# The Usefulness of Budgets in the Healthcare Sector

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ABSTRACT

In addition to setting the performance agenda for the year ahead, (revenue) budgets in the healthcare sector can facilitate tighter financial control, more responsive decision-making and staff motivation. However, many healthcare managers may lose respect for the use of predominantly incremental budgets given that they typically do not explore historical service redundancies that may exist nor reward efficient use of resources or facilitate long-term service planning. The lengthy budgetary process can also predispose to out-of-date budgets. Top-down budgetary allocation can also be susceptible to political influence and as supplementary estimates can be accessed, managers (and senior clinicians) may not exercise budgetary discipline. Rigid systems of budgeting can also stifle creativity and innovation. Hence, there is a need to link budgeted levels of multi-annual expenditure to recognised and meaningful performance indicators.

## INTRODUCTION

While budgets are an integral component of service level agreements with the private sector, for example private finance initiatives (Broadbent et al., 2001), this short essay will focus on the usefulness of revenue budgets as employed within the Irish Health Service Executive (HSE). Having defined the term 'budget', its

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usefulness will be briefly discussed under five distinct (but overlapping) sections. The conclusion then follows a short consideration of the ways in which budgets may be non-value-adding.

## BUDGETING IN THE HEALTHCARE SECTOR

Ideally, the annual budgeting process sets the performance agenda for the year ahead (Hope and Fraser, 2001b). However, healthcare budgets are often only an estimate of income and expenditure, with incremental budget setting the dominant budget type employed (Commission on Financial Management and Control Systems in the Health Service, 2003).

### Financial Control

Official accountancy terminology defines budgeting as an integral part of the control process (Croft, 2001) whereby monthly budgetary variance analysis can cue corrective action by operational managers (Chartered Institute of Management Accountants, 1992). However, such managers may not be able to influence their budgets (Croft, 2001). On a more global level, budgets are susceptible to political influence (Cassell, 2003) whereby financial control can be diluted by the personal preferences of 'well-connected' individuals or groups with vested interests. Hence the term 'budgetary control systems' may be a misnomer, at least at a global level (Flamholtz, 1983).

### Delegation

Given that no one person alone can manage the HSE, budgets can facilitate the necessary delegation of managerial responsibilities. Delegating expenditure consumption up to a certain level can also improve the speed of decision-making if there is no need for authorisation from a higher-level manager (Prowle and Jones, 1997). The quality of decisions may also increase given that (better-informed) individuals closer to the point of service delivery can make them (Hope and Fraser, 2001a).

### Resource Allocation

Given that funding is finite, budgeting facilitates internal distribution of resources to competing healthcare services (Prowle and Jones, 1997). Thus, although departmentalism may be reinforced

(Bourne et al., 2002), resources can theoretically be directed at particular elements of a service, such as specific clinical populations or geographical areas where they are most needed.

**Planning**

As an expression of the annual service plan in financial terms, budgets can be a critical element in the planning process (Prowle and Jones, 1997). However, their incremental nature results in baseline funding for predominantly 'doing more of the same', to the extent that letters of determination are little concerned with (new) service planning. In contrast to the multi-annual planning framework for capital expenditure, the annual and 'rear-view mirror' nature of (revenue) budgets (Hope and Fraser, 2001a: 24) also militates against long-term service planning (Commission on Financial Management and Control Systems in the Health Service, 2003).

If aligned to regional strategy, budgets can facilitate regional goal congruence (Laurence, 2001). However, such alignment is often absent (Bourne et al., 2002), with managers submitting budgets based on unfounded or unrealistic assumptions (Hope and Fraser, 2001a; Hyndman et al., 2003). Hence, for example, there have been incidences of unapproved capital expenditure. Ideally, the HSE will allocate resources according to evidence-based needs assessment (Commission on Financial Management and Control Systems in the Health Service, 2003). Additionally, it is necessary to review the lengthy estimates process that creates a predisposition to have both budgets which are out of date by the time they are signed off on (Hyndman et al., 2003) and a lack of responsiveness to new demands for service during the financial year (Bourne et al., 2002).

