Failing Organisations and Organisational Failures: The Case of Accounting and Health Care Regulation

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"There is widespread acceptance of these roles and responsibilities, but financial failure still occurs."
(*Learning the Lessons from Financial Failure in the NHS*, Audit Commission, 2006)

1 Introduction

The financial failings of health care organizations are a recurrent cause of discomfort for politicians and policy makers (Lewis et al., 2006). The recent history of health care systems across the globe can be read as a history of attempts to tighten financial management, so as to mitigate this discomfort (Humphrey et al., 1998). A range of organizational and managerial reforms have been deployed to such ends. In the UK, the introduction of internal markets in the early 1990s saw the creation of a new type of entity, called NHS trusts, with a statutory duty to break even.[1] Subsequent reforms have repeatedly sought to address the problem of financial failure through yet further organisational reforms, revised governance mechanisms, new risk management systems, and ever-renewed regulatory interventions. Despite these efforts, and a substantial increase in the level of health care funding by the UK government during the past decade, a significant proportion of NHS bodies keeps reporting deficits or overspends (Audit Commission, 2006 & 2008). Also, more of these deficits and overspends are significant in size.[2] A

1 Section 10 of the NHS and Community Care Act 1990 states as follows: 'Every NHS trust shall ensure that its revenue is not less than sufficient, taking one year with another, to meet outgoings properly chargeable to revenue account'. This is taken to mean that NHS trusts should break-even over a three year rolling period. Exceptionally, this may be extended to a five year period with the agreement of the Strategic Health Authority.

2 The NHS delivered a net surplus of £515 million in 2006-07. This was made up of 287 organisations delivering a gross surplus of £1,431 million and 82 organisations delivering a gross deficit of £917 million (National Audit Office, 2007, p. 4).

pessimistic conclusion that follows from these observations is that the cascade of managerial reforms during the last few decades to improve the financial management of health care organisations has had only limited effect (Perrin 1978, Hopwood 1984, Preston et al., 1992). A more optimistic conclusion would be that the improvements are somewhat lagged, and only just beginning to appear.

There is much debate about the reasons for the difficulties of achieving financial discipline within the health care sector in the UK and elsewhere. The literature from organisational scholars, together with the more sociologically informed accounting and management literature, have repeatedly focused on the distinctive culture and values embedded in these organisations, the professional power struggles, and the complexities of managing highly professionalised organisations. Despite repeated attempts over several decades to involve clinicians in practices such as budgeting, costing and cost management, a reluctance on their part to actively participate in financial management is considered to persist, at least within some quarters of the medical profession (see e.g. Audit Commission, 2006). The literature from economics, including those disciplines that draw significantly on economics such as some sub-sets of the public administration literature, have pointed towards the problems or limitations of the incentive systems that operate within publicly-funded healthcare. For instance, the impact of 'soft budgets' – where chronic loss-makers are always bailed out – has been held to explain many of the recurrent problems experienced in the health care field (Kornai et al., 2003; Martinussen and Hagen, 2009). Regardless of the disciplinary leanings of individual researchers, there seems to be common agreement that the design and operation of organisational control mechanisms in the healthcare field still needs considerable further development if effective financial management is to be achieved.

An important theme underlying much of the health care reforms during the past few decades is the central role of accounting. Appeals have repeatedly been made, and continue to be made, to the "potential offered by improved costing procedures, more specific criteria for resource allocation, improved management information systems, investigations of administrative efficiency and better audits [...] in locating the inefficiencies of the past and ensuring that better performance is achieved in the future" (Hopwood, 1985, p. 173). Despite the limited success so far in implementing these ideals, a belief in the power of accounting to make and mould appropriate behaviour appears to have intensified rather than declined. At each step, a perceived failure seems to have become a condition for a further intensification of accounting rather than its abandonment, while the calculative tools and technologies of managerial accounting have expanded their domain. In the field of health care, managerial accounting expertise is no longer confined exclusively to assisting with internal managerial decision making. Internal accounts, in the form of semi-standardised managerial accounting reports, are increasingly harnessed for regulatory purposes. Whereas financial accounting provides the basis for predicting failure on the basis of putatively rigorous ratio analysis, managerial accounting tools are seen as a vital device for rescue and reconstruction when failure looms. The example of recent attempts to reform the regulation of UK health care described below illustrates this trajectory. It highlights the expansion and transformation in the roles of managerial accounting in processes of negotiation and expert

judgement, precisely at those moments that are pivotal in pronouncing failure or prescribing remedial action.

