Cash Limits and Hospital Prescribing

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Abstract

A great deal of effort has gone into examinations of management and accounting practices within the NHS, however, very little attention has been paid to the management of medicines within the hospital sector. This paper aims to address this situation by examining from a secondary care perspective how clinicians within secondary care are responding to and coping with indirectly imposed cash limits, efficiency savings targets and increasing budgetary control. A major conclusion is that the application of this economic rationalism served to revitalise the concept of social care and professionalism contained within the clinical professional culture.

Key words: Budget; Cash-limits; NHS; Medicines
Introduction: Spending on Medicines

Much recent research effort has gone into examinations of management and accounting practices in the setting of hospital care. This effort has, however, generally neglected the management of medicines; a lack which is strange, given that, medicines provision is one of the major costs of the NHS. Where research has been conducted it tends to focus specifically on primary care prescribing and has largely ignored prescribing within the hospital setting. This paper aims to begin to redress this neglect by analyzing the changes that have occurred in the management of medicines within secondary care as a result of NHS reforms and strategies that have been adopted to bring the escalating drugs budget under control. The main focus of the paper considers the effects of cash limits and prescribing control initiatives on the professional activity of the medical profession and their working practices within a sample of acute hospitals in NHS Scotland.

Traditionally the organization and delivery of healthcare has been regarded as a ‘unique commodity that should be treated separately outside the realm of economic analysis and accountability’ (Malek et al., 1992, p1). Further, because of its specificity some would argue that it should be considered compartmentally with its own rules, regulations and organizational behaviour (Malek et al., 1992, p1). The organization and delivery of pharmaceuticals in the NHS reflects such peculiarities. Indeed the unpredictable nature and demand for medicines was the precise reason for its exclusion from the cash limited budget.
Medicines play a central role in the delivery of health care as they constitute the principal intervention for many problems presented in both primary and secondary care. As such the provision of medicines is thus a significant cost to the NHS. Indeed over the last two decades, the UK NHS drugs budget has been increasing by approximately 13%\(^1\) a year (Abraham, 2009). Within NHS Scotland, the total drugs bill for 2009/2010 amounted to £1,222,331 accounting for 15.1%\(^2\) of total NHS expenditure (ISD, 2010). A major contributing factor to the increasing drugs bill is thought to lie in the prescribing practices of the GPs and hospital clinicians. The volume of prescribing during the financial year 2010-2011 within the Minor Ailments Service, for example amounted to 1.7 million items. The total volume of dispensed items in Scotland (including GP prescribing) during the same period amounted to 91.1 million which was a rise of 2.4% on 2009-2010 (ISD, 2010).

Several studies that look specifically at prescribing within primary care have been conducted. For example Sussex, (1998), looked at the effects of bringing primary care prescribing expenditure under the cash limit and concluded that such an approach, whilst making it easier for healthcare planners to implement national service frameworks and treatment guidelines, also led to GPs adopting gaming strategies with patient services in order to minimise budget over runs. In the Scottish context, Llewellyn and Grant, (1996), in their investigation into the impact of fund-holding on primary care concluded that it was questionable whether cost savings in prescribing activity had been achieved. Similar conclusions were found in the work of Lapsley et al (1997) in their study of GP fund-
holders as agents of change. This was further exemplified by Fischbacher and Francis (1998) in their study of the purchaser provider relationships and innovation which noted that within GP practices in Glasgow, while improved efficiencies in terms of prescribing had been achieved the success of the fund-holding scheme was not unequivocal. Despite recent cash injections, the scope to increase NHS spending is limited, thus the need to ensure the efficient utilisation of resources such as pharmaceuticals and use of existing budgets is still a central focus of government attempts to reform the NHS (Lapsley, 2008). To date, however, there has been very little research into the effects of NHS reform and budgetary control on the provision of medicines within secondary care.

While it is true that the largest drug spend occurs in primary care, significant expenditure on medicines also occurs within the hospital setting. A report issued by the Auditor General for Scotland in 2005 stated that NHS Scotland ‘could improve the management of medicines in hospitals’ (AS, 2005, p1). The range, complexity and uptake of pharmaceutical treatments within hospitals have grown in recent years and are having a significant impact on NHS costs to the extent that ‘spending on medicines is rising faster that NHS spending overall’ (AS, 2005, p1). While the overall running costs of hospitals rose by 32% between 2000 to 2004, expenditure on medicines during the same period is reported to have increased by 56% (AS, 2005, p1). Total spending on medicines within acute hospitals in 2002/2003 amounted to £126 million. During 2007/2008 the drugs bill for acute hospitals amounted to £222 million. In cash terms this is a 76% increase (AS, 2009). The cost of medicines in NHS Scotland secondary care in 2008/2009 came in at £257 million accounting for approximately 5.1% of the overall
running costs (Fig1). Total hospital drug expenditure in 2009/2010 amounted to £293 million, 5.7% of the net hospital expenditure (ISD, 2008 & 2010a).

