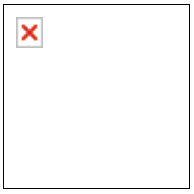
MANAGEMENT CONTROL SYSTEMS IN NON-PROFIT ORGANISATIONS

WITH SPECIAL REFERENCE TO HOSPITALS



Research Committee
The Institute of Chartered Accountants of India
New Delhi

Management Control Systems in Non-Profit Organisations
With Special Reference to Hospitals

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Foreword

Effective systems of management control play a significant role in the achievement of objectives of every organisation including a non-profit organisation. The basic data for a management control system is based on accounting information. Many non-profit organisations in our country suffer from inadequate management controls, one of the reasons being a weak accounting base. Chartered accountants can provide necessary leadership in this area. Their involvement in this area has been increasing in recent years with increase in the number of non-profit organisations.

This publication is based on case studies of two hospitals. The studies were conducted by Ms. Rozmin Ajani, a member of our profession, to whom I am thankful. I am sure that this publication would provide a very useful base for those who want to develop an effective management control system in a hospital. I congratulate the author for preparing the basic draft as well as the Research Committee for publishing this important study in an area, which so far had not received the attention it deserved.

New Delhi
August 12, 1996

T.S. Vishwanath
President

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Preface

Non-profit sector plays a vital role in a country like India. Amongst the category of non-profit organisations, investment in the health sector and, within it, in hospitals, is particularly large. In India, Government out-lay in health sector has increased manifold in the last three decades.

Owing to the growing importance of this sector, the Research Committee of the Institute selected this project on 'Management control systems in non-profit organisations with special reference to hospitals' under Research Fellowship Scheme instituted to commemorate the 40th Anniversary of Independence of India. The consequent document was in the form of a dissertation by Ms. Rozmin Ajani, a member of the Institute.

The Research Committee decided to publish the above dissertation after certain modifications as it was felt that the case studies of the two hospitals in non-profit sector - one government and the other private - will be very useful to those who want to establish a management control system in a hospital. In view of this, facts contained in this publication are as per the study conducted by the author and the views contained in this study are her views.

The study has been very carefully structured into five chapters. First chapter is an introductory one, outlining the objectives of the study, its scope and methodology adopted. The second chapter describes theoretical aspects of management control process and its techniques, effects of profit on operations and the characteristics of non-profit organisations. The third chapter gives a detailed overview of the operations of the two hospitals. The fourth chapter critically analyses the existing management control systems in the hospitals selected. The last chapter outlines the conclusions and findings of the study.

I express my thanks to Ms. Rozmin Ajani for taking up this project of topical interest. I am sure her contribution in this endeavour would be of immense value to the profession.

I hope that this publication will be useful to our members and others concerned.

K.S. Mehta
Chairman
Research Committee

New Delhi
August 12, 1996

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EMERGENCE OF THE DECENTRALISED ORGANISATION

Management function in the present era is extremely complex. It envisages within an organisation, the co-ordination of a wide range of activities, specialised in nature and requiring unique technical expertise. This complexity in the management function can be attributed, amongst other factors, to the increasing size of organisations, the rapidly changing technologies, and an extremely dynamic external environment full of challenges and opportunities. These changes have had considerable impact on the structure of organisations, which have undergone radical changes over the years. Traditional, closed forms of organisations have given way to a wide range of more open and decentralised forms.

When an organisation is small and its activities limited, the owner is able to co-ordinate all its functions and exercise effective control. As an organisation grows larger and its activities become more complex and varied, co-ordination and control become increasingly difficult tasks. It then becomes necessary to divide the organisation into smaller subdivisions or units to deal effectively with multifarious functions. With the growing complexity of these functions, the units become increasingly specialised and have to be attended to by technical and other experts in the concerned fields. Areas of responsibility for each of the units have to be clearly demarcated and levels of authority delineated.

An implication of the above on the control function is that authority, hitherto vested with the top management, has to be delegated at least to the heads of various units. This is essential because the units need operating, financial and administrative autonomy to carry out their functions effectively. As a result, unit heads have to be bestowed with authority to command and commit organisational resources. The level of the authority allowed to unit heads in an organisation, would depend upon a number of factors, including the type of environment – certain or uncertain; the nature of activities – structured or unstructured; and the style of management – restrictive or participative.

IMPLICATIONS OF DECENTRALISATION

All organisations exist for the achievement of certain goals and objectives, which are formulated within the framework of their overall missions. It is always the endeavour of these organisations to realise the maximum of their formulated goals and objectives. In fact, the organisational policies and practices, as also the organisational structure are framed, keeping in view the organisational goals.