**Motivation**

Given that HSE staff create what it sells, they are its most important asset. Hence, it behoves the HSE to make every effort to build employee motivation (Byrne, 2006). This can be achieved by a process of appropriately devolving budgets so that employees or departments can assess and adjust their own service contributions (Chartered Institute of Management Accountants, 1992). However, healthcare budgeting is typically a top-down annual event. Such 'macho' management (Lilly, 1994: 38) and use of accounting data

to control employees can make them feel undervalued (Bourne et al., 2002). Ideally, employees at all levels need to be consulted to promote budget ownership and, where possible, those responsible for improvements in service delivery need to be acknowledged and rewarded (Howard, 2004). One mechanism for facilitating this is to link employee (or departmental) goals and the appraisal process to overall service objectives (Hope and Fraser, 2001a).

Exclusive use of traditional budgets in isolation from other key operational performance indicators can also demotivate employees (Hope and Fraser, 2001a; Bourne et al., 2002; Hyndman et al., 2003). But performance indicators are poorly developed in the healthcare sector (Butler, 2000). Budgets may also have little credibility among managers who have learned from experience that they are no more than a management accounting exercise (Cassell, 2003). Hence, such managers may play games with, and manage around, budgets (Hope and Fraser, 2001a). For example, despite a commitment to the contrary, it appears that (considerable) supplementary estimates are still being accessed to cover some normal budgetary costs (Commission on Financial Management and Control Systems in the Health Service, 2003). Managers may not exercise budgetary discipline if there is a potential 'get-out' clause late in the financial year.

**Non-Value-Adding**

The budgeting process has become even more expensive (Hope and Fraser, 2001a; Bourne et al., 2002), consuming up to one-third of financial managers' time (Littlewood, 2000) and distracting them from more important responsibilities, such as strategy formulation and implementation (Cassell, 2003). While the risk of budgetary overspend is highly problematic in the healthcare sector (Wren, 2003), the overarching bureaucracy of what appears to be a rigid system of budgeting that rewards good housekeeping can stifle creativity and innovation (Hope and Fraser, 2001a).

The incrementally based estimates process does not explore any historical service redundancies that may exist. Thus, healthcare budgeting can compound existing inefficiencies (Lilly, 1994) and fail to align services to address demographic and social changes. Budgeting has also rarely been brought down to the first line of

healthcare service management. For example, there have been few incentives for professional groups such as consultants and general practitioners to manage expenditure to produce agreed outputs (Commission on Financial Management and Control Systems in the Health Service, 2003). Hence, there is a need to link budgeted levels of expenditure to projected workload and/or globally recognised performance indicators. The use of bottom-up budgets by well-informed front-line staff, once ratified by senior managers, could also identify and eliminate avoidable costs before they occur (Howard, 2004).

Annuality has traditionally motivated managers to inflate their funding requirements so that they will have more to spend (Hyndman et al., 2003). As unspent resources have also been used as a benchmark to reduce subsequent budgets, 'prudent' managers have typically had stand-by projects to ensure that unspent resources are consumed. Such wasteful year-end spending sprees (Cassell, 2003) have often not added to service improvements in a best value-for-money manner (Hyndman et al., 2003). Sometimes voluntary healthcare agencies have also been under pressure to provide extra services at short notice such that year-end service quality has been sacrificed. If, like supplementary estimates, annuality is not completely phased out by the HSE, (year-end) value for money could be facilitated by having an early identification system of potential under-spending and allocation of unused resources to projects consistent with organisational objectives (Hyndman et al., 2003).

## CONCLUSION

It appears that the increasingly expensive healthcare sector (Dranove and Satterthwaite, 2000) is, by necessity, 'wired for control', with budgeting systems serving as its 'traffic lights' (Hope and Fraser, 2001a: 25). However, these traffic lights could be wired somewhat differently without compromising the sector's inherent vertical command and control structure (Bourne et al., 2002). As espoused by the Beyond Budgeting Round Table (Cassell, 2003; Hope and Fraser, 2001a), budgetary reform could include the use of multi-annual, real-time and bottom-up activity-based budgets whereby individual departments (or services) are allocated resources based on evidence-based needs assessment (Commission

on Financial Management and Control Systems in the Health Service, 2003) and evaluated and rewarded using a more balanced set of key relative improvement performance measures (for example quality) (Cassell, 2003). To realise this, improved communication between different management levels and healthcare organisations is necessary (Howard, 2004). The latter recognises that rather than the principle of budgeting being at fault, the less-than-optimum application of budgets may have compromised their usefulness to date in the healthcare sector.

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