Medicines that carry a high cost per patient put particular pressure on already tight budgets. Eleven NHS boards during 2007/2008 spent over £25 million (12% of the total medicines expenditure compared to 4% in 2004/2005) on four high cost medicines in their acute hospitals (AS, 2009). No board however, could provide information on the number of patients treated with these particular drugs during that four year period. Additionally, NHS Borders and NHS Lothian were only able to provide partial information on their expenditure on some of these medicines in 2007/08. Thus the £25 million spend on these four medicines can only be viewed as an estimate (AS, 2009). The cost of medicine provision is therefore, still a major problem for policy makers and has resulted in healthcare officials being increasingly caught up in debates over the provision, cost and efficiency of prescription medicines.
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<td><strong>212,026</strong></td>
<td><strong>245,315</strong></td>
<td><strong>243,081</strong></td>
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<td>4,177,464</td>
<td>4,352,670</td>
<td>4,729,211</td>
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<td><strong>% of Total Hospital Expenditure (net)</strong></td>
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<td>5.08%</td>
<td>5.64%</td>
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**Figure 1: Hospital Drug Expenditure by NHS Board 2004-2009 (Source: ISD 2004-2010)**

This paper examines from a secondary care perspective the effects of bringing the drugs bill under the overall cash limited budget. It aims to investigate how clinicians within secondary care are responding to and coping with indirectly imposed cash limits, efficiency savings targets and increasing budgetary control. The paper begins with an overview of the management and budget arrangements of medicines within the NHS, highlighting specific changes to the management and control of medicine provision before moving on to present the research method and analysis of the qualitative data generated for the study. The information presented here is based on discussions held with clinicians from the hospital boards under investigation in light of the findings of the documentary sources. The views of the clinicians with regard to prescribing practice, cash limits and increasing budgetary control are then presented and analyzed. The study
conclusions will be presented in the final section. The most significant changes in terms of the management of medicines budget will be discussed in the next section.

**Budget Reform**

A major constraint to the management of NHS financial resources is the demand-led nature of the service. For example patient demand for treatment and prescription medicines that cannot be postponed until the next fiscal year. At the outset of the NHS financial planning and control was determined by the ‘Estimates’ system which required departments to submit annual estimates of their likely cash expenditure (Sussex, 1998). This system largely ignored the future implications of spending. As such it was replaced in 1961 following the Plowden report which recommended that public expenditures, including healthcare, should be planned on a 5 year basis and on volume rather than cash (CM1432, 1961). The high rates of inflation experienced in the UK during the 1970’s led to a further review of NHS financing.

Up until 1974, financial management in the NHS was limited to the control of costs on a subjective basis with the focus being on what the money was spent rather than on for whom, where, why etc (Lapsley, 1992). Budgeting was at its most basic, with simple roll-over historical budgets and no clear definition of lines of financial management or responsibility (Lapsley, 1994). The reorganisation of the NHS in 1974 was the first step towards placing an emphasis on the organisation, management and accountability of
where the money was being spent. In 1976, with the exclusion of demand-led expenditures such as prescription medicines, cash limits were imposed on NHS spending for the first time (CM, 6440, 1976). Under this system over-spending had to be justified and a specific case for more financing made to Parliament. The cash limit to NHS spending was reinforced by the Conservative government in 1982 and was presented as a vital element of government expenditure policy.

The 1982 reorganisation pushed the authority and accountability for resource consumption decisions down to unit level (Mellett et al, 1993, p9). However, those responsible for the day to day organisational decisions that determined the patterns and volume of resource consumption were not responsible or accountable for the management of the budgets that the costs were allocated to. For example, up until this point doctors held the ‘right to prescribe without limitations’ (Webster, 1996, p139). This presented Ministers with a dilemma. To increase efficiency and accountability meant introducing management and budgetary control measures which would potentially be perceived as threatening by the medical profession (Doolin, 2002).

Within secondary care the government sought to achieve efficiencies by transferring the responsibility for the drugs budget to the clinical directorate (Barber & Wilson, 1999). This obliged the clinical directorate to make strenuous efforts to control prescribing expenditure and to achieve optimum benefit at least cost. The prescribing practices of clinicians also became guided by control mechanisms such as predetermined care pathways, quality standards, treatment protocols, the imposition of locality formularies.
and input from clinical pharmacists (Millard, 1999). Any deviation from these pathways such as the prescribing of new drugs required closer attention to the balance of safety and efficacy due to their relatively high cost and had to be justified before implementation.

