Perspectives in NHS Management

Clinical budgeting and costing—friend or foe?

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Orwellian analogies are being rather overdone this year. Even so, the arrival of 1984 after Information Technology Year and the revolution in microcomputers coupled with a government wedded to cash limits provides an environment with more than a hint of Orwell's nightmare in which the medical profession needs to judge the role of budgeting and costing. Of all the changes facing the National Health Service, however, it is perhaps the present government's psychology that is the most crucial variable. How far is it prepared to apply its industrial and commercial analogy to the running of the NHS? The answer to that question will determine the role of the clinician in management and his attitude to budgeting and costing in the coming years.

A pattern seems to be emerging. Firstly, there was the 1982 reorganisation of the NHS, which removed an administrative tier—area health authorities—and increased the emphasis on management responsibility at unit level. Then came the introduction of accountability exercises, regional and district reviews, and performance indicators, and finally the Griffiths inquiry into management, which proposed the appointment of general managers.¹ All three set or alter psychological boundaries in the NHS—that accountability for the use of resources is acceptable and should be widely practised, that performance can be measured and compared, and that better managerial decisions are required.

All three concepts reflect an ideology based on the line management theory of commerce and industry, with general managers providing the impetus to managing the system. Managerial methods in commerce and industry generally rely on line management, with specific and reducing accountability from top to bottom for deciding on the allocation of resources. The board of directors has overall control of the business, looking at overall strategy including hiring and firing general or divisional managers. The general or divisional manager in turn controls the unit managers subordinate to him and sets each unit's objectives and targets. The unit manager is then responsible for the day to day running of the business and short term production decisions. Within the unit the supervisor supervises the foreman, who oversees the workers at the end of the assembly line where the final product emerges. A hierarchy of control is practised.

To see the present political philosophy on how NHS management should be organised, simply insert Department of Health and Social Security, region, district, and unit, with general managers where appropriate. The health service, however, fits uneasily into a simple line management system when we look at the structure from the perspective of allocating resources. The NHS might follow the pattern from parliament and the DHSS through regions and districts to unit level in that they make decisions on setting overall priorities and major capital investment schemes. Once "production" levels—the hospital—

are reached, however, the line management analogue becomes confused. Admittedly, at hospital level the NHS may soon have the unit team or the hospital general manager who will be responsible for the day to day running of the hospital. Moreover, there are already supervisors and foremen in the service departments to ensure the efficient running of departments like catering, laundries, portering, etc. But these are merely support activities to the hospital's main activity—the care of patients.

This is where any NHS line management system (and therefore the theory) runs into trouble, because those on the shop floor who commit resources and make decisions on their use are the *major* determinants in the system and not the minor ones envisaged in a traditional line management structure. They are the clinicians, who determine the levels of production (the number of patients), what is produced (the types of patients given care and treatment), and how it is produced (the methods of treatment and care given). These are not decisions normally taken by those at the "end of the line." Not only do clinicians not fit into the mould of line management but their non-conformity is buttressed by arguments about clinical freedom, which turn the concept of line management on its head.

Will clinicians fit into line management?

Can line management, which underpins Griffiths and the government's cost efficiency approach, be made to work in practice by "fitting" clinicians into the system? The Griffiths inquiry makes a play for budgets for clinicians "to involve [them] more closely in the management process, consistent with clinical freedom. Clinicians must participate fully in decisions about priorities in the use of resources." The idea of budgets for clinicians and of bringing them more closely into the management process is not new. Even so, bringing both concepts together under a "general manager" umbrella might well make clinicians worry as to their use and question whether they are the "trojan horse" to their autonomy. Certainly, this may be a danger if the system is misused. It would be unfortunate, however, if clinical budgets and, indeed, costing procedures were regarded purely as an administrative or a general manager's tool. There are other more laudable purposes.

There is little point in debating yet what should be included in budgets or how costs are calculated, though both will be seen to be complex and difficult questions once implementation begins. The general principle rather than the mechanics is at stake. Indeed, even the principle might not be worth arguing about if we had more than enough resources to meet the health needs of the country, but this is patently not true and any reader who believes otherwise will gain little from reading further. But if it is accepted that there are insufficient resources in the health service to meet all health care needs—and that there are unlikely to be in the near or foreseeable future—then the definition of clinical freedom must be a qualified one. It might still be regarded as the right to treat patients as the clinician wishes, but treatment is surely constrained by the availability of resources? There are already severe constraints on the clinician's

clinical freedom, as Professor J R Hampton eloquently warned in a *BMJ* leading article last year.² There is a limit to the number of patients the clinician can admit, to the diagnostic tests he can give, and to theatre time available. The question is whether clinical costing and budgeting would provide further constraints or simply clarify the existing position and enable the clinician to provide a better service.

