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Determinants of changes in accounting practices: Accounting and the UK Health Service

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Abstract

This paper uses the Social Forces Model to investigate the interplay between accounting change, institutional evolution and organizational transformations in UK healthcare delivery since 1800. At the same time, the catalytic role of individuals and events is highlighted. The reflexive organizational-accounting interactions are charted to reveal the changing nature of healthcare provision from communitarianism, through etatism to the (etatist inspired) market-based structure which, in turn, is now giving way to service provision based on local planning. By using a long time span it is possible to identify the modes of accounting which were present during the different phases of the development of healthcare. This analysis contributes to our understanding of the historical interplay of social forces by showing accounting as a technical instrument within an institutional setting, by highlighting the interactive nature of accounting and institutional change, by illuminating the role of individual action and by identifying the role of outside agencies.

Keywords: Accounting change; UK health service; Institutional evolution; Social Forces Model

The National Health Service (NHS), as it exists in the UK today, is the current manifestation of healthcare provision that can be traced back for over 200 years in terms of its ethos of separating the delivery of care from the ability of its recipients to pay. A history of a social activity over such a time span can concentrate on a number of different aspects such as medical advances or organisational changes. In this paper, we examine the involvement

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of accounting practice in the different phases of the development of healthcare in the UK. In particular, the philosophy underpinning accounting has moved from being customised and inward-looking through being control-based to being market-based.

Accounting has always played a role in healthcare. However, there was a widespread perception that, prior to the 1990s, accounting in the context of healthcare was relatively underdeveloped. "Hospitals and health management had invested lightly in the accounting craft, in part because health care had not been perceived as primarily an economic phenomenon" (Hopwood, 1990, p. 16). This perception was underpinned by findings, such as that of the Resource Allocation Working Party (RAWP), that "the system for collecting costing information is still in the process of development. There is a long way to go before the costs of the component activities of the NHS can be comprehensively analysed with absolute confidence in the result" (DHSS, 1976, p. 82). During the 1980s, as one result of the Griffiths Report (Griffiths, 1983), management budgets were introduced into hospitals, together with a further strengthening of the processes of financial accountability (DHSS, 1984). More recently such deficiencies have continued to be addressed and there is now "a much greater emphasis on the costs of health care" (Chua and Preston, 1994, p. 4). Spiralling resource costs, an ageing population and technological medical advances have led accounting to play a more visible and extrinsic role.

Considerable investment in information systems accompanied the market reforms in the UK's National Health Service (NHS) after 1990, and public discussion of medical matters now invariably includes cost considerations. What is particularly striking is that an active and lively debate about funding healthcare has arisen in the popular press. British papers such as the *Guardian*, the *Independent*, the *Observer*, and the *Times* regularly deal with these matters. Financial considerations enter into many facets of the debate about healthcare, such as prioritizing: "Is it worth spending £6,000 a month on an 11-year-old girl running around ... or to spend it on people who ... may never regain normal life?" (Gravett, 1996); or commenting on the costs of individual patients: "up to £1.4 million has been spent on her care ... the cost of 16 months treatment was £160,000" (Dobson, 1996); or "her local health authority said it would not pay the £500,000 needed for her maternity care by a top London specialist" (Nowicka, 1996); or "how the cost of his treatment estimated at £5,000 a month, will be met by the British taxpayer" (Arnold et al., 2001). Costs also enter into the discussion of new treatments: "Science has finally found a way to fight the [Aids] virus ... but Britain can't afford the price ... the cost per patient is around £7,000 a year" (McKenna, 1996); or "estimates of the total cost of prescribing viagra have ranged from as low as £50 million ... to as high as £1 billion a year" (Hawkes, 1998); or and "some health authorities ... are denying the drug to patients on the NHS on the grounds of cost [£1,000]" (Doek, 2001). Cost variation has also been discussed, "a lung transplant could cost as little as £2,488 or as much as £31,430" (Hartley-Brewer, 2000). The introduction of such financial considerations into the debate relies on an underlying accounting system capable of generating quantifiable cost information.

The profile of accounting has become increasingly visible in the underlying legislation. The 1946 Act, which established the NHS, placed a duty on the Minister of Health to "promote the establishment ... of a comprehensive health service designed to secure improvement in the physical and mental health of the people ... and the prevention, diagnosis and treatment of illness" (HMSO, 1946, p. 1). Cost was not mentioned. By contrast,

the 1990 Act rather than expressing objectives in terms of health gain, included the obligation for every NHS Trust: "to ensure that its revenue is not less than sufficient . . . to meet outgoings . . . [and] . . . to achieve such financial objectives as may from time to time be set by the Secretary of State" (HMSO, 1990, p. 11). Financial arrangements were also prominent in the legislation underpinning the 1999 reorganisation of the NHS (HMSO, 1999).

We now see accounting as a major feature of health discourse, but still comparatively "little is known about how accounting systems are created and developed" (Preston et al., 1992, p. 561). The creation of "accounting facts" which emerge from the process of organizational change are an end result of a fabrication process rooted in political, social and economic conditions (Preston et al., 1992, p. 566). Consequently, it is necessary to trace the genealogy of these conditions in order to contextualise the change. To understand the present position requires an appreciation of accounting accretions occurring over many years, if not centuries. A casual observer may identify points in time where a hiatus takes place, but closer consideration may show that the conditions needed for change are pre-established so that the antecedents of the current position are traceable to prior periods. With the benefit of hindsight, one event may seem 'inevitably' to lead to another, but such a progression is not necessarily inevitable.[1] Often individuals and events play key catalytic roles in the underlying social transformations, but, at the time, the significance of their contribution may not be appreciated.

The accounting activity displayed by an organization at any point in time represents the resolution of a set of forces acting on it. Some of these forces are internal with management using accounting to progress its own particular agenda. Others are external and usually couched in terms of user needs or agency theory. The forces may also be complementary or contradictory. In a societal setting, the forces may be created by a broad sweep of changing values, possibly aided by "powerful actors pursuing their own interests – political and economic" (Carpenter and Feroz, 1992, p. 638). In these circumstances, it is necessary to identify the forces and examine their influences on the organisation under examination, in this case, the health service.

As well as the slow development of accounting systems within the healthcare sector, there was, until fairly recently, a general acceptance that "the multi-faceted interplay of accounting with organizations' cultural and technical systems is under-researched" (Dent, 1991, p. 707). This perception was reflected by Broadbent and Guthrie (1992, p. 23) who concluded that their survey "indicates the relative paucity of research in the public sector which can be argued to adopt this "alternative" perspective". The position has now changed with health services in particular being the focus of studies seeking to contextualise the developments that have taken place (Bourn and Ezzamel, 1986; Chua and Preston, 1994; Lapsley, 1993; Preston et al., 1992). There has also been a shift in the focus of accounting, in the UK, from a treasury and reporting function to cost measurement and containment (Chua and Preston, 1994, p. 4).

We seek to identify, in particular, the modes of accounting which were present during the different phases of the development of healthcare in the UK. In the voluntary and municipal

[1] Progression is itself a teleological term implying betterment. In the health service, progression is not always synonymous with improvement.

hospitals we show how accounting had communitarian aspects such as being customised and stewardship-based. Under the early period of the NHS we show how etatist elements such as control and budgeting predominated. Finally, from 1991 we examine how in a quasi-market environment accounting became more orientated towards market principles such as preparing annual reports.

The main purpose of this paper is to apply an adapted form of the Revised Social Order Model (the Social Forces Model) in an historical investigation to produce insights which enable us better to understand accounting changes in the UK health service. In doing this, we seek to meet the "real need for more historical studies of the development of accounting" while not focussing on "a relatively short time horizon" (Burchell et al., 1980, p. 23).

In particular, we investigate four research objectives. First, we will examine accounting's role as a technical instrument within an institutional setting and how this has changed over time. Second, we will highlight the interactive nature of accounting and institutional change. Third, we will identify the role of individual action upon accounting practices within the wider organisational and societal setting. Finally, we will demonstrate the role of factors outside the immediate organisational setting in driving the accounting agenda for the delivery of healthcare.

This model provides an overarching framework in which to explore the contradictory and competing nature of these organising forces. It has been used to investigate a variety of international and historical contexts, such as the organising principles of advanced capitalism (Puxty et al., 1987), the comparative regulation of accounting (Parker, 1988, 1995; Willmott et al., 1992) and the transformation of education at Oxford from 1800 to 1923 (Jones, 1994). This model was originally pioneered by Streeck and Schmitter (1985), then customised for the accounting discipline by Puxty et al. (1987). This customised model diminishes the role of corporatism (or representational monopolies of, for example, professional interest groups). We adopt this customised model; however, we significantly extend it by stressing the role of individuals and events as determinants of change.

