Health was, generally, unwilling to 'manage' hospital entities directly. They appeared, instead, to see themselves as a databank, and acting like an advisory institution, with local control resting with the RHAs and HMCs.

6.4 Managerialism: A Hospital Chief Executive?

6.4.1 – Central Bureaucracy and Managerialism

The Ministry continued to be troubled about the internal management arrangements in hospitals and, by the mid 1960s there appears to have been a distinct change, and refocus, at the Ministry of Health, from techniques, or 'tools of management', to the issue of *management* itself in the hospital service (Harrison, 1988). Barnard suggests that the *'government caught the bug of the managerialism'* of the 1960s and cites as evidence the proliferation of government reports and *'numerous addresses from the*

conference platform' (1974. p.117). These reports (Harrison, 1988) included: Salmon (Ministry of Health, 1966), Farquharson-Lang (Scottish Health Services Council, SHSC, 1966) and the Cogwheel Reports (Ministry of Health, 1967).

One address from the conference platform, by the Permanent Secretary for the Ministry of Health, to the Institute of Health Service Administrators, appears to confirm this change in emphasis from efficiency tools to the ill-defined concept of management:

> *We have embarked upon a programme of study of hospital management; how it works, how decisions are made, and how it adapts itself to change. We want to discover firstly, the features of the present organisation and structure which help and those which hinder efficient management; second whether experiments in management might be made and the form they might take; thirdly, what the respective roles and tasks of the many hospital managers really are so that the management training of administrative and non-administrative staff can be related to them; and, lastly, what the management problems of the large DGH of the future are likely to be and how we can overcome them.*
>
> (Hospital, July 1965)

Perhaps the most radical, and largely neglected, of the official reports was the Farquharson-Lang Report (SHSC, 1966). This concluded there should be increased delegation from Boards to officers, and was critical of officers for a *'concentration on secretarial functions at the expense of the planning and management functions that were implicit in the original structure'* (SHSC, 1966. p.20) .Tellingly the Report produced a list of matters dealt with by Boards, illustrating the lack of delegation to officers and also the relatively trivial issues being dealt with by the formal Board of Management:

- *The committee selected a suitable colour for the cards to be attached to food carriers.*
- *The medical superintendent suggested that the new staff houses should be called numbers 1 and 2 East Grantile. The matter was adjourned until the next meeting so that he could consider the Committee's alternative names of Lower and South Grantile.*

(SHSC, 1966. p.21)

The controversial proposal from the Report was not about the relationship between Board members and operational officers, but between such officers, arguing that a

'post of chief executive should be established at each category of board (SHSC, 1966. p.97). However, as is described below, this proposal was ignored.

6.4.2 – Groups and Managerialism

A year after the Farquharson-Lang Report the Institute of Hospital Administrators and the Kings Fund also began to promote managerialism and published: THE SHAPE OF HOSPITAL MANAGEMENT IN 1980? This concludes that general management was needed within the hospital service, and suggests:

> *The title of General Manager - drawn from industry - correctly describes the scope of this post, as we envisage it, which is to manage the whole hospital as distinct from managing any particular service. While this idea may be radical, it is our firm belief that all administrative organisations must have one leader* (Kings Fund, 1967. p.33).

The title of the Report suggests the authors were aware that such a change might take many years, but there is little doubt that, for a short time in the mid-1960s this 'radical' change to general managers was being advocated both by some official publications and by groups within the service. In the Hospital Administrators journal, commenting on the Kings Fund Report, it is noted there is a

> *...growing belief that the pattern of management established in 1948 needs drastic reappraisal and its recommendations are a skilful and well thought out version of the currently popular belief that the board of management in industry offers the right mode* (Hospital, 1967. p.331).

Although the journal conceded that the concept of general management was too drastic and that organisational reform was more likely (Hospital, 1967. p.331). By 1968 this proved to be the case and the circular on the administration of health authorities, (HM (68)28, 1968), while commending parts of the Farquharson-Lang report, ignored the *'controversial'* (Hospital, June 1968. p.186) general manager issue. By November of the same year a review of the administrative structure of the health service was undertaken and the general manager concept appears to have disappeared.

6.4.3 – Academics and Managerialism

From the mid-1960s a new group of individuals began to emerge as advisors, and, indeed, opinion formers on hospital management, namely *academics*. Their interest

appears to have been stimulated by the Ministry's *'exploration'* of management and a number of reports are sponsored by the Ministry. Feldstein's work, outlined above, was an early example of academic interest, which also included: the London School of Economics (Professor Rosemary Stewart); Manchester University (Professor Chester); the Institute of Operational Research at Lancaster University; and, later, Brunel University led by Professor Jacques (MH 166/251).

As well as providing evidence of the Ministry's increasing focus on the concept of management, their subsequent reports offer further insights into managerial practice of the period. A summary of these studies, by the Research Branch at the Department of Health (MH 166/251), is particularly informative. For example, Stewart's study used the circular HM (64)102, on the management of out-patient departments, to assess the influence of Ministry circulars on the behaviour and actions of local hospital 'managers'. The Research Branch at the Ministry states:

> *The report concludes that overall, judged by the number and importance of changes made, the circular did not make much difference. One of the factors the report draws attention to is the lack of co-operation between doctors, nurses and administrators; 'one of the easiest alibis that an administrator could give for not doing anything about the circular was that consultants' attitudes made it impossible*
>
> And continues:
>
> *In brief, Miss Stewart's report suggests that about a third of groups and Boards have good managers who are trying to do a good job, but the rest are ineffectual or inefficient. Moreover, the HM as an instrument of management control by the Ministry, even when coloured pink and when reports are called for, is virtually useless* (MH 166/251. p.3).

Another report, by Manchester University, on the role of the Hospital Management Committee, tends to confirm the conclusions of the Farquharson-Lang Report on Hospital Boards '*The general impression left of the Hospital Management Committees was of gatherings of like-minded, well meaning, nice people, dutifully approving actions and recommendations of officers* (MH 166/251. p.6).

A much longer, and detailed, study was undertaken by the Brunel Health Services Organization Research Unit under the leadership of Elliot Jacques, which began in 1966 and continued into the 1980s. They suggest they were influential players in the

1974 reorganisation, and published two books on their work, HOSPITAL ORGANIZATION, (Rowbottom, 1973) and HEALTH SERVICES (Jacques, 1978). Their work provides interesting insights into the *'reality'* (Harrison, 1988) of management in hospitals and, in particular, the relationship between senior officers. The chief administrator, they state, had three levels of authority; *'managerial, borderline managerial'* and a *'monitoring and coordination relationship'*. For some staff, mainly non-medical support [clerical, catering, domestic], the chief administrator had full managerial responsibility, while senior medical staff had little managerial control. For example, they note, for hospital consultants:

> *Provided, however, he stays within these various limits, the consultant is accountable to no one for the way he exercises his freedom - for decisions he makes... Under normal circumstances the situation of having somebody armed with sanctions making a critical review of his work is unknown to the hospital doctor once he achieves consultant status.* (Rowbottom, 1973. p.78)

The third group, where the chief administrator had monitoring and co-ordinating responsibility, comprised *'engineers, builders, and various heads of paramedical departments'* (Rowbottom, 1973. p.175). The Chief Financial Officer, normally referred to as the Group Treasurer, was in this middle group, although this appeared to differ between hospitals, for example:

> *Of the three Group treasurers with whom we have had intensive discussion in field projects, two have seen themselves as directly accountable to their governing bodies, subject to the monitoring and co-ordinating authority of the chief administrator in certain respects. The third saw himself as accountable to the chief administrator, but with the right of independent access to the governing body on financial matters connected with audit.* (Rowbottom, 1973. p.184)

While these academic reports are interesting in themselves their influence is difficult to assess. Certainly they provided an independent eye on hospital management for the Ministry, but, until reorganisation in 1974, there appears to have been little action taken as a result of their investigations.

6.4.4 – The 'Reality' of Hospital Management in the Early NHS

Harrison (1988), using secondary sources as evidence, suggests that the *'realities'* of management at the hospital level was far from the *'text book model outlined by Stewart'*, where the manager:

Pursues organisational objectives related to serving the consumer, via a managerial hierarchy of authority, whilst consistently monitoring the outcomes of decisions. (Stewart, 1979 quoted in Harrison, 1988. p.51)

Instead Harrison likens the role of the hospital manager with that of a 'diplomat' and suggests:

> *Managers neither were, nor were supposed to be, influential with respect to doctors. The quality of management was judged by its inputs...managers in general worked to solve problems and to maintain their organisations rather than to secure major change. And, at least as far as managers were concerned, the consumer was marginalised.* (Harrison, 1988. p.51)

Learmonth in his *'content analysis'* of the journal THE HOSPITAL for 1946-1948 questions the term *'diplomat'* as a proper description of the role played by hospital managers. For example, although covering an earlier period, he notes

> *...that there is no evidence for a diplomatic role at this time - implying negotiation with medical and other staff and smoothing out conflicting interests. It seems almost as though the doctors had their job to do and the administrators another; the latter met the former relatively rarely and then only in a support capacity* (1998. p.327).

In addition Learmonth argues that administrators were content with technical tasks and that their non-university education *'did not equip them to be analytical'*, adding *'it probably socialised them to accept their role in life and to defer where appropriate to the university educated, socially superior doctors'* (1998. p.328).

There seems little doubt that hospital administrators/managers were severely limited in their powers and actions within the hospital, particularly in relation to senior medical staff (Rowbottom, 1973; Harrison, 1988). While there was some embryonic support for the concept of strengthening the authority of hospital administrators with the creation of general managers, particularly from the Kings Fund and parts of the

Institute of Hospital Administrators and, indeed, from one official report, the Farquharson-Lang Report, these ideas appeared to be a step too far for the Ministry.

6.5 Accounting Developments?

In the context of early efficiency drives; the creation of management tools, such as O & M; a disappointing response to departmental costing information; the dominance of hospital consultants; and a renewed effort by the Ministry of Health to examine 'management'; what role was envisaged for accounting?

Within the finance function the debate on accounting change appears to be somewhat muted. In Section 6.3 one sees that the annual costing exercise was often characterized as a useful *'attention directing'* device, but there is a little evidence that the data was used by the Ministry of Health. It was certainly time-consuming to produce and even finance directors appear to be less than convinced of its benefits (Montacute, 1962). Arguably this perceived lack of 'success' associated with departmental costing may account for what appears to be limited accounting reform in the 1960s. However there was a debate on the nature of accounting information required in the service, and a gradual response to changing technological and conceptual forces. This Section examines the accounting debate in the period and accounting changes instigated.