With the emergence of decentralised organisational forms, wherein a large number of units are involved in various activities, it becomes inevitable that each unit has its own formulated sub-goals within the framework of the overall organisational goals. This is an essential prerequisite in a decentralised organisation, because when the number of units is large, the management needs measures to evaluate performance of individual units, in order to exercise effective control.

One of the most inherent dangers of decentralisation is the possibility of dysfunctional decision making at

unit levels. Since the activities of the unit are highly structured, unit members work in watertight compartments dealing with their own specialised activities and the attainment of their own narrow goals. This implies that in case of a conflict between overall organisational goals and narrow unit goals, the unit heads may sacrifice the former in pursuing the latter. In the case of commercial organisations, where 'unit profits' are generally considered for evaluating unit performances, it is not uncommon to find unit heads avoiding important expenditures like maintenance of equipments and machineries to reduce their unit costs and thereby increase the profits of the unit. In another instance, we may find unit heads sacrificing a valuable venture beneficial for the overall interests of the organisation, just because it happens to reduce the profitability of their own units.

Waterhouse comments on this aspect of dysfunctional decision making as follows[1]:

> "The issue of authority and power distribution is crucial to an understanding of the control processes within an organisation. Whenever an individual is granted authority, the opportunity arises for that individual to exercise discretion in developing and implementing policies or procedures. If the goals of the individual diverge from those of the organisation because of differential interests, perception of reality or access to information, authority delegation will be accompanied by a leakage of authority. Since organisations exist to realise ownership rather than individual goals, compensatory mechanisms for coping with authority leakage, that is, control mechanisms, need to be developed if organisational goals are to be realised".

We may go a step further and state, in general, the broader the decision making discretion permitted at lower levels within the organisation, the more authority leakage there will be and therefore more difficult and costly the task will be to exercise control.

INTRODUCTION TO THE CONCEPT OF MANAGEMENT CONTROL AND ITS IMPORTANCE

Given the inherent danger of dysfunctional decision making in decentralised form of organisations and the importance of optimum utilisation of resources in the achievement of organisational goals, there exists an acute need for an overall control system within an organisation. Unit heads need to be motivated to view the organisation as a whole; to come out of their watertight compartments and function in organisation's interests; to take decisions that promote the more important organisational goals rather than narrow sub-goals.

The above objectives can be achieved by formulating an effective management control system with inbuilt mechanisms to ensure goal congruence at unit levels. This integrated control system should be designed in such a manner that even while a unit head is involved in his own specialised activities, he works in the overall organisational interests. The integrated control mechanisms should motivate him to do this by adopting evaluation measures that reward performance on the basis of a unit's contribution to the attainment of overall organisational goals.

Management control can thus be defined as follows:

> "Management control is a process by which managers ensure that resources are used efficiently and effectively in the accomplishment of the organisation's objectives".

"The efficient and effective utilisation of resources" implies that the said resources should be utilised as per established standards (serving measures of efficiency) and in the accomplishment of organisational goals (serving measures of effectiveness).

A wide range of control devices exist to help achieve the objectives of management control. However, the management control system of an organisation needs to be much more than an integration of isolated control devices. It has to be designed according to the unique characteristics of the organisation for achieving its own unique objectives.

It is natural that control devices have undergone radical changes, in keeping with the strategic occurrences over the years. Traditional devices have either been discarded or altered to suit current conditions. Similarly, newer and more sophisticated devices have been introduced to attain more effectively the objectives of management control. However, the basic objectives of management control remain more or less the same.

BEHAVIOURAL ASPECTS OF MANAGEMENT CONTROL

An important consideration in the application of a management control system is the behavioural aspects of control.

The extent to which unit heads work towards goal congruence depends on how well motivated they are. A control system has ultimately to rest on human beings for its successful functioning. It is the personnel who have to make it or mar it. 'Motivation' is a mental disposition of an individual towards the control system. It is essentially a psychological matter. An individual is bound to play his role with full spirit and vigour, if he is convinced of the utility of the system and his personal needs are fully met. There are thus two aspects to the behavioural study in the context of management control system. The first aspect is that he "is convinced of the utility of the system." An individual should understand and accept the organisational goals. Further, he should understand the role of his own unit and its sub-goals and their contribution to the overall goals of the organisation. The second aspect is that he should be motivated to act in the interests of the overall organisational goals. This implies that incentives should be provided to him to act in the desired direction. In this way his needs are fully met. He will thus attach more meaning to his job and will derive satisfaction in performing it.

NEED FOR THE STUDY

MANAGEMENT CONTROL IN NON-PROFIT ORGANISATIONS

While the importance of effective management control is well recognised in industrial and other commercial organisations (the profit oriented group of organisations), this culture is sadly missing in the equally important category of non-profit organisation. Paradoxically, while much research has been carried out in management controls in profit oriented organisations, not much effort has been directed in the non-profit sector.