The Revised Social Order Model is premised upon three interlocking and interconnected organizing principles: "communitarian" principles (spontaneous solidarity); "etatist" principles (hierarchical control); and "market" principles (supply and demand determining outcome).[2] Communitarian principles are typical of small, closed, self-governing communities. Typically, they were found in guilds, universities and early self-governing hospitals. Accounting in such societies tends to be typified by independent, self-financing operations, by customized accounting systems, by stewardship and by internal check. "Problems arise over the categorisation of income sources, definitions of hospital income, and over what appears as surplus or deficit" (Cherry, 1997, p. 309). Service rather than profit is often seen as the prime motivator of communitarianism and the participants "satisfy their mutual needs

[2] Strictly, this model is dynamic rather than static. The model is premised upon Streeck and Schmitter's (1985) original model which set out four social orders (Market, State, Community and Association). This model was customised by Puxty et al. (1987) for the accounting discipline by the dismemberment of the Association mode of control. Jones (1994) then amends this new model. Richardson (1989) prefers to use the Panitch (1979) model to focus on corporatism with its hegemony of coercion and control. He criticises the Puxty et al. (1987) approach for glossing over the contradictions within the social order categories and for its lack of dynamism. However, neither criticism is necessarily valid. The use of the label "spontaneous solidarity" does not necessarily exclude the fact that, within this category, various interest groups will hold different opinions.

for a shared affective existence and a collective identity" (Streeck and Schmitter, 1985, p. 6). They are internally-looking and like etatist systems often focus on efficiency with an emphasis primarily on costs.

Etatist principles are typical of centralized, bureaucratic control and are often associated with government control. Accounting in such societies is typified by state funding, by hierarchical control, by standardized and contract-based financial systems, by external accountability and by internal and external auditing. Macro-economic planning rather than service or profit is often seen as the prime motivator of etatism. Etatist systems are often characterised by efficiency drives to avoid wasting taxpayer's money. The rise of the nation state over the last two centuries dictates that nowadays all modern societies exhibit etatism to some degree. Authoritative regulations, hierarchical controls and bureaucratic structures are all essentially etatist. States involve themselves in institutions or societies with predominant communitarian or market principles in order to safeguard, loosely (and often self-) defined, national interests.

Finally, market principles are typified by the competitive striving after profits rather than the shared values and mutual esteem of communitarianism or the rigid and hierarchical regulation of etatism. Companies are typical market organisations. In accounting terms, markets are characterised by private-sector funding, by non-standardised accounting systems, by decision-making and by external auditing. In many developed countries, market principles have been introduced into many nationally provided infrastructure services, such as education and health, over the last generation.

It is important to appreciate the fluidity of the model. Not only are the three organizing principles broadly rather than tightly defined, but they coexist, sometimes uneasily. The existence of a dominant order does not necessarily exclude other orders. Similarly, transitions from one order to another occur gradually, with the remnants of prior orders surviving under the surface.

This model is particularly useful in tracing historical transformations in the delivery of healthcare in the UK over the past two centuries. Specific accounting developments can be located within the organisational and institutional structures of the health service. This model allows us to gain insights into the development of the NHS. In turn, these organisational structures react to wider societal forces. Thus, for example, the emergence of the NHS is seen to arise, in part, from the creation of a more interventionist state within which accounting provided the enabling and facilitating techniques to engineer strong centralised planning. The social order model frames and illuminates these developments.

The UK health service provides a particularly good arena in which to use the Revised Social Order Model as it exemplifies a current major British institution which has evolved slowly over time from a situation where communitarian principles were dominant, through to the dominance of etatist principles, and then to a situation where market principles have made great inroads. In particular, the increasing standardization of accounting practices has facilitated the establishment of etatist bureaucratic structures while the development of "accounting for the NHS" has revealed new areas of institutional visibility. In turn, these new visibilities have prompted further changes. From being a minor player in 1800, accounting has moved centre stage to the extent that the cost of procedures has become commonplace in the discussion of the provision of care, as typified by the debate over the cost of the viagra anti-impotence drug (Hawkes, 1998, p. 4) or the fight against AIDS (McKenna, 1996).

We introduce into the established model an important innovation. Within the powerful sweep of social forces, we believe, key individuals (both politicians and accountants) play a critical role. These individuals funnel and channel the wider currents of change.[3] Their actions are nonetheless conditional upon broader prevailing social conditions and do not arise in a social vacuum. In the context of the health service many of the forces that have moulded it can be identified with individuals (both politicians such as Beveridge, Bevan and Thatcher and accountants such as Burdett, Stone and Magee). Beveridge, in his influential 1942 report on Social Security and Allied Services, "assumed that there would be a comprehensive health and rehabilitation service for the prevention and cure of disease" (Keiden, 1963, p. 153). The health aspects of this report were operationalised by Bevan who "believed that the state should guarantee a free health service for all" (Rivett, 1986, p. 264), an approach that automatically removed their traditional sources of money from the voluntary hospitals. More recently, Thatcher "insisted that something must be done to introduce market principles to the nationalised service [the NHS]" (Young, 1990, p. 548). In the accounting domain, Burdett was instrumental in introducing uniform, standardised accounts; Stone advocated departmental costing and Magee developed hospital activity costing. We discuss the work of these individuals in more depth later on.

An important and crucial difference between the historical setting of this model in the UK health service and the international location of the Puxty et al. (1987) model is the role played by communitarianism. In the advanced capitalist world investigated by Puxty et al., the regulatory systems were dominated by the mixed modes of market and state forces. The strategies of regulation thus varied between different detailed combinations of market and state principles (1987, p. 283). In the historical area of the health service, however, particularly in the nineteenth century, the communitarian mode within health provision plays a dominant, not a subordinate, role. This mirrors the findings of Jones (1994) where communitarianism also proved a significant social force in the Oxford Colleges.

The remainder of this paper is structured as follows. The next section locates this paper within the existing literature. Section three links the historical transformations which have occurred in the health service during the previous two centuries with the role that accounting has played in these developments within the confines of the Social Forces Model. The modern NHS is shown to emerge as a result of social, political and economic pressures, from the twin strands of the voluntary and municipal hospitals. In particular, the major stages in the evolution of the health service are charted: from communitarian principles through etatist principles to the intrusion of market principles. The conclusion summarizes our study.

1. The healthcare perspective

The historical context has provided a useful framework in which to study the process of societal and organizational change (for example, Armstrong, 1987; Arnold and Oakes,

[3] The identification of individuals is more problematic than the identification of events. In order to locate individuals it is often necessary to deduce their roles from observed historical events. Our analysis, therefore, although it highlights certain individuals, is necessarily selective and subjective. It is consistent with Said's contention (1995, p. 23) that individual contributions can be significant.

1995; Burchell et al., 1985; Carmona et al., 1997; Gill-McLure et al., 2001; HassabElnaby et al., 2003; Hopwood, 1987; Hoskin and Macve, 1986, 1988; Loft, 1986; Miller, 1986; Miller and O'Leary, 1987). These transformations occur in many British institutions, for example, local authorities (Read, 1979) and educational institutions (Berdahl, 1959) and are particularly evident where activities are transferred from the public to the private sector (Ogden, 1995). In the UK, national institutions, such as the civil service, local authorities or health service, typically evolve slowly, punctuated by periods of readjustment. There is often a slow and emergent build up of social forces leading to a sudden, and sometimes dramatic, trigger event which activates change.

Other studies of accounting change see the necessary impetus for change coming from the emergence of a crisis. Hopwood (1987) reviewed three historical cases of accounting innovation which were driven by the need to respond to a threat or crisis. In the context of a university brought to crisis through funding cuts, Ezzamel and Bourne (1990) present a longitudinal study of the roles of the accounting information system and show how accounting terminology became an important medium of discourse. Puxty (1997) takes a broader view of crisis, placing accounting policy choice in a "world embodying fundamental social conflict" (p. 734), the dynamics of which enable accounting policy choices to be understood. In the public sector, Chan et al. (1996) saw the possibility of governmental accounting innovation stemming from some stimuli "such as financial scandals or government financial crisis" (p. 4). The idea of continuing crisis is one which anyone studying the history of the delivery of healthcare in the UK would recognise (Enthoven, 1985; Guillebaud, 1956; Jones, 1996; Klein, 1983; Tomlinson, 1992; Trevelyan, 1964; Webster, 1993; Widgery, 1979; Woodward, 1974). While accounting change has been associated with the responses to the recurring crises in healthcare, it is shown here to be part of continuing change driven by factors explicable in terms of social order and individuals.

Turning from the general historical perspective to the narrower topic of healthcare delivery in the UK, there has been little research into the financial development of hospitals and its associated accounting and, what there is, tends to concentrate on a single institution. Stemming from the marketisation of healthcare, several studies were produced to explore aspects of the impact of accounting upon organizational change in the UK NHS (in particular, Bourn and Ezzamel, 1986; Broadbent et al., 1991; Covaleski et al., 1993; Lapsley, 1993; Preston et al., 1992). All of these studies relate to the recent past, none taking a broader historical perspective, perhaps reflecting the conclusion of Burchell et al. (1980, p. 5) that the role of accounting "has come to occupy an ever more significant position in the functioning of modern industrial societies". Despite these studies Berry (1997, p. 3) notes that there has been a relative neglect of critical studies of the history of hospitals and other institutions, although Robson (2003) does provide an historical perspective.

This present paper with its longitudinal and accounting focus and its use of the more comprehensive Social Forces Model, serves to place Bourn and Ezzamel (1986), and Lapsley's (1993) findings in a broader, more societally-based context. Bourn and Ezzamel (1986) discuss corporate culture when a change is imposed by an external agency; in this instance a Central Government Department was seen to be forcing the NHS to adopt the managerial recommendations of the Griffiths (1983) enquiry. Owing to the hegemony of the medical profession, the clan form of culture is deemed to be identified with a high degree of ambi-

guity in performance measurement coupled with a low degree of goal congruence. One of Bourne and Ezzamel's (1986, p. 222) conclusions is that the Griffiths (1983) enquiry advocated a hierarchical control system. This is consistent with the analysis of this paper which frames Griffiths against a background of etatism.

