

Special Article

Management accounting for hospitals

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The worldwide trend today is for the health sector to be under siege with increasing patient loads, more complex procedures and ever-rising medical costs. The cost of hospitalisation is the most dominant cost factor, absorbing most of the resources.

Managing the process between the conflicting vested interests of funders, providers and patients is a mammoth task. This is one of the greatest challenges now facing the newly formed health management organisations (HMOs). The key role-players are the funders, predominantly medical aid societies whose resources are paid for by members', i.e. patients', contributions, and providers, who consist of hospitals, doctors, nursing staff, pharmacists and other health care workers. All this leaves the patient sidelined and bemused, while at the same time expecting enhanced services.

Current state

Traditionally hospital systems, especially in the government sector, have been unable to provide management with the necessary timely and meaningful information with which to manage.

In the public sector the hospitals are almost totally devoid of useful ongoing information. Managers are not in a position to make appropriate decisions as they do not know how much procedures or departments are costing. At best macro figures are provided for the hospital (months after they have been incurred) for personnel costs, capital expenditure, pharmaceuticals, consumables and utility costs. Statistical data are gathered for input into official records which is used to help motivate for more resources, and clinicians utilise the information for further analysis within the medical fraternity, often predominantly for research purposes.

In the private sector many hospitals have very sophisticated systems to ensure that all items directly used are appropriately costed and charged for. This cost-focused approach is a recipe for over-servicing; the long-suffering patient has little or no influence, and eventually is simply forced to pay higher medical premiums.

There is therefore either no ability, or no motivation, on the part of hospital management to manage more efficiently. In terms of optimising use of the resources under their responsibility, too many managers are not in a position to account for the various aspects from a financial perspective. The divide between clinicians and hospital administrators is a cause of great frustration which hampers any possible close working relationships that would benefit the hospital and its patients.

Future state

Hospital management needs to become more business-orientated with a system that provides cost-effective, efficient and meaningful information. The outputs need to be prepared timeously so as to be more useful and practical for day-to-day management.

Management should be optimising the utilisation of their resources without adversely impacting on the health delivery capabilities of the hospital and its staff. Improved management information and systems allow for better decision-making, which enhances health care delivery.

To succeed, the cost of various activities, procedures, departments and services must be known by the individuals responsible for making the decisions at the 'coal-face'. Being effective means 'doing the right things', while being efficient is 'doing things right'; when the two are done in conjunction with each other at the right time, the decision-making process is enormously enhanced.

Solution

The solution to better performance is to have a well-thought-out, structured approach to creating a comprehensive set of management information to add value. The creation and construction of the reporting outputs should be determined in a consultative and participative manner to maximise the benefits. It is absolutely critical for clinicians and management to work closely together from the outset with a shared responsibility.

The entire process is built around an agreed structure for the hospital, and all resources used or consumed must be accounted for in a matrix format and matched against revenues generated (Fig. 1). This would consist of a profit-centred (PC) approach with related activities, services or procedures matched to the resources needed to perform them. A profit centre is essentially any area or unit: (i) clearly identifiable in practice; (ii) of sufficient significance to be accounted for separately; (iii) for which an individual is responsible and may be held accountable; and (iv) where activities, procedures and/or services are performed.

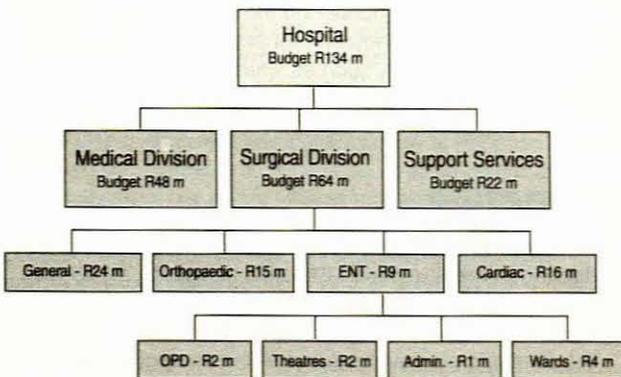


Fig. 1. An example of a high-level profit centre structure.