6.5.1 – Forward Looks and Cost Norms

There was an early attempt to introduce, what were referred to as, *forward looks,* which were longer term plans, beyond the one year time horizon of budget estimates, within the service. Like a number of other government reforms *forward looks* had been promoted by the Plowden Report (Treasury, 1961) and were obviously associated with the thinking on planning, which was to become a key concept by the mid-1960s. In addition *forward looks* were often linked to the need to establish a more 'rational' basis for agreeing hospital budgets and plans (Rigden, 1983; Klein, 1995). Budgets were still largely incremental with hospitals being funded largely on the basis of previous years' allocations. The problems associated with this, no incentive to under spend allocation or build reserves, and the perpetuation of inefficiencies, was recognised as far back as the Guillebaud Report in 1956.

However, the difficulty of finding a funding formula and replacing the incremental approach, was, and continues to be, an issue that senior managers within the service grappled with.

Longer term planning, via the *forward look* process, led again to the questioning of the incremental approach and to the possible use of a more 'rational' approach, based on *norms* or *standard costs.* These norms would be used for resource allocation and therefore as the basis for revenue budgets. For example, Sir Bruce Fraser, Permanent Secretary at the Ministry of Health, argues, in his address to the Chief Financial Officers annual conference, that:

> *As there was no real measure for need in the hospital service, and no minimum standard in terms of money could be laid down, yardsticks or standard – 'norms' – were needed to make estimates more rational.*
> (Hospital, 1961. p.769)

Fraser was unwilling to see this as a task that could be completed by the Ministry, suggesting instead that this could only be done at a local level, for example:

> *The Ministry should do what it could do, which was to facilitate and direct; it could not run or finance hospitals or develop defensible lines on how much ought to be spent.* (Hospital, 1961. p.769)

The importance of generated cost norms was also emphasised in a working party report by the Ministry of Health and Treasury on hospital revenue allocations in 1961. This report recommended that *'norms of good practice should be developed against which the reasonableness of expenditure could be measured and that an objective basis of estimating should be introduced'* (Hospital Service Finance, 1967. p.13).

Two individual champions of hospital finance, Montacute, and later Rigden, emerge as important advocates for standard costs, and the need to mimic 'industry' appears to be an important motivation in their advocacy. Montacute, for example, states:

> *The history of costing in industry shows that historical costs - such as those now produced in the hospital service - suffered from the drawback of having been prepared after the event. What was necessary was to set up, in advance of events, a carefully calculated estimate of what a well produced article or a particular service ought to cost under normal conditions. I consider that in spite of the peculiar difficulties in a humanitarian service of doing so, we should now take the logical step*

> *forward to trying to find out what the various parts of the service ought to cost and measure performance against these standards*
> (Accountant, 1962. p.253)

Rigden was the Treasurer of Sheffield Regional Hospital Board, a member of the working party on hospital revenue allocations and chairman of the research committee of the Association of Hospital Treasurers. He was responsible for a text on hospital finance (Rigden, 1983) and a keen contributor to professional journals. However, by the late 1960s Rigden admits that the *'implementation of norms had been disappointing, although some progress had been made with regard to feeding costs, and, to a lesser extent, nurse staffing'* (Hospital Service Finance, 1968. p.6).

While in the early 1960s forward planning attempted to estimate hospital revenue costs beyond the one year time horizon, these plans were still based on historic hospital expenditure presented on a subjective basis. Attempts to move towards norms or standard costs for estimates were very limited.

Another attempt to establish cost standards was related to the massive increase in hospital building in the 1960s as the Ministry were concerned to estimate the effect of this programme on revenue expenditure, referred to as the Revenue Consequences of Capital Schemes (RCCS). Senior finance staff and the Ministry, attempted to establish cost norms arising from new build schemes, with these norms based on the annual costing returns, and from data derived from the patient information system, adjusted for different regions and type of hospital (MH 170/208).

6.5.2 – Departmental Costing Scheme ~ 1966

While there were a number of references to standard costing and cost norms by leading hospital treasurers and senior civil servants; in practice standard costing was not adopted, either to aid resource allocation by the Ministry or for internal hospital budgeting. Instead, perhaps partly in response to the criticism associated with the operation of the 1958 departmental costing scheme, there was, in 1966, a new annual costing scheme introduced for all hospitals. It is important to note that this costing scheme, as with previous accounting reforms, Burdett's accounts and departmental costing, was to be based on uniformity of accounting practice with detailed guidance

on accounting treatment, to help ensure this. The idea of uniformity was deeply embedded within the service.

This scheme attempted to simplify the existing costing scheme, by limiting the amount of reallocation and effectively introducing a departmental system, based on direct costs, and Brinley-Codd (1974) states that:

> *The number of cost centres was increased and charges to these cost centres were limited to staffing costs and major expenditure subject to each department head's control. There was a considerable reduction in the re-allocation of costs and some modification was made in the method of allocating expenditures between in and out-patients.*

The Ministry of Health requested approval from the Treasury for the introduction of the 1966 costing scheme and the Treasury file on NHS costing provides illuminating insights into the development of the 'new' costing scheme, in particular, the conflict over full or direct cost for departments, and the use made of costing by the Ministry of Health.

The Treasury argued that the 1961 working party on revenue allocations supported the proposition that *'eventually all the financial processes, estimates, accounts, and costing, would be integrated on a departmental basis'* (T227/2230, memo. September 1964). This was supported in 1964 by the Association of Chief Financial Officers who agreed the scheme should be based on direct costs rather than the full costs introduced in 1956:

> *The costed expenditure will be confined generally to the direct expenditure arising within each department. (This should assist departmental heads as the expenditure concerned will be largely confined to items under their control).*
>
> (T227/2230, memo. September 1964)

Walker argues that direct costing rather than full costing was always the view of the Treasury, dating back to the debate on the 1955 scheme:

> *At the time of the 1955 working party, treasury challenged the need for full departmental costs and suggested a simpler system based on direct costs only. It would appear that the Ministry have changed their view.* (T227/2230, memo. January 1965)

These views on direct *versus* full costing appear to mimic the controversies within the wider accounting profession on this issue. Dugdale and Jones (2003) argue that in the 1950s and 1960s the *'dispute between advocates of different costing systems* [they refer to marginal and absorption costs] *reached a crescendo in the UK accounting press'* (p.11). They refer to this dispute as *'Battles in the Costing War 1950-1975'* (p.1). For UK hospitals the battle was won for direct costing in 1966, although Walker, at the Treasury, remained doubtful on benefit of the new scheme:

> *Whether or not the new cost units will be more useful, I am more concerned whether, in the absence of other measures, they will be more used. One of the selling points for the new system is to suggest that they will, I regret to say I doubt it.*
>
> (T227/2230, memo. January 1965)

In addition Walker suggests that the integration of the financial and cost accounts, with both being prepared on a departmental basis, as proposed by both the Kings Fund (1952) and the Nuffield Trust (1952), was vetoed by opposition from the Regional Treasurers (T227/2230, memo. February 1965). This further suggests, as in Chapter 5, that this group were far more conservative about accounting change than other groups, both inside and outside the service.

However, as with a number of subsequent accounting reforms, the new scheme, shortly after its introduction, suffered from a familiar ring of disappointment. For example, in 1974 Brinley-Codd argues that the scheme *'whilst reflecting a high degree of accuracy in accounting terms, failed in its purpose of providing up-to-date financial information for internal management purposes and the need for a new approach was again clearly demonstrated'* (1974. p.247). This retrospective analysis highlights that, despite earnest attempts to collect appropriate comparison data, the information was again of limited value, noting that:

> *The costing scheme was the first which produced roughly comparable cost information for all NHS hospitals, and as such represents a considerable improvement over the previous costing schemes but the lack of corresponding performance data generally reduced the validity of comparisons.* (1974. p.246)

Satisfaction with the 'new' 1966 costing scheme was also short lived and was quickly subjected to similar criticisms as the original 1956 scheme.

6.5.3 - Caution and the AGD 303

Evidence from the Treasurers' professional journal suggests that, while prominent individuals advocated the introduction of norms, or standards, hospital treasurers and particularly Regional Treasurers were far more cautious and showed little appetite for the introduction of standard costs, or, indeed, for delegation of budgets to departmental heads. They chose rather to rely on a tried and tested device, the AGD 303 Form, as in Figure 6.1, introduced in 1951 in an effort to control hospital spending. The deeply-embedded AGD 303 was probably the only budgetary control information used in the hospital service up to 1974. A survey conducted by the South East Metropolitan Branch of the Hospital Treasurers Association (Hospital Service Finance, October 1966) concluded in 1966 that a majority of hospital groups used the AGD 303 for routine budgetary control. This was produced for a group of hospitals rather than for a single hospital, which the survey found did not *'materially assist'* budgetary control.

Further evidence of the centrality of the form AGD 303 is provided in a letter by a hospital treasurer to *HOSPITAL SERVICE FINANCE*:

> *I believe that financial control is best achieved through the medium of that much maligned document Form AGD 303 and I am not convinced that we need to produce detailed interim cost statements to achieve overall budgetary control. In my view detailed costs can best be looked at in retrospect when the complete and accurate picture is available... I feel a simple system of this nature will produce just as satisfactory results as many of the more sophisticated systems which have been suggested, without involving the staff in a great deal of additional work.*
>
> (Hospital Service Finance, March 1967. p.9)

Montacute (1962), in his excellent survey of hospital costing, also finds, as noted in Chapter 5, that hospital treasurers were reluctant to devolve financial control to departmental managers by providing them with individual budgets. At this stage budgets were produced for each Hospital Management Committee. The budget was based on Form AGD303 (see page 122) which listed budget and expenditure by type (subjective) of expense for all the hospitals controlled by the Hospital Management Committee. For example, the catering department pay costs would be listed under Administrative and Clerical and other pay costs, while their non pay costs would appear under provisions, uniforms and clothing, fuel, light and power, etc, along with

all the costs of a similar type throughout the hospital group. There was no attempt to create a departmental budget that would identify the costs of each department.