Let me make an analogy with nuclear power. Nuclear power as a source of energy and as an alternative to using up rapidly disappearing natural resources might be of great benefit to society, but its misuse to create nuclear weapons arguably not. Budgets too can be good or bad depending on their use and the users. The definition of a budget varies: Collin's *Concise English Dictionary* defines it simply as "a collection of items," whereas Kohler's *A Dictionary for Accountants* sees it as "any financial plan serving as an estimate of and a control over future operations." A "collection of items" budget might simply be information on the activities of a clinical unit. If the information is relevant it should allow the head of the unit to identify readily where and how his resources are being used and should help him make better decisions to the benefit of patients and society in terms of improved care, as well as reducing the risk of a wasteful use of scarce resources. Moving more towards the accountants' definition is carrying out this procedure within an environment offering positive incentives and disincentives for better use of resources, but it also carries dangers of performance monitoring and control by people not best qualified to do so.

Information: neither friend nor foe

Information is neither friend nor foe, nor does it solve any problem; rather it should give the user the ability to assess, analyse, and make an informed decision. The information is not master, nor can it monitor, control, or alter anything, it is merely an aid. So far clinicians have, by and large, reacted against ideas of costing and budgets. Perhaps this is simply because these have been proposed by administrators and treasurers and the information produced or planned, reflecting this source, is biased towards the accountants' definition of budgets for use by administrators. Clinicians fear the potential misuse of this information. Two quotations epitomise the present position and the different psychologies: the first comes from an economist in the NHS concerned with constructing clinical budgets, the second from a consultant physician (see box).

The two quotations speak for themselves: the one approaches the problem of efficiency from the viewpoint that costing information and budgets are required for directing, planning, and managing the service and the other from the viewpoint that good patient care gets there in the end. Each has merit but tends either to ignore the other's view or to emphasise different parts of the same equation. Dr Young is correct, in that doctors' actions cannot at present be dictated by the management structure. That is the message from the line management analysis in the first part of this paper, and of course Dr Young is correct in saying that wasteful medical care is expensive and potentially dangerous. Nevertheless, and perhaps unfortunately, there are wider choices facing the clinician and the health service than simply the choice of treatment. Because of the scarcity of resources at our disposal there is an inevitable balance to be struck between the amount of resources we commit to one set of needs as opposed to another—for instance, more for general surgery implies less for mental illness. The amounts of time, effort, and money invested in programmes of transplantation and high technology medicine are set against how much is needed to reduce waiting lists. In this last case the former gives great benefit to a small number of people and the latter a relatively small benefit to a large number of people.

There is the conflict between us as patients, when we want the best care possible, and as taxpayers, when we are reluctant

"Budgets imply accountability, direction, and planning. Costing implies a statement about a given situation although the resulting information may be subsequently used for planning" (personal communication).

"... direction is not a feasible method; doctors practise as individuals and their actions cannot be dictated by any management structure. ... Efficient use of resources and good patient care are the same thing. Wasteful medical care is not only expensive but potentially harmful to the patient" (D W Young³).

to pay the bill for the care and demand that our health service resources be used efficiently and effectively.

The government's philosophy is that a system of general managers coupled with management budgets will achieve greater efficiency. To assess this belief we need to examine the roles of the players as well as the issues. Most importantly, will clinical budgeting necessarily compromise clinical freedom to any greater extent than the existing system? The answer must be no if it simply replaces the existing implied system of allocating resources with an explicit one. As to the role of the players, though I agree with Dr Young that the doctor should not be dictated to by management there is a difference between direction and dictation. The authority already directs the resources and their amounts to the clinician and the clinician dictates their use. Neither of these functions should change.

At present, however, clinicians make decisions in an implicit manner with little or no explicit consideration of how the resources have been used or might otherwise have been used. The resource consequences of decisions are largely unknown and little considered, and this is wrong when the resources in question are publicly funded through taxation. Even so, the explicit consideration of resource use needs to be put into context. The object of the exercise must not be to face the doctor with the query "can I afford to do this test, given my budget?" The resource consequences of treatment for a patient should not be made once the patient is admitted. Provided that there is medical justification for its use it should be done. But by giving the head of the unit the ability readily and routinely to assess past care this might lead to a reduction of what Dr Young calls wasteful medical care and also to a more efficient use of resources. At one level the head of the unit should have the ability to check the care and treatment given to patients within his unit and at another to "manage" and plan the use of the resources available to him to derive maximum benefit not only for the patients he admits but also for those waiting to be admitted. A budget of this sort—the stock of items idea—should lead to improvement of the authority's function of direction and the clinician's of patient management (if only by stopping uninformed criticism) through the existence of an information system (or systems) showing patient activity and relative costs (resource inputs).