Non-profit organisations exist primarily to render service without a profit motive. Decisions made by their management are intended to result in the best possible service with the available resources, and their success is measured, primarily by how much service they render and how well they render it.[2]

The main distinction of a 'for profit' organisation from a 'non-profit' organisation is in terms of their organisational objectives. The dominant purpose, or at least one of the major purposes of 'for profit' organisations is earning profits. Decisions made by their management are intended to increase (or at least maintain) profits, and success is measured, to a significant degree, by the amount of profits these organisations earn. This is not to say that profit is their only objective, or that their success can be measured entirely in terms of profitability; that would be an overly simplistic view of most businesses. But the fact remains that their prime objective is profit maximisation.

The central problem of management control in non-profit organisations is that 'service' is a less measurable concept than 'profit'. It follows that it is more difficult to measure performance in a non-profit organisation. Despite this and other limitations, the activities in an organisation must be controlled. Its management must do what it can to ensure that resources are used efficiently and effectively. Thus, the main aim is to find out what controls can be best used despite the limitations.

Although the basic control concepts are the same in both profit oriented and non-profit organisations, but because of the special characteristics of non-profit organisations, the application of these concepts differs in some important respects. Most, but not all, of the control techniques developed in profit oriented organisations are applicable to non-profit organisations, with appropriate modifications. However, it must be emphasised that the objective of management control is the same, irrespective of the kind of

organisation. This is because, in both kinds, the purpose is effective and efficient utilisation of resources towards the overall objectives of the organisation.

ECONOMIC IMPORTANCE OF NON-PROFIT ORGANISATIONS

Non-profit organisations form a very important sector of modern society. They contribute heavily to the economy's services sector and have a major impact on the use of national resources.[3] The effective functioning of these organisations is critically important to the quality of life one enjoys, especially in a developing economy like India, which has the persistent problem of poverty. India has financial resource constraint, which makes it very vital for this scarce resource to be utilised in the most effective and efficient manner. One only needs to have a look at the crores of rupees spent every year by the government on provision of social services, like health, education and public utilities. Added to these are the efforts and finances of voluntary organisations, doing charitable work in a number of fields. It is, therefore, unfortunate that despite such heavy investment, non-profit organisations have a tradition of inadequate management control, especially in India.

IMPORTANCE OF HOSPITALS IN THE NON-PROFIT SECTOR

Among non-profit organisations as a class, outlay in the health sector and within it, in hospitals, has increased manifolds over the last three decades. Public financing in this sector has increased by more than fifty times during the five year and annual plans of the Government. Added to these are the private and voluntary organisations, which also contribute largely to this sector. Major investments have thus been made by the nation, in the health sector and within it, in hospitals.

"In terms of man, money and material, the consumption of resources by hospitals cannot be ignored. 4-5 employees per bed, 150-200 rupees per bed-day expenditure and an inventory of upto 1000 items are common features in running a hospital. A hospital bed may cost approximately two lakhs in terms of capital expenditure. Obviously, utilisation of hospitals as valuable resource in the community, assumes significance when the initial capital costs and recurring expenses are so high. It assumes more importance in the face of resources crunch"[4].

India has more than 7000 hospitals varying from 25 to 2000 beds. The total bed strength is approximately 5,35,735 and is likely to increase when 2000 community health centres of 30 beds each are commissioned by the turn of century[5] . By ownership, 70% of hospitals belong to the government and the public sector[6]. We can appreciate from these statistics the extent of investment that has been made in the 'non-profit' hospitals.

Unfortunately, in keeping with the trend of other categories of non-profit organisations, hospitals too have a tradition of inadequate management controls[7]. Further, as mentioned earlier, not much research has been carried out in this field. A study conducted by Ms. A.N. Dalal, in the year 1980, dealt with administrative issues in three municipal teaching hospitals in Bombay. Though the study did not concern itself, in detail, with management control aspects, Ms. Dalal concluded that control mechanisms were ineffective and the employees were indifferent to controls imposed by hospital authorities. The conclusions drawn by Ms. Dalal, emphasise the need of an in-depth research on management controls in non-profit hospitals.

Hospital Management – A Complex Task

Management of a modern hospital is a very complex process. Vast changes have taken place in the field of medicine and newer and better technologies have been made available over the years for diagnosis and treatment.

Alphonze Dochez gives a striking example of the complex changes that have taken place in hospital practices over the years. He contrasts the case histories of two patients with similar heart disease, over a time lag of thirty years. The written record of the first patient consisted of 2-1/2 pages containing

observations of two physicians, one specialist, one house officer and one pathologist. The record of the second patient amounted to 29 pages and represented the combined observations of 3 visiting physicians, two residents, 3 house officers, 10 specialists and 14 technicians (32 in all)[8].