Montacute's survey, which is worth repeating in more detail, provides some evidence to suggest that hospital finance managers were protective of their position regarding financial information, and did not want to trust managers with their own departmental budgets. Montacute states that of the Treasurers' questioned:

> *About 30% were definitely in favour... a further 30% though not against them had certain provisos - the chief of which was that time was not yet ripe to introduce them. The remaining 40% were against their introduction.*
>
> *Most of the objections centred around: (a) the need for the budget to follow statutory accounts... (b) the inflexibility that would result from parcelling out the budget (c) the fact that departments would tend to spend the whole of their allocation even if changed circumstances merited a reduction; (d) the difficulty of fixing the level of budgets.*
> (1962. pp. 230:231)

A study undertaken by a number of hospital treasurers, reported in *HOSPITAL SERVICE FINANCE*, also demonstrates the limited role played by hospital secretaries in budgetary control stating that *'little control was exercised by hospital secretaries in general, apart from expenditure on provisions'* (1966. p.25). In a discussion on this report at a Hospital Treasurers conference it was suggested that *'trends could often be ascertained by keeping the Hospital Secretary 'in the picture''* (Hospital Service Finance, October 1966. p.25).

This confirms later research on the devolution of financial control, for example, on the introduction of Management Budgeting in 1984, Pollitt *et al.* argue that while clinicians were *'reluctant managers'*, the managers themselves *'demonstrated scarcely more enthusiasm'* (1988. p.1). Certainly in the 1960s Montacute's research and the comments noted above suggest that hospital treasurers had little appetite for devolving budgets to lower levels within the organisation.

6.5.4 – Finance Staff ~ Early 1960s

An explanation for the reluctance of finance staff to innovate can, perhaps, be found in a personnel profile of these staff. Professor Roy Sidebottom of Manchester

University completed a study of the pay, qualification and age of these staff in 1962 (Hospital, September 1962. p.583). The summary of this report in THE HOSPITAL suggests that there were *'a small number of top jobs'* (p.583), and that, while the majority of staff were from grammar schools (66.8%), this proportion was falling. Finance personnel with a university degree were *'only 28 out of 3913 officers'*, and the study notes that this was *'surprising in view of the expansion of educational facilities'* (p.583).

The number of qualified accountants within the service is not clear from the summary of the Report in THE HOSPITAL but it confirms that many finance officers were members of the Institute of Hospital Administrators rather than accountancy bodies and *'the service does not seem to have made its mind up on whether the future leadership should be in the hands of people qualified in accountancy, or people qualified in secretaryship and administration'* (p.584). Sidebottom notes that the number of qualified accountants had diminished since nationalisation in 1948, stating that *'initially the service was endowed with a leadership of well qualified accountants, but it is clear that these are not being replaced'* (p.584).

6.5.5 – Patient Costing

A further indication of the limited aspiration of hospital treasurers is the little involvement of these staff in early efforts to introduce some form of patient costing information, which begins in the late 1960s. In the mid 1960s we saw a number of references to the possibility of developing hospital patient costs. [A broad term embracing specialty costs, disease costs, and, later, diagnostic-related and healthcare-related groups]. For example, Treasury correspondence from 1965 suggests that the Ministry of Health saw the new revamped departmental costing scheme, based on direct costs, as *'pointing the way to the introduction of specialty costing and further development and improvement in the presentation of financial and costing information'* (T227/2230, memo. March 1965).

There was little progress in the direction of patient cost information from practitioners within the service. Instead the earliest study was completed by an academic, Babson, and was presented to the Ministry of Health in April 1971 (MH 166/466). Babson was

working closely with the University of Manchester and with Professor Chester at this institution, and, like a number of other authors (Guillebaud, 1956; Montacute, 1962; Forte, 1986), his report first outlines the historical development of hospital costing, particularly in the period 1948-1956. Here he makes reference to a number of unpublished studies by staff at Manchester, including R. W. Wallis' COSTING IN THE HOSPITAL SERVICE and STUDIES IN WARD ADMINISTRATION by B Hunter.

Babson states that the purpose of his report was *'to collect and relate performance data to presently available cost information for specific diagnoses, thus producing 'disease costing' data'* (PRO: MH 166/466, 1971 p.12). The benefits he outlines for disease costing are similar to those advocated for earlier costing schemes. First, to improve efficiency:

> *From the point of view of internal management, disease costing provides an opportunity to identify areas of inefficiency and by relating all cost centres to the hospitals end product, patients, it permits the hospital management to view the hospital activities in a perspective not afforded by existing cost data.* (PRO: MH 166/466, 1971 p.12).

Secondly, resource allocation using standard costs could be developed from the data:

> *Once sufficient disease costing data becomes available, 'standard costs' could be established, (perhaps varying in accordance with hospital size, teaching status, etc.) for each diagnosis or group of diagnoses. Allocation of funds in accordance with these standard costs would automatically compensate for a hospital's casemix and would provide an incentive for efficiency which is lacking under the current system of allocation- which simply reimburse hospitals for costs.*
> (PRO: MH 166/466, 1971 p.13)

These aims for improved efficiency, and the acquisition of standard costing information for resource allocation, were also themes in the uniform costing and departmental debates discussed in previous Chapters. What was perhaps new was the increasing sophistication of the data and the first attempt to produce information that linked costs to clinical decision making. For example in the minutes of the meeting held at the Ministry of Health in April 1971 to discuss Babson's Report it was stated:

> *It would be particularly useful for providing information to doctors and managers about the cost implications of their own procedures and comparisons between procedures and those of others. It could be used as a criterion of effectiveness for both lay and medical management.*
> (MH 166/466, letter, 28th April 1971)

The increased emphasis on the need to compare clinical performance is also evident from other Reports in the early 1970s. In 1973 the Kings Fund produced a report called ACCOUNTING FOR HEALTH written by a working party including Abel-Smith and this first acknowledges *'that it has for so long been tacitly accepted within the NHS that the activities of the medical profession lie outside management control'* (Kings Fund 1973. p.16).

The report suggests that increased pressure on hospital funding has led to *'the need to devise management procedures for determining and controlling medical policies without impinging on the clinical freedom of the doctor to treat each patient as he thinks fit'* (Kings Fund, 1973. p.16). This report discusses the problems associated with finding an appropriate unit of output for health services, and concludes that *'classification by the condition or problem of the patient is essential'* (Kings Fund 1973. p.39). As noted in Chapter 3 the Kings Fund report also makes interesting reading because of the use of *'units of activity for costing'* which have some resemblance to the Activity Based Costing system, later developed by Cooper and Kaplan (1988; 1991). However these attempts at patient cost information were not adopted by the Ministry, and like other accounting changes, while initial pilots were explored, crystallisation was not possible.

6.5.6 – Programme Planning Budgeting Systems (PPBS)

Another, much talked about, initiative was PPBS and Klein (1995) notes that in the 1960s *'new techniques of government were developed'* and that there was an increased *'faith in techniques: such as cost-benefit analysis, Planning, Programme Budgeting (PPB) and Programme Analysis Review (PAR)'* (1995. p.58). (See also Rose and Miller, 1991)

It is easy to over-emphasize the impact of these techniques both at senior policy level and for individual hospitals. The case of PPBS is particularly illustrative. PPBS can be traced to the USA and Feltes argues that its origins lay with General Motors but that it was *'during the 1950s'* that *'the RAND Corporation, under contract to the*

United States Air Force, refined and developed the PPB concepts' (1976. p.1) and *'by 1964 PPB was fully operational in the Department of Defence'* (1976. p.2).

Although there were suggestions about the merits of PPBS in the Department of Health and Social Security (DHSS), Lee and Mills (1982) note that:

> *The DHSS explicitly rejected the use of a programme budget for operational management. Instead programme budgeting was to be used primarily for planning, in particular: 1, to assist in the DHSS internal planning system; 2, to act as a basis for guidelines to the NHS; and 3, to act as a means for monitoring and control.* (p.86)

Even this limited Departmental aspiration was largely unfulfilled and, by the 1980s, PPBS consisted of little more than *'the attaching of costs to broad programmes of activities... and this might help to explain why, despite DHSS encouragement, local health authorities in England have been reluctant to embark on programme budgeting'* (Lee and Mills, 1982. p.87).

For the finance function, even those at the forefront of new developments, like Rigden, saw little prospect of PPBS penetrating existing budgeting practice for Hospital Management Committees. In a 1971 article in *HOSPITAL SERVICE FINANCE* Rigden states that PPBS *'is still more theory than practice'* (January. p.7), and, in addition, after an explanation of the basic tenets of PPBS, he adds:

> *Perhaps we are not ready for all the detail yet. Certainly when it has been tried in the States, only some departments of Government have found it really effective...at this stage it is really the top-end of the exercise which we need to begin with, and I am encouraged to learn from my friends in the Department that attempts are already being made to analyse our total activity in terms of broad programmes.* (p.8)

However, the debate on PPBS and the use of some form of patient costing systems appears to have bypassed an essential group; the hospital treasurers. Their journal *HOSPITAL SERVICE FINANCE* makes no mention of patient costing in this period and little of PPBS; instead there is renewed interest in budgeting and, in particular, functional budgeting. This focus is partly a reflection of the changing managerial relationships within the hospital from around the mid 1960s and the emergence of the functional manager, based on hospital professions. In addition, the concept of

planning was to reach its height and instead of costing information, budgetary planning and control was to take on a renewed significance.

As with many hospital accounting reforms they return, sometime decades later, in another form and PPBS reappears in 2005 with Primary Care Trusts being required to *'breakdown how it spends its total allocation across the 23 Programme Budgeting category headings'* (Kenyon *et al.*, 2005).

6.5.7 – New Concepts: Functional Management and Planning

By the late 1960s, moves towards general management and indeed more complex costing and budgeting systems were quietly shelved. Instead there were a number of technological, professional forces, and new concepts, which led to a gradual change in managerial relationships at hospital level that would eventually result in the introduction of *functional budgets*.

Hospitals became more complex, particularly with the continued expansion of specialist technical departments and this was accompanied by the growth in the status of the healthcare functionalist (Crossley-Sunderland, 1977). Indeed Argent, in *THE HOSPITAL*, notes there was a significant change, from 1948 to 1968, in hospital management. The hospital, as an autonomous single managerial entity, was replaced with management by functional service heads, often independent of specific hospital control (Hospital, 1969. p.355). These functional services were often referred to as 'group services' and Argent suggests that their emergence meant the *'sphere of the hospital secretaries responsibility retracts'* (1969. p.355).

