

Target costing in the NHS

Reforming the NHS from within

CIMA NHS Working Group

Executive summary

A fundamental shift in performance often needs a radical change in the way an organisation is managed. Today's NHS faces significant challenges, not least the need to maximise the use of the available resources and to demonstrate sound financial management. Recent developments such as payment by results and the introduction of a national tariff have only added to the pressure. To exacerbate this, the media is continually scrutinising the mixed financial performance of NHS Trusts which continues despite significant increases in funding. Part of the response must be the finance community bringing to the table better approaches to managing NHS organisations to improve their understanding and management of costs of services and their effective delivery.

This discussion paper proposes that the application of target costing in the NHS presents an opportunity to radically improve the operational delivery of patient care. This approach has raised the performance of many manufacturing companies, most notably Toyota, and CIMA is leading a debate on whether NHS organisations could see some of the same benefits.

Target costing originated in the Japanese manufacturing industry in the 1970s as a response to the challenges posed by consumer demand for more diversity and shorter product life cycles. Companies also began to recognise that most of the cost of products was committed at the design stage. Target costing developed as a multidisciplinary approach to managing costs from the earliest stages and was complemented by techniques such as process re-engineering and total quality management.

The basic stages in target costing are the establishment of targets for market price, volume and profit, from which a target production cost is derived. Cost analysis is carried out to determine an actual cost and identify the extent of, and develop plans for, the cost reduction required to target cost. Finally the decision is made whether or not to introduce the product. However, many organisations have found that the real strength of target costing is as an overall framework for cost improvement and efficiency within which a range of different techniques for analysis and re-engineering are used.

Organisations, which have implemented target costing, have found that it has brought them a number of benefits that could be transferable to the NHS and make a significant difference to performance. In particular target costing is an approach that:

- Improves the understanding of the costs of products and services, where issues are identified early in the service development process at a point where action can be taken.
- Brings a focus on the final users of the service or product.
- Is multidisciplinary and involves staff from all areas in the cost analysis and encourages them to take responsibility for managing the costs.
- Provides a framework which encourages a focus on the wider supply chain, in effect a whole systems approach.
- Can be used by service organisations to look at the impact which new services have on the existing ones.
- Develops specific and real targets which ensure satisfactory financial performance.
- Highlights other problems in areas such as purchasing which affect the cost of the product or service.

To secure such benefits may require a fundamental rethink on how NHS organisations are managed and a commitment and readiness to institute change. Surmountable, but significant challenges to this, could include organisational structures (where NHS Trusts are organised on functional rather than process lines), the way people are rewarded and incentivised, an unwillingness to try new approaches at the highest level, not identifying the skills required in the workforce to enable change of this type and magnitude, and a lack of champions who can spell out what is required and expected, and lead people to work in new ways.

How can you contribute to this debate and significantly improve your organisation's performance?

CIMA's NHS Working Group would like to hear your views about target costing and its relevance to the NHS, in particular your responses to the questions below. Please see the [Next Steps](#) section for contact details (page 13).

- Do you think target costing could bring any advantages to your organisation or the NHS in general? If not, why not?
- What barriers do you think there would be to its successful implementation?
- What do you think the important issues are?
- Do you have any comments on the issues raised in this paper, particularly those related to the NHS?
- How would you like to see this work progress? What would be the most useful format for any output from CIMA?
- Do you have any experience which is relevant to this discussion which you would be willing to share?
- Are there any other techniques which you feel would be more useful?

Introduction

The improvement of financial management is a major challenge facing today's NHS. The National Audit Office and the Audit Commission¹ identify the need for many NHS bodies to improve their financial systems and finance management skills to meet the needs of both the existing financial regime and the new demands of payment by results and other developments. Finance professionals recognise the importance of improving current practice but are often not sure of tools and techniques that might be able to make a difference.