The hospital today is one of the most complex type of contemporary organisations, partly because it has such diverse purposes and partly because of the wide range of occupations of the personnel who work in it. It provides by way of patient care, highly specialised medical and surgical procedures, as well as simple hospital facilities. There is, however, a difference in the complexity of an industrial organisation and a hospital organisation. In industry, extremely complex processes are mechanised and work hours are made routine so that co-ordination is achieved automatically. But, in a hospital, every patient has to be treated as a separate entity and the care given to him has to be suitable to his requirements. The condition of the patient may change unpredictably in the course of treatment. Co-ordination then depends on co-operation by staff at all levels and the understanding that different individuals have about each other's role.

In such a situation, authoritarian patterns of organisation become inappropriate because they are not flexible enough to fit all the intricacies of patient care. In many an emergency, everything depends on the readiness of the people to help each other. Co-ordination becomes self co-ordination.

Need for Effective Management Control in Non-Profit Hospitals

It can easily be inferred from the preceding discussion that there exists an acute need for effective management control in non-profit hospitals, suited to their complex nature of activities and organisational forms. This need, however, has not been fulfilled or even fully recognised in Indian non-profit hospitals.

Tremendous advances have been made in the field of medicine, but the field of management control has not kept pace with these advances. It is thus unable to extend the required support to the achievement of organisational goals. The reason for this can again be traced back to the service motive of a hospital, which neglects the financial and control aspects of management. Colin Grant et. el., has conveyed this idea in the following words:[9]

> "The traditional and continual emphasis on the importance of rendering good care rather than of financial aspects of hospital operations, has resulted in distortion of some management principles in their application to hospitals compared with other undertakings. In normal commercial ventures, the product or services produced, no matter how socially useful it may be, assumes a lesser importance in the long run, than the production of a profit which ensures the continuous existence of the venture. But in hospitals, it is the service provided, which is of paramount importance and that takes precedence over questions of profitability or even solvency. In the long run, chronic financial problems do assume critical significance for the hospital, but in the short run, they are less important, even for the profit oriented hospital, than for commercial enterprises."

While, on the one hand, effective and efficient utilisation of resources is important in the context of Indian hospitals, on the other hand, there exist difficulties in proper evaluation of performance, because it is difficult to measure 'service' effectively. On top of these, are difficulties in co-ordination and control of hospital functions which are becoming increasingly complex due to the highly decentralised forms of modern hospitals.

The above analysis of the existing situation in the context of management control in non-profit organisations, especially hospitals, leads one to an obvious conclusion, that there is an acute need for an in-depth study concerning the various aspects of management control in non-profit organisations, with special reference to hospitals.

OBJECTIVES OF THE STUDY

The study has been undertaken with the following objectives:

1. To study the design of management control systems in non-profit organisations with special reference to hospitals.

2. To analyse whether the existing set-up in the two hospitals selected for case studies meets with the overall objectives of the management control system.

SCOPE OF THE STUDY

Any management control system has essentially to be effective in three distinct areas in order to be operationally successful. These three areas are its design, implementation and administration. While all the three areas are equally important, it is difficult to focus in detail on all of them in a single study. The present study basically deals with the design of management control system.

Secondly, the research was concentrated on only two hospitals as it was felt that such a methodology would provide a better opportunity for an in-depth study and a greater scope for coverage than studying a larger number of hospitals. This line of thinking has been substantiated by Roberts who stated: "When phenomena are heterogeneous, generality can be gained at the price of the content. One is forced to say less and less about each case in order to include all possible cases."[10] In a management control system, 'phenomena' differ from organisation to organisation. Hence, the study of several organisations would have been possible only at the cost of content and coverage of the study.

METHODOLOGY

CASE STUDIES

The study relies principally for its evidence on the results of in-depth studies of the control systems in two hospitals belonging to the two broad categories of non-profit hospitals, viz., private (hereinafter referred to as 'Hospital A') and the other Government, falling under the jurisdiction of a Municipal Corporation (hereinafter referred to as 'Hospital B').

Background of Hospital 'A'

Hospital 'A' is a typical example of private voluntary hospitals operating for charitable purposes. It is typical in the sense that it has faced all the problems and limitations that most hospitals in the same category are facing. The hospital had been established as a small 16 bed hospital by a group of volunteers. It has come a long way since then, to become today, a modest sized hospital with fairly modern techniques and professional management. The hospital has faced acute financial problems, suffered from low capacity utilisation and inability to face competition, lack of professional management and outdated technology. However, with the help of technical experts and huge funding aids from an international funding agency, the hospital framed developmental plans, upgraded its services and managerial expertise and considerably improved its workings. Moreover, especially during the last five years, a great deal of effort and resources have gone into the analysis and planning of the hospital. A variety of financial, marketing and management studies have been conducted in order to highlight the problems and offer possible solutions. These studies suggest that the hospital continued to face major financial difficulties. Although, from its internal resources, it is able to meet its operating expenses, yet, it is unable to finance its own development. If this trend continues, experts feel that it will soon become outdated in a few years considering the rate at which medical technology is advancing, unless supported by external fundings. The question of long term financial self-sufficiency, which is currently posed before the hospital, is one which many such hospitals are facing.