Lapsley (1993) uses a markets and hierarchies model to explore the merits of alternative modes of NHS governance. Effectively, markets and hierarchies in this model equate to market and state in the Social Forces Model. Lapsley (1993) focuses on the market reforms introduced in 1989 and sees that "the domination of its [the NHS] activities by the medical clan has been challenged by reforming the bureaucracy" (p. 392). The marketisation of the NHS reduces the ambiguity in performance assessment and so moves it away from the clan culture and the method of accounting assists in this shift. Communitarianism, an important force in the development of the modern NHS, is thus omitted along with the human agency aspect. These topics were also neglected in prior uses of the RSO Model by Puxty et al. (1987) where international regulatory systems were identified as being dominated by mixed modes of market and social forces.

Broadbent et al.'s (1991) research locates accounting change in Habermas' critical theory of social development. The relationship between the Department of Health (DoH) and the NHS is examined through the various mechanisms issued over a ten year period by the former to guide the behaviour of the latter. The research concludes that given the differentiation of purpose and the need to have steering media, dissonances are likely to occur between the DoH and the NHS. From 1979 to 1988 there were continuing attempts by the Central Government Department to change the structure and information base of hospitals to create "new relationships of accountability" (p. 24).

In the context of the NHS, the present paper shows that costing has been used to underpin the essentials of the market-based purchaser/provider interface, which the Social Forces Model identifies with the market mode of social organisation, and continues to provide benchmarks for comparing units within the NHS. This can be contrasted with Preston et al. (1992) who examine the birth of clinical accounting and show that accounting practices do not emerge as fixed technologies, but that their development "includes individuals' interpretation of, and responses to, the proposed or implemented system" (p. 567). Meanwhile, Covaleski et al. (1993) view case-mix accounting not as a means to facilitate rational decision making, but as a ritualised procedure for creating and affirming order and meaning. By taking a broader historical approach, this paper shows how accounting has been embedded in the workings of healthcare delivery over many years.

Robson (2003) focuses on the move from the uniform system of accounts, first introduced in 1893, to departmental accounting in 1956. He shows that the medical profession's opinion on departmental accounting was not homogenous and follows the debate in detail. With its longer time span, albeit not as long as that covered in this paper, Robson's paper reinforces the idea that the accounting process observed at any particular time is the manifestation of many forces, possibly unobserved from the outside, acting relatively slowly over a period of time with occasional observed significant changes taking place.

In comparison with other extant research, this paper approaches the role of accounting in the delivery of healthcare in the UK as a continuum. Previous research tends to distinguish between pre- and post-NHS whereas this paper shows how, despite significant events such

Date	Development Stage	Key Features	Accounting Features	Dominant Mode
1800-1948 Voluntary Hospitals	Self Governing	Administratively and financially largely independent. Pressure on funding	Customised accounting, stewardship-based, inward looking. Moves towards standardisation	Communitarianism
1800-1948 Municipal Hospitals	Self-governing with over time increasing state-set parameters	Administratively and financially gradually become less independent	Initially customised charge/discharge systems although standardised accounting introduced	Communitarianism with etatist umbrella over time
1948-1991	State governed	Administratively bureaucratic, increasing centralisation	Budgeting, speciality costing and departmental costing	Etatism gradually established
1991-2005	State governed with increasing market-based mechanisms	Administratively bureaucratic, centralised but with market-based mechanisms	Quasi-market costing and pricing mechanisms, annual report	Increasing adoption of market mechanisms within an etatist-based framework

Fig. 1. Development of UK health service 1800–2000.

as the creation of the NHS, changes in the underlying accounting can be explicated in terms of the underlying social forces.[4]

2. Transformations, social forces and accounting

The delivery of healthcare in the UK substantially predates the creation of the NHS.[5] The current position can only be properly understood in an historical context. History shows how communitarianism, state and market principles have coexisted with each, at various times, dominating health provision (see Fig. 1).

Broad social forces shape the transformations in healthcare, but individuals within the social context or events play significant catalytic parts. In particular, as the state expands and develops, communitarian principles are eroded and replaced by etatist principles.

National organization replaces community provision. This is followed by state-engineered market principles manifested by the retention of internal market structures and accountings created to implement the market, but operationalized through etatist planning. Financial and accounting reforms are implicated in these transformations. Not only do they encourage new spheres of thinking about healthcare provision, but they permit and encourage new spheres of control and accountability. This operationalizes and creates new forms and structures.

[4] The Social Forces Model links human agency, (expressed by Carlyle as "The history of the world ... was the biography of great men" (1964, p. 251)), with the impact of social order. This echoes Giddens' (1979, 1984) structuration theory where although human beings have the capacity to change their social circumstances, they are in turn constrained by the specific social context in which they are located. Social structures are created, reproduced and regulated as part of social order. The Social Forces Model unifies the role of individuals and the impact of other social drivers, such as war, technological change and increased expectations of healthcare provision.

[5] Indeed, in the UK, spasmodic and local healthcare was administered by the church before the reformation (1536–39) and afterwards by Secular Hospitals such as St. Bartholomew's in London that was originally built in 1123, confiscated by King Henry VIII in the reformation and reopened when the citizens petitioned the King to endow it, thus creating the first instance of secular support of hospitals. However, the Poor Law of 1572 probably marks the true genealogy of the communitarianist municipal and voluntary hospitals which we discuss, in this paper.

The analysis in this paper tracks the development of healthcare delivery to the general population. The NHS is but the latest manifestation of this. Its roots can be traced back far before its formal creation in 1948 when 1545 municipal hospitals (with 390,000 beds) and 1143 voluntary hospitals (with 90,000 beds) (Guillebaud, 1956, p. 51) were amalgamated.

In essence, the NHS emerged from the combination of two distinct patterns of parallel health development: the voluntary hospitals and the municipal hospitals. Voluntary hospitals emerged from non-governmental, community provision; often these were the result of local, private philanthropy. By contrast, municipal hospitals developed out of parochial work houses. They served as localised solutions to deal with the problem of sickness amongst the lower social orders. The relationship between the two was often confused and uneasy. In essence, the two types of hospital served different social strata of the population. Sick paupers were mainly treated in workhouse-based infirmaries while the voluntary hospitals were more selective in their admissions admitting "deserving cases, capable of rapid improvement" (Rivett, 1986, p. 28).

The location and quality of these hospitals, the product of many forces, created neither an equitable geographical distribution of resources nor an equality of access for every member of the population. This initial distribution in 1948 formed only the platform upon which the edifice of subsequent funding was built: These inequalities were institutionalized until recently as a result of incremental funding. Many ensuing reforms have sought, as part of their remit, to identify and redress the inequity caused by this inertia. This disparity proved persistent. In the 1970s (DHSS, 1976, p. 128), the North Western Health Region was reckoned at one extreme to have a deficiency in capital stocks of £16.54 per head with the Mersey region having an excess of £17.53 per head. Moreover, revenue funds were skewed towards London.

Using Burchell et al.'s, (1985, p. 399) terminology the NHS emerged from "a very particular field of relations which existed between certain institutions, economic and administrative processes, bodies of knowledge, systems of norms and measurements, and classification techniques". For the NHS, this was an amalgam of social and economic pressures such as the inadequacy of the voluntary and municipal hospitals, pressures from social activists such as the Socialist Medical Association and Aneurin Bevan, and the social upheaval caused by the Second World War.

2.1. Bastions of communitarianism

The abolition of the system of poor relief, established by the Poor Law Amendment Act in 1834, can be seen as creating a mobile labour market in England which responded to the new industrial system by deserting the countryside for the city (Polanyi, 1957, p. 77). There was a practical requirement to improve the health of the new industrial labour force. In addition, social philanthropy created a charitable concern for those worst affected by such factors as war, trade depression and the impact of mechanisation. Christian values also suggested that benefiting the poor and sick in this life could help one in the hereafter.[6] Providing medical care for those in distress could be a matter of civic pride (Marland, 1991, p. 151). This medical care was inevitably locally-based, as apart from the major towns, the

[6] We are grateful to an anonymous reviewer for suggestions about the reasons for social philanthropy.

United Kingdom was characterised by small, self-governing communities. This was still an age where communitarian principles held sway.

At the same time, the nature of hospitals began to change: "from being places of refuge, they began to develop into institutions for curing, rather than care and comfort" (Rivett, 1986, p. 25). This coincided with the spread of voluntary hospitals. These voluntary hospitals were community-based charitable institutions, separate medical and accounting entities. A few of these voluntary hospitals were established with significant endowments by wealthy individuals, but most relied on regular subscriptions and donations that initially did not provide a regular income. The introduction of regular subscriptions prompted the need for traceability and record keeping (e.g. Birkenhead Hospital, 1848). There was an emphasis on receipts. A great increase in the number of voluntary hospitals in Britain took place in the latter half of the nineteenth century, with the number of general hospitals rising from 130 to 385 between 1861 and 1891 and the establishment of specialist hospitals, especially in London (Prochaska, 1992, p. 3). The hospitals were created by a "group of like minded individuals [forming] a charitable association with one or more medical men" (Rivett, 1986, p. 24) and they displayed typical communitarian features, being mostly small, self-governing and reliant on ideas such as service and respect.