The accurate costing of NHS services and the reduction of those costs is one area that can influence success in NHS organisations. As part of its work to support finance managers in the NHS, CIMA's NHS Working Group focuses on developing guidance to raise the standards of financial management, specifically in areas where better approaches to management accounting can make a significant difference to performance. This involves considering techniques used successfully in the private sector that could be applied in the health service and providing guidance on their application. The principle of target costing is a tool that could help improve costing practice in the NHS.

This paper provides an understanding of target costing based on an analysis of what has been written, its advantages and disadvantages and the benefits which it offers to organisations using it. It then looks at issues relating to the use of target costing in the NHS in order to facilitate further discussion and debate.

The structure of this paper is as follows:

- background to target costing
- the target costing process
- advantages of target costing
- key characteristics of successful target costing
- target costing in process and service businesses
- costing in the NHS
- target costing and the NHS
- next steps.

¹ *Financial Management in the NHS: NHS (England) Summarised Accounts 2003-04*, National Audit Office and Audit Commission, 2005

The background to target costing

According to the CIMA Official Terminology² a target cost is 'a product cost estimate derived by subtracting a desired profit margin from a competitive market price.'

Target costing is a technique which developed in the early 1970s in Japan's manufacturing industry as consumer demand for more diversified products and shorter product life cycles made the development and planning stages of new products more important. At the same time increased automation and decreased labour costs made standard costing less important as the main method of cost management within manufacturing companies. It was also recognised that the major part of product cost (around 80%) is determined at the design stage and that cost management needed to start earlier in the process. Sakurai (1989)³ defines target costing as a 'cost management tool for reducing the overall cost of a product over its entire life cycle with the help of the production, engineering, R&D, marketing, and accounting departments'. The use of target costing spread as increased competition, and shorter life cycles, in global markets meant that companies needed to manage costs from the design stage forward, and launch products at prices to attract customers and forestall imitation. Target costing as a technique to achieve these aims spread into other countries and industries.

A review of the literature, however, reveals that target costing is not seen as a technique for cost control but a management process which involves all disciplines and brings a focus on the customer from the beginning of the design process. Cooper and Chew (1996)⁴ 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.'

The target costing process

Historically, target costing has been developed and used in manufacturing companies, and therefore the language used to describe it in the literature, and in this part of the discussion paper, reflects that. Later sections of the paper will consider the application in service oriented organisations.

There are a number of stages in the process of target costing, as described by Gagne and Discenza (1995)⁵:

1. Establish a selling price for the new product and estimated sales volume from an analysis of the market, and a target profit.
2. Determine the target cost by subtracting the profit from the selling price.
3. Perform functional cost analysis for individual components and processes.
4. Determine the estimated cost for the product.
5. Compare estimate with target.
6. If estimated cost exceeds target cost, repeat cost analysis/value engineering to reduce estimated cost (an iterative process).
7. Make the final decision whether or not to introduce the product once cost estimate is on target.
8. Manage costs during production of the product.

Determining estimated costs

Once an overall target cost has been established for the product, it is necessary to identify the gap between the target cost and the estimate of the cost to build the product based on current processes, suppliers, productivity levels and materials. The gap gives an estimate of the excess cost which must be taken out of the new product (Cooper and Chew, 1996).

² CIMA *Official Terminology*, CIMA publishing, 2005

³ *Target Costing and How to Use It*, Sakurai, Journal of Cost Management for the Manufacturing Industry, Summer 1989, pp 39-50

⁴ *Control Tomorrow's Costs Through Today's Designs*, Cooper and Chew, Harvard Business Review Jan-Feb 1996, pp 88-97

⁵ *Target Costing*, Gagne and Discenza, Journal of Business and Industrial Marketing 1995 Vol. 10 No. 1 pp 16-22

Achieving target costs

Once the gap has been identified between the target cost and the cost estimate, it is necessary to identify ways to close the gap. Target, or allowable, costs are identified for individual components or processes and cost improvement teams work to reduce the estimated costs to meet the target. However, cost-reduction requirements are not usually applied uniformly across all the components and subsystems of the product, but based on an informed assessment of how much cost can be removed from each component based on value to the customer, historical trends and other data. There may also be a process of negotiation between different production departments and between the company and its supplier to arrive at final target costs for the individual components. This process of cost reduction is an iterative one which continues until the target cost is reached or it is concluded that the overall target cost can not be reached and a decision is made not to launch the product.