In a retrospective essay on the antecedents of the 1974 reorganisation, Crossley-Sunderland (1977) suggests that the move to functional management was promoted by professional interests within the service:

> *The drift into functional management has been a consequence of the perceived need, in the past, to improve recruitment to the NHS, which meant competing with private sector salaries. To justify high salaries pyramidal career structures were devised and to justify the structures functional management theory was cited and invoked. Thus although born out of a sequence of official reports relating to particular occupational groups as different as nurses, supplies officers, pharmacists and scientific officers, functional management was promoted as a*

> *separately inspired theory. It could then be used to provide the rationalisation for decisions that were really taken on quite different (economic) grounds.* (p.156)

It is not clear if hospital administrators resisted functional management, but evidence from their journal suggests it began to take hold before the 1974 reorganisation:

> *Functional management is now appearing more and more in hospital groups and the budget for a single hospital is being fragmented with parts controlled by other officers or officer groups than the Hospital Secretary, with functional divisions covering all or some of the hospitals in the group.* (Hospital Service Finance, May 1971)

Around the late 1960's there is therefore a new term, *functional management*, and a new organisational structure developing, based on functions or group services, which was gradually encroaching on the hospital as a separate entity. Decision-making was moving more and more towards these service, or functional, heads and perhaps in an effort to consolidate their position, these functional heads, may have been searching for more control via their own budgets.

Partly fuelled by the increase in hospital building, corporate planning began to emerge as an important concept within the service and Barnard (1974; 1977) identifies a number of universal trends that impacted on the management of hospitals including increasing interest in health planning by the *'expert publications of the World Health Organisation'* (1977. p.160). While he fails to provide specific references for his claim, the World Health publication HOSPITAL PLANNING AND ADMINISTRATION is a good example, arguing that health care should be:

> *Planned on a wide area basis; planning on an individual or local community basis creates gaps and overlapping. Civic pride, though commendable, does not necessarily produce a hospital service that combines efficiency and economy and that serves the best interest of the patient.* (Llewelyn-Davies and Macaulay, 1966. p.15)

Barnard (1974) also notes that corporate strategy and planning began to develop in private sector organizations, and that J K Galbraith's, 1966 Reith lectures, may have been influential in promoting planning as the *'new panacea'*.

6.5.8 – Reorganisation and Functional Budgets ~ 1974

The first major reorganisation, in 1974, cemented the trend towards functional management and planning at all levels within the NHS. For example, the publication, MANAGEMENT ARRANGEMENTS FOR THE REORGANISED NATIONAL HEALTH SERVICE states:

> *Because of this complexity, organisation in a single hierarchy controlled by a chief executive is not appropriate. The appropriate structure is 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)

The new organisational structure created three levels within the service, Regional Health Authorities (RHA) Area Health Authorities (AHA) and District Health Authorities (DHA), with planning and budgeting now central to the operation of the hospital service. The AHA was the lowest level of statutory authority, with full planning and operational responsibilities, and their functions:

> *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.* (DHSS, 1972. p.21)

In a paper by the Management Accounting Committee of the Association of Hospital Treasurers in 1973, reprinted in their journal with the title BUDGETARY CONTROL IN THE RE-ORGANISED HEALTH SERVICE, they suggest that:

> *The development of systems of management control based on standards and budgets, which reflect the ultimate purpose of each level of management... they must be clearly related to the planning system, which will determine the aims and objectives of the service in any period of time.* (Hospital Service Finance, November 1973. p.7)

The central role of the financial function and, in particular, the use of functional budgets, was outlined by the new [re-appointed] Minister of Health, Sir Keith Joseph, at the treasurer's annual conference:

> *The new accounting system would ensure that the budgets for each function would be the responsibility of the individual manager. Their costs must be monitored as the year proceeded. It would be the role of treasurers to keep track of budget costs, to keep managers informed, and to advise on how best to control the budget. The treasurer must be actively engaged at all levels of management. He must understand what*

> *individual managers were doing and how they proposed to cope with the fluctuating demands for the services of their departments.*
> (Hospital Service Finance, 1974)

Brinley-Codd, writing at the time of the reorganisation, suggests that the reorganisation provided new opportunities for the use of management accounting techniques:

> *Ever increasing importance is being placed on the accurate forecasting of the future needs of the service in financial and statistical terms, and development plans must be based on accurate costings and up-to-date financial information. The further development of management accounting techniques within the service is essential if adequate information is to be available for top management of the future.*
> (1974. p.247)

The functional budgets created after the 1974 reorganisation were only marginally different to the departmental budgets proposed almost twenty years earlier by both the Kings Fund (1952) and the Nuffield Trust (1952) and a number of authors, suggest that while they 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). Like previous accounting reforms the limitations of functional budgets were, within a very short period, quickly exposed.

6.6 Discussion and Conclusions

There were three attempts to influence [and change] the management and the operation of the hospital service by the NHS bureaucracy, from the late 1950s to early 1970s and all of these represented a change in emphasis from local autonomy to upwards accountability (Klein, 1995). This commenced with the introduction of a number of management techniques, particularly O & M and improved methods of costing, under the umbrella of the *efficiency* concept. There is little evidence of any resistance to the introduction of these techniques within the hospital professional associations, and, from some, for example, O & M in the Royal College of Nursing, active support.

The commencement of the hospital building programme in the mid-60s also had a significant influence on hospital management and organisation. Firstly, there is some suggestion that, through economies of scale and technological improvements, the new hospital building programme was the answer to the problem of efficiency (Webster, 1998). Secondly, the enormous amount of senior management time devoted to the new building programme may have resulted in less concentration on more mundane tasks, such as accounting and management reform.

Accounting professionals, within the service, made an early start on developing one management tool, with the introduction of departmental costing in 1958. Although evidence, from two reviews of the departmental costing scheme, and indeed from practitioner journals, suggests that this had little impact and the central bureaucracy made little use of the enormous amount of data generated (Montacute, 1962; Walker, PRO: T 227, 1545). The annual departmental costing scheme was amended in 1966 to one based on direct costs rather than full costs. This again, like early accounting change, reflected current professional debates, or conflicts, between supporters of absorption and marginal costing techniques (Dugdale and Jones, 2003).

In the mid 1960s the concept of *management* replaced *efficiency* as the key concept within the service. Again the driver of this change appears to be the central bureaucracy but they were certainly supported by the Institute of Hospital Administrators and official reports, such as Farquharson-Lang (Scottish Health Services Council, 1966). For a short time the idea of a General Manager for each hospital is advocated, but was to prove too radical for the central bureaucracy. This period also saw the influence of a new group on hospital organisation, namely academics. Particularly prominent was the Brunel Health Services Unit (Rowbottom, 1973) and their research paints a picture of hospital management dominated by medical staff with hospital administrators playing what Harrison (1988) describes as a *'diplomatic'* role.

There were some important internal advocates [champions] of accounting reform, in the 1960s, most notably Montacute and Rigden. Their reform agenda was a pre 1948 nationalisation one of departmental budgets and the introduction of cost norms or

standards. However evidence, while limited, from the Treasurers' professional journal suggests that the Treasurers, as a group, were reluctant to adopt 'new' standard costing techniques, preferring the relatively simple budgetary control document, AGD 303, introduced in 1951. This conservatism appears to have fitted well with the central NHS bureaucracy, where caution and reluctance to intervene in hospital management was the order of the day. There are a number of illustrations: their insistence that O & M should be introduced at a local hospital level rather than centrally controlled; reservations about the appointment of Ewart-Smith to ACME; the rejection of the general manager concept; and their failure to use the enormous volume of hospital costing data available after the unit costing scheme was introduced in 1958.

Accounting change, when it did arrive in 1974, was linked to dominant concepts, functional management and planning. Argent (Hospital, 1969. p.355) suggests that there was a fundamental change in hospital governance from independent hospital entities to hospital functional groups and, with it, a concentration of senior staff at group level. The hospital secretary's responsibility was gradually diminished in favour of functional managers. Crossley-Sunderland argues that the need to justify high salaries was partly responsible for the creation of functional managers and these *'pyramidal career structures'* (1977. p.156). This movement away from individual hospital administrators, or managers, to functional managers at group level was eventually formalised in the 1974 reorganisation, along with the perceived need for planning.

There were to be long and short term plans at all levels within the organisation and the main responsibility of Area Health Authorities was to agree a plan and budget for each district and assess their performance against this. The hospital as an entity had finally disappeared from the organisational charts. As with the creation of the service in 1948, accounting, in this case budgets, was to be central to the operation of the service after the 1974 reorganisation. Area and District Health Authorities were required, for the first time, to produce budgets below hospital group level and the long-lasting budgetary control document AGD 303 came to an end. However, this devolution of budgetary control was not to individual department heads at each

hospital, recommended by both the Kings Fund and Nuffield Trust as early as 1952. Indeed there appears to have been a significant reluctance to devolve financial control to an operational level.

There is some evidence to suggest that patient costing was beginning to emerge in the early 1970s, promoted mainly by academics (Babson, 1973) and the Kings Fund (1973). These studies suggest that this type of information could be used for *'controlling medical policies'* (Kings Fund, 1973. p.16) and to provide *'information to doctors and managers about the cost implications of their own procedures'* (Babson; MH 166/466, letter. 28th April 1971). Like previous hospital accounting reforms these would have to wait.

Although during this period the NHS bureaucracy made a number of attempts to influence hospital management they were unwilling to force change by using any punitive devices, and, instead, sought compromise and consensus. Many of the reforms, such as O & M, costing and later 'management', appear to have had limited impact on the operation of the service at hospital level and certainly on the influential doctors. Whether this was a lack of will or due to the sheer size and complexity of the organisation is debatable. Previous disappointment with departmental costing may have restrained change agents with incremental 'improvements' becoming the accepted norm.

Chapter 7 ~ Discussion and Conclusions

7.1 Introduction

The aim of this historical study is to track the process of, and forces influential in, accounting change in the UK hospitals over a period of almost a Century (1880-1974). This study takes a dual perspective on accounting change. The first perspective is the contextual factors shaping accounting technologies, and the second the interaction of change agents; individuals, groups and institutions advocating and, often, implementing change. This duality broadly follows the elements suggested by Porter (1981) for examining historical events; individuals, groups, institutions, forces, concepts and universals although, of course, this duality is not mutually exclusive as change agents help shape contextual factors, and *vice versa*, particularly within the internal hospital environment. The research is also influenced by other researchers interested in accounting and strategic organisational change, particularly Hopwood (1983; 1984; 1987), Pettigrew, (1987); Bhimani (1993); Guthrie (1994); Burns (2000) and Dawson (2003), whose work is discussed in Chapter 2.