Generally, these voluntary hospitals relied on charitable appeals and annual subscriptions rather than endowments. Contributors were entitled to nominate patients for treatment in accordance with the size of their donation. For example, in the case of the Caernarfon and Anglesey Infirmary towards the end of the nineteenth century, "the people who subscribed one guinea a year . . . were entitled to have one patient's name at all times on the books . . . [and] . . . could issue recommendary letters to suitable "objects of charity", for admission as out-patients or in-patients" (Jones, 1984, p. 115). The need to obtain a recommendation from a subscriber restricted use to a limited social group by excluding outsiders. Such tight-knit groupings of "insiders" and foreigners is characteristic of communities (Streeck and Schmitter, 1985, p. 5). As a consequence, inter-class compacts and esteem were reinforced because the poor received treatment as a gift from the rich.

It is interesting to reflect that in some ways these hospitals existed as bastions of communitarianism within a society dominated by laissez faire market forces. Indeed, the development of these communitarian health safety nets was arguably a response to the great social uncertainties and upheavals created by the dominance of laissez faire economics as the prevailing contemporary socio-economic-political doctrine. State intervention was limited to sanitation and other public health institutions.

The creation and treatment of each voluntary hospital as a stand alone entity led to diverse management practices. In 1873, *The Lancet* criticised the fact that none of the eleven largest hospitals in London was managed in the same way. Administrative independence was reflected in the voluntary hospitals' financial and accounting systems. Following communitarian principles, accounting systems in voluntary hospitals, were often customized, paid little attention to external reporting, were stewardship-based and inward-looking. For example, the Report of the Birkenhead Hospital for 1847 contains eight pages which list individual subscribers, but only one page (p. 22) is devoted to detailing payments. There was a preoccupation with projecting the interests of the community of patients and subscribers. The emphasis was on funding rather than control or surveillance.

Each hospital's constitution was customized, having different rules and regulations for the production and publication of accounting records. In summary, "there was no standard method of keeping accounts" (Rivett, 1986, p. 129). Berry (1997) shows that developed, localised accounting systems were in operation at an early stage in the evolution of voluntary hospitals; these underpinned both managerial decisions and the production of a published report. These reports emphasised the hospitals' charitable nature by listing subscribers and presenting a financial statement and an enumeration of activity. In this way the hospital addressed its community and sought to attract funds. Often hospitals were established by individual Acts of Parliament. For example, an Act of Parliament dealing with the rebuilding of the almshouses (which also provided medical care) of St. Catherines Hospital requires the annual accounts to be submitted to the Lord Bishop of Hereford (Herefordshire, 1819, p. 53), while "an account of its revenues should be annually ... lodged in the archives of the parish of Ledbury" (p. 8).

The need to be self-financing through the immediate community led to a hand to mouth existence which had consequences for accounting. Internally, it focused attention on costs, with an early recognition of the need "to combine efficiency with economy" (Rivett, 1986, p. 33). Shortage of money had direct consequences, such as the need to "restrict the number of patients each subscriber was entitled to recommend in a year and to close wards" (Berry, 1997, p. 24). It was thus important to achieve as much as possible with the funds available. The shortage of money also created tensions within communitarianism. It forced the communities to look outside themselves to raise money. In addition, regional inequalities became obvious.

Interestingly, many of the accounting debates of the 1990s were rehearsed over a century earlier. As early as 1857 financial imperatives led to inter-hospital cost comparisons. These showed the cost per patient in older, larger hospitals was greater than that in newer, smaller hospitals (Lancet, 1858). For example, in 1857 the cost per head at Guy's Hospital was calculated to be 18s.0d, while the Royal Free Hospital treated a similar number of patients at 3s.8d per head.

Accounting also had a role to play in addressing the other side of the equation, that is raising money. "It seemed to be a major duty of a hospital secretary to arrange for the accounts to show a deficit, a crisis which could then be made the basis for an appeal" (Rivett, 1986, p. 129) and "managers seemed to make a trade of poverty and those who succeeded in spending less than they received took great pains to conceal the fact from their subscribers" (Rivett, 1986, p. 171) "even if to do so they sometimes had to put substantial sums into reserves, e.g. for repairs and renewals funds" (Rigden, 1983, p. 11). In this way, a poor financial condition, presented by means of accounts, was used as a metaphor for a deserving organisation worthy of support. On the other hand, a surplus was used to stress the effect of good management and the need for continuing contributions (Berry, 1997, p. 6).

Despite attempts to reduce costs and boost income, continual minor crises occurred as the increase in the number of potential patients exceeded the provision of medical services. The effect was exacerbated by fluctuations in the income of the hospitals. In part this was caused by their reliance on "investment income [which] was critical to voluntary hospital finances" (Cherry, 1997, p. 312). Towards the end of the nineteenth century the problem became acute and the financial position of hospitals began to deteriorate.

The great agricultural depression following the poor harvest in 1879 reduced income from estates, "[many voluntary hospitals] were adversely affected by falling rent values and inflation in the early twentieth century" (Cherry, 1997, p. 313). In response to this crisis a Hospital Saturday Fund and a Hospital Sunday Fund were created. The Saturday Fund collected money from working men on a Saturday, this being pay day, and the Sunday Fund ran a collection on one Sunday in June. Both types of fund could be found nationally, although the Metropolitan Sunday Fund was London-based and the Saturday Funds were of greater significance outside London. Being community based, the Saturday and Sunday funds developed independently but, over the years, some standardisation came about so that "in the late 1880s Saturday fund-raising featured in more than forty English provincial centres [with] many now systematized around a halfpenny or penny per week contribution" (Cherry, 2000, p. 471) and church collections were made after sermons, preached on the anniversary of a hospital's foundation (Berry, 1997, p. 18). Also, the Prince of Wales, later Edward VII, established a fund to channel philanthropic donations to London hospitals. This became known as the "King's Fund".[7] These developments introduced one important new feature of centralisation; money was given centrally rather than directly from the donor to the recipient hospital. "The change in the nature of funding was from individual subscribers who were entitled to nominate patients for hospital admission, to funding institutions" (Robson, 2003, p. 103). This both created a need to establish a mechanism for distribution and also introduced an external body that could demand information and accountability through financial accounts. This break of the direct link between donor and hospital was an important erosion of the self-financing local nature of the communitarian hospital. If philanthropic and voluntary donations proved inadequate, then it also opened up the possibility of alternative funding such as governmental contributions.

An important part of the new information system was formal financial accounts. The need to attract both donors and board members "rendered it essential that the accounts of every important hospital and charitable institution shall not only be accurately kept but that they shall be published" (Burdett, 1916, p. vi). This also fitted the contemporary enthusiasm for social science and the gathering of facts as a prelude to enlightened reform. The publishing of relative cost data was considered as helpful "for it shows an institution where it is spending too little as well as where it is spending too much" (Burdett, 1916, p. 4). As a result of the pressures of rising costs, falling income and greater reliance on centralised funding, the existing system became unworkable. "Development was idiosyncratic, lacking any mechanism for matching provision to need, beyond the perception of individual voluntarists" (Gorsky et al., 1999, p. 468).

The individual who crystallized these pressures into reality was Sir Henry Burdett.[8] A hospital administrator based in Birmingham, he identified many instances of inefficiency

[7] The King's Fund was established as part of the activities commemorating Queen Victoria's Jubilee in 1897 under the patronage of the then Prince of Wales. The objective was to establish a fund to support voluntary hospitals within London.

[8] Sir Henry Burdett (1847–1920) worked in hospital administration at the Queen's Hospital Birmingham and was Secretary to the Share and Loan department of the Stock Exchange. He was a prolific publisher. His *Uniform System of Accounts for Hospitals, Charities, Missions and Public Institutions* first published in 1893 effectively became the key accounting model for the UK Health Service prior to 1948. In addition, he published *Hospitals and Asylums of the World* (1890).

and poor provision, especially within London, including poor geographical distribution, crowded outpatient departments, lack of co-operation between institutions and nursing crises. His responses were diverse: promoting efficiency within hospitals through the compilation of comparative statistics, pressing for a royal commission to identify problems and raising funds through charitable donations. Burdett established the Prince of Wales's Hospital Fund for London (later to become the King's Fund) in celebration of the diamond jubilee of Queen Victoria. In addition, Burdett saw that accounting provided a solution to the financial shortfall by systematizing and ordering a hospital's finances. He, therefore, developed and introduced a Uniform System of Accounts at the Queen's Hospital Birmingham, where he then worked (Burdett, 1903). However, attempts to institute this uniform system more widely were met with initial apathy.