Additionally, clinicians increasingly became faced with a shift of emphasis from process accountability to output accountability; with traditional costing and budgeting systems that focused on the control of total expenditure and provision of information for government purposes being replaced by new systems that delegate financial responsibility and accountability for medical decisions (Moon & North, 2000). Under this new system the clinical autonomy of clinicians was preserved but made more visible through financial calculation and accountability (Kurunmaki, 2004).

This brings us to another element of reforms of the NHS which established commissioning authorities covering both primary and secondary care to address prescribing issues (Panton, 1998, p49). Up until this point, the provision of medicines had been excluded from the overall budget due to the highly variable demand for medicines that result from demographic differences, the unpredictability of epidemic disease, an ageing population and technological advancements that put pressure on the demand for treatments. The introduction of the Indicative Prescribing Scheme and the GP fund-holding scheme (now abolished and replaced with Primary Care Trusts) resulted for the first time, in the provision of medicines by GPs who participated in the fund-holding scheme being brought under the cash limit (Sussex, 1998). This however, did not impose a direct cash limit to prescribing.
In comparison to primary care a much larger range of drugs are utilised within the hospital setting. Secondary care also has the advantage of achieving economies of scale through its ability to bulk buy and negotiate discounts directly from the pharmaceutical companies (Upton et al, 1989). Prescribing at the interface between primary and secondary care has always been problematic and hindered by poor communication and coordination. Indeed, clinicians in the hospital setting had little appreciation of the cost of medicines within primary care and the effects of their prescribing decisions that would accompany the patients into primary care (Beaza, 2005). In an attempt to resolve this situation the implementation of a ‘joint formulary’ that spans across this interface was put forward (AC, 1994). Moves to integrate primary and secondary care drug budgets in some areas were also undertaken. It was hoped that this would increase secondary care clinician’s awareness of the implications of their prescribing patterns on the primary care sector and encourage more cost effective prescribing within the hospital setting that can be continued in primary care. Thus where integrated drugs budgets were established this effectively also imposed an indirect cash limit to hospital prescribing.

In addition to these changes moves were also taken to improve information on the costs and benefits of existing and new drug treatments in order to support the planning and budget setting for medicines provision within the hospital setting. For example an Area Prescribing and Medicines Management Committee was established which pulls together drug information from a variety of committees such as the National Institute for Health & Clinical Excellence, the Scottish Medicines Consortium, the Scottish Intercollegiate
Guidelines Network etc (HCHC, (2002), SIGN, (1999)). Better information on the monitoring and use of medicines within hospitals was also recommended by the Auditor General in 2005 (AS, 2005). Unlike primary care, information on medicines prescribed and issued within the hospital setting has not, in the past been collated in any formal or standardised system. Thus in addition to the changes outlined above the Hospitals Medicines Utilisation Database (HMUD) was established and rolled out in February 2010 (AS, 2009). The primary purpose of the HMUD is to enable comparison of patterns of medicines use between different hospitals and NHS Boards across Scotland. Access to this data, however, is restricted to senior health board members.

The successive round of NHS reforms and the increased focus on efficiency and value for money in service provision has thus resulted in the cost of treatments becoming an important element in healthcare delivery. As has been demonstrated, the cost of medicines provision is substantial. In addition to the initiatives outlined above, the Scottish government response to the cost of medicine provision has been to set efficiency savings targets of between 1 – 2% for health boards overall spending Individual boards are responsible for determining how such savings can be achieved. As doctors in the past were relatively isolated from financial control, there was little incentive for the medical profession to consider the costs of their treatments. Safety and efficacy were considered to be more important than cost in prescribing decisions. Such a position led to wide variations in prescribing habits both in primary and secondary care, resulting in unconstrained growth of the drugs bill (Abraham, 2009).
Steps towards tackling NHS spending and control of the activities of the medical profession have been around for some time. Several studies demonstrate resistance on the part of the medical profession to such intrusions (Dent, 2003), Spicer & Bohm (2007), Dopson, 2009). Other studies also show that the medical profession are increasingly becoming cost conscious and are responsive, to an extent, to cost control initiatives (Lapsley, 2001), Jacobs, (2005)). However, such studies have not focused specifically on the control of prescribing costs within the hospital setting or on the tensions that tight prescribing control raises.

**Sources and Research Method**

This paper presents the results of a project conducted within acute health care boards within Scotland. The study sought to investigate the effects of budget changes and potential cash limits on prescribing practices of clinicians exercising their professional duty within secondary care and contributes to closing a gap in research in this area. Hence the research design selected was documentary and interview based and was chosen in order to focus on those key players who take part or have an interest in the management of the drugs budget. The study participants included three clinical directors, five senior clinicians, nine clinicians and four junior clinicians. In all, twenty interviews were conducted for the project. The study participants are labelled according to their rank and position in the interview schedule, for example, CD1 relates to the first clinical director interviewed, SC1 relates to the first senior clinician interviewed, JC1 relates to
the first junior clinician and so on. The study participants were drawn from three acute hospitals within Scotland.