The work of both would be greatly enhanced if administrators and clinicians could indulge in informed argument instead of, as now tends to happen, uninformed "slanging" matches. Setting up systems of information centred around a consultant's activity therefore should be beneficial to the health service. But a move towards the accountant's "budget" with all that that entails is less likely to be the case, and in truth is even less likely to be successfully implemented. A precondition for any system is that clinicians and especially heads of units have a substantial influence on decisions at an early stage—that they help to decide exactly what information is required for them to assess their present levels of activity and the possible implication of any changes that they might want in their unit rather than having a system chosen for them by general management for general management.

Collaboration between FPCs and DHAs

If the Health and Social Security Bill is enacted (it has just completed its passage through the House of Commons) ministers will be appointing family practitioner committees and will expect them to fulfil at least three important objectives:

- They must develop positive policies for the promotion of the family doctor, pharmaceutical dispensing, dental, and optical services in their locality.
- They must be properly accountable to ministers, parliament, and the general public for those policies and the way that they carry them out.
- They must collaborate closely with district health authorities who are responsible for the hospital and community services, so that the planning and financing of the National Health Service can be considered as a whole.

Mr Kenneth Clarke, Minister for Health, spelt out these objectives when he announced the publication of a report of a joint working group on arrangements for future collaboration between district health authorities and family practitioner committees. Mr Clarke said: "This [report], and other reports and guidance which will be coming out over the next few months, will provide a basis for a wide discussion with the public and the professions about how the committees should carry out their exciting new role in helping to deliver primary health care to patients in the most effective way.

"The group suggests ways in which the policies of the family practitioner committees ought to be presented to the outside world. It suggests an annual programme and a profile and strategy statement every five years. I am attracted by the idea of these policy statements and I also intend to issue, later this year, guidance on the form in which information should be submitted to our Department as part of the process of holding committees to account. We need some standardisation in the way in which these policies and information are presented, in order to enable valid comparisons to be made, and also some flexibility to meet

local needs. The model profile and strategy statement and the outline programme in the group's report are offered as a basis for development to meet local and national needs.

"The report also considers how collaboration between authorities can be promoted, how it should work, what it should cover, and how it should apply to planning. We realise that it may not be possible to redeploy to do everything recommended in the report much in advance of the introduction of computers. However, we are giving very high priority to the computerisation of the work of family practitioner committees and a great deal could be achieved in the very near future.

"The most important message of the report is that the new family practitioner committees should broaden and develop their experience and technical capacity in order to make a stronger contribution to the planning of health services. District health authorities will have to ensure that their plans really do encompass health services as a whole and not just those under their immediate control. Both sets of bodies will be expected to produce and follow plans and policies, which put the interests of patients as consumers above others when they choose priorities."

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Doctors must demand information

The managerial structure and psychology are changing. The medical profession must not be left behind in a defensive position but should be positively attacking management to provide them—the real patient managers—with information to allow *them* to run their own units efficiently and effectively in terms of *both* their use of resources and their clinical outcomes. The accountants' definition of a budget is insufficient.

to administrators, treasurers, and politicians. They will search for the efficient use of inputs into the health service, but who will balance the equation by assessing the quality of outcomes? Both need to be performed together, and at present clinicians, who are best qualified to do so, are allowing themselves to be led rather than leading.

As to the question of friend or foe posed in the title of this article, it is not easily answered and indeed might be unanswerable. Knowledge of the pros and cons, however, might

Friend	Foe
<ul style="list-style-type: none">● More informed decision making.● Less wasted resources; inefficient use denies other patients care.● Greater control over own resources.● Better patient management.	<ul style="list-style-type: none">● Misuse of information and system by administration and finance.● Possible lack of flexibility; of give and take when necessary.● Highlighting problems, which are at present conveniently ignored.● Overemphasis on input side to detriment of quality of outputs.

Data of use to clinicians need to be patient based since this is their focus of management. To my knowledge the information systems being set up for management budgets are of particular interest and use to managers of the "general manager" ilk for monitoring and control but of limited value to the clinician in his search for better patient care and management of his unit. The revolution in microcomputers is already making the collection of patient related resource information a reality. This should be encouraged. In a research project at Hope Hospital, Salford Health Authority is already producing patient related cost data for a surgical gastroenterology unit. So it is a practical proposition. Moreover, it was instigated and guided by the consultant, not by the administration. Clinicians should be pressing for greater responsibility and say on how their units and patients are managed, not abdicating the search for efficiency

help future development and the forewarning of problems, and allay them. But the essential difference between the two is their early anticipation and the active participation of the clinicians (see box).

References

¹ NHS Management Inquiry. *Report*. London: HMSO, 1983. (Griffiths report.)
² Hampton JR. The end of clinical freedom. *Br Med J* 1983;**287**:1237.
³ Young DW. Costs and clinical decisions. *J R Coll Physicians Lond* 1983; **17**:86-7.

This is the fourth in a series of articles on NHS management and administration, which started on 28 April.