Burdett's system, however, provided a calculus of accountability. The fund-giving bodies strived for the means to apportion funds between hospitals. Burdett's system injected transparency and visibility into the apportionment process. The Funds, therefore, gradually imposed his system on recipient hospitals as a managerial and functionalist tool. All hospitals seeking support from the King's Fund and the Saturday and Sunday Funds were required to produce reports using the system. Accounting thus contributed to the standardisation of hospital administrative systems. The chief achievement of Burdett's system was that it standardised the detailed breakdown of income and expenditure. In particular, there were 60 expenditure categories (Robson, 2003). There was a further erosion of local, communitarian, diverse and individualistic accounting systems. In particular, the standardisation of income and expenditure categories paved the way for centralised, bureaucratic control through uniform, comparative information. Thus, a key precondition for etatism was gradually instituted throughout UK healthcare. In addition, in 1898 the King's Fund set up a system of hospital inspections for medical and managerial practices so that, for example, a hospital in receipt of a grant would receive six to eight visits a year. Once more a centralised bureaucratic type of control was being set up (Robson, 2003).

By the end of the nineteenth and into the twentieth century Burdett was collecting data centrally but there was "inconsistency of reporting from individual hospitals . . . [and] . . . reliance . . . on current income and expenditure . . . rather than the hospitals' capital holdings can be misleading" (Gorsky et al., 2002, p. 536). Neither was coverage complete or representative (Cherry, 1997, p. 308). However, at the local level, a more scientific approach to management was being taken which "entailed new procedures for accounting" (Gorsky et al., p. 543).

Burdett, himself, was an impressive figure who eventually oversaw the collection and analysis of data from over 100 hospitals that then was collated and published in a statistical report. These data which included both financial and statistical information and the systematic gathering of facts were "one of the principal means by which it [a co-ordinating organization] gained power over institutions" (Prochaska, 1992, p. 73). By identifying differences in costs, purchasing patterns were instituted to achieve savings and the reports helped hospital visitors (another requirement of the Kings' Fund) when carrying out inspections. "Hospital accounts were documents of record, compiled and published soon after the end of each financial year to demonstrate that the governors had carried out their fiduciary role and not misused the charity's funds" (Berry, 1997, p. 6). There was, at first, no standardisation, and the accounts generally took the form of a statement of receipts and

disbursements with a variety of headings used for analysis. In some cases the opening and closing balances of investments were included and so the accounts resembled the traditional charge-discharge format. However, by 1904, the King's Fund produced a statistical report for all grant-receiving hospitals. This included average cost per occupied bed as a key statistic. Accounting had created new visibilities and a system introduced for apportionment began to be used to enforce a particular form of analysis and hence control.

Notwithstanding savings made and funds attracted by the provision of more information, the financial problems of the voluntary sector continued. National economic and social pressures necessitated national solutions; community healthcare, being essentially local, became increasingly dysfunctional. Discussions took place about how to overcome the financial problems in institutions (such as the charity organisation society (founded 1869) and the National Association for the Promotion of Social Science (founded 1857), in the medical and general press (e.g., *Lancet, Medical Times and Gazette*) and in the British Medical Association). The three way charitable compact between those giving, those receiving and those paying for care was becoming strained and unable to meet the demands placed on it. At the same time, while the governors were not publicly accountable, "these privately run institutions came to bear public responsibilities" (Rivett, 1986, p. 31). As such this "move towards inspections and statistical data may have been a reflection of social change at the turn of the twentieth century and the ideology of natural efficiency" (Robson, 2003). As such these developments presaged etatism.

Voluntary hospitals thus emerged in an ad hoc and uncoordinated manner, enjoying localised freedom and independence. The Social Forces Model shows that this independence was reflected in their communitarianism and characterised by independent locally-financed operations often in non-competitive environments. The communitarian accounting aspects of the voluntary hospitals were evident in their early historical accounting systems. Stewardship and accountability were emphasised. Voluntary hospitals were evident in their early historical accounting systems. Stewardship and accountability were emphasised. There was a local, unstandardised orientation to them that reflected their communitarian nature. However, when economic pressures forced the voluntary hospitals to become more standardised, a uniform accounting system developed. Gradually, etatist centralisation replaced the diversity of communitarianism.

2.2. *Creeping etatism*

The municipal hospitals, which evolved out of the Poor Law system of workhouses, represented the second strand of hospital development that ran parallel with the voluntary hospitals. Their expansion marks the start of acceptance of a public responsibility for the individual's health, which would later be expressed by the etatist legislation of Central Government. However, interestingly this state provision was driven by pragmatic rather than moralistic concerns. The imperative was to care for the sick so that they would no longer be a burden to the state and could thus return to work. In particular, the Poor Law Amendment Act of 1834 "established that the parish workhouses should have sick wards where inmates could be treated when they fell ill" (Levitt et al., 1995, p. 1). Finance was derived from several, often mutually reinforcing, sources. Some hospitals had endowment funds, others charged for their services, some benefited from trading, and finally, some were

paid from the general rate fund contribution, including an increasing proportion represented by central government grants.

The financial reports of municipal hospitals were initially diverse, being based on cash flows and, typically, using customised charge/discharge systems. They were thus quintessentially communitarian, local and fragmented. Gradually, attempts to institute centrally imposed standardization were introduced. 1835 marked the end of an era during which local administrators were free of virtually all central control (Coombs and Edwards, 1996, p. 12–3). Centripetal forces increasingly began to predominate. Prior to 1835 some charters contained accounting provisions, but, afterwards, increasing regulation was imposed so that the treasurer had to prepare accounts of receipts and payments. Thus, the Lunatic Asylums Act 1853 required the Clerk of every Asylum to keep records of receipts and payments and prepare an annual abstract (Coombs and Edwards, 1990a, p. 78).

Despite these moves to introduce standardisation around the end of the nineteenth and start of the twentieth century, a diversity of regulation still existed in respect of municipal hospitals. In essence, this can be seen as community within a framework set by the state. Such a situation was not uncommon in late nineteenth century Britain (see, for example, Oxford University, Jones, 1994, p. 15). The position was outlined in the 1907 Report of the Departmental Committee on the Accounts of Local Authorities (Coombs and Edwards, 1990b, p. 342–3). Managers of Asylum Districts were regulated by orders issued under the various Poor Law Amendment Acts, Joint Hospital Boards were governed by an order of 1892 from the Public Health Acts and Isolation Hospitals set up under the Isolation Hospitals Acts complied with an order of 1899.

In 1889, the use of the double account system for each fund was recommended and by 1930 the main principles of local authority financial reporting had been established (Coombs and Edwards, 1996, p. 25). This included the use of accruals, rather than cash, as the basis of measurement. A standardized control was sought via the Poor Law System of Accounts which became a requirement for Boards of Governors throughout the country (Heyes, 1904, p. 73). For example, detailed returns were prepared, such as a 96-column quarterly report on provisions consumed. These analyses were broadly similar to those used by the voluntary sector which divided expenditure according to its nature rather than the department to which it related. Attempts to use a standard form of accounting were more advanced by the 1920s in the municipal sector "because it was easier for local authority accountants to communicate with each other and to put pressure on the Clerks and Stewards to report to them in an approved form" (Rigden, 1983, p. 11). However, even by the 1930s a variety of formats could still be found even within the accounts of a single authority (Boucher, 1931, p. 215–65). For example, the City of Cardiff Accounts not only adopted different presentational formats for different types of hospitals, but recorded revenue, capital and balance sheet items relating to hospitals together with non-hospital items in their general rate fund accounts (City of Cardiff, 1936). *The Accountant* (1946, p. 78) reported: "a complete lack of uniformity in the form of these published [municipal hospital] abstracts as even a cursory examination of them will show. The form, and the extent of the information published, would appear to vary with the status and size of the local authority."

There was also a growth in municipal activity with increasingly effective public sector general hospitals, specialised fever hospitals and asylums which developed from the workhouse infirmaries. These demonstrated aspects of etatism arising from the implementation

of the 1834 Poor Law Amendment Act with more detailed supervision coming from the Poor Law Commissioner. However, the effectiveness of the healthcare provided can be judged by the fact that half the male volunteers for the Boer War (1899–1902) were rejected as unfit (Adams, 1998, p. 3).

The Social Forces Model thus shows that in the municipal hospitals' accounting systems were initially diverse and locally-based, reflecting communitarian aspects such as customised charge/discharge systems. However, gradually communitarianism became embedded in an etatist structure within a framework set by the state. As more state control was sought accounting was used as a control mechanism, with mixed success, in an attempt to impose standardized presentation and reporting.

2.3. The genealogy of the NHS

The First World War brought some financial relief for the voluntary hospitals as the government paid for treating casualties. An important precedent was thus set of direct central government intervention in healthcare. There was a recognition that national problems necessitated national solutions. This had already been realised in the broader social sphere a decade earlier by the Liberal Government of Lloyd George that introduced measures such as old age pensions and compulsory insurance for workers. However, there was still little support among the voluntary hospitals for either state intervention in hospital provision or for an extension of state bureaucracy with its associated increased taxation (Robson, 2003).

Once the precedent of state intervention had been established it became increasingly difficult for the state to withdraw.[9] For instance, the immediate post war withdrawal of funds and the inter-war depression resulted in further, increasingly severe, financial crises. Further injection of state funds and co-operation between the voluntary and state sector became enshrined in the Local Government Act of 1929. This, however, proved to be only an interim solution. By the mid 1930s, "(t)here was a widespread acceptance of the fact that the voluntary hospital system was no longer viable financially" (Klein, 1983, p. 4). One response was for hospital funding to move away from charitable contributions towards more direct payments from patients and the promotion of workmen's contributory schemes. "Despite these innovations [organized contribution and direct payment], voluntary hospital finances remained insecure during the 1930s, when annual deficits and reliance on borrowing were an ingrained feature of the system" (Gorsky et al., 2002, p. 554). The Second World War again brought state intervention as the Ministry of Health took over healthcare planning and provision through the Emergency Medical Service. Centralised managerial control and finance was established over both the voluntary and municipal hospitals.

