Management budgets in the NHS

PHILIP DAVIES, MALCOLM PROWLE

The Griffiths report on the management of the National Health Service, published in 1983, has been intensively discussed within the health service. One of the main recommendations of the report was that systems of management budgeting should be introduced at unit level. To this end the Griffiths team initiated work to introduce systems of management budgeting in the acute units of four pilot health authorities. As management consultants to two of those authorities we were concerned in developing and implementing these systems in acute units at Basingstoke and Ealing.

In this article we have outlined what management budgeting is and how it differs from traditional budgetary control systems in health authorities; considered what it aims to achieve; and discussed the participation of clinicians in the management budgeting process and its likely impact on their methods of working.

Traditional budgetary control systems

Traditional budgetary control systems are based primarily on a structure of what are normally termed functional or departmental budgets. In this structure budgets are held by those people responsible for providing a service.

Examples of functional budget holders are the heads of nursing, pathology, radiology, physiotherapy, pharmacy, catering, cleaning, portering, maintenance, and administration.

There is normally no participation of clinical staff in this budgetary control structure other than the possibility that the budget holders for pathology and radiology might be the consultants in charge. This seems strange given the considerable influence that clinicians have over the use of hospital resources.

Several major deficiencies in this traditional form of budgetary control can be identified, and management budgeting aims to overcome these deficiencies.

RESPONSIBILITY

In any system of budgetary control a key principle is that individual budget holders should be held responsible only for those items of expenditure over which they can exert control. In health authorities this principle does not always apply. An extreme example of this concerns the pharmacy budget, where the pharmacist is often held responsible for drugs expenditure even though he has no direct control over the level of spending.

SETTING OF BUDGETS

Budgets in health authorities may be described as incrementally based. This means that a department's budget for a particular year is based primarily on the amount of money that it received in the previous year plus an adjustment for inflation. The result of this approach is that a department's budget,

being historically based, may not adequately reflect changes in the volume of work that it undertakes. In addition, this approach to budget setting may lead to difficulties when resources need to be shifted between budgets in response to changes in practice.

INFORMATION

It will be of no surprise to clinicians that the range and accuracy of information in the National Health Service is inadequate for many managerial purposes. This is especially so in respect of budgetary control and the feedback of information to budget holders.

LACK OF INCENTIVE

Perhaps the commonest complaint from budget holders is that any savings that they might achieve by good management tend to be lost. Such savings might be swallowed up by more profligate colleagues or taken by the district for use elsewhere. Clearly such an approach does not encourage good management.

Principles of management budgeting

There is no single system of management budgeting that is suitable for "off the shelf" implementation in any hospital. The precise approach to be used needs to be specifically defined after a survey of activities and practices in each individual case. There are certain general principles of management budgeting, however, which apply in all cases.

UNIT BASED DECISION MAKING

An underlying principle of management budgeting is that the responsibility for day to day management and decision making should rest with the unit management team. Clearly, district management teams would still retain overall responsibility for strategic and operational planning matters and for monitoring the performance of units. Once an overall budget for a unit has been set, however, the unit management team should be given wide discretionary powers about the use of resources within that budget. In saying this we are simply reinforcing the principles of unit management laid down at the time of the 1982 reorganisation.

REVISED BUDGET STRUCTURE AND RESPONSIBILITIES

A new structure of budget holders is required, based on the following four classes:

- (i) Support service budget holders. These are the managers of departments such as catering, cleaning, and laundry.
- (ii) Facility budget holders. These are the nurse managers in charge of locations such as wards, theatres, and clinics where patients receive treatment or care.
- (iii) Diagnostic and treatment budget holders. These are the managers responsible for the budgets of the various diagnostic and treatment departments in the hospital. Examples of such budgets would be radiology, haematology, physiotherapy. In the case of radiology and pathology departments the budget holder would normally be a consultant in the department.
- (iv) Consultant budget holders. The fourth type of budget

Coopers and Lybrand Associates Limited, London EC4A 4AQ

PHILIP DAVIES, MSC, management consultant

MALCOLM PROWLE, BSC, MA, management consultant

Correspondence to: Mr P Davies, Coopers and Lybrand Associates Limited, Fleetway House, 25 Farringdon Street, London EC4A 4AQ.

holder is the hospital consultant. Budgets could be set for individual consultants or for a group of consultants working as a specialty team.

Bearing in mind the above comments about responsibility, the next step is to assign responsibility for items of expenditure to those persons able to exert control over them. Thus, for example, responsibility for drugs expenditure would rest with consultants while nurse managers would be responsible for the use of sterile packs.

RECHARGING

A hospital is a complex organisation and within it services may be provided by one department for many others. Domestic and cleaning services, for example, are supplied to all areas of the hospital, and all users of those areas thus benefit from those services. Indeed, whichever service we consider, it could be argued that it is provided directly or indirectly to support clinicians in their work of treating patients.

