National health service reorganization

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Any UK government is faced with a long list ofhealthissues, this list would include macro questions such as the relationship of the National Health Service (NHS) to broader policies which might affect the health of the population and how tofinanceand staff health services. The NHS has gone through many stages of development in the last century, however the 1990 act introduced the most radical accounting control system since the birth of the NHS. Much accounting research has been developed on this topic and this paper will bring together some of their findings.

By the late 1980" s general management in the NHS was in full force, and expectations of 'management discipline" were high, however there were a series of recurrent crisis. These crises were particularly evident in the hospital services and were caused by a combination of scarcity of compatible resources and an infinite demand for health care. Through a fundamental view of operations in 1989, two reviews were drawn up by the department of health, 'working for patients" and 'caring for people" (DoH, 1989a, 1989b), and these formed the basis of the NHS and Community Care Act 1990.

The main focus of the impact was the concept of the internal market. This essentially involved the separation of two of the main functions of the NHS, purchasing and providing. Purchasing is defined as the buying of health services to satisfy local needs and providing, is defined as the day to day business of delivering that care. The purchasing agencies are provided with a budget which reflects their defined population, from which they must identify health needs, plan ways to satisfy them while ensuring the quality of the service.

When the purchaser identifies their requirements, they produce a contract with the providers, who in turn invoice the purchaser for the materials and services provided. This illustrates the 'Quasi-market" in operation, a Quasi-market being a market which seems to exist but doesn" t really. Flynn (1993) described the internal markets in the NHS as a mechanism to match supply with demand, and allow hospitals to compete on price and quality to attract patients. This new ideology of governance of the NHS has changed dramatically, especially through the Thatcher administration.

Harrison (1997) describes how there are three ways of co-ordinating the activities of a multiplicity organisation, through markets, clans and hierarchies. Clans and hierarchies are based on using the process of co-operation to produce an ordered system of outcomes. The historic NHS was built very much around them; a combination of bureaucracy and professionalculture; labelled as 'professional bureaucracy" by Pugh and Hichson (1976). The new NHS is now reflected as having a market orientated organisation. The reformed NHS was established on 1st April 1991.

On that day the internal market became operational, it" s main features were, that there is a fixed level of 'demand" whose total is determined by NHS funding, trading takes place among a large number of buyers and sellers, and there is competition among suppliers. In this market it should be expected that managers respond with price, quality and branding as weapons of competitive behaviour (Flynn 1993). Llewellyn (1993) described the introduction of an 'internal" or 'Quasi-market" in health and social care, as a reaction to and was practically enabled, by an expanding population.

Her research that looked at two factors, which forced reform in the NHS, demographic trends and technological advancement. The first factor focused on the growing problem facing nation states in the developed world is that of an ageing population and hence a greater dependence on the NHS in future years. Between 1961 and 1990 the percentage of the UK population over sixty five increased by one third and the numbers aged eighty five and over, more than doubled (Population Trends 1992).

The second factor looked at the advancingtechnologyof medical care across the developed world, which offered a new range of medical services and techniques. These advances however caused a problematic escalation in the supply and demand for medical treatment, and therefore total cost of that treatment to the purchaser. The basic rationale of her paper, was how the introduction of a market into health care causes an anticipated stimulus to competition and hence constant improvement in resource allocation and cost management.

Hood (1994) identified two aims of the government in office as regard to the public sector, first the desire to lessen or eliminate differences between modes of private and public sector organisation. Secondly, the intention of exerting more control over the actions of public sector professionals. However, to discuss the first aim it is important to realise that there is a fundamental difference between developing a customer orientation in the private sector and a user orientation system in the public services (Flynn 1993).

Private sector problems tend to be in efforts to market their products or services to the consumer, usually in competition with other firms. Whereas, public sector problems tend to be trying to deter too many people using their services, as opposed to attracting them. Therefore, this produces a fundamental problem in the trying to eliminate these aspects. Several issues caused the government desire not only to control, but also to make resource usage more efficient.

Firstly the deepening public sector problems had to be addressed, and the adoption of more accountable systems seemed a perfect solution. There was also the desire not only to be able to control but also reduce public expenditure. Finally, political promises were made to reduce the share of public expenditure in National Income, to curtail the range of functions being performed by government, whilst also seeking to improve, nurture and stimulate the business attitudes and practices necessary to re-launch Britain as a successful capitalist economy, this was a conservative attitude.

The government therefore promoted the view that accountable management reforms are needed for the public sector to be more accountable to those who receive, pay for or monitor public services; to provide services in a more effective, efficient and publicly responsible fashion (Humphrey 1991). The emergence of an internal market for health services inevitably resulted in the emergence of various accounting techniques, their purpose was to act as a stimulus to ensure efficient allocation of resources and to minimise costs.

The increasing competition derived from this market created a need for management control systems. Hood (1994) categorised international

accountable management as having up to seven dimensions, for government implementation of a system in the public sector. First, that it sought a greater disaggregation of public sector organisations, secondly, it would be searching for a stronger competitive use of private sector management techniques. Thirdly, a heavier emphasis on efficiency of resource usage, fourthly, reforms inaccountabilitymanagement.