Finally, after the war, the NHS was formally established by combining the resources of the voluntary and municipal hospitals. The municipal sector brought the majority of hospital beds to this compact, while the voluntary hospitals prided themselves on a high quality of care and on their teaching and research functions. The municipal hospitals had already established the principle of governmental involvement in the nation's health provision. By contrast, the voluntary hospitals' contribution was more practical and administrative.

[9] As one of the anonymous reviewers points out there was, however, a widespread desire to return to a pre-war normality without state intervention. The return to the gold standard perhaps typified this.

The emergence of the modern nation led to an increase in state (hierarchical control), principally at the expense of community (spontaneous solidarity) principles. This involvement was most obvious in the municipal hospitals, but was clear, especially by the end of World War Two, in the voluntary hospitals too. Recurring financial crises provided the impetus for reform, but the political change after the War brought with it the idea of strong centralised planning, based partly on the conception that the War had been won by planning.

The social tides therefore were flowing towards state health provision. The practical interpretation was, however, driven by two key actors: William Beveridge and Aneurin Bevan. William Beveridge in 1942 recommended extending the Liberal's national insurance model. The state was to become responsible for healthcare. The Beveridge Report was effectively implemented by Atlee's government. Aneurin Bevan believed that accounting information was central to an efficient health service. "Decentralisation to local bodies, a minimum of itemised central approval, and the exercise of financial control through global budgets, relying for economy not so much on a tight detailed Department grip but on the education of the bodies concerned by the development of comparative costing, central supply and similar gradual methods of introducing efficiency and order among the heterogeneous mass of units" (Public Records Office, Kew, CAB 134/518:1, quoted in Robson, 2003, p. 110).

In the NHS, the initial accounting procedures were traceable to the King's Fund system used by voluntary hospitals (King Edward's Hospital Fund for London (KEHFL), 1952, p. 26) and were governed by regulation in a strictly hierarchical manner. The procedures were etatist in nature and designed to enable each higher level of administration to control the lower level's activities. Periodic statements compared actual with expected expenditure and analyzed accrual-based revenue flows using aggregated figures for such items as "salaries and wages". Details of cash receipts and payments were prepared (SI 1414, 1948, p. 738) to control cash advances, accruals were used for revenue items in the annual accounts and a reconciliation between the results based on cash flows and those using accruals was obligatory (Brown, 1952; part IV). All the substantive elements of a control-based, hierarchical system were put in place.

Embryonic interest began in the use of accounting as a national, rather than as a local, control mechanism which, by relating costs to activities, could show that "grants have been spent wisely" (The Accountant, 1946, p. 78). The value of a national approach to costing was recognised in 1949 with the requirement to split hospital expenditure between in-patient and out-patient departments. From this, a measure of cost per in-patient day and out-patient attendance was calculated. This simple approach "at least began to make hospital officers more cost conscious and created the desire, particularly among financial officers, for something better" (Rigden, 1983, p. 15). It was recognised that the basic cost calculations using subjective analyses were not sensitive enough to identify cost variations caused by such factors as severity of illness, mode of treatment or higher costs in teaching hospitals. This was exacerbated by the increasing complexity of potential treatments resulting from advances in medical techniques. As a response, the Minister of Health commissioned two reports on hospital costing (KEHFL, 1952; NPHT, 1952). These introduced trials of expenditure analysis in large hospitals in order to reveal in an objective way the cost of separate activities such as catering and X-ray. The etatist use of unit cost identification as a means of control is a theme which runs through the life of the NHS and finally underpinned the prices used to drive the market-based reforms of the 1990s.

At this point another influential accounting individual appears. Captain J.E. Stone[10] was employed by the KEHFL as a full time consultant on hospital finance in 1939 and in 1941 he became head of the KEHFL Economy Department. Since the 1920s, when he was Chief Accountant at St. Thomas's Hospital, he had favoured an accounting system based on a departmental analysis of costs and was an influential member of the KEHFL committee on costing. In 1924, he wrote *Hospital Accounts and Financial Administration*. The departmental costing system which he advocated in this book was introduced into large acute hospitals in 1956 and the costs of different departments were matched with measures of their activity so that valid comparisons could be made. Control was extended from the hospital as the controllable entity to the individual department. Such hierarchical control typifies etatism. The complexities of the NHS and the costs of implementation proved too great, and the development and extension of the proposed scheme was deferred. "In the 1960s much less was heard . . . about departmental accountancy" (Prochaska, 1992, p. 186). However, Stone had sowed the seeds of uniform activity costing, and they remained in place. Stone himself was even more forward-thinking, anticipating the intrusion of market forces into the NHS. In an interesting reflection on modern day practice Stone surmised that "there is nothing in the management of a large hospital which sets it apart from that of a commercial undertaking and to those who are responsible for the efficient and economical management of hospitals it is obviously more satisfactory to have the accounting records on such a system" (Stone, 1924, p. 95, as quoted in Robson, 2003, p. 108). This emphasis on efficiency coincided with the emphasis on cost consciousness and technocratic politics in the NHS from 1960–1975 (Robson, 2004).

The advent of the NHS was thus the culmination of the intermittent transformation which occurred in healthcare provision from 1800 to 1948. A gradually more interventionist state involved itself in healthcare just as it was becoming involved in other traditionally communitarian areas such as education. In particular, successive wars, such as the Boer War (1899–1902), First World War (1914–18) and Second World War (1939–1945) gradually changed the governmental attitudes from one of non-intervention to intervention in the nation's health.

Initially, therefore, the NHS built upon the accounting procedures developed by the voluntary hospitals. These were developed into a control-based, hierarchal system which facilitated etatist management. Although attempts were made to further refine accounting, thus anticipating market-based NHS accounting, these proved unsuccessful.

2.4. The establishment of an etatist health service

One of the main outcomes of the first major administrative reorganization of the NHS, instituted in 1974, was greatly to reinforce etatist aspects of control throughout a hierarchical bureaucracy. The country was divided geographically into regions and the Department of

[10] Captain J.E. Stone (1888–?) was the Chief Accountant of St. Thomas's Hospital and wrote perhaps the only text on hospital accounting produced in the period 1924–1957. In 1939, he was employed as a consultant by the King's Fund and, in 1941, became head of the Economy Department. Then, in 1948 he was appointed Director of the Division of Hospital Facilities. He was a member of the International Hospital Association, becoming President of the Commission on Hospital Accounting and Finance.

Health, at the top of a pyramid, distributed funds to the Regional Health Authorities (RHAs); these, in turn, funded Area Health Authorities (AHAs) that finally funded the District Health Authorities (DHAs). Administration was carried out with "delegation downwards" and "accountability upwards" (Iliffe, 1983, p. 83).

The reorganisation brought with it a renewed interest in accounting for activity. National standardised accounting, and thus etatism, was reinforced with additional secondary departmental analysis and comparisons of actual against budgeted expenditure. Professor Charles Magee,[11] was commissioned to develop a system of hospital activity costing. Magee was another catalytic individual who demonstrated the feasibility of speciality costing, i.e., to identify the costs of different specialities and then relate them to activity (Magee and Osmolski, 1978). Perrin (1978, p. 148) noted that such a system would be "useful for financial planning by local management, for the motivational effects of making inter-hospital comparisons and for planning and resource analysis at both the regional and national health departments". In this context, costing was seen as part of the etatist system of centralised planning, with no mention of any role for a market in healthcare. However, they did provide exemplars for those who later decided to use costs to drive the quasi market for healthcare. Accountability Service Planning and Evaluation (Rigden, 1983, p. 205), patient costing (Jones and Prowle, 1982, p. 130) and, in particular, speciality costing in the 1970s took place against a background of increased interest in the financial aspects of healthcare (Perry, 1974; West Midlands RHA, 1979).

During this period there was growing acceptance of the fact that national health service resources, were still, as at its inception, inequitably distributed. An ad hoc accounting approach to quantifying the inequality in capital resources was adopted in which all assets were valued and a "theoretical" stock established for each region; a pattern of future funding designed to redress the imbalance was then developed (DHSS, 1976). This foreshadowed the market-based systems of the 1990s by introducing the idea of using value as a proxy for resource volume and concentrating on the stock of resources rather than just on their flows. Both of these aspects are automatically formed from the preparation of a balance sheet within a system of double-entry accounts.

By the early 1980s, budgeting was firmly established as part of the planning system at all levels. Primary and secondary analysis, showing both the type and purpose of expenditure, and linked to measures of throughput, provided detailed insights into the efficiency, economy and effectiveness of the health service. Local results were compared to national norms. The state had found a useful mechanism by which the NHS could be reshaped. Financial performance indicators identified in a Research Programme (Financial Information Project, 1979) became essential management tools. Accounting's role was expanding into previously "invisible" areas such as patient costing and by the mid-1980s, accounting rather than being a by-product of the new administration had become central to its application.

