

SUPPLEMENT

TALKING POINTS

Specialty budgeting in the new district health authorities

M EDWARDS, B G STRUDWICK, M A THOMPSON

A major and growing problem facing the Health Service is the conflict between a limitless and, apparently, insatiable demand for health care and a limited supply. This is so despite the NHS's increasing share of the national budget, and the future will see the Service striving to restrict demand and to meet it at an acceptable cost—acceptable within the considerations of equity and doctors' demands to treat patients as they see best. The *Economist*¹ recently highlighted the steadily growing demand and the growing cost of technology. The Government is anxious over medical costs and sees a pressing need for cost effectiveness. DHSS circular HC(80)8² provides the opportunity for cost saving by better management methods but we do not believe that the restructuring itself is likely to produce much overall cost saving.

NHS reorganisation will mean the transfer of power to new local units and the granting of considerable local autonomy. The strongest influence on the shape of the service has always been the medical profession, and restructuring offers the opportunity for the medical profession to meet, to some extent, the call for cost effectiveness on its own terms rather than entirely at the behest of those holding the purse strings. Doctors must ensure that they agree what local changes they want and that they know how to set about achieving them. The process of clinicians' representation was set out in the report of the Chief Medical Officer's Working Party on Medical Advisory and Representative Machinery.³ The renewed emphasis on resource allocation raises again questions about the adequacy of financial and non-financial information to help decision making.

As each new district health authority (DHA) now has to decide its own management structure there is an immediate opportunity for the development of teams at unit level. The use of specialty divisions and multidisciplinary groups, for example, could lead to the better use of doctors' time. Health circular HC(80)8 and a report prepared by the Association of Health Service Treasurers⁴ have drawn attention to the importance of unit budgets. Better budgeting and costing arrangements are necessary to get decisions down to the lowest level. One possible method is to develop specialty budgeting and specialty costing. The use of clinical teams with specialty budgets could provide a way of balancing clinical freedom and resource control.

Incentives for the medical profession

The DHSS policy document *Care in Action*⁵ highlighted the need for greater efficiency in the NHS. In particular, it drew attention to the need for improved resource management by the clinicians and others who directly or indirectly make resource allocation decisions. The course of events and the train of expense is largely in medical hands. Unfortunately, the present systems of budgeting and accounting in the NHS, especially at the sharp end in the districts, do not give adequate information (and give virtually no incentives) to clinicians to operate efficiently—in the economic rather than the purely clinical sense.

Clinicians should have budgets with built-in incentives to use resources more economically. The present functional budgeting system—for example, nursing, pharmacy, pathology, etc—cannot do this by itself, neither can the present under-developed costing system. This would not mean the loss of clinical freedom, rather it would give clinicians a greater say, backed up with knowledge of financial consequences, on the use of the resources largely under their control.

Lesley Garner has outlined the problem: "A sense of market values, an instinct for business efficiency, a cost-effective approach to his own patients are the last things that the average doctor wants to develop, or that the individual patient wants his doctor to have."⁶ She continues, however, "Our interests as taxpayers and as patients conflict." As taxpayers we should all be for evaluation, rationalisation, and streamlining. As patients, or potential patients, we want the best treatment, with no expense spared. Generally, the doctor still sees himself as the champion of the individual patient but economic pressures may limit the kind of medicine he can afford to practise.

When patients are admitted to hospital they expect to receive the mix of resources, staff, equipment, materials, etc, which will improve their condition. As those resources are, however, limited, choices have to be made. Clinicians, because they authorise the bulk of resource consumption, must work together with other professional groups, including accountants, to assess how best to meet health needs. According to Lesley Garner, the BMA agrees that multidisciplinary health teams are now basic to health care.

A key problem of financial control is that of motivation, specifically how to motivate budget holders to redistribute their budgetary allocations in more optimal combinations of spending and to make savings where it is feasible to do so. Probably this can only be achieved if budget holders are clinical teams and thus "front-line" controllers of resources. Incentives could come through flexible specialty budgets with scope for identifying savings and approving redeployment (virement), of an agreed proportion of proved savings, to alternative purposes as clinicians see fit. A formal incentive system would encourage clinicians to economise in some areas in order to develop others.

School of Accounting and Finance, Preston Polytechnic, Ringway, Preston PR1 2QD

M EDWARDS, BA, IPFA, senior lecturer
B G STRUDWICK, BA, principal lecturer
M A THOMPSON, BSC, MSC, senior lecturer

This point is important and requires detailed research. It is important primarily because of the opening it provides for balancing the clinical freedom and the need to redirect resources to meet changing circumstances. Basic to our view that organisation structure, decision-making processes, and information flow (especially financial information) need to be aligned is that the new authorities will promote sufficient analysis to enable the effect of basic decisions to be assessed.