Cost management techniques and target costing

Target costing is not so much a cost management technique but rather an overall approach or framework within which a range of different techniques are used for the cost management required to achieve the target costs. The choice of technique or combination of techniques varies from one company to another. Specific techniques mentioned in literature on target costing, some of which have already been used in the NHS, include:

- value analysis
- value engineering
- just-in-time (JIT)
- total quality management (TQM)
- MRP (materials requirements planning)
- kaizen
- lean manufacturing
- activity based costing and management (ABC/M)
- cause-effect analysis ('fishbone' diagrams).

Sakurai (1989) describes target costing as a system for reducing cost and promoting the use of cost-engineering tools such as those listed above.

Managing costs once production commences

Once the target costs have been determined, actual costs can be monitored and managed against the targets using the usual budgeting and costing methods such as standard costing.

Advantages of target costing

Obviously a primary reason why companies use target costing is to plan or project the costs of products before they are introduced, and to ensure that low-margin products are not introduced which do not bring sufficient returns. There are, however, additional purposes for which companies have introduced target costing which vary from company to company. A number of other reasons are given in the literature for the use of target costing, as outlined below.

To reduce costs before they are locked in

As previously mentioned, it is being increasingly recognised that the major proportion of product costs, around 70 to 80% (Cooper and Chew, 1996) are effectively fixed during the design stage. Target costing provides a means to manage costs from the design stage to maximise the potential for cost reduction.

To control design specifications and production techniques

Target costing is a tool which can be used to control decisions such as design specifications and production techniques. For this reason it tends to be oriented more towards management and engineering than accounting, and to be successful requires the use of cost engineering techniques such as value engineering (Sakurai, 1989).

As an analysis which highlights other problems

The discipline of target costing and the detailed review of costs can reveal more general managerial problems. For example, Chen and Chung (2002)⁶ cite a company which uncovered corrupt practices in the purchasing department as a result of the detailed examination of component prices.

As a driver for cost improvement

As already discussed, target costing was originally introduced into Japanese companies as a way to integrate the use of other tools such as JIT and TQC (total quality control) and promote their use (Sakurai, 1989).

To encourage a focus on the customer

Target costing is, by nature, market-driven. It therefore stimulates behaviour which is customer-focused and encourages all functions within the company to respond to market demand and competitive trends rather than internal performance indicators. In addition the marketing department is free to make product decisions without the costs being a given (Gagne and Discenza, 1995).

Key characteristics of successful target costing

Focus on the customer

Target costing focuses on the customer. Customer requirements for quality, cost and time are incorporated into the product decisions and guide the analysis of costs. Indeed target costing forces companies to be specific about what customers want and the prices they are prepared to pay (Cooper and Chew, 1996). Swenson et al (2003)⁷ identify as a feature of best practice in target costing that companies actively solicit input from their customers on design issues to examine whether or not customers are willing to pay for the design innovation and to ascertain whether the cost exceeds the value to the customer, in which case the innovation is abandoned. The process may also involve discussions with customers of different design options, making trade-offs between cost and value. This is a key difference from other cost management processes which tend to be disconnected from the value perceptions and requirements.

Emphasis on cost reduction at early stages in product development

Target costing starts at the earliest stage in new product development, indeed is embedded in the development process, such that detailed financial analysis takes place from the outset and engineering changes are made before production begins. This often means initial designs are simplified before manufacture, resulting in lower costs and time-to-market once the design is finalised.