The early 1980s also saw an interest in establishing a uniform basis on which to collect statistics about all aspects of the NHS (DHSS, 1983, p. 29). The main features of the etatist system in the early 1980s were bureaucracy and standardization. The Department

[11] Professor Charles Magee (1909–1998) was appointed to a Chair in Accounting at University College, Cardiff in 1970 having been an accounting academic and practitioner for many years. His work on hospital activity costing started with a project, funded by the DHSS, to investigate Cervical Cytology (Magee et al., 1974).

of Health presided over regions, areas and districts. Standardized budgetary systems had emerged, uniformity had been imposed and control-based accounting systems established. The etatist nature of the NHS was, however, weakened by the recommendations of the 1979 Royal Commission.

These proposals, implemented in 1982, resulted in a move away from consensus management towards increased decentralization (Merrison, 1979, p. 377–8). Governmental attitude thus shifted from believing that the NHS could be run from the centre using a system of planning towards the view that "we must see the NHS not as a single organisation, but ... as a series of local services run by local management" (Patrick Jenkin, Secretary of State, quoted in Klein, 1983, p. 138–9). However, the fragmentation was not a return to communitarianism where local services were funded locally; the finance was still provided from the centre. This retreat from etatist principles provided the genealogy of a market-like approach as it identified the providers of healthcare as separate operational entities.

At this juncture, another catalytic individual emerges: Roy Griffiths,[12] whose enquiry into the health service led the general manager to be elevated in importance and clinical staff relatively demoted. Roy Griffiths introduced market principles into the health service. General managers were introduced in an attempt to improve decision making, as well as removing from doctors "an excuse to procrastinate" (Levitt et al., 1995, p. 23). The non-specialist, but more 'business-like', manager (i.e., modelled on the private sector company manager) was beginning to undermine the specialist, but non-business-like, clinician. As etatism waned, it was market rather than community principles which waxed.

Although, by 1982, the new etatist management structure was struggling to cope with new demands, the role of accounting remained untarnished. Early rudimentary costing systems opened up new areas of accounting, "but there was very little information available at the level required for costing and pricing health care contracts" (Ellwood, 1996, p. 285). More sophisticated costing techniques, such as speciality costing, that identified the average costs of clusters of activity, continued to gain in popularity. This was the contribution made by accounting to the later transformation to a market-driven health service. Patient costing that traced costs to individual patients, or groups of patients, a prerequisite for pricing, was instituted.

The reforms made to the NHS between 1948 and 1991 all modified a core system based on funding facilities to which all citizens had a right of access. At the start of the period etatist (hierarchical, standardised and budgetary systems) were introduced as there was an attempt to provide an effective national service. However, by the end of the period etatism was eroded through decentralisation, the introduction of managers and of sophisticated accounting systems such as patient and speciality costing. In its final, pre-market form, there were "no serious incentives to guide the NHS in the direction of better quality care and service at reduced cost" (Enthoven, 1985, p. 13). A health district which sent its patients to facilities located in, and financed by, another authority did not suffer a corresponding reduction in its funding, and the receiving district gained no corresponding benefit. Where cross-boundary compensation was operated, average costs were used; this was likely to fall

[12] Sir Ernest Roy Griffiths (1926–1994) pursued a successful career in the private sector, rising to the deputy chairmanship of Sainsburys in 1988. In 1983, he was invited by Margaret Thatcher to carry out an analysis of the administration of the NHS.

below actual cost because centres of excellence tend to attract difficult, and hence costly, cases. The government decided that as much local autonomy as possible should be developed to provide incentives, and the principle that "cash follows the patient" established.

2.5. *The intrusion of market forces*

The latter part of the twentieth century saw the adoption in many countries of "New Public Management" (NPM) which sought to introduce aspects of private sector managerial practice to the public sector. In general the public sector has lagged behind the private sector in the adoption of new accounting practices and technologies and therefore imported rather than exported accounting innovations. NPM emphasises "cost control, financial transparency, the autonomization of organizational sub-units, the decentralization of management authority, the creation of market and quasi-market mechanisms . . . and the enhancement of accountability to customers" (Power, 1997, p. 43). This approach was applied to the NHS and the period from 1991 marked a new phase in the transformation of the health service. The etatist hierarchical structure of centralized state control was increasingly replaced by a quasi-market driven environment. This reflected wider socio-economic developments as the Conservatives under Margaret Thatcher sought to introduce market principles into areas previously immune from the competitive world such as utilities and central government. In the health service, management, especially at local level, was decentralised and commercialised and, in addition, accounting provided the data which drove the purchaser – provider interface. Hospitals offered a priced list of procedures and purchasers shopped around for the best deal, although, in practice, elements of local monopoly were created and contracts were finalised by negotiation. In short, accounting provided the mechanism by which the post-1991 quasi-market health system could be delivered.

The rhetoric and language of the market was adopted to signal these changes (i.e., board of directors, chief executives, contracts, purchasers, providers) built on a previously expressed, influential belief that "there seems to be no substitute for competition and consumer choice" (Enthoven, 1985, p. 41–2). The government's original intention was that NHS trusts would have significant freedom to take their own decisions on matters which affect them most without detailed supervision from above (HMSO, 1989, p. 3). Providers (i.e., individual NHS trusts) were to compete in contractually based quasi-autonomous enterprises to meet the demands of purchasers (i.e., the District Health Authorities and fund-holding GPs) acting on the behalf of their populations. The 'market' philosophy was that this dispersed competition would result in more cost-effective treatment. The market mimicry was encouraged by partnerships between the private and public health sectors to fund capital projects and by the growth of the professional manager. Although the state had set up a quasi-market, politicians still intervened if the market did not produce politically acceptable results. To illustrate, the government announced increased numbers of intensive care beds, but without providing any additional funds to finance them (Jones, 1996, p. 18).

Application of the Social Forces Model to the movement towards a market driven system of healthcare delivery shows how the accounting seeds were sown during a time of etatism. In the central command and control approach of the 1970s and 1980s accounting techniques were developed to provide input to the planning process and act as performance indicators. The purpose of this data "was not to provide the basis for specific decisions but rather to

be an informational warning system" (Saltman and von Otter, 1992, p. 27). The system might not have been designed to enable NPM development, but was adapted to its service; emphasis was placed on financial aspects and it was used to drive a programme of cost reductions.

Trusts inherited embryonic costing/pricing accounting systems and then had to develop their own individual systems, so that they could also produce the information required for an annual public report in which the accounts broadly complied with normal commercial accounting practice based on the accruals concept. This resulted in full capital accounting with fixed assets in the balance sheet and a depreciation charge in the income and expenditure account; notional charges for interest on capital were also introduced. Full accruals accounting, a feature of the private sector was adopted along with its market mechanism. Sheila Masters,[13] who did not previously support the use of full depreciation accounting (1982), became the Director of Financial Management at the Department of Health in 1988 and acted as a catalyst for changes involving the adoption of private sector methods. She now wrote, without qualification, that NHS Trusts "will be required to depreciate their assets in accordance with normal accounting practice" (1990, p. 34). The trusts were also charged with making at least a 6% return on their net assets, and so were driven by financial as well as health imperatives. As a result, the etatist based costing system, that included only revenue costs, had to be extended to account for the full cost (including depreciation and interest) of procedures.

Further indications of the adoption, by the NHS, of the private sector, market orientated ethos came with its embrace of the Private Finance Initiative (PFI). This was one aspect of the attempts to increase efficiency in the public sector through the adoption of private sector organisational forms (Hood, 1995). Under PFI, the infrastructure assets of the NHS are provided by the private sector and the NHS obtains the services provided by these assets in exchange for an ongoing charge. The extent to which the adoption of PFI represents a form of privatisation of healthcare will only become apparent "through time, experience and research" (Broadbent and Laughlin, 1999, p. 107). The PFI continues to be used to finance substantial amounts of infrastructure investment, although a planning based system has replaced the market (DoH, 1997; HMSO, 1999).

In 1997, a Labour government was elected with reform of the NHS as a key agenda item. However, New Labour has reshaped rather than dismantled the Conservative's market-based approach. The split between health commissioners and healthcare providers was retained, but the more extreme market-based aspects have been abolished. The system moved to one in which services for the local community were commissioned by Primary Care Groups (PCG) on the basis of three year rolling plans. Trusts remained as autonomous units, but became partners in local Health Improvement Programmes and agreed long term service contracts with their PCG.

Accounting continues to be based on the private sector model, with each trust preparing an annual report containing an Income and Expenditure Account, Balance Sheet and

[13] Dame Sheila Masters (now Baroness Noakes) (1949–), a chartered accountant and partner in Peat Marwick Mitchell (later KPMG) was seconded to the Department of Health as Director of Finance in the NHS Management Executive for the period 1988–1991. She then served on the NHS Policy Board (1992–1995) and the Chancellor of the Exchequer's Private Finance Panel (1993–1997).

Cash Flow Statement. Costing is no longer the basis of pricing, but is part of the information used to formulate the rolling plan. These arrangements were operationalised by the Health Act 1999. Perhaps, rather surprisingly to their traditional socialist supporters, New Labour have thus reshaped rather than dismantled the market in healthcare and espoused, in the vigorous championing of PFI, "an ideological commitment to increase the involvement of the private sector in the public sector" (Broadbent and Laughlin, 1999, p. 96).