Background of Hospital 'B'

The choice of Hospital 'B' was also simple because it easily fitted into the description of a typical government hospital. The hospital is characterised by financial problems, overcrowding, under utilisation of resources and bureaucratic management. However, since all operations and development are funded by

a Municipal Corporation, the problem of financial viability, though critical, is not really a priority with the hospital. The more obvious issues of overcrowding and bureaucratic management, resulting in administrative and personnel problems, form the basic and priority problems for the hospital.

THE RESEARCH METHODOLOGY

All through the study, efforts have been directed towards highlighting the differences in the organisational environment and constraints faced by each category of hospital.

The scope of the study was limited basically to operational departments. Secondly, no attempt has been made to go into the details of administrative aspects since the scope of the study was limited to management control. However, since administration and personnel do form integral parts of a control system and have an impact upon its success, these issues have been dealt with, in brief.

The study was conducted with the help of questionnaires. The basic objective of preparing questionnaires was to obtain necessary information on the structure and operations of the management control systems in the two hospitals. Another objective was to obtain views of the key executives about the perceived behavioural impact of the prevailing management control system in the hospitals. The questionnaires are given in the Appendix to this study. Separate questionnaires – seeking information and attitude evaluation – were drafted for Executive Officers, Finance Officers and Departmental Heads.

The questionnaires were supplemented by personal interviews with the chief executive officer/Dean, finance officers, administrative personnel and departmental heads. Further, the functioning of individual departments was observed. Records and reports maintained/prepared/submitted at various levels were also studied in order to arrive at conclusions. Documents such as those pertaining to the history of the hospital, the operating manual, the accounting manual, the budget manual, the financial manual, the organisational chart, the strategy papers, financial statements, status reports, management reports, budget documents and minutes of managing committee meetings were analysed to obtain the relevant information.

The responses needed careful interpretation and could not be taken at face value. They had to be correlated to responses from other personnel and other evidential sources.

The co-operation received from Hospital ‘A’ was wholehearted. The staff provided full co-operation and at times the Chief Financial Officer (who was also in charge of administration at the time this study was conducted) spent many full working days in discussions regarding the functioning of the hospital. Easy access was available to all documents and records which facilitated the study.

Hospital ‘B’, however, did not provide such an easy access to information. The co-operation of the staff was restrained. No formal manuals existed to guide operations, financial control or budget preparations. Policies pertaining to these were determined through the questionnaires and personal interviews. Some material, however, did exist in various files containing minutes of the standing committee, reports of various departments and correspondence with the Municipal Corporation.

A lot of information and insight on the functioning of this hospital was available in the research work conducted by Ms. A.N. Dalal, University of Bombay, on “Hospital Administration in Bombay, with reference to Bombay’s Municipal Teaching Hospitals”. Though her work did not touch upon management control, it dealt, in detail, with basic managerial and administrative issues prevailing in the hospital. Her conclusions were useful in understanding the environment and constraints within which municipal hospitals function.

NOTES

1. “A Contingency Framework for Management Accounting System,” J.H. Waterhouse and P. Tiessen, in “The Organisational Context of Management Accounting” - Robert H. Chenhall, Graeme Harrison, and David J.H. Watson. Pitman. (1981), p. 105.

2. "Management Control in Non-profit Organisations," Robert N. Anthony and Regina Herzlinger, Irvin Inc., (1975), p. 2.
3. "Strategic Management in Not-For-Profit Organisations," Mary Louise Helten, Strategic Management Journal Vol. 3, 89-104 (1982), p. 89.
4. Academy of Hospital Administration (Journal) Vol. 1, No. 1, (January 1989), All India Institute of Medical Sciences.
5. Ibid.
6. Ibid.
7. "Hospital Administration and Internal Controls," G.R. Kulkarni.
8. This example by Alphonze Dochez has been included by Ms. A.N. Dalal in her research work titled "Hospital administration in Bombay with reference to Bombay's Municipal Teaching Hospitals".
9. "Hospital Administration," Colin Grant and Churchill Livingstone, 1973.
10. Quoted by Brajaraj Mohanty in "Management Control Systems: Implementation and Administration", MacMillan Company of India Ltd., (1979).