This thesis, after examining previous research on hospital accounting, explores three distinct episodes of accounting change: ***the uniform system of accounts***; ***departmental costing;*** and ***functional budgeting***, with each event explored separately in Chapters 4 to 6. This Chapter now provides an overview of the three events assessing whether there are any common contextual factors driving accounting change and comparing them in their historic context. In addition the part played by significant change agents; individuals, groups and institutions, in 'orchestrating' change, are compared and contrasted. It is these elements, outlined by Porter (1981), for examining historical change that is the focus of this final chapter and Table 7.1 provides a comparison of the dominant elements relating to each event.

Table 7.1: Porter's elements and the three events

	Uniform Accounts	Departmental Costing	Functional Budgeting
Individuals	Burdett, Michelli	Stone, Livock	Montacute, Rigden
Groups	COS/ICAEW, Sunday Fund Hospital Association	Kings Fund Nuffield Trust Regional Treasurers Association of Hospital Administrators	Regional Treasurers Association of Hospital Treasurers Academics
Institutions	House of Lords	Civil Service	Civil Service
Concepts	Efficiency Self Help Localism	Efficiency Central/De-centralised Departmental Control	Efficiency Planning Functional Control
Forces	Economic Medical technology Professional norms Managerialism	Economic Medical Technology Professional Norms	Economic Hospital construction Professional norms Early managerialism
Universals	Voluntary Control	State Control	State Control

The Chapter also explores some 'conventional wisdom' surrounding pre-1974 accounting change and, using the new evidence collected in this thesis, debates their validity. The Chapter begins, in Section 7.2, with an exploration of the contextual factors common to the three accounting events. These include the concepts of efficiency, commercial practice and professional norms, economic crises and technological developments. In Section 7.3 universal and specific forces are examined. The role and interaction of change agents, and their influence on the long process of change, are examined in Section 7.4. The following Section 7.5 assesses a number of assertions made by contemporary accounting studies on the period before 1974, and in Section 7.6 the author makes suggestions for potential research, and comments on the limitations of this study. Concluding comments are in Section 7.7.

7.2 Common Contextual Elements

7.2.1 – Concept of Efficiency

Interestingly all three events have a common *conceptual* factor driving, or certainly used to justify, change. This is the concept [Preston (1992) prefers the term 'discourse'] of *efficiency*. For example in the period prior to the creation of the uniform accounts, from around 1880-1893, Sturdy and Cooter consider efficiency as

the *'abiding concern within voluntary hospitals'* (1998:424), and draw on changes to hospital construction, the use of hospital managers and, indeed, the creation of uniform accounts to support their thesis. Here, Burdett's obsession with the production of accurate, and comparable, cost-per-bed data, to compare hospital performance and efficiency, adds to the evidence regarding the centrality of this concept in the period. In addition, other academic work, by Rivett, (1984), Prochaska (1992) and Jones and Mellett (2000), also suggests that influential groups, such as the Kings Fund and Saturday Fund, used efficiency tests as an aid to the allocation of funds to hospitals.

The second event, departmental accounting, was also forged with appeals to the concept of *efficiency.* The investment in accounting systems was supported by key individuals from across the political spectrum and, indeed, associated with opposing organisational forms for hospital care, like Stone, a leading hospital accountant and keen supporter of voluntarism and Bevan, the Minister of Health; widely credited with nationalisation. Stone, as early as 1924, argued that *'to those who are responsible for the efficient and economical management of hospitals it is obviously more satisfactory to have the accounting records on such a system'* (Stone, 1924. p.95). On the creation of the NHS Bevan also wanted to adopt new accounting systems to *'educate'* hospitals and suggested that *'the development of comparative costing'*, would assist in *'introducing efficiency'* (PRO: CAB 134/518).

This 'discourse' on efficiency is rekindled in the late 1950's and early 1960's, with Klein arguing that the defining characteristic of the period *'was the emphasis on efficiency and rationality in the use of resources'* (1995. p.57). Klein (1995), Webster (1988; 1996; 1998) and this study all identify a number of reforms to justify these claims. These included the introduction of O & M and Work Study, the creation of an Advisory Council on Management Efficiency, the construction of larger hospitals and the closure of smaller units, as well as, by the mid 1960s, an increasing interest in managerialism and general management (Harrison, 1988). The accounting field's contribution to these demands for efficiency was dominated by two accounting techniques; annual departmental costing and the use, or possible use, of standard costs or norms.

By the 1974 reorganisation the efficiency agenda is linked to planning and cost information. For example, Brinley-Codd, an accounting practitioner, writing in a 1974 article: COSTING AND EFFICIENCY IN THE HEALTH SERVICE notes that:

> *Ever increasing importance is being placed on the accurate forecasting of the future needs of the service in financial and statistical terms, and development plans must be based on accurate costings and up-to-date financial information.* (1974. p.247)

Indeed so strong is the emphasis on efficiency in these three accounting events that it could be argued that it serves the same role as profit in commercial entities, as the primary conceptual driver of healthcare accounting reform both before and after nationalisation? Perrin states, in relation to later managerial reform, that the Value For Money [economy, efficiency and effectiveness] *'concept represents the concern of government that the NHS and other public enterprises not exposed to the competitive discipline of the market place should be required to assess their own performance'* (1988. p.9). Within market or profit seeking organisations Jones (1997) argues that many accounting histories have *'long been accustomed to regarding the imperatives of profit-seeking behaviour as possibly the most important factor in understanding changes in accounting practice'* (p.791).

Is it a little too obvious to suggest, as Perrin does, that efficiency replaces the profit motive, or the economic driver for accounting reform, in UK public sector hospitals?

7.2.2 – Commercial Practice and Professional Norms

Another element that spans the whole period is the influence of commercial practice, or perceived commercial practice, and professional norms. Using Porter's elements these can be described as 'forces', whereas processual and organisational change researchers, like Pettigrew (1987) and Dawson (2003), would regard these as external contextual influences. For example, Chapter 4 of this study identifies similar demands for uniformity, as those taking place in UK hospitals, in both the profit and other 'not for profit' sectors. Parker (1984) traces demands for uniformity in company accounts to the mid 19th Century, while Coombs and Edwards (1993) and Jones (1992) identify uniformity as central to the accounting change agenda within local government in the latter part of the 19th Century.

Within hospitals there are a number of professional forces beginning to develop in the late 19th and early 20th Century with the creation of medical and nursing professional organisations and this thesis identifies the creation of the Hospital Association, and the journal *THE HOSPITAL*, as influential in the professionalisation of hospital managers and, subsequently, the spread of the uniform accounts. It is important to note that these developments did not take place in a vacuum and were themselves influenced by concepts, such as efficiency and the managerial culture in wider society (Sturdy and Cooter, 1998).

Attempts to mimic commercial practice and perceived accounting norms is also evident from the debate surrounding the introduction of hospital departmental accounting. Vollmers (1996) notes that the 'department' emerged in accounting texts as the key accounting theme, or concept, in the 1920s and 1930s, and Stone (1927; 1954), a key promoter of the accounts, was strongly of the view that the management of large hospitals should follow commercial practice in this respect. This need to follow commercial practice was also, according to Preston, (1992) a key reason for moves towards departmentalisation in US hospitals.

Even the debate between the Kings Fund and the Nuffield Trust on whether to use full or direct costing for hospital departments, mirrors the debate taking place within the wider accounting professional community in the late 1950s and early 1960s (Dugdale and Jones, 2003). Interestingly the hospital service tried both systems; introducing departmental costing information based on full costing in 1956, but changing to direct costing in 1965.

In addition to accounting reforms, in the 1960's we also see the introduction of a number of other techniques, partly influenced by the 1961 Plowden Report, (Klein, 1995) that suggests the transference of technologies and behavioural norms firmly rooted in the private sector. For example, in the early 1960s, organisation and method techniques and later the planning 'obsession' (or 'panacea' – Barnard, 1974) within the NHS both reflected similar trends in the commercial sector and indeed appear to have been introduced due to their success in such organisations. Like

Bhimani's study of Renault (1993) the NHS was influenced by these *'external rationalities'* that altered the *'conceptualisation of legitimate action'* (1993. p.36).

However these rationalities were adapted for public sector institutions rather than adopted wholesale. For example departmental accounting information was produced annually rather than quarterly or monthly and the depreciation charge was limited to a very small number of assets. O & M and Work Study were introduced but the approach adopted appears to be co-operative rather than confrontational, and there was the recognition that local autonomy should be maintained.

It is worth noting that the transference of accounting techniques slowed in the 1960s and commercial practice and external professional norms were not strong enough to generate significant accounting change, despite being promoted by key individuals within the service. This is illustrated by the fact that the Association of Hospital Treasurers and key individuals within this association, such as Montacute and Rigden, were *unable* to persuade the NHS bureaucracy to adopt standard costing throughout the NHS, or to drop subjective analysis for routine budgetary control, and replace it with departmental budgets. Major accounting reform was avoided; instead the Ministry preferred to adapt the annual departmental costing system to prime cost in 1966, rather than adopt either of the major changes suggested by leading practitioners within the service.

It is possible to suggest a number of explanations for the limited number of accounting reforms throughout the 1960s. There appeared to be a lack and indeed declining number of professionally-qualified accountants within the service which obviously would have impacted on the transference of professional practices (Sidebottom, Hospital, 1962. p.583). After the 'spin' surrounding the benefits of the departmental costing information and the subsequent disappointing reality, central bureaucracy was even more cautious about accounting change. This disappointing reality was perhaps confirmed by the work of Feldstein who suggests that *'much of the variation in cost may be outside management control such as hospital's case mix'* (Hospital Service Finance, January 1965. p.6). This complication must have helped

critics who, perhaps, before Feldstein's work, instinctively suggested that 'no two hospitals are the same'.

Other explanations for the continuity of accounting practice were the growing influence of the Civil Service (Webster, 1988; 1996) and their reliance on techniques of management, other than accounting. Civil servants appeared largely unconvinced of the benefits of departmental costing even before its introduction in 1958 and also, on the whole, rejected the view that hospitals were like commercial organisations. This central cynicism appears to have been a major contributory factor in preventing further accounting reform. Related to this was the increased faith placed in other 'tools' of management, particularly O & M, long term planning and the creation of large scale District General Hospitals. This could be seen as an attempt to 'engineer out' inefficiencies in hospital organisation by the creation of new, well equipped technologically-advanced hospital institutions, rather than improve existing hospital efficiency.