Consideration of the whole product life-cycle

In order to ensure that total costs are minimised for both the producer and the customer, successful target costing examines the full life-cycle cost of the product. This includes consideration of the purchase price, operating costs, maintenance and distribution costs (Swenson et al, 2003).

A multidisciplinary process

A characteristic mentioned in all literature on target costing is the multidisciplinary nature of the process and the importance of the involvement of all functions in the analysis and decision-making. Responsibility for achieving targets must also be shared across functions. In a study of Toyota Australia's target costing system, the International Federation of Accountants' (IFAC) Financial and Management Accounting Committee (now Professional Accountants in Business)⁸ highlighted the multi-disciplinary involvement in the cost management process and the vital roles played by different functions:

- **Finance** — a co-ordinating role, managing the assignment of cost targets for individual components and subsystems, performance reporting and monitoring performance achievements across the business, and promoting target achievement and highlighting the need for action when deviations occur.
- **Sales planning and distribution** – driving the formulation of the overall target cost.

⁶ *Cause-Effect Analysis for Target Costing*, Chen and Chung, *Management Accounting Quarterly*, Winter 2002, pp 1-9

⁷ *Best Practices in Target Costing*, Swenson et al, *Management Accounting Quarterly*, Winter 2003 Vol. 4 No. 2 pp 12-17

⁸ *Target Costing for Effective Cost Management: Product Cost Planning at Toyota Australia*, IFAC Financial and Management Accounting Committee, 1999

- **Purchasing** – looking for cost savings through the analysis of parts and components to be used in the new product and working with suppliers to improve their cost base and to redesign parts.
- **Engineering** – using techniques such as value engineering to identify cost savings which can be made whilst maintaining the functionality of the product.
- **Manufacturing** – looking for cost savings through improvements in the manufacturing processes, either through continuous improvement or more long-term fundamental changes.

Team members understand their role and how it impacts cost

According to Gagne and Discenza (1995), the target costing teams which are the most successful are those whose members have a basic understanding of how their work is translated into numbers which represent the firm's performance, using indicators which are meaningful to them. In addition, the best team members are those who have rotated through several departments, including design, purchasing and marketing before being assigned to a cost-planning project, as broad backgrounds give team members a unique ability to spot and implement ways to improve costs.

Involvement of the whole value/supply chain

A number of writers describe the importance of working with the company's supply chain to identify opportunities for cost savings. This is particularly important where a high proportion of the total cost of a product is in purchased raw materials and components, and target costing goals would be impossible to achieve without supplier involvement. Some companies view their supply chains as part of an 'extended enterprise' where design and cost information is shared and inter-company teams are established to meet cost reduction goals (Swenson et al, 2003).

Banham (2000)⁹ identifies getting suppliers to buy in to target costing as probably the most difficult aspect of target costing as experienced by US companies implementing the process. Amongst the methods used to achieve this are joint classes and team-building and promises of shared savings.

An iterative process

Target costing is not an exact science and depends on credible data and sometimes difficult judgements. It is also an iterative process where targets evolve as teams seek to balance functionality, price, volumes, capital investment and costs (Cooper and Chew, 1996). However, it is important the overall top-level target cost is regarded as an unalterable commitment and if this cannot be met, the product cannot be launched.

Specific and real targets for improvement

Although the cost targets for individual components or processes evolve, once they are set, they should not be changed. Also, as Cooper and Chew (1996) point out, targets must be more than hypothetical, so that managers have an imperative to meet them in order to ensure the launch of products. They should also be attainable, but require effort to meet them (Sakurai, 1989).

Target costing in process and service businesses

Target costing is as relevant to the service sector as the manufacturing sector. Cooper and Chew usefully (1996) identify ways in which target costing can be applied to service-oriented businesses, which is of particular interest when looking at its applicability to the NHS.