The design and construction of the interview questions were developed by drawing upon the issues identified within the literature and documentary sources. The questions were devised with the objective of eliciting the views of the clinicians on financial constraints, cash limits and their effects on their ability to exercise their clinical duty. The questions formed the basis of the discussions held with the clinicians and were divided into three main sections that dealt with matters concerning cost awareness, indirect cash limits, budgetary control and their impact on prescribing practice.

The interviews produced a large volume of qualitative data, from which the clinicians’ responses were analyzed to reveal key issues. The findings of this study add richness to our understanding of the issues and structures surrounding the management of medicines within secondary care and, of the outcomes of the regulatory pressures and tight financial constraints which are not evident within the extant literature. The research findings are presented in a descriptive form to provide an overview of the perceptions of the clinician’s experiences in managing the costs of medicines by describing, analyzing and interpreting the project results.

In the following sections the perceptions and responses of hospital clinicians who have to deal with increasing managerial and financial control and cost issues will be presented.
Empirical Results

What has been established so far is that the cost of the provision of medicines is a significant burden on the finite financial resources of the NHS. Common features of NHS reform centre on efficiency, value for money, and financial accountability with regard to the use of financial resources and provision of services including pharmaceuticals. Furthermore a major change as a result of the successive NHS reform has resulted in the inclusion of clinicians into managerial and financial management roles thus moving them away from their traditional autonomous individual position into one more inclusive within the organisation and its control systems (Llewellyn, (2001), Kitchener, (2000)). Such a change implies that a clinician’s judgment is now circumscribed by the needs of the organisation rather than individual autonomy. Prior to the NHS reforms safety, efficacy and quality of care were generally held as being the most important factors to consider in prescribing matters for clinicians; the issue of price was not their concern: ‘Considering cost first is not appropriate or very ethical. We have to make sure we can still treat the patients in the best possible way for them’ (SC1). The majority of respondents held the view that cost should not be taken into account in prescribing decisions: ‘I have reservations with imposed rigid financial constraints and cash limits…it has implications for how you can treat patients’ (C3)

The discussions revealed that efficacy and safety remain the main factors in prescribing decisions with cost often being ignored completely. Such sentiments are fuelled by the
belief that prescribing according to cost will have a negative impact on the quality of patient care: ‘I’m willing to consider different treatments but at the end of the day I prescribe according to the patients need. We have to maintain quality of care’ (C5). Clinicians in general believed that medicine, as a profession, aims to care for the sick, alleviate pain and suffering, treat disease, cure patients, and to create healing environments. Indeed, social care and professionalism are reputed to lie at the heart of being a good doctor (Abbott, 1988).

‘I went into medicine because I wanted to help people. I get a buzz out of curing their ailments or just easing their pain and discomfort. For me it’s very important to retain this. I’m not really interested in the managerial side of things’ (SC4).

While clinicians share some of the same desires as government officials, such as the creation of a superlative healthcare system, it is also clear from the discussions held that such altruistic values clash with financial constraints, imposed cash limits and the perspectives contained within some of the NHS reform initiatives.

‘What I want is to ensure that my patients get the best possible treatment I’m not an accountant so I don’t think I should be wasting my time trying to find such things out. It’s more important for me to be getting on and helping my patients’. (SC2).

Thus clinicians find that prescribing and financial cost issues raise tensions when it comes to them discharging what they consider to be their primary duty; patient care. Indeed the general view of the clinicians is that it is impossible to meet the budget
without compromising patient care which indicated a conflict between professional care and financial concerns.

‘I don’t think we have ever worked within the budget. It’s really impossible. Lots of things affect it: patient needs change constantly, new treatments become available. So it’s impossible really to meet the budget, achieve efficiency savings and meet the patients needs without compromising their care too much’ (SC5).

All of the interviewees indicated that being able to deliver high quality of care to their patients gave them a sense of prestige. Meeting the managerial and budgetary aspects of their role on the other hand did not add much to their sense of satisfaction or professionalism. Professional norms and values thus remain strong among this sample of clinicians.

‘It shouldn’t just be about control we’re professionals and have to be able to get on with what we’re here for we have to prioritise our professional role otherwise we spend too much time on administrative stuff’ (C4).

Reactions to the intrusion of managerial and budgetary discourses into the day-to-day management of the organisation depended to a large extent on whether such discourses were perceived as instruments which could be used by them to improve their own position or clinical service or as devices intended to control their activities. Where perceptions of managerial initiatives were viewed as a controlling device that challenged clinical activity and autonomy and in effect threatened their professional identity, resistance occurred.
‘The only managerial thing I’m interested in is making sure we get enough money. If we over run the budget, but the patients get the right care then that surely should matter more than just balancing the numbers’ (SC4).