7.2.3 – Economic Crises and Technological Developments

There is some evidence to support Hopwood's view that economic crises trigger an increased interest in accounting techniques, and to confirm his conviction *'that organisations tend to increase their investment in economic calculation and visibility during periods of restraint'* (1984. p.171) with less interest during periods of economic stability. For hospitals these economic 'problems' are often linked to developments in medical technologies and the increased costs, through new or improved treatment, they often generate. This is evident from increasing concern about health costs following the 'transformation' in hospital care, largely as a result of technological change in the later decades of the 19th Century, which coincided with the debate on the introduction of uniform accounting and also led to changes in the nature of funding.

The overspending crises in the early years of the NHS, 1949-1951, was also shortly followed by a prolonged debate on department costing and was partly responsible for the re-evaluation of this technique in 1956, even though it had been rejected in 1948.

These early spending problems were given a high profile within the government, the NHS and more widely in the public arena (Klein, 1995; Webster, 1988). Bevan, then Minister of Health, was forced to respond to criticism of alleged government waste and therefore introduced an interim costing statement in 1950, and also invited, external groups, the Kings Fund and Nuffield Trust, to prepare their own proposals on accounting reform. Whether the Ministry would have sought the aid of these groups without the political profile accorded to these overspends is doubtful, given the dominance of public sector groups on earlier accounting working parties at the Ministry.

Stone (1927, 1954), and indeed Preston (1992) in his study of accounting in US hospitals, suggest that changing technology and the increasing use of diagnostic departments was the driver for departmental accounting, with Preston noting that, in the first decades of the 20th Century, expenditure was increasingly associated with costs other than residential care costs. This is supported in this thesis by an analysis of healthcare costs which illustrate that in 1891 31% of total hospital costs were related to food and drink and 25.7% salaries and wages; whereas by 1938 this was 16.2% and 38.1% respectively (see also Berry, 1997). This change in cost structure helps illustrate the changes in hospital care and why accountants and managers needed to move away from the previous focus on provision costs.

In the 1970s more general concerns about public expenditure led to the first major reorganisation of the NHS in 1974, and the introduction of functional accounting. In contrast, periods of spending growth, such as the 1960's, were relatively stable in terms of accounting change, indeed during this period the NHS notably avoided professional demands for the introduction of standard costing.

7.3 Universals and Specific Contextual Factors

7.3.1 – Universals

The previous Section identifies a number of concepts and forces that helped shape all three events within which the debate on hospital organisation, and accounting, took place. There were also a number of specific contextual factors relating to each event

that impacted on the key change agents in the, sometimes, long process of change. However before the author considers these it is important to identify the *universal* concepts wherein efforts to change accounting practices operated. Jones and Mellett (2000) used the social order model to explore the universal context, and to chart developments in UK hospital accounting, identifying three periods; communitarian, before 1948; etatist, 1948-1989 and markets 1989 to the present. The author broadly agrees with these periods and the classifications, although preferring the terms voluntarism, rather than communitarian, and statism (Klein, 1995), rather than etatist, but, however classified, it is important to recognise these broad all-pervasive environments where accounting change was fostered.

The first event, the introduction of the uniform accounts, takes place within a totally different universal context than the other two events; it is a period dominated by, what has been referred to as, *laissez-faire* liberalism and a commitment to *voluntarism* (Prochaska, 1992). State control was rejected, and, instead, voluntary charitable institutions, friendly societies and local market-based solutions provided the primary source of health care for the majority of citizens in the UK. This helped stimulate groups and institutions, not directly responsible for hospitals or healthcare, to question hospital organisation, governance and efficiency.

After 1948 the nationalisation of hospital care created a new universal; statism. The vast majority of hospitals are nationalised and although there is an emphasis on local autonomy within the organisational structure of the NHS, central funding and political expediency quickly reduce the flexibility of local hospital institutions (Klein, 1995). Indeed just as there was a consensus in the later part of the 19th Century around voluntarism, this is reversed post-1948 [certainly up to 1974] where a political accord develops on State control and funding (Klein, 1995; Webster, 1998). The debate revolves around the correct 'tools' for managing the service rather than challenges to the structure and funding of the service (Klein, 1995; Webster, 1998).

1948 is almost 'year zero' and there were two consequences. Firstly, external financial reporting became quite limited, as hospital management committees were, predominately, only required to report up the chain of command within the structure of the NHS. Secondly, State control heralded a new attempt to assess hospital

efficiency which manifested in a prolonged debate on departmental accounting, and, later, functional management. The next Section identifies the contextual factors specific to, or more dominant in, each event; however, they need to be read with regard to the universal concepts described above.

7.3.1.1 Uniform Accounts

Although efficiency was an important concept underlying the introduction of uniform accounting, it was not the only concept, or indeed the dominant concern, of a number of important individuals and early promoters, particularly the Charity Organisation Society (COS) who challenged, or objected to, free hospital out-patient care on almost moral grounds. They believed this system led many patients, who could afford to pay, instead, to use a modern phrase, to 'free load' from charitable hospitals. In addition COS suggested that hospitals manipulated their accounting information to manufacturer deficits as a fund-raising device (Rivett, 1986) and that a uniform accounting system was needed to help prevent this manipulation. For COS accounting reform was about improved corporate governance, more accountability and fraud prevention. For them uniform accounting would provide transparency to hospital organisation and funding, which they regarded as solely lacking in the late 1880s. This does not suggest that attempts to use uniform accounting to measure hospital performance and efficiency were absent during this period, but rather that this was not the prime motivating concept for one of the most important groups central to the process of change.

7.3.1.2 Departmental Costing

For departmental accounting the decentralisation/centralisation control dichotomy (Klein, 1995) was the dominant concept to engage those charged with managing the service. How to organise hospitals to respond to local needs while, simultaneously, providing a national service and ensuring maximised efficiency for the taxpayer was, and indeed is, the main dilemma facing those charged with running the service (Klein, 1995). Bevan envisaged that accounting would provide some form of reasonable comparative information which would assist in this task. However, it was quickly established, following budget overspends, that controlling the expenditure of hospitals would require closer monitoring by the Department of Health and Regional Health Authorities. Although there was early rhetoric around decentralisation,

autonomy and 'education' of hospitals, via 'comparative cost information'; after substantial overspends, tighter central control and living within annual budgets, become the dominant themes (Klein, 1995). This re-ignited interest in departmental costing as a means of both control and performance measurement but also introduced the AGD 303, a subjective analysis of monthly expenditure, which was to prove the mainstay of financial control within the service for over twenty years.

7.3.1.3 Functional Budgeting

By the early 1960s *planning* emerged as the overriding concept in healthcare management (Barnard, 1974). This was eventually linked to functional management which, in turn, led to functional budgeting in 1974. From the creation of the first national hospital plan in 1962, which closely followed the Plowden Report (Treasury, 1961), planning appears to have dominated the agenda of senior managers within the service. Simultaneously one sees the continued rise of the functional manager, perhaps at the expense of the hospital administrator (Hospital, 1969, Argent; Crossley-Sunderland, 1977). This helped created a new type of reporting and accounting entity, based on functions rather than hospitals, or even departments within hospitals, in the 1974 reorganisation. In addition the hospital building programme itself helped promote larger functional departments at District General Hospitals, and helped fuel demands for budgetary control information prepared on this basis.

It is worth noting that other 'tools of management', such as O & M, statistics, and the creation of a council to examine efficiency, were also overriding concepts and these, rather than accounting, were the 'panaceas' of the period (Webster, 1996). There are a number of accounting concepts that emerged during this period, which were discussed, but not implemented. Examples include the introduction of cost norms for resource allocation, general management, PPBS and case-mix costing information.

7.4 Interaction with Change Agents

The preceding paragraphs outline some of the most common, and specific, contextual factors influential in accounting change. In this Section the author explores how the

contextual factors identified were *'orchestrated'* by *'individuals and groups during the change process'* (Dawson, 2003. p.26) to generate accounting reform.

7.4.1 – Uniform Accounts ~ 1893

Uniform accounting emerged in the context of technological change, the growth of managerialism and the efficiency agenda, the moral concerns of COS and the universal concept of voluntary control. However an understanding of the final form of accounts, and their spread, is aided by an analysis of the competing groups and institutions prominent in the process of change.

COS were early promoters who sought technical expertise and professional validity for their reform agenda by collaborating with ICAEW. These two institutions appear to have broadly agreed on the moral concept of self help, but they were unable to control the development of hospital accounting policy. Instead groups and institutions more closely associated with hospital organisation were able to resist change, and introduced Burdett's accounts in 1893. Prominent groups were the Sunday Fund and the Hospital Association, or, certainly, key individuals within these associations. Indeed it can be argued that these key individuals, like Burdett and Michelli, created an informal group dedicated to managerial accounting reform, in direct opposition to COS.

This conflict, together with the intervention of the House of Lords (Rivett, 1986) was central to the speed with which this internal group responded to COS and the creation of the uniform accounts in 1893. While Burdett was crucial to the spread of the accounts they were not dissimilar to, or indeed perhaps not as sophisticated as, some of the other alternatives suggested by COS and ICAEW. Rationality was not the key to Burdett's 'victory'. Instead a combination of factors, strong internal groups and individuals, access to appropriate printing technologies, and dislike of State control and outside interference, all contributed to Burdett's form of accounts being adopted in 1893.

COS and ICAEW's interest in hospital accounting proved to be temporary, with neither institution playing much part in the spread of the accounts. Instead the

internal groups and institutions were quick to consolidate their positions with Burdett, the Sunday and Kings Fund and the Hospital Association all attempting to adapt the widespread managerial and efficiency agenda to the hospital environment.

Largely as a result of their efforts the uniform accounts were quickly adopted in London, and later by hospitals throughout the UK. As Jones and Mellett (2000) and Prochaska (1992) suggest, the funding institutions were instrumental in promoting the uniform accounts by requesting the production of uniform accounts from hospitals before offering funding, and also encouraging managerial 'best practice' via hospital inspections. However, a key to the adoption of the accounts was the urge to embrace 'appropriate' professional norms by hospital secretaries, and the role played in this by the Hospital Association. This included hospital visits by Burdett on behalf of his journal: *THE HOSPITAL,* annual conferences and Burdett's annual publication, HOSPITAL AND CHARITIES. The spread of the accounts was also assisted by the production of standard forms (Craig, 1991) and supplementary account books by Burdett and this could be regarded as a technological force aiding professional conformity.

