

Introduction

As the management accountant of a local NHS hospital this report has been written for the senior management to help identify, explore and analyse some of the issues raised by Gordon Brown in comments surrounding 'poor management' within the NHS. These comments were made in response to the varying range of costs involved in various procedures within the NHS.

This report will begin by analysing the costing methods employed and giving a breakdown of the method. Costing is vital to the success of any organisation and the NHS is no exception. Costing allows us to budget, compare and contrast which allow us to benchmark and measure efficiency. The report will then move on to tackle possible causes for the variation in costs and finally look to offer some possible improvements based on the report's findings.

Terms of Reference

Below are some terms that will appear throughout the report:

Direct costs – These are in relation to any cost that has a direct link with a procedure e.g. a specific piece of equipment, direct labour (heart surgeon, neurological surgeon) etc.

Indirect costs – These are costs which cannot be directly assigned to one procedure e.g. indirect labour (nurses, admin staff etc.), Utility bills (Heating, electric, water), maintenance etc.

Cost drivers- The activity that drives the cost to be incurred.

Costing in the NHS

“Healthcare systems face pressures to deliver cost efficient care in the face of escalating demands” (Lapsley, Irvine 2005)

It is important, before trying to explain the possible reasons for the varying costs within procedures that we understand what costing methods are being employed by the NHS. The NHS faces increasing scrutiny and pressure from the media, government and stakeholders in regards to its financial and efficiency levels, across the organisation. In the past ABC was only found in the private sector however, the increased spotlight from the government, media and general public has meant the public sector being viewed in a more ‘business like’ manner, hence the promotion of ABC into NHS.

The traditional costing method was seen as inefficient with particular scrutiny placed on proportioning indirect costs efficiently. Activity-based costing was first conceptualized by the academics Kaplan & Burns in the late 80’s and they described ABC as a method in which indirect costs could be more accurately reported when dealing with a range of products or service.

Within each individual hospital in the NHS there is a wide and varied range of procedures being carried out. To use a traditional costing method would see the emergence of some of the problem previously listed i.e. disproportionate allocation of indirect costs. Issues occur within the traditional costing method when dealing with a wide range of activities as volume is used as the only cost driver. A traditional approach to costing would simply divide the indirect costs by how many procedures have been performed. Below is a simple example which shows the traditional costing method and a brief explanation of ABC.

Procedure	Number of patients	Direct Cost of Procedure
Fractured arm	80	£120
Heart Surgery	15	£2,500

Appendix	5	£1,500
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Indirect Costs (overheads) = £100,000

Traditional costing works on the basis that overheads are worked out as a proportion of volume of activities e.g. Total procedures = 100, Fractured arm = 80% of overheads

However, ABC costing works on a cause and effect basis, recognising that volume is often not the only cost driver. For example ABC takes into account the time the patient spent in hospital (drain on Utilities), the drugs they required (painkillers, anaesthetics), bed rental (ward space required, laundry, cleaning staff), administration (legal work etc.) and diagnosis and assessment. By recognising these cost drivers, a more specific picture can be built up of actual costing figures.

The two hypothetical costing profiles for indirect costs are shown below

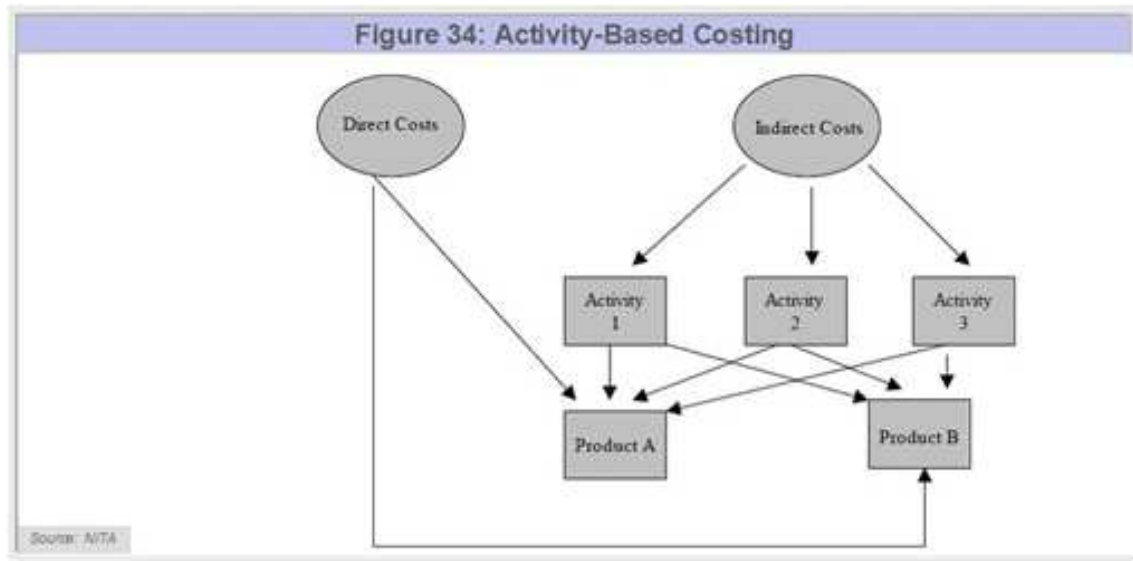
Procedure	Traditional Costing	ABC
Fractured arm	£80,000	£25,000
Heart Surgery	£15,000	£65,000
Appendix	£5,000	£15,000

This leaves us with the following results (after direct costs have been added)

Procedure	Traditional Costing	ABC
Fractured arm	89,600	£49,600
Heart Surgery	52,500	£87,500
Appendix	12,500	£17,500

The table above shows us two drastically different results. ABC helps us recognise that although the 'fractured arm' procedure incurred the greatest volume, the other two procedures were a greater drain on costs. This highlights the inaccuracies that can occur due to the simple nature of the traditional costing method and even in this basic example, the strength of ABC is shown, when there are a variety of procedures in place. ABC costing works by identifying how resources are being used (staff time, work space, equipment hours etc.) and allocates them directly to the activity that uses them.