2 Reference Costing, Payment by Results and Service Line Reporting

The concerted programme of 'marketisation' of healthcare during the 1980s and 1990s, under the Conservative governments of Margaret Thatcher and John Major, was not exactly abandoned by the New Labor government of Tony Blair, elected in 1997. But there was a renewed emphasis on accounting, under the dual banners of 'transparency', and the need to 'make costs visible'. Calls for a "system of cost accounting which will show the cost of the various activities carried out in hospitals so that the cost of an activity in one hospital may be compared with the cost of a similar activity of equal size and type" had been expressed since the early days of the National Health Service (Accountant, 1950). However, in the late 1990s, those who demanded to know the costs of care obtained a new weapon in their crusade – 'Reference Costs'. Introduced in 1998, Reference Costs represented a promise of 'transparency' and of 'making costs visible', so that 'unacceptable' variation between service providers could be demonstrated (Llewellyn & Northcott, 2006). This was to be achieved by compiling and publishing details of unit cost, average length of stay and activity levels for a wide range of services across all service providers. The comparing of unit cost data would, so it was proclaimed, help to 'name and shame' those who failed to keep their costs under control, and raise overall standards in the NHS. And this could all be achieved without the need for overt competition, with its possibly destructive results.

Before long, however, 'competition', together with gradually extended patient 'choice' over service providers, was firmly back on the government agenda. Reference Costing came to be harnessed for new uses, as the primary mechanism underlying the reform of the NHS funding system called 'Payment by Results' (DoH 2002a & b; Audit Commission, 2004). Money was to follow patients, and Payment by Results - introduced gradually from 2003 onwards - was set to pay providers of healthcare fairly and transparently for services delivered on the basis of fixed standard national tariffs. Tariffs, set by the government on the basis of national average costs, i.e. 'Reference Costs', were designed to make total hospital revenues dependent on the volume, type and mix of activity undertaken. The financial success or failure of a hospital was to be made dependent on the efficiency with which services were delivered (DoH, 2006; Audit Commission, 2005a, b & c).

Payment by Results changed the regulatory landscape within which hospitals function. Regulating and governing by accounting numbers rapidly became the norm (Kurunmäki and Miller, 2008). Complementary institutional and organisational reforms in the health care landscape supported this reform of funding principles and mechanisms. The creation in 2004 of the first NHS Foundation Trust hospitals - new types of independent public benefit corporations – started a gradual transfer of the ownership and accountability of NHS trusts from Whitehall to the

local community, allowing hospitals greater freedoms to manage their own affairs. With these increased freedoms, however, went greater financial accountability: under the new regime, the Secretary of State would no longer guarantee the debts of an NHS Foundation Trust (DoH, 2004, p. 3).

A spate of predictions concerning the likelihood of hospitals failing financially quickly followed the launch of the new funding and governance regimes. Monitor, founded in 2004 to act as the independent regulator of NHS Foundation Trust hospitals, was given responsibility for overseeing and supporting the aim of improving the financial management of Foundation Trusts. The creation of an independent regulator allowed a liberal arms-length mode of governing service providers to be combined with a more interventionist regulatory apparatus based on intermediary mechanisms. Monitor was to assess and review the risks of each NHS Foundation Trust at regular intervals with respect to finance, governance and service provision. The resultant risk ratings were to form the basis of intense within-year monitoring (Monitor, 2008). Financial risk rating, based on the computation and aggregation of financial accounting based data and various ratio analyses according to specified rules, provided a routine assessment of 'performance' to be diagnosed and analysed relative to institutionalised norms by those with neither detailed knowledge of individual organisations nor a developed understanding of financial statements. Anything lost through the absence of close contact with the individual organisation or an appreciation of the underlying accounting constituents of the risk ratings would be offset by the promise of distilling organisational performance into a single figure, capturing the economic essence and allowing it to be displayed and compared in charts and tables (Miller and Power, 1995).