3. Discussion and conclusion

The Social Forces Model is used, in this article, to chart the changing nature of accounting in the context of healthcare provision in the UK since 1800. In 1800, a primarily communitarian health service existed in which accounting played a passive, supportive role. By 2000, the health service, through the institutional framework of the NHS, was primarily based on etatist-inspired market principles. Overall, a marked transformation has occurred. Accounting not only played a central role in these developments, but was also central to the implementation and delivery of the market-based system.

The role of accounting as seen in the NHS is consistent with the conclusion of Burchell et al. (1980, p. 5) that it "has come to occupy an ever more significant position in the functioning of modern industrial societies". From the start of the era covered by this paper the various forms of accounting observed at different points can be seen as part of the system of control that accrued over the years.

In the UK, the provision of healthcare over time has thus been a gradual, halting move from a communitarian phase to an etatist phase and, then, to a market-based phase with an etatist umbrella. The first communitarian phase lasted from the early 1800s up to 1948. There were two mains strands: voluntary hospitals and municipal hospitals. Voluntary hospitals were characterised by private philanthropy, were self-governing and funded by private subscriptions, all communitarian features. This accounting was also characterised by communitarianism with customisation of accounting systems which were stewardship-based. These features were well-suited to small, fragmented, local organizations, but also reacted to the principal line of cleavage associated with communitarianism, that is, the line between "natives" and "foreigners" (Streeck and Schmitter, 1985). Overall, voluntary hospitals developed in an uncoordinated manner. Municipal hospitals were also locally-based and locally-run. Their financial reports were initially diverse, based on cash flows and used customised charge/discharge systems. It was in municipal hospitals that etatism made the greatest inroads before the Second World War. This was primarily through a series of legislative acts with the introduction of the double account system based on accruals. Standard forms of accounting, although in existence, were still rudimentary but were nevertheless more advanced than in voluntary hospitals. In the voluntary hospitals, however, the King's Fund was a catalyst for the adoption of uniform, corporate information. This was the precursor of etatism.

The etatist epoch of the UK health service emerged from the voluntary and municipal hospitals. Essentially, it built on the King's Fund approach. Over time, the etatist features of centralisation, hierarchal planning and bureaucratisation gradually developed. Etatist

accounting techniques, such as budgeting, speciality costing and departmental costing gradually developed to provide detailed information.

In the late-twentieth century, there was an infusion of market-based principles into the National Health Service. A quasi-market system was created. The commercial world was mimicked through costing/pricing accounting systems, annual reports and the introduction of normal commercial accounting practices based on accruals.

The social forces model thus demonstrates that there has been a fundamental reshaping of the accounting systems within the health service. These accounting systems were well matched to the underlying institutional structures. The early nineteenth century systems were characterised by non-standardised, customised systems based on receipts and payments or the charge-discharge system. These were well-suited to small, local hospitals. These were replaced by more accountability-oriented, double-entry, control-based budgetary systems, standardised across the UK and using accruals accounting for revenue items. This reflected a national orientation to healthcare. Finally, more aggressive market-based systems have arisen, where surpluses and deficits are measured in the income and expenditure account and a full balance sheet is prepared. This was symptomatic of New Public Management and the commercialisation of the hospitals.

Costing and budgeting now flourish, developing from the early ad hoc exercises carried out in the voluntary sector. More detailed departmental analysis was demanded throughout the NHS in the early 1970s. Eventually, the production of standard cost returns became a requirement, although these did not go as far as patient or speciality costing. Management was responsible for using the information to take any action identified as necessary, aided by the finance function which would interpret and explain the figures. Areas for investigation were identified by comparing local results with nationally established norms. Thus, accounting, by identifying the costs of different activities, became part of the control and disciplinary system.

The creation of a quasi-market was facilitated by, and indeed would have been impossible without, a full accruals-based system. The mimicry of the private sector accounting method requires the production of an annual report, including financial statements, complete with a measure of return on capital employed. The intention is to encourage the efficient use of assets as well as to generate as much healthcare activity as possible from a finite allocation of funds. The prices used in the market were based on the full cost of activity, including capital charges so as to remove any distortions caused by different levels of capital intensity being used by different institutions. So within the market mode of the Social Forces Model accounting played a major role.

Control is a developing theme throughout the period with accounting being used as its medium while at the same time underpinning the organisational structure. At one time accounting may be the tool through which apparent control at a distance is maximised through the use of quasi-market forces under which overall accounting-based targets are set and monitored. At another time, it meshes with finely detailed planning systems controlled from the centre where activity is scrutinised and costed. The construction and development of healthcare as a social activity was enabled by and intertwined with accounting (Burchell et al., 1980, 1985; Lianos, 2003). This was consistent with Laughlin's (1989, p. 483) ideas which discern the mechanisms leading to the emergence of accounting change and locate the position and significance of human agency in this process.

The analysis presented in this paper contributes to our understanding of the historical interplay of social forces in four ways. First, accounting is shown to be a technical instrument within an institutional setting. Accounting was matched to the social forces, identified in the Social Forces Model, although not always perfectly. For example, in the nineteenth century hospitals sometimes existed as communitarian institutions within a more laissez faire economy. Under communitarianism, there was a relatively simple accounting system based largely on receipts, cash flows and customised accounting systems. Under etatism costing and budgeting systems developed in ever more complex ways through such techniques as speciality and departmental costing. Finally, under market-based systems normal commercial accounting practices based on accruals were developed within an etatist umbrella.

Second, the interactive nature of accounting and institutional change is highlighted. Accounting became an instrument for change. It reflected the changing pattern of societal forces. For example, once Burdett's uniform system had been introduced, hospitals seeking funding were forced to adopt it. Accounting also made previously hidden costs visible as in departmental costing (Morgan and Willmott, 1993). This enabled comparisons between hospitals to be made. The improvement in costings also allowed speciality costing, cost per operation and cost per patient to be identified. The mechanisms were also in place for market-based pricing and the foundation of the quasi-market.

Third, the role of individual action within the Revised Model is highlighted. Certain key individuals are identified within the accounting context. Burdett developed uniform costing which set the seeds for standardisation and then comparative inter-departmental and inter-hospital analysis. Stone introduced departmental costing. He was able to build on Burdett's work. Magee showed how speciality costing was possible within the context of the etatist system of central planning. This was later picked up in the market for healthcare. Finally, Griffiths introduced market-based principles into the health service thus paving the way for the quasi-market.

Fourth, the role of "outside" agency can be seen throughout. These influences flowed from the wider social world into the health service. As the entities responsible for the delivery of healthcare, mainly hospitals, become dependent on more remote funding, then the accounting procedures adapt to provide the oversight demanded by the funders. Under the earliest communitarian systems, local hospitals could fashion their own accounting methods. However, increasingly they were forced to look outside: successively to organisations like the King's Fund, in London, and the government in general. The result has been greater standardisation and detail. Both etatist control mechanisms (e.g., costing and budgeting) and market-based mechanisms (e.g., annual reports and annual general meetings) have imposed external controls on initially self-contained organisations.

The Revised Social Order Model enabled the changes in the mode of healthcare delivery to be plotted over time. Although there may be apparent periods of stability, the application of the model provided a framework within which to show how social forces interact, along with the interventions of individuals, to move the system between the different modes of order. These movements are gradual and no single mode dominates to the exclusion of the others. The creation of prerequisites for change is accumulated within one mode to facilitate movement to the next, but, even after change, significant remnants of the previous dominant characteristics remain embedded. These moves are accompanied by changes in

the accounting system which are needed both to facilitate the move and operationalise the revised position.

The Revised Social Order Model thus both reinforces and extends the prior theoretical lens which have been used to view the health service. Like Burchell et al. (1980, 1985), Lianos (2003), Bourn and Ezzamel (1986) and Lapsley (1993) the broad sweep of social forces can be identified with change. However, the Social Forces Model allows a broader period of change to be examined than the previous studies which looked only at the recent past. In addition, the Revised Social Order Model shows the persistence and existence of the communitarian model which stretches in time back to the Middle Ages. None of the prior studies identifies this strand in relation to the NHS.

The Social Forces Model, like Laughlin (1989) and Preston et al. (1992), stresses the role of human agency in developing and refining accounting techniques. However, for the first time the key role of specific individuals has been identified in the RSO model. This is not, however, to say that the Social Forces Model is beyond criticism. The focus on the broad macro sweep of social forces is not without cost. The micro-based elements of the NHS are to some extent inevitably obscured. There is thus a consequent danger that the historical trends and transformations become oversimplified. It would thus be useful for the differing epochs of accounting history covered in this paper to be more closely analysed and investigated to identify the trees within the wood of the social forces.

The use of the Social Forces Model to map healthcare provision has illuminated areas of historical interest. It shows that capitalists often participated in the charitable provision of healthcare. Nonetheless, those members of the population who benefited from this philanthropy, the working class, did not turn to capitalist market healthcare solutions but, instead, instituted communitarian responses.

The Social Forces Model has proved a useful framework in which to investigate these social transformations. In particular, using this model highlights the role played by the state as well as showing how accounting has gradually been transformed from a passive recording mechanism to an active facilitator of, and participant in, change. The success of the Social Forces Model in this particular institutional environment suggests that the model may have potential utility for the study of other organizational histories. For example, the transformations in the universities or in central government may prove a fruitful area of study.

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