

Targeting cost

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The message being sent to all NHS managers is getting louder and louder. Financial management in the NHS must raise its game to meet the challenges of a changing, modernising NHS. The Audit Commission, in its paper 'Achieving First Class Financial Management in the NHS', conclude that financial management has a vital role in delivering improvements to patient services. Monitor, in its response to the Audit Commission document 'Early Lessons from Payment by Results', reiterated the view that good planning and financial management are essential if the NHS is to meet the challenges of payment by results. Following the investments of recent years, the signals from Government suggest that calls of 'underfunding' will no longer be tolerated. The electorate now expects a responsive NHS with short waiting times for treatment. And yet for those of us on the inside, managing the demand for health services and balancing the books is proving ever more difficult. The policy advisers present a changing NHS - plurality, choice, the death of the DGH (Financial Times 8/8/05) and so on; and as self-fulfilling prophecies go, they are probably right. Oh and by the way, in this period of major structural change, faced with fixed costs and labour protection rules the Scandinavians would be proud of, we have to balance the books throughout.

NHS managers and clinical colleagues could be forgiven for looking to their finance colleagues for the solution. But financial management does not start and end with the Finance Department... the current berating of Finance for the state of the NHS books, in many cases, is nothing more than 'shooting the messengers'. Yes the Finance toolbox will deliver some solutions and, yes, we should all strive for continuous improvement, but the size of the task demands much more than mere strong financial control, timely reporting, with the odd technical fix thrown in to ensure the dash to the year end finish line is met with break even.

So what do we do? Benchmark? The NHS loves to benchmark... we compare ourselves to peer groups, to our neighbours, against national averages and so on. In some circumstances we obtain some great insights into how we can change the service for the better, both for the patient and financially. But more often than not we end up with one of two outcomes: our service comes out favourable, in which case, the I told you so's win or the service compares below the benchmark, in which case, argument and debate ensues to prove that we are not comparing like with like, the data was wrong or some similar line of attack to make the answer appear inconclusive; and any proposed action will only cause damage to patient care. The result is to become paralysed by data and analysis until the exercise becomes frustrated. This, of course, oversimplifies and belittles valuable comparisons that serve to share different practice and pass on success. However, benchmarking with another service, if it is considered to be leading edge, will, at best, bring your service up to the current required level. To be a true leader and maintain competitiveness in the future a service must aim to be better than the current best. Moreover, a service should aim to be the best it can be within the current strategy set by the organisation i.e. not all organisations want to (or, for that matter, should) be at the cutting edge of technology, this may be appropriate for a specialist centre but not a DGH or a GP with a special interest. Instead the service should be the best it can be within its chosen competitive environment ('best' being fittest for purpose, including cost-effectiveness, not best possible). Where benchmarking is backward looking, we should consider looking forward using a process that stimulates original ideas to create competitive advantage and, most importantly, improvements to patient care.

An alternative is the process of target costing. In short we set a target and then focus creativity to give us a service model that fits. Target costing evolved in the 1970's in Japan's manufacturing industry. As consumer demand grew for more diversified products, and product life cycles became shorter, the Japanese evolved a process that focussed on the development and planning stages of a product. The same could be applied to the design of care pathways. The manufacturers in Japan realised that the major part of product cost, around 80 percent, is determined at the design stage and, therefore, cost management needed to start earlier in the process. The same could be applied to the design of care pathways, or similar, with a focus on delivering care at an affordable level. It is important the process is recognised as more than just about cost control i.e. a management process that involves all disciplines and brings a focus on the patient from the outset. Cooper and Chew (1996) describe the value of target costing as 'its ability to bring the challenge of the marketplace back through the chain of production to product designers.' Accountants should see themselves as facilitators of this process but if organisations leave this process to the finance department, it will fail.

So what benefits does target costing bring to an NHS already bequeathed with targets, standards and reference costs? A primary reason why companies use target costing is to plan or project the costs of products or services before they are introduced. An interesting concept the NHS would do well to consider as payment by results unfolds and more Trusts move to Foundation Trust status. Clearly the private sector are interested in margins and returns, which are not relevant to the NHS (yet) but we should at least be avoiding the introduction of treatments which are not viable for the organisation. In practice, of course, new treatments are often forced upon the NHS irrespective of the question of affordability; for example NICE recommendations or National Service Frameworks or, even more controversially, the use of *herceptin* through a legal challenge. But where we do, it would be a huge leap to actually know they are generating a loss and have a counter strategy, linking with commissioners and neighbouring providers, to manage the position. Even better, a process could be adopted by standard setting bodies to incorporate the cost of developments in line with relevant national tariffs. As outlined above, costs are identified at the design stage – hence the emphasis on standard setting bodies to take responsibility for the financial implications of their proposals. A loss may be short term i.e. as the volume of service increases, economies of scale develop. The design and planning process should the potential for cost reduction for a given specification of quality for a treatment. This includes the design specifications and production techniques. Translated to healthcare services this could, say, be the requirement to specify that 98 percent of patients are treated as a day case, set the time in theatre, use a specific anaesthetic for the procedure, exclude IV antibiotics in favour of oral administration and so on. In practice the process of target costing should force a much more detailed analysis of practice through the disciplines to seek out efficiency in every area of the treatment process. Taken much further the process will be embedded within the organisation's strategic framework to support optimal delivery of healthcare in every aspect of the service. It will cover support areas such as procurement, questioning every component and the price paid for every component of the treatment, asking how better deals can be struck and so on. In Japan Target Costing brought together a number of other tools to increase efficiency including Just In Time delivery and Total Quality Management i.e. reducing the number of errors in the manufacturing process. This could present an opportunity for the NHS to develop its own tools specific to the delivery of patient care. Target Costing focuses on the 'customer'... in this case, the patient. Target costing is market driven. All functions in the organisation are forced to respond to market demand and competitive trends rather than internal performance indicators, personal or professional interests.

To many in the NHS 'markets', 'competition' and 'customers' are dirty words but, like it or not, the Government is adopting market principles (albeit diluted) to drive improvements in healthcare. Target costing does not have all the answers, but finance managers, along with others involved in delivering patient care, should not overlook this tool for the development of sustainable improvement.

Further information on the use of Target Costing and how this can be applied to the healthcare setting is provided in a CIMA Discussion Paper on Target Costing, available at www.cimaglobal.com