An essential ingredient of what may be termed a strategic cost management system is to extract and identify the major processes within the hospital as well as the cost drivers.

By creating a closer link between strategic and operational objectives a fuller and more dynamic understanding is gained. This becomes a major positive contributing factor to enhanced management performance at all levels.

Managing

Each PC will have assigned to it resources in the form of people and assets, activities, procedures, services and consumables, as well as revenues, in order for the manager responsible to review and monitor progress against budget.

The design and use of the system should in no way impinge on health care delivery capabilities to patients. The medical care any patient needs remains within the domain of the clinicians to ensure that appropriate health care and medical practices are correctly applied.

A matrix management format should develop with a built-in peer review aspect. Any areas or individuals who may either be under- or over-servicing patients will be monitored through the process of peer review and benchmarking. This approach is becoming the cornerstone of the new HMO culture.

Fig. 2 is an example of how information, which will have been prepared on an agreed common basis, may be presented and shared between PCs.

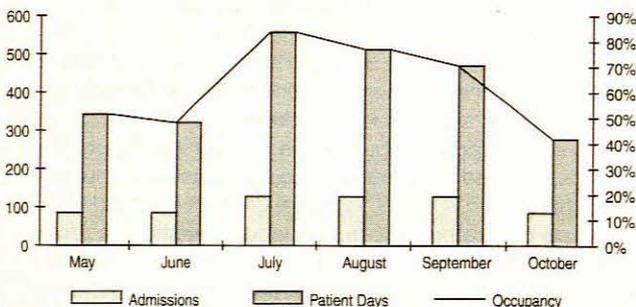


Fig. 2. ENT ward activity report.

Managers, who in many instances will also be doctors, will be responsible for monitoring the results of their PCs. There would be an expectation for staff to be reallocated or deployed between PCs, such as wards, to maximise utilisation as patient loads fluctuate.

Budgeting

No system is of any use unless there is a correctly practised budgeting process in place. Effective budgeting starts with having a sound strategic plan with measurable results against which annual budgets can be compared.

The strategic plan evolving out of the strategic process (Fig. 3) should note the high-level core services aimed for over a 3- to 5-year period. The annual budgets on the other hand are prepared at an operational level, and it is critical for them to be 'in sync' with the strategy.

The budgeting process (Fig. 4), including the higher-level strategic elements, must be transparent and well communicated to PC managers.

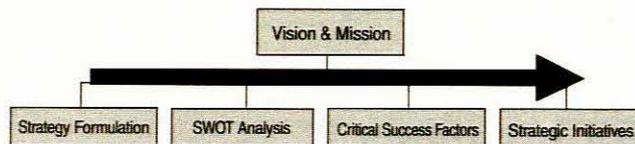


Fig. 3. The strategic process.

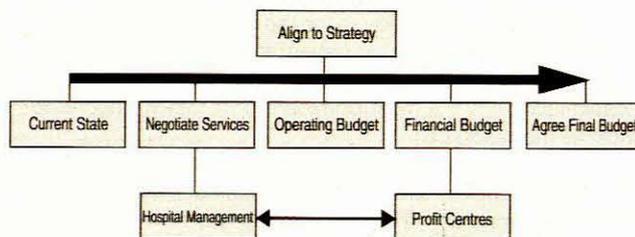


Fig. 4. The budgeting process.

This requires a participative and consultative management style by senior management and has been the catalyst for some positive form of cultural change. In many instances, senior management have traditionally tended to behave in a more remote and autocratic manner.

A complex implementation process of change and training is needed to achieve such a system.

Implementation

It is not the objective of this article to labour the difficulties and issues surrounding the implementation process.

An overview diagram of the implementation process is set out below (Fig. 5).