A key principle of management budgets is that all users of services should be informed of their costs. This is achieved by means of recharges made between those budget holders who supply services and those who use them. Considering domestic and cleaning services again, this would entail a recharge between that department's budget and those of other departments and facilities in the hospital. Cleaning costs would then appear on budget reports.

In the case of, say, pathology services, consultant budget holders would be charged according to the number and type of tests that they request. Such recharges would be based on an agreed price list for tests rather than the actual cost of performing each individual one. This would have the effect of protecting the consultants who use pathology services from bearing the costs of any inefficiencies in the laboratories.

BUDGET REPORTS

Each month all budget holders would receive accurate information about the expenditure that they have incurred. This would include details of the costs recharged from other departments. An example of a possible format for such a report for general medicine is shown in table I.

We do not, however, believe that it is sufficient to give information on expenditure alone because to interpret this information budget holders need information on the amount of work that they have done for the money spent. Additional reports should therefore be provided covering workload,

TABLE II—Example of a possible monthly report to a specialty (general surgery) giving details of clinical activity, manpower, and unit costs*

	Estimate	Actual	Variance
Clinical activity:			
Discharges and deaths	180	140	-40
Average length of stay (days)	7.2	9.3	2.1
New outpatient attendances	70	50	-20
Total outpatient attendances	240	210	-30
Day cases	30	210	180
Theatre hours	48	43	-5
Intensive therapy unit inpatient days			
Total pathology requests	300	260	-40
Total radiology requests	120	120	0
Bed occupancy (%)	65	84	19
Manpower (whole time equivalents):			
Consultant	4.2	3.5	-0.7
Registrar	1.0	1.0	0
Senior house officer	1.0	1.0	0
House officer	1.5	2.0	0.5
Total	7.7	7.5	-0.2
Unit costs (£):			
Per inpatient case	760	720	-40
Per inpatient day	85	80	-5
Per outpatient attendance	30	35	5

*All figures are fictitious and do not relate to real data.

manpower used, and unit costs. An example of such a report, in this case for general surgery, is shown in table II.

SETTING BUDGETS

It is beyond the scope of this article to describe in detail the revised procedures for setting budgets that would apply in a system of management budgeting. Two features of importance should, however, be noted.

The first is that all budget holders, including clinicians, would be invited to discuss possible changes in their budgets. Such discussions would consider options for service developments if additional resources became available and options for retrenchment should this become necessary as a consequence of reductions in resources. Also included would be an assessment of alternative ways of using existing resources to achieve greater efficiency. These reallocations might be made within a specific budget or might mean the movement of resources from one budget to another.

Linked to these discussions would be several financial incentives intended to encourage good budgetary control. Typically, these would permit budget holders to retain a proportion of any planned underspendings to use in improving the services that they provide.

Objectives of management budgeting

The NHS as a whole is constrained to operate with finite resources. Furthermore, each individual district, as a consequence of the cash limit system, has a fixed sum of money available to it each year for the provision of services. These financial facts of life must be recognised by all those who use the service or work in it. From the point of view of the district they lead to two apparently contradictory obligations—namely, to provide the pattern of services that best meets the changing needs of the community as a whole; and to do so within a fixed financial allocation.

The provision of services that meet the needs of the community requires constant appraisal of the way that resources are used. This may indicate that growth in a certain area of activity is required. Cash limits, however, imply that growth in one area can only be achieved either through contraction in another or by an overall improvement in efficiency. Management budgeting provides the means to examine and tackle these issues and thus can help to reconcile the conflicting demands that confront districts.

Budget holders and unit management teams are encouraged,

TABLE I—Example of a possible monthly budget report provided to a specialty team (general medicine)*

	Budget (£)	Actual (£)	Variance (£)
Direct costs:			
Medical staff	6000	5350	-650
Medical expenses	100	0	-100
Drugs—via wards	460	200	-260
Drugs—dispensed	30	300	270
Patient appliances	700	100	-600
Medical and surgical equipment	1200	1300	100
Pathology consumables	350	300	-50
Facility consumables	820	1230	410
Radiology consumables	470	390	-80
Total	10 130	9 170	-960
Non-direct costs:			
Wards	8850	12780	3 930
Theatres			
Outpatient clinics	1870	1810	-60
Day case unit			
Intensive therapy unit			
Pathology	1800	1540	-260
Radiology	1650	1370	-280
Pharmacy	270	260	-10
Paramedical	700	1370	670
Total	15 140	19 130	3 990
Total costs	25 270	28 300	3 030

*All figures in this report are fictitious and are not intended to relate to real expenditure data.