The key issues are still relevant

For process businesses, the focus of target costing shifts from the product to the process, and for service businesses the focus is the service delivery system. Although, the key issues – understanding the needs of the market, customers and users, and ensuring satisfactory financial performance at a given cost or price which does not exceed the target cost – remain.

⁹ *Off Target?*, Banham, CFO Magazine, May 2000, pp 127-130

Focus on the impact of new services on the whole system

Cooper and Chew (1996) point out that in people-intensive, customer-responsive service-delivery systems, it is not only possible to add new services, it can be hard not to – for example menus are easy to extend and firms can enter new areas of practice. But a discipline is still needed which ensures that these service extensions are still profitable.

Where a single delivery system is used to deliver a wide range of services, determining the profitability of individual services can be an exercise in the arbitrary allocation of costs. In services, particularly where waiting time is critical, it is the systemic effects of individual new services, such as whether they make the process more complex, which determine whether their revenue and value to customers offset the costs. Target costing which focuses on the systemic impact of new services can help organisations resist the urge to create new services just because they can (Cooper and Chew, 1996).

Costing in the NHS

The need for improved financial management in the NHS

As already mentioned, the joint report published in June 2005 by the National Audit Office and the Audit Commission identified the need for improvements in financial skills and systems to meet the challenges facing the health service. Indeed in 2004, in its paper *Achieving First-class Financial Management in the NHS*¹⁰, the Audit Commission had already concluded that first-class financial management has a vital role in delivering improvements to patient services.

The 2005 report described the unprecedented level of pressure on the NHS financial regime, due to the combined effect of increased annual expenditure, structural reform, new staff contracts, developments in information technology and changes to funding. In this environment, better costing of services and management of those costs can have particular impact in helping organisations to meet their financial responsibility to at least break-even by ensuring that services are delivered within budgeted costs. In addition cost comparisons with other organisations and other financial analyses can provide vital information in tackling deficits which do arise. Better understanding of cost will also aid forecasting and transparency. Target costing may provide a framework for achieving this.

Payment by results

The development which most directly suggests that target costing could be of use to the NHS is the move towards a new method of funding services with NHS Trusts being paid a pre-set tariff for each service they provide, rather than a price based on their own costs. Target costing, with targets related to the national tariff, might provide a discipline within which Trusts could manage costs to improve efficiency.

Current use of target costing in the NHS

Literature concerning the use of target costing in the NHS is very limited, and it does not appear that it is used in many health care organisations. In a survey of accountants working in the public sector in Scotland published in 2003, Jackson and Lapsley¹¹ reported that 6% of those in the health service reported that their organisations were using target costing. However some research has been carried out into costing in general in the NHS, which highlights some issues which are of relevance to further discussion on the use of target costing in the Health Service. These are outlined in the next paragraphs.

The development of financial management in the NHS

Reform of the NHS over the past two decades has involved the establishment of new organisations, accountability frameworks, management systems and processes and new accounting practices and procedures. There has been an increased emphasis on 'management' rather than administration of services and a shift in the focus of the accounting function from stewardship to cost management. There is an emphasis on value-for-money supported by performance measurement, budgeting and costing techniques (Jackson and Lapsley, 2003).

¹⁰ *Achieving First-class Financial Management in the NHS: A Sound Basis for Better Healthcare*, Audit Commission 2004

¹¹ *The diffusion of accounting practices in the new "managerial" public sector*, Jackson and Lapsley, International Journal of Public Sector Management 2003 Vol. 16 No. 5 pp 359-372

From the above survey, Jackson and Lapsley (2003) concluded that there has been little experimentation with accounting techniques in the public sector, possibly because there has been so much change in accounting systems in recent years that finance managers have not had the time to do so. Respondents also indicated that the accounting techniques used were mostly at the recommendations of official bodies and that accounting changes took place when forced by regulation, statute or exhortation. The authors, however, also identified a key role to be played by professional bodies in providing the support to financial managers in implementing new systems.