While not strictly within the confines of this thesis it is interesting to note that the uniform accounts were also influential in early US hospital accounting (Allen, 1906), and indeed a similar organisation to the UK Hospital Association was also created in the USA (Vogel, 1989)

7.4.2 – Departmental Accounting

The contextual background to the introduction of annual departmental costing includes attempts to find a measure of efficiency to 'judge' hospital performance after nationalisation, and the problem of how to control the vast number of 'decentralised' hospitals within the massive organisational structure created in 1948. The dominance of departmentalisation in the accounting literature and an economic restraint driver in the form of early NHS overspends were also influential forces.

In the early years of the NHS one sees a power struggle between groups influential in the pre-NHS world, particularly the Kings Fund, who clash with the institutional power of the civil servants, coupled to practitioners within the service. These internal groups appear to have been very conservative and cynical, or perhaps practical, about the benefits of departmental accounting. For example the Regional Treasurers (1952) were far more concerned than other reformers on the practicality of implementation and the usefulness of departmental information. As Montacute identifies in 1962, finance managers within hospitals were generally very cautious about accounting reform.

It was the Regional Treasurers' opposition to departmental budgets that prevented them being accepted in 1956. Instead annual departmental costing was introduced, with some form of devolved budgets only introduced in 1974. Other evidence in the mid to late 1960's also suggests that the Treasurers were wary about the possibility of introducing standard costing, or indeed delegating budgets to departmental heads (Montacute, 1962).

This cautious approach fitted well with the views of civil servants at the Ministry who, for example, were not convinced that attempts to mimic commercial 'best practice' was valid within the NHS, arguing that *'patients could not be regarded as units of cost comparable with articles produced by a manufacturing process'* (MH 137/13, copy of report para. 2). This was echoed in their attitude to other reforms, such as the use of O & M and their reluctance to use departmental information after it was produced (Walker, T227/1545).

The professional accounting associations are an interesting group absent from the debate on hospital accounting after 1948. The ICAEW were drawn into the debate on uniform accounting but, after a brief period of activity, and the production of specimen accounts, they were successfully excluded by internal groups within the hospital movement. In the lead up to nationalisation there were a number of critical articles on hospital accounting in *THE ACCOUNTANT*, which supported Stone on departmental accounting and, particularly, the need for a depreciation charge in hospital accounts (Mellett, 1992). Also in the critical period between 1946 and 1948 the Institute of Hospital Administrators attempted to create an alliance of interest

groups, (ICAEW and ICWA) from the accounting profession to help set the accounting agenda for the new service.

They were, however, effectively excluded from the subsequent debate on accounting, and the advisory committee on hospital accounts, set up in 1947, contained only one representative from the accounting profession – The Institute of Municipal Treasurers. The subsequent debate on departmentalisation takes place between internal representatives [Regional Treasurers] and external healthcare lobby groups [Kings Fund and Nuffield Trust].

7.4.3 – Functional Budgeting

In the period leading to the introduction of functional accounting in 1974 one also sees the absence of professional accounting associations from accounting debates on hospitals. Between 1956 and 1974 there were very few articles on hospital accounting in the accounting press [e.g. *THE ACCOUNTANT*] and practitioners within the service appear to have 'turned in on themselves'. This may partly be due to the number of qualified accountants within the service declining, while finance had not, at this stage, established itself as a distinct function within the service. Certainly Sidebottom's (Hospital, September, 1962. p.583) profile of hospital finance staff suggests that few accountants had a university education and that the number of qualified accountants in the hospital service had declined since 1948. Many finance staff were members of the Institute of Hospital Administrators rather than accounting institutions.

This suggests the service was lacking technically-competent staff and that these staff were relatively isolated from debates in the wider professional community. Movement of these staff between commerce, or other public sector institutions, may have been limited, particularly for those with specialist qualifications specific to hospital administration.

One also sees a new group, the Association of Hospital Treasurers, beginning to influence the accounting debate, producing a monthly journal and organising conferences. The influence of the Kings Fund declines, after nationalisation, but the

Institute of Hospital Administrators continues as the foremost managerial professional association.

The civil service also begin to use its funding power to introduce a new group to help shape management and accounting reform – academics. The civil service was drawn to the issue of 'management' and they began to use a number of academics to prepare advisory reports, including Rosemary Stewart, Feldstein and Jacques. Interspersed with these studies were a number of enquiries and government reports, such as the Salmon, (Ministry of Health, 1966), Farquharson-Lang (SHSC, 1966) and the Cogwheel Reports (Ministry of Health, 1967) on hospital organisation and management. However Harrison's (1988) retrospective review of hospital management, suggests that in this period, managers were limited to day-to-day problem solving rather than objective setting, and that hospital doctors were largely outside the control of hospital 'managers'.

A number of academics also began to add to the debate on hospital accounting information. Feldstein (1965) appears to have been the first to attempt to quantify the effect of case-mix on hospital costs. This was followed by Babson (1971) and his disease costing exercise, which itself was quickly followed by a Kings Fund Report in 1973, ACCOUNTING FOR HEALTH, with some resemblance to activity based costing. But this debate on patient cost information did not appear to be of primary concern for practitioners within the service. Articles from their journal *HOSPITAL SERVICE FINANCE* suggests they were more focussed on budgetary control information, particularly for functional managers, rather than complex and sophisticated costing data.

Therefore even though a number of studies suggested quite radical changes to accounting information, in the form of patient cost information, in 1974 practitioners and the civil service introduced a budgeting system that was based on hospital functions. This data was only marginally different from departmental budgets proposed by Stone, the Kings Fund and Nuffield Trust more than twenty years earlier.

7.5 Observations and Conventional Wisdoms

Perhaps the most striking observation on the three accounting events was the optimism of accounting reformers prior to the introduction of the accounts, followed by disappointment in practice. This was the case with all three reforms. For example, the main performance measures produced by the uniform accounts, cost-per-bed comparisons was, by 1924, described by Stone as *'largely absurd'* because of the fact that it ignored the complexity of treatments carried out in departments. Similarly departmental costing while trumpeted by a large number of groups, both within and outside the NHS, appears to have been little used and burdensome to produce. Others within the service were often more direct; *'useless and valueless'* figures (Hospital Service Finance, 1961. p.3). Even those broadly supportive of the reforms, such as Montacute [a hospital accountant] and Walker [a Treasury civil servant] suggested that the enormous amount of data produced was under-used, both at local hospital level and for more strategic purposes within the Ministry. This may partly explain, throughout the 1960s, the reluctance to introduce quarterly departmental information or to set hospital budgets/allocations by departments.

Similarly the functional budgeting system introduced in 1974 was quickly criticised [e.g. the 1979 Royal Commission] because these budgets were not allocated to hospital clinicians responsible for making the main decisions on healthcare spending. Indeed the 1983 Griffiths Report was critical of the functional organisation structure itself, recommending instead the introduction of general managers. An early academic paper on NHS management accounting found the adoption of functional budgeting surprising within such a large organisation, and Bourn and Ezzamel (1986), quoting Drucker, argue that:

> *Functional decentralisation is universally applicable to the organisation of management. But it is the second choice for any but the small enterprise.... Federal decentralisation has been widely adopted in manufacturing industry, and increasingly in service industries. It is only now beginning to emerge into the thinking about the hospital service in the form of discussion about the devolution of budgets to clinicians.*
>
> (1986 p.57)

Another observation that appears to be common to all three events is the internal groups' domination of the accounting agenda and, in turn, their care in preventing more radical change. This is evident from the 1893 uniform accounts and the subsequent battle by Burdett, and groups close to him, preventing COS and ICAEW from taking control of the accounting agenda.

Between 1946 and 1956 internal groups, particularly the regional treasurers and civil service, were far more cautious about reform, and limited the influence of outside groups, like the Kings Fund and Nuffield Trust, on accounting reform. It was these Regional Treasurers, the 'practical men' that prevented some form of departmental budgets being introduced, settling instead for annualised departmental costing information. By the early 1970s a number of reports suggested a need for patient cost information but internal groups were content with less radical reform and the introduction of functional budgets.

7.5.1 – Conventional Wisdoms

Secondary research identifies five 'conventional wisdoms' on hospital accounting prior to 1979.

Firstly, that 'New Public Management (NPM) after 1974 introduced a new paradigm to hospital accounting that was substantially different from previous initiatives'. This historical research certainly questions this assumption. In the late 1890s and early 20th Century key hospital reformers, like Burdett and the funding institutions were attempting to gather a set of techniques that would allow them to 'judge' the performance of hospitals. In the early years of the NHS (1948-1954) there is intense interest from a number of groups and institutions in departmental accounting and its use for performance measurement. This is followed in the early 1960s by a renewed effort to increase efficiency within the service by the use of a number of management tools popular at the time: O & M, Work Study and Planning. Certainly during this period practitioners seemed to suggest that this interest in efficiency was an 'obsession'. There is a change in the late 1960s and early 1970s to a more 'steady state' with a limited number of organisational, and managerial, reforms, and this was followed in the late 1970s and 1980s with a

massive increase in initiatives. However comparison with the late 1960s may be historically unrepresentative.

This research project, like that on more recent accounting reforms (see literature survey in Chapter 3), suggests there is a difference between the '*rhetoric*' and '*reality*' (Humphrey *et al.* 1993) of accounting change. All three reforms in this research were promoted as essential tools to measure efficiency, judge managerial performance and to control hospital institutions. The reality of application was that, by the standards of the time, a vast amount of information was produced but senior managers were unsure of its validity or usefulness.

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* (1966. p.52).

The second conventional wisdom, that pre-1979 accounting information was 'primarily concerned with the treasury function', is also an over-simplified summary of previous attempts to introduce 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 attempting to use financial devices to control hospital entities. Indeed the 1893 uniform accounts were, for those most closely associated with hospital organisation and management, primarily promoted as a performance measurement and a resource allocation device. While functional budgeting was an attempt to recognise the new power structures within hospitals, and the increasing dominance of functional managers, although much criticised, it did seek to devolve decision-making to lower levels within the organisational hierarchy.