Within this new regulatory environment, the regulator's role is not limited to representation and diagnosis of possible financial failure. Monitor also has at its disposal various powers to intervene. These include the ability to remove any or all of the directors or members of the board of governors, and to appoint interim directors or members of the board of governors. Monitor can also require an NHS foundation trust to do specific things within a set period, or indeed not do them (Monitor, 2008). Multiple guidelines and tools have been issued by Monitor to help hospitals improve the understanding of their income and costs, and to enhance their 'performance', 'productivity' and 'profitability'. Accordingly, under the banners of 'service line reporting' and 'service line management', Monitor has promoted the use of various well known managerial accounting tools (Monitor 2006a, 2006b, 2006c & 2007). [3] Although all hospitals are encouraged to use these tools as part of good governance, any NHS foundation trust whose financial risk rating falls to 2 or 1 out of the maximum 5, are required, in accordance with Monitor's Compliance Framework, to provide the regulator with an analysis of the trust's income and

3 Monitor's toolkit for presenting service line reporting data comprises six elements: a portfolio matrix reporting tool to assist priority setting and strategy development across the whole set of a trust's services; a comparison table for the analysis of the key financial metrics; a table for the detailed breakdown of income and expenditure per directorate, service line, point of delivery, or Healthcare Resource Group; a cost matrix for the breakdown of costs by cost-line and cost-centre; *ad hoc* variance analysis reporting to identify outliers in performance; and forecasting models and sensitivity analyses to predict 5-year performance at the level of service line (Monitor 2006b).

earnings by service line for the previous and current year (Monitor 2008). In the event of the 'significant' financial failure of an NHS Foundation Trust, Monitor has the responsibility to initiate a failure regime based on the Insolvency Act 1986, yet to be created by secondary legislation (DoH, 2004, p. 3).

Prima facie, this system of regulating and governing by accounting numbers sounds reasonable. For who could object to the sharing of information, the benefits of cost comparisons, and the rewarding of efficiency? Shouldn't poorly performing organisations be allowed to fail? And why should one doubt the promise of future benefits, while the system adjusts? Even if some pain is experienced in the short-term, is this not needed in order to ensure financial robustness in the longer run? But governing health care by accounting numbers produces problems which go beyond these supposedly temporary adjustments. Mimicking a private sector failure regime, which has hardly proved robust even there, may not offer the solutions desired. For company failures do not have the objectivity or self-evidence that is often attributed to them. Organisation failure, even in the corporate sector, is a process, one that has to be agreed, negotiated and adjudicated on step by step (Miller and Power, 1995). While many risk regulation regimes centre on the notion of 'failure', they allow for considerable negotiation as to what constitutes failure, and what the key metrics are that allow it to be pronounced. The calculative expertise of accountancy plays a potentially significant role in certifying, adjudicating and intervening in instances of failing organisations. These processes are of heightened importance in those domains where 'failure' is deemed politically and operationally unacceptable.

3 Health Care and Financial Failure

How should we define failure? In the private sector, financial failure is typically equated with the pronouncement of insolvency. Yet even in the private sector, failure regimes come into play only after lengthy negotiations with various stakeholders, such as lenders, trade creditors, shareholders, possibly governmental agencies and regulators. In domains where failure is considered politically and operationally unacceptable at an organisational or systemic level - as exemplified by the recent threat of meltdown of the global financial markets - logics other than those of the market may be brought into play. Corporate failure should therefore not be considered as an objective state of affairs, but negotiable and constituted out of various expert claims and modes of judgement. But regardless of these other logics, the calculative technologies of accounting provide financial norms around which complex processes of negotiation of possible outcomes can take place.

The question of what constitutes failure in the health care field, populated as it is in the UK largely by publicly owned organisations, is even less straightforward. Given the political imperative of retaining health services for the public even where providers are performing poorly in financial terms, the Department of Health has historically had little option but to keep funding the deficits of failing trusts through financial assistance or brokerage. In these circumstances, it has been possible for health economies to take shelter within historically opaque, and sometimes

complex, financing arrangements (Audit Commission, 2006). The reality has been that NHS hospital trusts have failed only when the DH *says* that they have failed (Palmer, 2005, p. 20). Impending failure has often meant little more than the Department of Health bailing out the 'failing' organisations with the required supplementary funding.[4]

The Health and Social Care Act 2003[5] that introduced Foundation Trust hospitals, as well as the independent regulator called Monitor, can be interpreted as an attempt by central government and policy makers to break away from the tradition of excessive political and governmental intervention, and the associated expectation that the state is always a guarantor of last resort. The enforcement of such a liberal mentality of government was sought through a new failure regime, with significant commercial aspects. This detailed the mechanisms for administering the collapse of contractual relations based on the Insolvency Act 1986, with modifications applied to allow for the protection of essential NHS services and assets (DoH, 2004, p. 3). Employing long-established commercial company insolvency procedures in the health care domain was hoped to impose a credible threat for the health care actors to alter their behaviour. A message was to be sent out that even if the state could 'afford' to finance the deficits, it would be unlikely to do so.