Fifthly a clearer specification of input/output relationships, sixthly, a greater use of measurable performance standards and targets, and finally, the use of 'hands on" management of staff in control. These categories relate to Hood" s (1994) two aims, discussed previously, with the first three dimensions relating to his first aim of eliminating differences of public and private sector organisations. The four are geared towards the second aim of control. Hood" s research was based on a comparative study of cross-national experience of accountable management reforms.

Arguably the views on the adoption of management control systems in the public sector depends on our position in society. As our society is more focused on markets, competitiveness and efficiency, it is likely that accounting techniques will play an important role, however, the importance of keeping the welfare of our society should be first and foremost. After all thegoalsof public sector organisations should differ from those in the private sector (e. g. they should not be profit maximisers).

The objective of the NHS as an organisation remains unchanged since the reforms, in terms of securing an improvement in the state of the health of the population. However, it is now faced with the dilemma, that the means of

achieving this greater improvement has been surfaced with financial considerations (Mellett 1998). One of the consequences of the reforms carried out on the NHS, after the NHS and Community Care Act 1990, is that at the level of health care delivery, it has been fragmented into over 500 separate trusts.

Each of these trusts is a clearly defined autonomous unit which has an obligation to monitor performance in terms of both finance and patient care activity (Clatworthy et al 1997). This was the governments preferred mode of organisation and it becomes universal along with the associated accounting regime (Mellet 1998). Mellett (1998), looked at how the revised accounting system operated within trusts, and found that their procedures included a system of capital accounting; it" s objective was to increase the awareness of health service managers of the cost of capital and the incentive to use that capital efficiently.

However, introducing a new control system into an organisation, and also the fact the management team are unlikely to have experience in it" s application, could lead to several implementing problems and introduce another element of risk. Preston et al (1992) emphasis, that when a new accounting method is introduced, it is naive to assume that by simply assembling the components of a system, that the desired or officially intended outcome will be achieved.

Since 1979 the UK government has tended to favour private sector management styles and culture (Flynn 1992), although there has been many debates about the different contrasts between the adaptable, dynamic,

entrepreneurial private sector management styles and the bureaucratic, cautious, inflexible, rule bound public sector management. Could this be due to the strain on public sector managers, who work on a tight budget, and also that scope for reward in expanding the organisation is limited.

So can we compare managers in the public sector with those in the private sector, for example accountability structures make managers jobs different from those of the private services. A public service manager for example, could be instructed to keep a hospital open, while the regional authorities may have different ideas and wish the hospital to close. This dubious accountability has no resemblance to the private sector, where managers are ultimately accountable to shareholders (Flynn 1992). An important part of managerial work in the public sector involves managing the relationship between the organisation and the political process.

Therefore, the government is faced a health policy dilemma; how to reconcile increasingly flexible NHS management and greater freedom to become competitive, with requirements for manageability of the NHS, for public accountability, and for political management (Sheaff et al 1997). The government then introduced a process to set about placing former private sector directors, into director positions of NHS trusts. Therefore directly introducing private sector experience into public sector management.

However, Sheaff et al (1997) research, found that board members of trusts, with a predominant NHS background were likely to be less conservative, more flexible and less risk adverse than those with a non-NHS background. This highlights the emphasis put on different management styles associated

with the public and private sector, and puts into doubt these classifications when developing the 'strategy of managerialism" for the NHS. The new era of the NHS has left managers of trusts faced with a new dilemma, they are now accountable to producing two sets of information, finance activity and patient care activity.

Clatworthy (1993) identified three users of this information, the electorate, the consumers of the public service and central government politicians. All these groups will have an interest in the NHS, but their concerns are likely to focus on different aspects of this information. This gives the managers the task of balancing two incompatible goals. As part of the NHS, trusts are charged with the intangible task of improving the state of the nations health, while also having to remain financially viable (Clatworthy 1993).

Jackson (1985) perceives that by their very nature, performance indicators motivate individuals and cause them to modify their behaviour in order to meet the targets set. Could this give rise to anxieties of how managers could react to potentially bad results? Published performance indicators issued cover aspects such as percentage of patients seen by a hospital within 13 weeks. Looking at this as an example; this indicator could be enhanced by treating as a priority those that have been waiting longest, but these patients may not be those, whose health status would benefit most from treatment (Clatworthy 1993).

It could be argued that in the pursuit of a goal, managers lower the possible increase in overall welfare. These performance indicators, both financial and patient care are produced in an annual report, although superficially similar

to it" s private sector counterpart it is not addressed to an audience which can exercise control. Unlike a private sector shareholders meeting, the directors of the public sector trust cannot be removed from their position by a voting process, so it" s existence can be perceived as not a tool of control. This paper has analysed the introduction of the new reforms taken place in the NHS in the early nineties.

The reasons for change were identified as being the change in the demographic structure of the UK population and the increased emphasis of technological advancement in medical health care, and their effect on the financial burden of the health service to the government. Changes brought about were to increase cost effectiveness and encourage efficient use of the scarce resources available to the NHS. Due to the competitive nature of the internal market, many management control techniques have been implemented to aid managers of designated hospital trusts to meet their budget targets.

Due to the complexity of these systems, many trusts have had previously private sector managers, appointed as directors in charge of managing the budget. Many fears have been raised that these budget constraints and the introduction of performance indicators will have a detrimental effect on the health service" s ultimate aim, to improve the overall state of the nation" s health. It seems that managers are stuck in a conflict of interests, of whether to keep financial control of the trust, by cutting back in the overall service offered to the public.