continued on page 1554

Curbing "large discounts" on drugs

The Minister for Health has announced modifications to the arrangements for reimbursing pharmacists for drug costs incurred in dispensing National Health Service prescriptions. In a parliamentary answer on 13 November Mr Kenneth Clarke said:

"The present contract between the government and retail pharmacists is based on the reimbursement to the pharmacist of the actual cost of the drugs he dispenses. However, for some time now pharmacists have been able to obtain large discounts when they purchase drugs from wholesalers and this enables some pharmacists to make unintended profits, over and above the negotiated profits in the contract, when we reimburse them at manufacturers' list prices. We attempt to deal with this by withholding some of the reimbursement by an amount representing the usual discount which the pharmacist ought to be able to obtain. We assess the usual level of discount prevailing by holding periodic inquiries. This covers the practice of most pharmacies in a fair way. However, some are now obtaining exceptionally high discounts on some drugs and making large unintended profits when they are reimbursed by the NHS for their NHS prescriptions.

"Last May I announced new safety controls on imported drugs and referred to these difficulties. I said then that we were considering with everyone concerned how we

could modify the reimbursement system to make the arrangements fairer for the taxpayer, the pharmacists, and the pharmaceutical industry. We have now decided to introduce new arrangements setting the amount withheld for deemed discounts at two levels, depending on whether drugs used in a prescription were obtained at ordinary or exceptionally high level.

The Minister for Health, Mr Kenneth Clarke.

"In dealing with this new situation I want to continue to encourage the system to maintain a reasonable level of discounts generally, without allowing those pharmacists who are able to obtain some drugs at very advantageous prices to make very large unintended profits on a limited range of their supplies.

"The round of consultations is now being completed and I propose to introduce the following modifications to apply to NHS prescriptions dispensed in England and Wales on and after 1 January 1985. The existing reimbursement arrangements will continue, but in addition the pharmacist will be required to endorse those prescriptions for which he has used a drug obtained, from whatever source, at a discount of more than 12%. When those prescriptions are priced a single average rate of discount, 20% of the current drug tariff price, will be applied to them, and reimbursement will therefore be at 80% of the drug tariff. These arrangements will apply to all discounts, including extended credit, free goods, and discounts for cash. I intend to keep this situation under very close review and the rates of threshold and single discount to be introduced initially may be changed, as necessary, in the light of information available on discounts generally. Full details of the revised arrangements will be promulgated to pharmacists, family practitioner committees, and the pricing authorities as soon as possible."

Advertising locum vacancies

Each week the classified advertisements carried by the *BMJ* are put on Prestel. A new facility has recently been introduced enabling health authorities to advertise locum vacancies within 24 hours of receipt of the advertisement. These will be put on a separate Prestel page for ease of access and will give minimal details of the specialty, the hospital, and the authority to be contacted.

Management budgets in the NHS—continued from page 1153

during the budget setting process, to examine alternative ways of providing services and to formulate plans accordingly. Routine feedback of budgetary information should ensure that these plans are actually put into effect. The inclusion in the reports of both financial and activity data should also aid the monitoring of efficiency.

No organisation as complex as a health authority can be certain that it is making the best use of resources. Planning and control mechanisms such as management budgeting can, however, go a considerable way towards reducing this uncertainty.

Management budgeting: its impact on clinicians

How is management budgeting likely to affect the work of clinicians, and what will it require from them?

It is sometimes suggested that management budgeting will interfere with clinical freedom. This is not the case. Clinical freedom implies that the clinician has the right to treat each individual patient as he or she thinks best, and no management system could or would jeopardise this right. Clinical freedom does not, however, bring with it the right to spend money at will; to do so would prejudice the overall level and quality of services provided.

Management budgeting is concerned with decisions that relate not to the treatment of the individual patient but rather

to the effective allocation and use of resources, such as beds, clinics, and theatres.

Clinicians often point out that their main task is to treat patients. Though this assertion is correct, it is also incomplete. The clinician's task is to treat patients *within the constraint of the resources available*. As has already been pointed out, the resources of the health authority are fixed and if one clinician overspends on his budget the net effect must be that another will have to underspend. Hence it is necessary and desirable that clinicians devote a minimum amount of time each month to the management of their budgets. In practice the amount of time required is unlikely to exceed an hour each month with some additional effort for budget setting. Support provided by able management accountancy staff should ease the burden at all stages.

Clinicians have, quite rightly, criticised the range and quality of information available to them. The development of management budgeting has put great emphasis on the need to improve information systems. Such improvements, however, cost money, and hence it is important that this information is put to best use. We are often asked by clinicians about the savings that such systems will achieve. This misses the point. The systems produce information that will help clinicians and other budget holders to identify savings in their own budgets and use part of those savings in a manner that improves the service that they provide. It will doubtless take time for the full potential of the system to be realised, but from the outset there will be opportunities for beneficial change.