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Management Control Systems in Non-Profit Organisations
With Special Reference to Hospitals

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Management Control Systems – A Theoretical Framework in Non-profit Organisations, with Special Reference to Hospitals

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INTRODUCTION

All organisations exist for the achievement of certain goals and objectives which are formulated within the framework of their overall missions. Managerial decisions, having short term as well as long term implications on organisational resources, are taken on the basis of their contribution towards the achievement of these formulated goals and objectives. In order to provide a formal framework for managerial decision making, the organisations have to develop a culture for planning and control at all levels of management.

Planning is a managerial function of systematically visualising the desired future position of the organisation over a specified period of time and the determination of the required course of action to reach that position. It involves relating the organisation with its future and its external environment, which is a very complex task. Robert Anthony[1] has advocated a three-tier approach to the planning and control process:

(a) Strategic planning.
(b) Managerial control.
(c) Operational control.

He goes on to define these processes as follows:

> "*Strategic planning* is the process of deciding on the objectives of the organisation, on changes in these objectives, on the resources used to attain these objectives and on the policies that are to govern the acquisition, use and disposition of these resources.
>
> *Management control* is the process by which managers assure that resources are obtained and used, effectively and efficiently, in the accomplishment of the organisation's objectives.
>
> *Operational control* is the process of assuring that specific tasks are carried out effectively and efficiently".

The following conclusions can be arrived at about the nature and scope of management control from the above definitions.

The process of management control is carried out within the framework established by strategic planning. It takes place in an organisation that already exists, has objectives, and has decided on broad policies for achieving these objectives. Thus, management control is a process that occurs when the organisation is engaged in work that is undertaken to achieve its objectives; it does not have anything to do with the formation of these objectives. Decisions on what the objectives should be and on the major policies that are to be followed in reaching them, are made during the strategic planning process. Management control takes the objectives as given.[2] Implicit in the above is the assumption that the organisation already exists. Whether or not there should be an organisation or whether or not it should have the mission it does have is not the concern of management control.[3] Management control is thus that level of planning which takes place within the framework of strategic planning, while providing a framework for operational control for performance of specific tasks at unit levels.

PURPOSE OF MANAGEMENT CONTROL

Within the framework of existing objectives, the purpose of management control is to ensure 'effective and efficient' utilisation of organisational resources towards the achievement of these objectives. The performance of an organisation is measured on the criteria of effectiveness and efficiency.

Effectiveness is the relationship between an organisation's output and its objectives. The more the output contributes towards the objectives, the more effective the organisation is. Since both objectives and output are often difficult to quantify in a non-profit organisation, measures of effectiveness are difficult to

come by. Effectiveness is therefore often expressed in non-quantitative, subjective terms.

Efficiency is the ratio of output to input, or the amount of output per unit of input. Unit 'X' is more efficient than Unit 'Y' either if it uses less resources than Unit 'Y' for the same or greater output, or if it uses the same resources as Unit 'Y' for a greater output. In most cases, a measure of efficiency can be determined by identifying some standard against which actual performance can be related to. Such a measure would be a useful, though not a perfect indication of efficiency. In fact, the measure would be as good or as bad as the standard, because standards by themselves are, at best, only approximate measures of what resource consumption ideally should be in the circumstances prevailing. The criteria of effectiveness and efficiency are almost always used in a comparative rather than in an absolute sense, i.e., we do not ordinarily say that organisation A is 80 per cent efficient but rather say that it is more (or less) efficient than organisation B, or more (or less) efficient currently than it was in the past.

An organisation should be both efficient and effective; it is not a matter of either one or the other. Not only are the scarce organisational resources to be used efficiently, but also they should be used for attaining the goals of the organisation.

There is a clash today between stress on the efficiency of administration (in the form of emphasis on perfect paper work) and stress on effectiveness (which emphasises results). Management emphasis should be balanced between these two criteria.

One of the most important objectives in profit oriented organisations is profit maximisation. It is, therefore, a measure of effectiveness. Since profit is the difference between revenue which is a measure of output, and expenses which is a measure of input, it is also a measure of efficiency. Thus, profit is a measure of both efficiency and effectiveness. When such an overall measure exists, it is unnecessary to determine relative importance of efficiency versus effectiveness. However, when such an overall measure does not exist, it becomes imperative to determine performance measures as relative either to effectiveness or to efficiency. In these situations, as in the case of non-profit organisations, there arises the problem of balancing the two types of measurements.

Management control in the context of a decentralised setup, revolves around unit heads, who are in charge of different functions of the organisation. Since these managers also have the authority to commit organisational resources, they have to be motivated to take actions which are in the interest of the organisation. Thus, combining the two broad 'purposes' of management control, namely the 'effective and efficient utilisation of organisational resources' and the 'motivational aspect' involving goal congruence at unit levels, the overall purpose of management control in a decentralised organisation can be articulated as being that of motivating the (decentralised) unit managers to make the most efficient and effective utilisation of organisational resources towards the achievement of overall organisational goals.