In the past there were no incentives for clinicians to have an awareness of costs. All of the clinicians interviewed, did however, acknowledge that drug treatment costs were increasingly becoming an issue and that the changes embedded within the NHS reforms, including pulling the drugs budget under the umbrella of the overall cash limit, were an attempt to make them more aware of the cost of their clinical decisions which includes the cost of prescribing: ‘Money is limited there’s been lots of initiatives to make us more cost conscious with our treatment and prescribing’ (SC3). Indeed it is evident from the discussions held that clinicians are for the most part aware, although grudgingly perhaps, of the importance of managerial initiatives and budgetary control.

‘Of course we try and meet our targets and work within the budget but having the medicines budget under the cash limit makes it really difficult to meet the overall budget. It’s really hard to plan for the cost of medicines patients and health needs change all the time so it’s really problematic’ (CD2).

However, cost was only partly accepted as being legitimate consideration. All of the respondents regarded financial issues as secondary to their professional role, even those clinicians who were involved in the budgetary setting process: ‘We have to provide the patients with the medicines they need even if the budget is stretched’ (SC5). When discussing if budget overspends caused them a problem when presenting their financial
report to the financial administrators it was reported that the bigger the overspend the more stressful it was to defend it: ‘the bigger the overspend the harder it is to justify so it can be very stressful’ (CD2). Some reported that even a small overspend could be quite stressful for them. Several respondents also indicated that when a budget overspend occurred they had to recourse to professional norms of social and professional duty in order to defend themselves: ‘Overspends are debated and questioned but when it comes to patient care this comes first we can usually hold our ground on that for professional reasons’ (CD1)

In the past the exclusion of medicines from the cash-limit provided a safety valve. Where integrated budgets were in operation it was reported that this had resulted in better communication, collaboration and understanding between the hospital clinicians and their primary care partners: ‘We have more connection now to our colleagues in primary care mainly due to them taking on more responsibility and the development of collaborative care schemes and such like’ (C2). However, it was also reported that where integrated budgets and cash limits have been adopted budget control is found to be difficult and problematic primarily due to the demand-led nature of medicines provision.

‘In recent years we’ve had efficiency savings targets imposed on us these are really problematic it’s hard to meet these targets and maintain quality of care especially when demand on prescription treatments increases’ (CD1).

Despite such tension the interviewees in general, acknowledged that it was reasonable for some budgetary control and cost considerations to be exercised within the provision
of medicines: ‘Imposing financial accountability is reasonable after all its public money’ (CD3). Indeed it is clear that they recognise the need for prudent management of limited resources within the healthcare system: ‘Financial resources are limited; we don’t have bottomless pot of money so we need to be prudent with how it’s used’ (CD1).

While the spheres of clinical practice, budgeting and efficiency savings targets were identified, as territories for conflict and debate it is also clear that the clinicians spend considerable amounts of time involved in debates and decisions on resource utilisation.

‘Many hours are put into making such decisions we work with the finance guys as well as some of the support staff within the healthcare [collaborative] teams [including GPs] and committees [such as SMC, NICE etc.] to plan resource issues’ (CD1).

Despite this acknowledgement, however, when questioned on the issue of costs using specific drug treatments as a test sample, clinicians’ response and knowledge of drug treatment costs tended to be vague and inaccurate. The lack of cost awareness, however, may be attributed to the prevailing belief within the profession that considering cost, when it comes to patient care, is inappropriate and unethical. However, given the drive towards efficiency, value for money, financial prudence and the incorporation of clinicians into financial management roles, it is not unreasonable to expect a greater knowledge of such issues. Further investigation revealed that this lack of knowledge could be attributed in part to some costs not being readily available, either because a standard method of assigning costs is not used (for example diagnostic tests) or because costs of drug treatments are not widely publicised. This was rather surprising given the
establishment of various information committees that are in operation to support cost effective prescribing and treatment.

It is evident from the above comments that clinicians, while aware of cost issues, are resistant to excessive managerial control of their medical practice and are thus concerned with ensuring the maintenance and protection over their level of clinical autonomy. Indeed, many of the above comments are indicative of a strong mind set towards professional autonomy and the pursuit of clinical quality and excellence which are juxtaposed against potentially detrimental effects of managerialism.

‘We have lots of quality standards, protocols and so on for the most part they are very effective in terms providing acceptable treatments and keeping the costs down but sometimes they can leave our hands tied when it comes to treating some patients.’ (C8)

Discussions with the interviewees revealed that efficacy and safety remain the important factors in prescribing decisions but in the non-life threatening areas, treatment decisions were indicated as being made more on a cost effective basis, even if the quality of care was compromised to an extent. In contrast, it was reported that in the acute areas, cost in some situations was ignored almost completely. This was especially the case in specialist treatment areas. This may perhaps, be due to the fact that such areas generally have patients with more serious and complex conditions.