But of course the dissolution of an NHS foundation trust in accordance with such formal mechanisms should only be considered as an option of last resort (Monitor, 2008). Or, to put it differently, 'failure' should be carefully distinguished from 'failing'. Rather than focus only on the moment of failure, with its attendant matrix of rules, rights and duties pertaining to assets, and elaborated in company insolvency legislation, regulatory attention in this instance should focus initially and perhaps even principally on the process that *precedes* the moment of failure. Here, the roles of accounting technologies and expertise is pivotal. Analysis centres on the financial representations of organisational performance prior to failure, including the search for adequate definitions of success and failure, and ways to predict and possibly avoid actual failure with the help of accounting based risk ratings and other risk management technologies. For the legal regulation of insolvency is dependent on extra-legal bodies of expertise, such as accountancy. While the legal definition of insolvency focuses on procedural matters that follow the pronouncement of insolvency, it offers no definition of the economic substance of insolvency. Before financial failure can be invoked and internalised within the legal system, it has to be represented and calculated as an accounting event (Miller and Power, 1995). We need to know more about how the tools and technologies of accounting operate as mediating instruments within this complex process of negotiation between competing demands and aspirations (Miller et al, 2008). We need to know more about the roles of accounting in the forming of judgements regarding the exact moment at which a particular organisation comes to be considered insolvent, and the various legal processes triggered.

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4 Financial support is defined in the Department of Health's Manual for Accounts as 'additional income during the year, provided wholly to assist in managing financial problems'.

5 Now consolidated into the NHS Act 2006.

This means commencing analysis before the moment of failure itself. We need to understand the range of events that make up the process through which an organisation is considered unable to pay its debts, or as exhibiting persistent and long term financial distress, and hence subject to the panoply of rescue and reconstruction practices specified by the regulator. In the field of healthcare, such processes are both central to understanding the regulatory process, and are also likely to be more fruitful empirically. For the moment of actual failure of any individual hospital trust is likely to be immensely sensitive politically, once the various actors including patient associations become part of the process. Perhaps unsurprisingly, and like the Insolvency Act 1986, the Health and Social Care Act 2003 does not elaborate on exactly how Monitor is to define which types of failure are 'significant' enough to lead to the actual dissolution of any individual trust, but leaves it unspecified and in the domain of expert judgement. In determining whether a potential failure is 'significant', and what action if any is appropriate, Monitor is expected to assess each incident on a case-by-case basis. While illustrative examples have been provided by the regulator – such as persistent and long term financial distress, as well as failure to prepare or deliver recovery plans or undertake effective planning or budgeting – these still leave considerable room for judgement and negotiation (Monitor, 2008).

4 Conclusions

Only the future will show the success, or failure, of these new regulatory mechanisms designed to allow the state to pursue an increasingly liberal mode of governing health service provision through intermediate organisations and expertises. An indication of the difficulties of the task ahead is the proposed launch to establish a failure regime for state-owned providers that is currently under consultation (Department of Health, 2008). This proposed failure regime is intended to provide practical answers to the question, unresolved since the inception of NHS Foundation Trusts, of what happens when an NHS Foundation Trust fails. Whereas the Health and Social Care Act 2003 envisaged an insolvency procedure with significant commercial aspects, the Department of Health has not yet devised an appropriate way of making this operable, while recognising the reality of healthcare provision in the UK. The proposed regime for state-owned providers upholds the independence of Foundation Trusts and of their regulator, Monitor. But it also allows that, in the event of failure, Monitor is able de-authorise Foundation Trusts where it sees fit, thereby placing accounting once again at the heart of the process. This reaffirms our argument for focussing on roles of accounting in mediating across domains and interest groups in the various processes that precede the moment of actual failure. For regulatory initiatives, such as the ones described above in the health care field, can be influential in the creation of new forms of hybrid expertise which do not map neatly onto existing domains and practices.

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