Difficulties in defining the product and attributing costs

Based on research into the costing and pricing methods in the NHS, Ellwood (2000)¹² identified difficulties in ensuring comparable prices across providers due to problems defining the 'product'. Clinical specialties cover a wide range of disparate treatments and, in addition, services include high levels of indirect cost. Consistent methods of cost attribution are needed, and this is not always straightforward. Much work has been carried out within the health service to address this through the development of reference costs – however, the Department of Health's Costing Manual (2005)¹³ still recognises that direct charging is not always possible and that there are different configurations of cost centres across providers. This may limit the consistency which can be achieved.

Cost variability is still an issue

Recent research carried out by Northcott and Llewellyn (2004)¹⁴ identified cost variability as an ongoing issue within the NHS which impacts on the use of reference costs for benchmarking and as a basis for the national tariff. One factor contributing to this is a real and inherent difference in costs, both direct and indirect, which is due to variations in emphasis and case-mix between hospitals, geographical considerations and the characteristics of the local population.

Northcott and Llewellyn also pointed to variations in cost allocation methods and levels of sophistication of costing which limit the usefulness of reference costs for benchmarking and pricing.

An absence of standards

A further issue identified by Northcott and Llewellyn (2004), when considering the use of the National Schedule of Reference Costs for benchmarking, is the lack of a benchmark as there is no indication of what an excellent performance would be or any definition of unacceptable performance. In the absence of such standards Trusts aim for average or 'normal' performance, such that the norm becomes the standard aimed for. Although, it is not clear whether a provider having a low reference cost index compared with the average is a superlative outcome, and whether having a high index should be worrying or seen as an indicator of being a high quality centre of excellence.

Target costing and the NHS

The following section includes questions (not an exhaustive list) which may serve as a starting point for discussion about the applicability of target costing to the NHS. CIMA welcomes comments on any of the points below.

Can management techniques used in manufacturing be applied in the healthcare sector?

The application of techniques developed in manufacturing companies to other sectors such as healthcare is often resisted on the basis that they are irrelevant because of the obvious differences between the operational activities of companies and hospitals. Whilst it is true that organisations in different sectors may have very different aims and objectives and processes, general management approaches may well be transferable.

A number of healthcare providers in the United States have made significant improvements to patient care and resource utilisation by adopting approaches used in manufacturing and service businesses, including the principles of the Toyota Production System. Spear (2005)¹⁵ describes a number of case studies from hospitals and clinics where learning from business and applying their techniques has brought significant benefits in improved quality of care, decreased mortality and cost reduction through a multidisciplinary approach.

¹² *The NHS Financial Manager in 2010*, Ellwood, Public Money and Management Jan-Mar 2000, pp 23-30

¹³ *NHS Costing Manual*, Department of Health 2005

¹⁴ *Decision Making in Health Care: Exploring Cost Variability*, Northcott and Llewellyn, CIMA Research 2004

¹⁵ *Fixing Healthcare From the Inside, Today*, Spear, Harvard Business Review, September 2005

To what extent does the NHS face similar problems to the companies which introduced target costing?

The companies which first made use of target costing were facing consumer demand for more diversified products and shorter product life cycles, increased automation and decreased labour costs. This meant that companies needed to manage costs from the design stage forward and launch products at prices to attract customers and delay imitation. NHS organisations operate in a different environment, but some of the same needs exist. For example, service developments should still be based on the needs of users. Resources are limited and costs need to be managed. Companies using target costs were also facing costs which were largely built in at the design stage – the extent to which changes can be made to NHS services after they are up and running could also be an area for discussion.

Can NHS organisations make the same decisions about provision of service as manufacturing companies?

Manufacturing companies used target costs as a basis for deciding whether or not to introduce new products – one question which should be asked is to what extent NHS organisations are in a position to decide not to continue with an existing service or establish new services if they are unable to do so at a sufficiently low cost.