The third conventional wisdom that the NHS was a 'slow adopter of accounting technologies' is borne out by the evidence, and the gestation periods for accounting reform, particularly after state control in 1948, are long and complex. Obviously change is continuous and it is difficult to identify precise starting points but intense negotiation for the introduction of uniform accounts took place between 1888 and 1893. Whereas demands for departmental information begins in the mid 1920s, is intensified after 1946 but is only introduced in 1956, with a partial victory for accounting reformers like Stone, because departmental budgets are not introduced. Budgeting at local functional level [not quite a department] took another eighteen years and the first reorganisation of 1974.

Interestingly it is possible to see the roots of most subsequent reforms in early periods. For example functional budgeting (1974) can be traced to Stone's paper of 1924. Case-mix costing, introduced in Körner's 1984 specialty cost returns, and refined by current HRG information, can be traced to 1965 and Feldstein's research on the effect of case-mix, Babson's, early 1970s work on disease costing, or the Kings Fund 1973 study on accounting for health.

The fourth contention, that 'accounting technologies were predominately promoted by government initiative rather than practitioners', is partly borne out by evidence after 1948. The uniform accounts were promoted by non-governmental agencies, such as COS/ICAEW, Sunday Fund and the Hospital Association, although the House of Lords enquiry helped mobilise these groups into swift action. But in the two subsequent reforms, assessing the role of the 'hand of government' is more difficult. For departmental accounting it was individuals, groups and institutions, some of which were powerful before the NHS, that were the promoters of departmentalisation.

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 throughout the sixties accounting practitioners appear to have been cautious, conservative, incremental

change reformers, with radical reform, such as cost norms or standards and disease costing, avoided.

The final contention that accounting information systems were 'inadequate for the needs of 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 were more numerous and perhaps more local than those introduced with the development of the District General Hospital.

However in the mid-1960s there appeared to be more and more concern over the independence of clinicians from managerial control. This is evident from the recommendations of the Farquharson-Lang Report (SHSC, 1966) and early attempts to introduce the General Manager concept. But it was in the early 1970s that accounting was first suggested as a tool to challenge clinician power, with Babson (1971) arguing that disease costing would provide a *'standard cost'* and *'provide an incentive for efficiency'* (MH 166/466, report, p.3). The Kings Fund Report ACCOUNTING FOR HEALTH argued that it was time to *'devise management procedures for determining and controlling medical policies without impinging on the clinical freedom of the doctor to treat each patient as he thinks fit'* (Kings Fund, 1973. p.16).

By the early 1970s the large scale District General Hospitals were only just established, and providing clinicians with useful information on clinical data was at a very early stage. Indeed with the gift of retrospection it is easy to suggest that accounting was poorly developed within the service. However given the problems associated with previous reforms, such as departmental costing, the lack of IT systems and the trust accorded to clinicians, it is easy to understand how further investments in accounting technologies were not at the top of policymakers' agendas.

7.6 Future Research

There are a large number of possible contextual factors influencing the three events, some of which are common, and categorizing the contextual of these elements is a

difficult and, inevitably, subjective task. As suggested by Pettigrew (1987) the present author searched for both internal and external contextual factors and aimed to allow the contextual elements to emerge from the evidence examined during the course of the investigation.

However this research has not examined accounting change and implementation at the micro level, in particular, how these accounting reforms affected hospital managers. Although there were attempts to assess departmental accounting by contemporaries, like Montacute (1962) and Walker (1965), they concentrate their research at the policy level rather than at the local hospital level. In this respect a limitation of this research, and other accounting histories, is that the voices of those perhaps most closely affected by the reforms, remain relatively silent. There is some evidence of 'discontent' at the local level drawn from the letter pages of *THE HOSPITAL*, particularly on the introduction of departmental accounting but again this is not comprehensive. There is therefore an opportunity for accounting historians to record the experiences of local managers and workers, which could take the form of oral, or indeed questionnaire research, on events over the last fifty years.

Another possible project could concentrate on archival records of one, or a number of hospitals. This could provide more insight into the implementation, and, indeed, the debates on accounting at the local level. However this is not without its difficulties. Firstly, the availability of records varies enormously and tends to consist of official meetings rather than central internal documentation. Secondly, those hospitals with substantial archives are the larger teaching hospitals, particularly in London, and this, obviously, may bias any results.

7.7 Conclusions

This research project explores the wider forces that *'help shape the different forms that the accounting craft can take'* (Hopwood, 1983. p.289) and also analyses the *'actions and reactions'* of key individuals, groups and institutions (Porter, 1981), in their attempts to respond to these forces and drive accounting change. Using a processual approach to historical investigation the research tracks three accounting changes, identified in the secondary literature as the most significant in UK hospitals

over nearly a century. These were the introduction of the uniform system of accounts, annual departmental costing and functional budgeting.

The period, from 1880-1974, encompasses different forms of funding and governance, both voluntary and state control, but there are a number of common factors driving accounting change. In particular, appeals to measure efficiency and to follow professional norms, or good practice, are common to all three events. It is possible that the exact meanings of these terms are different, or indeed were not used, by those participating across the three events. However these are the elements that the author believes, with the benefit of hindsight, were those driving accounting change and are recognisable to an accounting historians using the lens of the 21st century. While these factors are omnipresent it is other concepts, and forces, that appear to trigger accounting change in the three events, and key players, in the form of individuals, groups and institutions, that 'orchestrate' these.

The creation of the uniform accounts appears to have been initiated by a group, the Charity Organisation Society (COS) whose early motivation was concern about moral behaviour, stemming from the provision of free out-patient care. Their interest in hospitals then extended to corporate governance concerns, and the organisation and management of voluntary hospitals. COS were also successful in mobilising into action other institutions, particularly the Institute of Chartered Accountants in England and Wales (ICAEW) and the House of Lords, thereby raising the profile of hospital accounting reform. Internal players respond to the threat posed by COS by creating their own accounts, and, using economic [Sunday Fund] and professional forces [Hospital Association], are able to pre-empt the House of Lords enquiry. Those forces coupled to a key individual, Burdett, and a dominant group, the Kings Fund, were then successful in promoting the accounts to the vast number of voluntary hospitals.

Departmental costing information was also promoted by a key individual, Stone, who was, subsequently, closely associated with the Kings Fund. A number of groups, centred on the Institute of Hospital Administrators, and Stone, were instrumental in promoting the dormant accounting technology, departmental costing and budgeting,

prior to the start of the NHS in 1948. But the civil service was concerned about the practicality of introducing change and also expressed doubts about commercial parallels. They therefore successfully prevented the introduction of such change at the outset of the service, although there is little doubt that politicians, particularly Bevan, were keen to find an accounting technique that could be used to evaluate hospital performance. When economic forces intervened, in the form of substantial and controversial overspends, led by three groups, the Kings Fund, Nuffield Trust and the Regional Treasurers, departmental costing and budgeting returned to the top of the agenda.

However, echoing the 'battle' over the uniform system of accounts, it was the internal institutions that took control of the reform agenda, and the Regional Treasurers and Civil Service prevented the radical reform of departmental budgets, introducing instead annual departmental costing.

In the late 1950s and early 1960s one sees another efficiency agenda develop and the promotion of management tools, such as O & M, together with the attempted transference of best practice via an Advisory Council on Management Efficiency. It is these tools, rather than accounting technologies, that are now the focus of senior management activity. Departmental costing information begins to be evaluated with most reviews suggesting, at best, disappointment. In the mid 1960s there is much rhetoric, on introducing general managers, by some internal groups and Government Reports, but this was short lived, and, instead, two concepts emerge; functionalism and planning. It is these two new concepts that appear to be fused together in the first major reorganisation of the NHS in 1974, with functional managers taking responsibility for budgetary control, and planning for health care.

Throughout the 1960's hospital treasurers made a number of attempts to introduce cost norms or standards but with little obvious progress. The antecedents of the future development of information for clinical activity are also evident. Babson (1971) and the Kings Fund (1973), both suggest that disease costing or other *'management procedures for determining and controlling medical policies'* (Kings Fund, 1973. p.16) should be developed. However there appeared to be little appetite

for these major reforms at the Ministry of Health, or by local hospital treasurers, with both groups appearing cautious and conservative in their approach to accounting change.

Hospital accounting literature on the period after 1979, and particularly after the introduction of the internal market in 1990, is extensive. But few researchers have explored the historic context to UK hospital accounting and appear largely unaware of the *'ideas, experiments and lessons that constitute our heritage'* (Previts *et al.* 1990. p.3). The objective of this research was the *what, why* and *how* of accounting change, and seeks to help remedy this historical deficit, while challenging some of the conventional wisdoms of post-1979 research. The 'what' was largely gathered from the secondary literature which identified the three accounting events explored in this study. Although this research suggests that the 'temporary' budgetary control device, the AGD 303 was far more important to practitioners within the service than was appreciated by academic accountants.

The *why* and *how* of accounting change was explored using Porter's processual approach to historic investigation and the elements, common and unique to each event, were summarised in Table 7.1. This exploration used a number of sources including, practitioner journals, government publications and records, as well as secondary sources. The research particularly in this final chapter, but also in chapters 4-6, attempted to offer an 'explanation' for these changes, while recognising that this is inevitably a subjective process.

This historical study also set out to engage with more recent debates on accounting in UK hospitals and challenge some *conventional wisdoms* regarding former accounting practices. It finds that using accounting information for performance measurement and resource allocation have a long history, pre-dating New Public Management (NPM) (Hood, 1991;1995) and that current reforms should be seen as a continuum of those preceding them. Other 'lessons' from this study include the similarity of 'rhetoric' accompanying hospital accounting reforms over time. In UK hospitals, accounting is nearly always promoted beyond its capability; this was true of uniformity, the use of cost-per-bed data to 'judge' hospital performance,

departmental costing and functional budgeting to generate efficiency. The unrealistic 'spin' surrounding these reforms quickly resulted in disappointment shortly after introduction.

This research demonstrates the crucial importance of the process of change and the role of individuals, groups and institutions in the 'metamorphosis' (Porter, 1981; 1998) of accounting ideas into subsequent reform. All three events examined suggest that accounting rationality was *not* the key to understanding the accounting technologies eventually introduced, rather the *'actions, reactions and interactions of the various interested parties'* (Pettigrew *et al.* 1992. p.7), over time, substantially affected the outcomes of hospital accounting reform.

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