‘In simpler cases [referring to non life threatening] we can save money by prescribing cheaper forms of treatment, they might not be as good [meaning quality of care] but are
effective so by making those kind of choices we can divert more money to the acute [life threatening] areas… It’s the acute areas that give us the most concern every day we have to make tough choices about patient care this is especially difficult when the prognosis is relatively short or the patient is young or maybe has a family.’ (SC1)

Indeed when asked about prescribing the more expensive treatments or treatments that were out with the set guidelines for such patients, half of the interviewees felt that the budget should not be a factor in the planning of medication regimes. It was reported that in some situations, if it was deemed worthy, that more advanced and expensive treatment would be utilised but to help balance the budget that money would be moved from one area to another: ‘Increased expenditure in one area ideally should be matched by a reduction in expenditure in another area’ (CD1). It was also indicated that: ‘If the unit overspends the budget in total, the board is required to finance the deficit so we have to try and keep overspends to the minimum’ (CD2).

When asked if this would affect patient services in other areas, the majority of interviewees indicated that cuts to services that were non patient related would be avoided as much as possible. However, it was also recognized that if they continually ignore the finances that such services would ultimately suffer as a consequence.

‘Obviously if we don’t try and control spending and keep overspending something will have to give cutting non patient services to keep us within or a as close as we can get to the cash limit is one option but we do try to avoid that as much as possible.’ (C9)
Thus in order to make the most clinically efficient use of limited financial resources within their area clinicians are effectively pushed into a situation where they have to make trade-off with clinical decisions between the acute and non acute areas. Such gaming however appears to be causing clinicians, at all levels, some tension.

Discussions with junior clinicians revealed that while they were not fully aware of the cost of treatments or had access to budget information they were quite aware of cost issues: ‘Budget control is not one of my responsibilities so I don’t have access to that kind of information but we are expected to prudent in our use of resources’ (JC1).

Further discussions revealed that as a result of their lower professional status the issue of cost and working within tight cash limits caused them some frustration and created tensions: ‘We have a few [colleagues] who are not interested in cost they do their own thing and get away with it because of their position’ (JC2). Indeed the junior clinicians in general felt that the senior clinicians: ‘Really get on our case when it comes to money’ (JC3).

The use of formularies, clinical guidelines, treatment protocols and such like are intended to control and direct prescribing practices of clinicians. Such frameworks are also intended to provide consistent, equitable and cost effective treatment regimes.

‘Our main concern is treating our patients in the most appropriate way the hospital formulary, treatment guidelines, standards etc are all designed to help get safe and consistent treatments that are also cost effective for our patients.’ (JC4)
Indeed such initiatives were recognised as important tools of reference for the more junior staff that supported their prescribing practice: ‘The formulary, treatment guidelines etc provide a reference point for junior staff and enable them to make appropriate prescribing decisions’ (SC1). However, further frustration was also expressed at the imposition of such frameworks which are directed at specific clinical targets and therapeutic outcomes that are designed to direct the clinicians prescribing decisions: ‘they are quite constraining at times’ (JC1). The freedom of the more senior clinicians, however, to exercise more innovative practice raised further tensions within the more junior staff: ‘Some of the senior clinicians don’t appear that concerned with cost when it comes to their activities they prescribe what they like and get away with it’ (JC3). Whilst it was acknowledged that such frameworks had benefits, particularly for the activities of junior clinicians, these were held to be less relevant by more experienced clinicians:

‘There has to be sound clinical reasons for prescribing outside of the protocols so control is much tighter ....Clinical guidelines and protocols are fine but at the end of the day each patients is different they have individual needs and therefore need individual treatment experience guides you on this so there’s issues with clinical independence and autonomy.’

(C5)

While professional experience and clinical independence were continually put forward as justification for working out with the guidelines and putting cost issues aside, the general consensus between senior clinicians indicates that clinical practice is becoming
too bureaucratic and restrained by such initiatives and that this is causing clinicians some tension.

Working within limited financial resources and efficiency saving targets means that managing the provision of medicines safely and efficiently is challenging. While there have been efforts to make clinicians more aware of the financial implication of their medical decisions, not all clinicians agree that that costs should be taken into account in prescribing decisions. Such sentiments are fuelled by the belief that prescribing according to cost will have a negative impact on the quality of care and is an infringement on their clinical duty: ‘We have more information now on costs and this can be really useful but it shouldn’t be what we base our clinical judgement on’ (C4). However, despite such recognition another clinician informant felt that such initiatives were restricting his professional ability, autonomy and level of independence compared to that enjoyed prior to the emphasis being placed on cost effectiveness.