There are three main types of decision for which the use of target costing could be of relevance:

- The introduction of completely new services; but the extent to which organisations have influence over this will depend on the role of the National Institute of Clinical Excellence (NICE) which approves some aspects of new services. NICE does assess value for money (e.g. cost per quality-adjusted life-year), but the current process is rather different from target costing.
- A local decision whether to start or stop providing a service already done elsewhere in the NHS.
- A Trust using target cost as a tool to drive down existing costs by, for example, making changes to the way it provides the service.

Are the concepts of 'market price' and 'profit' relevant to the NHS?

Whilst the NHS is not a free market, for many activities payment by results has introduced a national tariff (adjusted for a market forces factor) which could be seen as representing a 'market price'. These tariffs will not exhibit the same behaviour as in the private sector; as they are set centrally, based on an annual calculation of reference costs, there may be unpredictable changes from one year to the next, but once tariffs are set for the year there is certainty over the price which cannot change in-year except in exceptional circumstances.

For such activity there is also an implicit surplus (profit) or deficit (loss) between the cost and income. There are a number of questions which this raises, for example:

- Will this 'implicit' profit have to become more transparent in the future?
- What is an acceptable level of profit?
- How should issues of 'profitable' services cross subsidising 'loss making' service be handled?
- Will there be a requirement for a more explicit Trading Account element on the Income & Expenditure account?

How would you define a product or service in the NHS for the purposes of costing?

For target costing to be useful it is necessary to define the 'product'. The moves to reference costing and a national tariff means that there is more clarity about the definition of specialties and procedures for which they apply, which should aid the implementation of target costing.

For activities covered by the national tariff this is likely to be the activity as defined in the tariff but there may still be organisations, or clinical areas, where it is more appropriate to use a different definition of a product (such as based on medical conditions or care profiles built up from individual components). For example, the NHS Costing Manual identifies a need to 'provide cost information that is accurate and relevant to clinicians, nurses and managers at all levels.' The key to this described as 'the development of costing below specialty level and the identification of major 'blocks of costs' for services. These 'blocks' can then be assembled in a variety of ways to meet the various needs for cost information of NHS clinicians and managers, and form the building blocks for the development of Care Pathways.'

Would it be used for existing services or new ones?

The private sector developed the use of target costing when looking at new service developments. In Cooper and Chew's work on target costing in process and service businesses described in a previous section, the authors suggested that target costing should focus on the systemic impact of new services rather than existing ones. This may also be an appropriate approach for the NHS; however this would demand the establishment of target or affordable costs for the service, for which there may be no comparative data. There is also the question of the role of NICE in this. In addition, if this were the approach taken there would be no benefit of target costing in improving existing services.

Would there be any problems caused by the current methods for attributing costs?

There are still differences between providers in the way in which costs are attributed, particularly overheads, which may have implications for the use of comparative data and in particular the national tariff as a target. Although NHS organisations are all required to use the principles laid out in the current costing manual, different NHS organisations do have different costing models, methodologies and approaches such as the differing approaches used to split out Category C income.

In common with other service businesses, service costs in the NHS include a significant proportion of allocated overheads. This factor could be seen as a challenge to the use of target costing, but it further emphasises the need to understand cost make-up and ensure appropriate targets are set. Equally important is the need to be able to explain the necessity for multi-disciplinary action to achieve targets and address the sometimes falsely-held perception that the 'problem' is the high overheads added to the cost of a service and not the direct cost. Target costing may provide a method of addressing such misunderstandings.

The issue of cost variability has already been mentioned as identified in research carried out for CIMA (Northcott and Llewellyn, 2004). Some of this variability was due to structural differences such as case mix, but some was a result of variations in definition or cost allocation. Consistency in definitions and counting of activity is particularly important in a system based on national tariffs. For target costing (indeed any activity which involves comparison with a target or benchmark) a Trust may want to attribute costs in the way which seems most realistic in the local context but it is essential to compare like with like and eliminate any differences between the organisation's costs which arise from such factors.