The district management team can balance administrative, financial, and medical considerations only if it has information relevant to the decisions that must be taken—for example, statistical information, work measurement data, medical data, and financial information, including detailed costs by functions and specialties. In the NHS the patient does not pay directly for the service he or she receives and therefore calculating the cost of treatment may be seen as an academic exercise of little value. This does not apply, however, when the patient has private treatment. When a patient from Scandinavia recently had a heart transplant the cost was calculated at £20 000. This illustrates the fact that when it is necessary—for example, the benefits exceed the costs—the actual cost of providing health care can be calculated—or at least assessed.

A solution?

Specialty costing is important and offers a way forward for the Health Service in the present economic climate. Specialty costing is the procedure for gathering together costs associated with medical specialties, where a specialty is a group of like diseases or treatment types. In systems terms this means analysing further the existing budgets held by heads of services and functions and recompiling the information under medical and surgical specialties. This means tracing costs—directly (by allocation) or indirectly (by apportionment)—to particular activities and to patients, or groups of patients, receiving benefit. Only in this way can the cost of alternative activities be compared.

The detailed questions that specialty costing seeks to answer include the following:

What is the present cost of providing a given service or treatment at its existing level?

What will be the cost of increasing the capacity of a given service by a certain percentage or, alternatively, what increase in that service can be achieved by injecting a given amount of money?

What will be the cost of providing one type of service or treatment instead of another type (at specified levels), and which resources would be varied in input?

What is the cost effectiveness of one treatment as against another?

What is the relationship between the differential in cost and the differential in benefit of alternative approaches?

A recent research programme on financial information has set out in detail the need for costs and the shortcomings of the existing system.⁷ Major work on costing specialties by cost accounting (rather than statistical) methods has been undertaken at Bridgend Hospital,⁸ and results suggest that such an approach may be adopted with benefits and only a small increase in administrative costs. Our own findings are that much of the necessary information is available but is in the wrong form and is largely unused. The detailed costing would not make it any more difficult to account in total for expenditure for allocation and cash limit purposes and the standard accounting system now developed provides a better framework than has previously been available.

Specialty costing—the practical realities

In order to explore the feasibility of altering information and accounting systems in the NHS we undertook a “one-off”

and limited exercise in the Preston District of Lancashire Area Health Authority. The exercise aimed to relate the hospital budget for 1980-1, by direct allocation and apportionment (sharing), to the three supraspecialties of neurology, neurosurgery, and plastic surgery. Our method of research was to analyse the 1980-1 budget for the three hospitals housing specialty beds in order to arrive at the total cost of the specialty.

As a starting point we split the budget headings into three categories according to their ease of traceability to specialties.

DIRECT EXPENSES

These were defined as salaries, wages, materials, and expenses that could be identified with and allocated to specialties. The bulk of these expenses are to be found under direct treatment services and supplies, diagnostic departments, and other medical and paramedical services.

INDIRECT EXPENSES

These were defined as salaries, wages, materials, and expenses that while not directly traceable to a particular specialty could with a minimum of analysis be shared between the specialties. Such expenses include catering costs shared according to the number of meals served; laundry expenses shared on the basis of the number of articles laundered; and domestic and cleaning costs, which can be shared on the basis of floor area occupied by specialty beds.

OVERHEADS

These we defined as expenses which cannot be allocated directly to specialties and for which it was difficult to find a realistic method of sharing the expenses. Such expenses include administration, medical records, miscellaneous expenses, etc. We decided here that inpatient days per specialty was a reasonable if arbitrary method of sharing such costs. From a clinician's viewpoint it is of limited use to share these costs because clinicians have little or no control over the level of such expenses. But from the point of view of putting a case for increased resources for a particular specialty it is important to know the true cost of a specialty.

We then examined each heading in turn and were surprised to find that in many cases it was possible to allocate directly expenditure to the supraspecialties. Obviously, it required much digging for the appropriate information but if Preston DHA is a typical organisation then it would seem that the recording and collating of the information and statistics required to allocate expenses to specialties would not significantly increase the work loads of the clinicians and officers. This is not to underestimate the task, for in some departments it may require additional clerical support.

We do not intend to detail all of our methodology but to illustrate the point that costing of specialties is feasible and could lead to the benefits outlined earlier. For example, nursing staff services, by far the largest item of hospital expenditure, have been charged to the three specialties using ward or department manpower budgets, analysed by staff grade, and a mean gross salary. In addition, allowances have been made in respect of (i) time spent by learner nurses in the classroom; (ii) nursing headquarters—for example, inservice training, occupational health, etc. staffs. While recognising the flaws in this somewhat simplistic approach, we consider that the resulting information gives a reasonably accurate estimate of the costs of the three specialties bearing in mind the small additional extraction costs incurred.