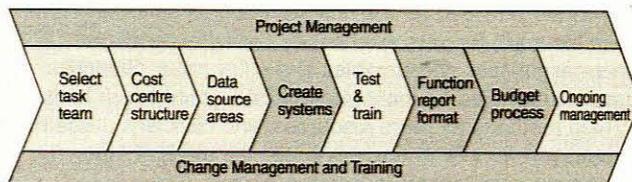


Fig. 5. The implementation process.

The implementation process must: (i) have top management support; (ii) be provided with appropriate resources; (iii) involve as many key role-players as possible to maximise 'buy-in'; (iv) recognise all stakeholders — including the patients, who are often forgotten; (v) be transparent and well communicated throughout the process; and (vi) include genuine consultation and negotiation.

However, an essential aspect of any major project of this nature is the correct application of change management.

Change management

It would be inappropriate to dwell too extensively on the change management issues. This should not be misinterpreted as dismissing or minimising the importance

of change management, as without it, a large project is doomed to fail.

There are essentially three phases to building commitment to change from an initial contact to finally reaching an instinctive internalised organisation-wide acceptance. This is well illustrated in Fig. 6.

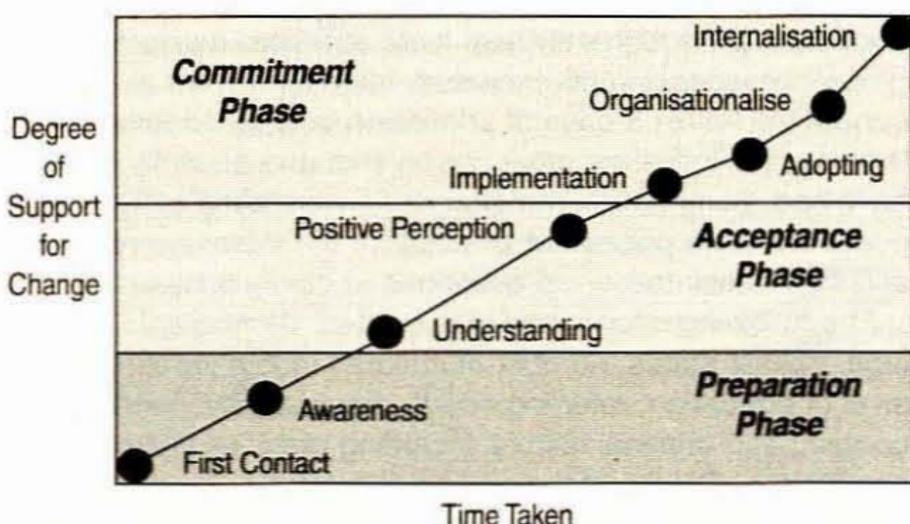


Fig. 6. The three phases of building commitment to change.

Benefits

There are enormous advantages resulting from the implementation of a management accounting and information system. These include: (i) 'ownership and buy-in'; (ii) greater empowerment; (iii) decentralised identifiable profit centres; (iv) a spectrum of useful specific expenditure categories; (v) consumption based in the same timeframe; (vi) responsibility and accountability known; (vii) consultative and negotiated activities; (viii) meaningful information is presented in a timely manner; (ix) report writing is flexible; (x) ongoing changes are reflected; (xi) PC heads interpret reports more easily; (xii) information is correlated between financial and non-financial activities; (xiii) decision-making process is improved; (xiv) incentives and rewards linked to results; (xv) planned measurable strategies; (xvi) budgets are used to manage; (xvii) results of remedial actions and decisions become defined; (xviii) more accurate pricing and costing activities and procedures; (xix) a wider variety of services is likely; and (xx) patients receive better value for money.

Conclusion

The debate is not whether hospital management information systems should be improved, but rather how and when. The applications need to be affordable, yet provide the essential data and information needed by both hospital management and clinicians. The often-quoted 'cost benefit analysis' would point in favour of implementing an effective management accounting system, providing hospital management, profit centre heads and clinicians with the tools to manage.

This will be to the benefit of all stakeholders — hospital owners, managers, clinicians and, of course, the patients. It is, after all, the patients who are paying their monthly contributions in good faith in the expectation that at some future time they will receive the best service possible.