THE NEED FOR CONTROL

The need for control arises because human organisations are, by their very nature, imperfect systems liable to serious faults. In almost all organisations, formally or informally, objectives, strategies, policies and programmes are formulated, the system is designed and provided with resources, and the points of interface with the external environment are established. Despite this, there is generally no evidence to suggest that an organisation would achieve goals in a self-regulating process. On the contrary, left to itself, the organisation is likely to go wayward, inefficient and may even breakdown. Thus, without a steering mechanism, objectives may get diffused in activities, means may be misunderstood as ends and resources may be misdirected and wasted. To counteract these tendencies, there should be a formal control system to monitor, regulate, measure, evaluate, correct and adapt the pattern, in a desired direction.

In a traditional bureaucratic type of control system, the function of control is concerned with certain negative connotations such as to curb, to restrict, to command, to police, and so on. It is thus perceived as an instrument of oppression and as a symbol of authority. These connotations give the impression that control is contradictory to freedom, that it compels people to surrender their judgement and subjugate their own views and values in favour of organisational wisdom and culture. Such a control system is

likely to have certain negative consequences. Subordinates think only of minimum performance under such a system, and they tend to resist controls, because they perceive them as threats to their individual freedom. They may even, overtly or covertly, sabotage the operation of the control systems.

As per the modern concept of participative management and decentralisation of the decision making process, control cannot be exercised in a dictatorial manner. According to Likert[4], the ideal management system is one, where relations between managers and subordinates are cordial and friendly. In such a system, the latter are closely involved in decision making and goal setting processes, the communication system is open and effective. Superiors adopt liberal, humanistic leadership processes and are very supportive in their attitudes towards subordinates, who then feel highly motivated to assume responsibility for achieving organisational goals of high performance. Group approaches are adopted in supervision and control.

According to Likert, participative democratic leadership is the only positive and progressive approach to management of people at work. It results in desirable distribution of power between the leader and his group members. It promotes organisational harmony by helping the process of removal of obstacles between them. It fulfills a range of needs of group members. It also facilitates greater understanding of, and control over, work environment so far as the group members are concerned.

The above discussion leads one to the conclusion that the managerial function of control needs to be combined with supportive leadership, positive motivation, provision of information and an attitude of understanding. Managers should thus play a motivating role to make their subordinates comply with organisational requirements.

IMPORTANCE OF MOTIVATION IN MANAGEMENT CONTROL

It has been noted in the earlier section that participatory management and positive motivation are the key to effective control in the modern era. This is particularly true in the context of management control in decentralised organisations, which range from very large multinational and conglomerate corporations to extremely large multi-service institutions such as hospitals and universities. Such organisations have coped with dynamic environment and technology by assigning responsibility for information processing and decision making to fairly autonomous sub-units. This shift of lines of business and functions towards decentralisation and divisionalisation has placed a great deal of pressure on management control systems to induce and motivate the heads of these sub-units, who are responsible for efficient and effective performance of the organisation, to work in harmony towards goal congruence[5].

The process of motivation is a multi-step one. The elements of this process are motives (needs, expectations, urges, etc.), drives, efforts, incentives, goals, rewards, performance, satisfaction and feedback. The presence of motives in an individual creates situations wherein he strives to satisfy them. The individual puts in efforts to reach for incentives or rewards. If they have the propensity to satisfy his motives, his efforts lead him into certain performance and behaviour, which at once meet his goals and also the goals of those who offer the rewards or incentives for the efforts and performance of the individual. Rewards or incentives which help the individual to meet his needs or motives cause satisfaction to him. The individual evaluates the level of his performance, rewards and satisfaction and uses such evaluation to form his future behavioural patterns of motivation and need fulfillment.

Significant recent behavioural research has focused on the differential effects of intrinsic and extrinsic rewards on motivation. Intrinsic motivation refers to an internal state, resulting from knowledge of having accomplished something by individual effort and extrinsic motivation refers to an internal state brought about by the occurrence of external (reinforcing) events, such as pay and promotion.

Relating the concept of motivation to management control, it can be inferred that the overall control system should be designed in such a way that the motives of the unit heads are satisfied in the process of achieving the objectives of management control. This implies that at every stage the system should reward and encourage goal congruence. For example, if a hospital has an objective of patient care, the control system should promote this objective by incorporating devices that reward, both formally and informally, the contributions of individual units towards the achievement of patient care.

To conclude the discussion it can be said that the management control system is influenced by two major disciplines. To the extent that it helps management decide on the optimum allocation of resources, it is governed by the principles of economics. The system also influences the behaviour of people and to this extent it is governed by the principles of social psychology. Both these disciplines must be considered together in designing and using a management control process.