Similar comments apply to the apportionment of the central sterile supplies department (CSSD) expenditure. This was apportioned in two stages:

(1) Labour costs—on the basis of a cost per standard minute for the different types of packs. These calculations were based on the standard minutes of the CSSD bonus scheme.

(2) Material costs—the contents of the packs were costed and these were applied to the number of packs issued to wards, theatres, etc.

Conclusion

Throughout our research we have been aware of the danger of looking at a limited number of specialties—for example, the danger of not recognising the relevance of a particular expenditure head. The benefit of our research, however, is that it has illustrated to us that progress may be made in improving the NHS financial and non-financial information systems. Problems will be encountered. One is the regular compilation of certain statistical information—for example, work measurement, arrangement of sessions, numbers and types of tests, drug issues, etc. This is particularly the case where there are multispecialty wards, theatres, etc. Another problem is promotion of the sense of need for the information in the various departments. This is particularly important if accurate information is to be collected.

The reorganised NHS structure offers an ideal opportunity to improve the information systems so that management has information relevant to decisions and in particular so that

clinicians can redirect resources to meet changing circumstances. Undoubtedly it will be argued that there are more pressing operational and organisational problems to be faced in the DHAs but we would counter that this is shortsighted and in any case is there ever a right time for a change?

References

- 1 Anonymous. Your money or your life. *The Economist* 1980 November 22: 12-14.
- 2 Department of Health and Social Security. *Health Service development: structure and management*. HC(80)8. London: DHSS, 1980.
- 3 Joint Working Group on Medical Advisory and Representative Machinery. *Report on district management arrangements*. London: DHSS, 1981.
- 4 Association of Health Service Treasurers. *Financial arrangements in the restructured National Health Service*. Bristol: South Western RHA, 1981.
- 5 Department of Health and Social Security. *Care in action*. London: HMSO, 1981.
- 6 Garner L. *The NHS—your money or your life*. London: Pelican, 1979.
- 7 West Midlands Regional Health Authority. *NHS financial information project—research programme. Preliminary statement by the Centre of Responsibility*. Birmingham: West Midlands RHA, 1979.
- 8 Magee CC, Osmolski RJ. *A comprehensive system of management information for financial planning, decision making and control in the hospital service*. Technical paper, Royal Commission on the National Health Service, 1978.

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Community physicians and NHS reorganisation in England

D P B MILES

On 1 April 1982 the Health Service in England will be reorganised. Ellis¹ has recently discussed the implications of this for clinicians but not for community physicians, who are once again the only group of the medical profession in career grades whose current jobs will disappear overnight. Naturally, anyone, however able, who has to apply and compete for a new job becomes anxious about it, particularly when as in this case his old post is whisked away from under his feet. Anxieties have not been lessened by the experiences of the many community physicians who went through this traumatic process for the 1974 reorganisation—some had been through it previously with London local government reorganisation—and it is from these experiences that present attitudes to further change have been derived.

In 1974 the rules for competition were tightly controlled nationally and area medical officer (AMO) and regional medical officer (RMO) posts were open to national competition. Thus many able medical officers of health and hospital board medical staff had the difficult choice of where to apply (only five applications were allowed) and where they might stand the best chance of appointment. Inevitably, some doctors failed to achieve the appointment they wanted or even any appointment in the AMO or RMO grades, and so they then joined other aspiring community physicians in a region-by-region competition for specialist in community medicine (SCM) and district community physician (DCP) posts. Many families had to move to other parts of

the country and the appointees had to learn instantly the health profiles of their new authorities. The net results of these changes were a loss of some community physicians by early retirement, the disaffection of others by changes forced on them, and the time lost to new authorities by the need to learn about the new areas. It is not always recognised by those outside the specialty how important continuity is to the practice of community medicine in order to know the history of local services and their potential for change. One benefit of the reorganisation rules in 1974 was the infusion of some younger doctors into career grade posts at an earlier stage than would have occurred in the old services.

Avoiding previous traumas

The aim of community physicians for 1982 has been to avoid the traumas of the past and to try wherever possible to arrange for minimum turbulence with the hope that most doctors in the specialty will be working in the same community before and after 1982. But despite earlier hopes it has not been possible to negotiate separate reorganisation terms for community physicians and they will be bound—as are all other Health Service workers—by the final offers of the management side^{2 3} on protection, staffing, appeals, and compensation. For protection and compensation the terms offered are less satisfactory than in 1974, but the proposals for staffing do go some way to achieving the aims for minimum turbulence in the profession. But the management-side proposals give only a broad outline of rules for change; a lot will depend on how each regional health authority interprets these in its negotiations with regional staff side groups. What is clear is that competition in the initial round of job filling—the district medical officer (DMO) posts—will be

Aylesbury and Milton Keynes Health District, Milton Keynes Hospital, Eaglestone, Milton Keynes, Bucks

D P B MILES, MB, MFCM, district community physician