‘We do have situations where our clinical judgement conflicts with managerial initiatives because what we consider to be the best treatment might not fit into the guidelines and standards set out by NICE etc but we shouldn’t be dictated to when it comes to patient care it’s our reputation that’s on the line if the patient isn’t treated right.’(C4).

Indeed for some it appeared that the acceptance of imposition of managerial discourses and budgetary considerations represented a betrayal of their professional identity.
‘Unfortunately a lot of what we do now is tied up in counting the pennies and budget balancing this takes us away from our primary duty – patient care but more than that its turning us into managers which is not what I’m here for I feel a bit resentful of that.’ (C5)

It is also clear from the data that operating within tight clinical guidelines, treatment protocols and so on are considered to negatively affect the clinician’s ability to treat patients more creatively. This was especially the case in specialist treatment areas. This may perhaps, be due to the fact that such areas generally have patients with more serious and complex conditions. Resource constraints and budgetary considerations were identified as: ‘Obstacles which affect our ability to discharge our proper duty to the patients’ (SC2). When asked to be more specific the interviewee went on to state: ‘well some treatments while they’re better than others are just not allowed because of their cost…In such circumstances the quality of treatment is sometimes compromised’ (SC2).

Debates over resource utilisation, particularly where it is very visible to patients, become major points of debate from both a social care and professionalism perspectives. Indeed some treatments were described as being: ‘Very much rule based and guideline governed according to cost’ (C5). This was considered to be very problematic and stressful when trying to discharge their principle duty; patient care: ‘When you have a patient demanding the newest and best treatment that the Board cannot sustain it’s very distressing for both the patient and us’ (C7).

A significant sense of professional identity was attached to the professional and social care role that their clinical activities served. Although such clinicians acknowledge the
level of financial limitations they were at the same time quite critical of the imposition of the rigid application of clinical guidelines, treatment protocols and financial limits to treatment. Thus the dominant focus on financial aspects is regarded as being a distraction from the core activity of clinical service and highlights the difficulty that clinicians have when trying to reconcile financial considerations with their core clinical function: ‘Management and medicine don’t necessarily go hand in hand. I am and always will be a doctor first. My clinical judgement is what counts’ (C6).

Furthermore it appears that there are no financial penalties as such, for those who exceed their budget and relatively weak incentives for those that under spend as such savings are reinvested at the discretion of the unit management. Units that overspend attract attention but are not punished. This was also partly attributed to the fact that benchmarking within the hospital at present is difficult to achieve. This perhaps may be attributed to the fact that spending comparisons between boards, as yet cannot be made: ‘The HMUD [Hospital Medicines Utilisation Database] is still in its infancy so we don’t have data yet that can used to make comparisons between different areas’ (CD1).

Another common attitude observed in older clinicians was an aversion to non-clinical matters, such as management and administration, with costs being perceived as a management function and not a clinical entity and therefore of little importance.

‘The problem with managers [referring to non medical] is that they are only concerned with the finances not the overall quality of patient care so this causes conflicts....The financial systems don’t reflect what is most important – how the patient was treated, how successful
Their treatment was which is upper most in our minds. If we only provide treatments based on cost then we run the risk of not providing what the patients really need so it affects their quality of care and also impacts on our professionalism. (C1).

Those clinicians that breach the clinical guidelines and treatment protocols and flout the budgetary constraints therefore provide a strong temptation for others to do likewise thus causing the board to overspend and risk the disapproval of the Treasury.

Discussion

To date there has been relatively little research into the management of medicines from an accounting perspective. Research into the impact of bringing the medicines budget under the umbrella of the overall cash limit and introducing integrated budgets into some areas however, has so far failed to consider its effects on secondary care. The objective of this paper was to contribute towards filling this gap by investigating the changes that have occurred in the management of medicines within secondary care as a result of NHS reforms and strategies that have been adopted to bring the escalating drugs budget under control. The main focus of the paper considers the tension that cash limits and prescribing initiatives have on the professional activity of the medical profession and their working practices within a sample of acute hospitals in NHS Scotland.

Health authorities have a long and bitter experience when it comes to making funding allocations. Setting efficient targets within healthcare, particularly where they are visible
to the general public, attracts much criticism and debate within the press. Over spends in one area of the service under the cash limit budget inevitably leads to cut backs in other areas in order to balance the budget likewise leads to much criticism and controversy. Bringing prescription medicines under the cash limit adds to the already difficult task of keeping spending within the cash limit budget. It also adds yet another administrative burden on to the medical profession. In the past the exclusion of the medicines budget from the cash limit provided a safety valve for the unpredictability of demand for prescription medicines. Within primary care GPs have more ability to control prescribing cost in order to meet the cash limit. For example they can cut back on repeat prescriptions, reduce prescription quantities, defer elective surgery etc. Such manipulations within the hospital setting, however, are more difficult. Pulling the drugs budget under the overall cash limit however, indicates that the government perceives that the demand and provision of medicines can be more precisely anticipated and controlled even in the hospital setting.