The discussion so far has provided a broad outline of ABC however; the following diagram gives us a more insightful indication of how the process works



(Miedema, 2010, 6.7)

In the first stage, costs are allocated to activities or cost centres this is known as a resource driver e.g. the wage of a hospital cleaner could be allocated to the activity pool of cleaning or, the equipment cost of an x-ray machine to the activity pool of X-Rays. The second stage is where the activities are related to the product or service, known as the 'cost driver' e.g. the fractured arm requires the X-Ray activity pool and so costs could be proportioned according to usage (using the cost driver ratio). The direct cost is then added to achieve the total cost for an activity or service.

ABC helps managers control indirect costs and monitor efficiency of services and activities therefore; it is a very useful instrument. However, ABC has a number of limitations or disadvantages.

The first of these is that an ABC is extremely costly to implement and maintain. According to Meyer and Rowan (1977, pp. 91) efficiency and institutional pressures contradict one another and these pressures have a negative influence on the institutions. This is in reference to the drive for ABC from senior stakeholders (government, senior management etc.) to promote efficiency although, the process of ABC itself could be classed as inefficient in terms of cost and time, its real advantage however, it makes managers aware of the drivers that force costs to be incurred.

Secondly ABC still relies on judgement and interpretation. This is in terms of drawing information from the presented data and determining the value of the cost drivers. As it is impossible to create recognised standards for each procedure, there will always be contentious points when using this method.

Finally ABC does not offer a complete solution to all costing issues, some costs simply cannot be categorized and so fall into the 'business sustaining' category. This

category's costs have to be fulfilled by contributions from all procedures e.g. the chief executive of a hospital has a salary which cannot be categorized into any specific activity.

Variation in Costs

Now we have explored ABC we have an understanding of how the NHS formulates its costs. This gives us the platform to further explore some of the variances between the hospitals within the NHS.

It is important to understand the costs reported are influenced by a high degree of variables some of these occur within the ABC costing method however, there are also external factors to take into account .

One of the most important factors is the individual and diverse nature of health care. Different individuals require different degrees of care , for example; a 20 year old man who breaks his leg is on average, likely to require a lower degree of care than a 75 year old man who breaks his leg. This may be due to the fact the older man might require to stay in hospital or require other treatment as a result. This is expressed by the department of health here "Costs can differ due to the different drug regimes required because of the severity of the condition when the patient is admitted, and due to the length of time in hospital" (DoH, 1999, p.15). In reference to the cost variation over different hospitals, the fact that we can't predict just which individuals, require which procedures means discrepancies will always exist between the various trusts. Although this will have an effect , its influence on the results can be argued and other factors are involved.

One of the major contributions to hospitals costs are its utility expenses. Different hospitals will have varying degrees of utility costs to cover e.g. an old inner city hospital in the centre of London; will have a much higher utility bill than a newly built energy efficient hospital elsewhere. Factors such as this will undoubtedly have a significant impact to the overhead costs which, are then passed down to the activity cost.

Another variable in costing may occur due to Geographic location. This is evident in the higher salaries paid out in certain geographic locations which, are ultimately pushed through to the final costing figures of activities.

Finally an absolute key factor is the diverse range of procedures offered by hospitals. The consequences of this are that a truly NHS wide standardisation for individual procedures is near to impossible as seen in the trouble with clinical coding practices. These are designed to encourage standardisation across the NHS however, the problem is the quality of data varies which; ultimately , this leads to individual interpretation and flexibility . This result of this is that the way costs are defined, plays a significant role in final costing figures (cost drivers, Resource pools etc.).

Conclusions

“The underlying assumption is that cost variability, (i.e. where different NHS Trusts report different costs for the same clinical treatment), highlights inefficiency between Trusts.” (Northcott, 2003, p5)

This inefficiency is what Gordon Brown refers to as ‘poor management’ however, Costing within the NHS is both complicated and hosts many problems. To describe the inefficiency’s as poor management is a far too simple assumption. To truly be able to describe the variances as inefficient, the results have to be put in to context against other indicators which bring with them definition problems of their own.

It is clear, that the problem remains in standardizing the ABC costing procedure across the NHS (the current system leaves too much room for flexibility between hospitals). Although comparing efficiency’s and promoting benchmarks encourages good performance, until ‘true’ standardisation across the health service is employed it cannot be effectively used as a measurement. Because of this Gordon Browns comments cannot be justified or expressed with absolute clarity.

At the heart of the problem is the drive for hospitals to be viewed as ‘business like organisations’, costing methods such as ABC, only help to promote these views by putting an intense pressure and increased competition on hospitals in terms of efficiency and performance. Until hospitals return to what Chapman (p2) refers to as a ‘patient-centred organisations’ we will continue to see a focus on resources rather than the most important issue – the patient.

Recommendations

An NHS standard for each individual procedure is the only way to truly measure the efficiency of a hospital and this should be the aim for moving forwards. It is important to remember that even then context is required to consider other factors.

Finally a more radical response would be to cut the problem from the source (the wide range of services offered) and promote ‘centres of excellences’ for specific procedures within areas. By cutting the range of activities, costing and measuring efficiency becomes a more realistic target, whilst at the same time promoting specialism.

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