Is the information available reliable enough to carry out target costing?

It is important that any in-depth analysis of costs is based on accurate, timely information, both to ensure that the right decisions are made and to give target costing credibility as an approach. This has implications for the quality of clinical coding and other information on the use and cost of overhead resources. However, it may be that it is unrealistic to look for perfect information and that using a target costing approach highlights information issues and forces improvement.

A further problem facing the NHS is that as reference costs were only used for benchmarking purposes in the past, there was often a lack of resources in the costing area. However as the significance has increased, organisations need to invest more in costing and improve the accuracy of cost information.

What would be the relationship between the national tariff and target costs for an individual provider?

Does the target cost have to be the same as the national reference cost or can it be independent of it?

If the target cost is not the same as the national tariff how could it inform target costing?

In looking at existing services or those new to the provider but carried out elsewhere, the most obvious approach would be to use the national tariff as this is the amount which the Trust will earn, although there may be circumstances in which this is not the best approach. For example, if the actual cost is significantly above the target cost, use of the national tariff as the internal target could be seen as unachievable, at least in the short term, leading to a lack of support for the approach. It might then be better to take a staged approach and work with a series of intermediate cost targets.

Conversely, if the actual cost is below the national tariff the organisation could still choose to use target costing to improve costs, but this would mean setting a different target. Organisations may indeed learn from using the target costing approach to understand why some services are performing well.

Is target costing too bureaucratic?

Whilst the majority of literature focuses on the advantages of target costing, Davila and Wouters (2004)¹⁶ criticised it for being too detailed, bureaucratic and time-consuming. Target costing does require formal procedures to assess customer needs, determine target prices and costs, break perceived value down to subsystems and components to come up with allowable cost per part, and apply value engineering to achieve the target cost in an iterative manner. However large complex organisations do need system wide, broadly understood rules to facilitate interaction both internally and externally and target costing may provide a framework for this. However, it may still be appropriate and of benefit to use it for specific services even if not across the whole organisation.

Is target costing an approach which could be implemented by individual organisations in isolation or does it require a whole systems approach?

Private sector companies found target costing to be an approach which needed to take into account the whole supply chain. If this also applies to the health service, this may mean that it needs to involve the whole local health economy, including patients and suppliers.

Is the culture ready for target costing – would there be buy-in throughout the organisation/health care system?

Linked to the point above is the need for a multidisciplinary approach, which was key for successful implementation in the private sector. These two areas were ones which many organisations found most challenging – the NHS is not likely to be any different. However case studies described by Spear (2005) demonstrated that in hospitals in the US, which adopted management approaches from companies such as Toyota, staff began to work collaboratively in solving problems. Rather than maintaining defensive positions or blaming other functions they explored solutions together and made significant improvements.

How would it link with other techniques which are or could be used in the NHS e.g. ABC? Are there other methods which are more appropriate?

In the private sector target costing was used as a framework for applying other techniques, some of which have already been used in parts of the health service, such as activity-based costing and total quality management. However as described above, Jackson and Lapsley (2003) discovered that limited use had been made of new techniques. If target costing is to be used successfully, consideration needs to be given to the support which managers implementing the technique would need.

Next Steps

CIMA is currently considering whether to extend this work to produce further guidance for NHS managers on target costing specifically or costing in general. Your comments on any of the issues raised in this paper or your views on what form you would like further work to take are welcome. Please contact Technical Services at CIMA, 26 Chapter Street, London SW1P 4NP or email technical.services@cimaglobal.com. Please note correspondence cannot always be entered into.

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¹⁶ *Designing Cost-Competitive Technology Products through Cost Management*, Davila and Wouters, Accounting Horizons 2004 Vol. 18 No. 1 pp 13-26

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