Managerial and budgetary control is often portrayed as an intrusion that is defensively resisted within the literature. However, such positions assume that systems of professional values are static and adversative towards managerial value systems. While this paper does not dispute the findings of such studies, indeed it provides a considerable amount of data that supports such a view, it is also evident within this data that clinicians are to an extent, responsive to cash limits and initiatives aimed at achieving a tighter financial regime and balanced accounts particularly where managerial responsibilities are viewed as non-challenging. However, it is also clear that the imposition of managerial
and budgetary controls do not go uncontested or without impact on the professional role of the clinicians. Indeed to suggest such a thing would be to deny the agency of individuals. Despite an element of resistance on the part of clinicians, the healthcare arena is continually faced with increasing financial, legal and regulatory complexities which are arguably having an impact on the power base of clinicians as managerial and accounting control becomes a key element in the changes advocated by the reformers.

While the budget has the potential to be used as a restraining and controlling device by management, framing clinical issues and redefining performance in the language of business can however, problematize healthcare delivery as exemplified with the espoused views of the senior clinicians. The application of cash limits to health care provision indicates a perceived need by the government to control expenditure wherever it can and suggests an expectation that such cash limits and efficiency targets should be complied with. However, simply requiring clinicians to work within an allocated budget does not guarantee that they will comply. The placing of the drugs budget under the overall cash limit umbrella, presumably to make them more aware of the cost of clinical decisions, largely seems to have failed as a mechanism of cost control. This, it has been suggested, might be because clinicians prioritize the efficacy and safety of drugs over their economy, or, because they simply do not have the required knowledge about the cost of drugs to make sensible economic decisions. The loose control could also perhaps be accounted for by the ambivalent attitude of clinicians towards the treatment protocols and standards and their desire to maintain their ability to exercise clinical innovation and autonomy.
The data further reveals that despite pulling the drugs budget under the umbrella of the overall cash limit it is questionable whether there has been any real change in attitude towards the issue of cost, as many clinicians remain outside of the managerial process and are therefore relatively isolated from the cost containment pressures that are being exerted by the government and health boards. Even where clinicians held budgetary control, it would appear that while a budget overspend could be stressful and ideally should be avoided that budget overspends were a common occurrence. Indeed it would appear that those who have to work within the budget only do so when they perceive the budget to be genuinely fixed or serious sanctions for overspends will be applied. Rather than being used as a control tool, it appears that the information contained within the accounts was used to explain the budget deficit and as a justification for asking for more financial resources. This was reported to be particularly the case in areas that had excellence in specific specialism. The majority of interviewees aired the view that, even in situations where they have a large amount of autonomy, to always work within the constraints of the budget and cash limits would mean that patient care would suffer. Budget deficits are thus legitimised by emphasizing public service over budget control.

Furthermore, working within tight financial constraints and budgets appeared not to be considered as a legitimate control tool due to the adverse effect it has on the clinician’s primary duty, caring for patients. It would appear that although the principles contained within the NHS reforms encouraged new attitudes towards efficiency, productivity and value for money, there remains a strong perception of professional care and duty; that
health is not a business but a social duty and therefore adherence to strict management and financial regimes is not appropriate. The creation of bureaucratised systems of medical care thus has the potential to push clinicians towards gaming strategies that enable them to maximise apparent performance and maintain their sense of identity and professionalism. Indeed the application economic rationalism and tight financial control served to revitalise the concept of social care and professionalism contained with their professions culture.

Notes

2 The Scotland figure is summed from the annual accounts of each NHS Board. More detailed figures can be found on the ISD Prescribing & Dispensing website.
3 This includes both drugs used during the patients stay in hospital and drugs supplied to the patient on their discharge.
4 A formulary is a comprehensive list which recommends drug treatment regimes, information on the pharmacological aspect of the drugs - dosage side effects etc and cost. Locality drug formularies were first implemented in a few hospitals in the late 70s and early 80s (Jackson, 1989), and contain a list of drugs for use within that specific locality. A full discussion of the impact of formularies on prescribing practice is the focus of a following paper by the author.
5 The joint formulary is a list of permitted drugs on the NHS that can be prescribed in both primary and secondary care. For examples of the first official formularies see Jackson, 1989, Joshi et al, 1994, Basu, 1999 also drug cost containment strategies such as those discussed by Kutch-Lojenga, 1989 and Levy, 1993.
6 For studies that look specifically at primary care see Llewellyn & Grant, 1996, Burstall, 1997, Gosden & Torgerson, 1997.

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