GENERAL CHARACTERISTICS OF MANAGEMENT CONTROL

Let us review a few general characteristics of management control which will, at a later stage, help us to comprehend the process and the techniques involved in its implementation.

(a) Ordinarily, a formal management control system is a total system in the sense that it embraces all aspects of the organisations' operations. It needs to be a total system because an important management function is to ensure that all parts of the organisation are in balance with one another. It is reasonable to expect that persons will act according to what they perceive their own best interests to be. A management control system should be designed so that actions that managers take in accordance with their perceived self interests, are actions that are also in the best interests of the organisation. In other words, the system should encourage goal congruence. It should be so structured that the goals of the people in the organisation are consistent with the goals of the organisation as a whole. Perfect congruence between individual goals and organisational goals may not always be possible but in any case the system should not encourage the individuals to act against the best interests of the organisation. For example, if the system signals that the emphasis should be only on reducing costs, and if the individual responds by achieving this at the cost of sacrificing quality, or by reducing his own costs by adopting measures that cause a more than proportionate increase in costs in some other department, the person has been motivated in the wrong direction.

(b) With rare exceptions, a management control system is built around a financial structure because the resources are expressed in monetary units. Money is the only common denominator by means of which the heterogeneous elements of resources (e.g., hours of labour, types of labour, quantity and quality of material) can be combined and compared. This does not mean that accounting information is the sole, or even the most important part of the system; it only means that the accounting system provides a unifying code to which other types of information can be related. Although, the financial structure is usually the central focus, non-monetary measures such as minutes per activity, number of persons, rejections and spoilage rates, etc., are also important parts of the system[6].

(c) Although, the control structure is generally designed around the formal accounting system, one important aspect of the structure is often not part of this account structure, that is, the concept of key variables. A key variable is one which can change unexpectedly and in which a change can have a significant effect on the success or failure of the organisation. For example, in many profit oriented organisations, the number of sale orders booked is a key variable because the level of incoming orders usually cannot be predicted accurately and a change in the level can have important repercussions. A management control system is designed to bring to management's attention quickly, information about the behaviour of key variables. The number of key variables is small, usually half a dozen or so, but they are extremely important.

(d) The management control process tends to be rhythmic, i.e., it follows a definite pattern and time-table, month after month, and year after year. In budgeting, for example, certain steps are taken in a prescribed sequence and at certain dates each year, e.g., dissemination of guidelines, preparation of original estimates, transmission of these estimates up through the several echelons in the organisation, review of these estimates, final approval by top management, dissemination back through the organisation, reporting, and the evaluation of performance. The procedure to be followed at each step in this process, the dates when the steps are to be completed, and even the forms to be used are generally laid down in a manual.

(e) A management control system is, or should be, a coordinated, integrated system, wherein all controls form part of an overall master plan. Line managers or unit heads are the focal points in

management control. They are the persons whose judgements are incorporated in the approved plans; they must influence others whose performance is measured.

COMPONENTS OF A CONTROL SYSTEM

The components of the control system are classified into three categories: Structural, Social and Support.

The structure of the system is embodied in two sets of variables, viz., (a) the information structure (measurement and communication of information is carried out through this network), and (b) the actual control techniques or the management control process. The techniques of control, viz., budgeting, performance evaluation, responsibility accounting, etc., are integrated into an overall control plan while using the information network which facilitates feedback for effecting control.

The social side of the system revolves around the manager-subordinate interaction needed for goal accomplishment. If envisages two sets of psychological variables, viz., (a) subordinate personalities, which together with their needs, wants, and attitudes, governs how they perceive and react to a control system, and (b) leadership style, which essentially represents the personality and attitudes of managers and how they interact with subordinates.

Support refers to the extrinsic and intrinsic rewards available to a subordinate. Only some of these rewards are controlled by an organisation which uses them to facilitate the social interactions for goal achievements.

There is an overlap in these components, which represents their interaction, that is, their mutual influence upon each other. This is necessarily so, because the management control system has to be an integrated and co-ordinated mechanism. All the components, namely the control devices, the information structure, the rewards, the leadership style and the subordinate personality have to interact with each other to achieve the objectives of management control. Change in any one component is thus likely to have system-wide effects. Also, the choice of any one component cannot be made without considering its impact upon the other.

PRE-REQUISITES OF A GOOD MANAGEMENT CONTROL SYSTEM

The following are prerequisites of a good management control system:

(a) One necessity for a good control system is of clearly defining organisational relationships and levels of autonomy. Levels of autonomy in operating, administrative and financial fields should thus be clearly defined and responsibilities clearly delineated.

(b) There is a need for clarity in philosophy and goals not only of the organisation as a whole but also of its individual units. Further, the goals of the units should be related to the organisational goals and this relation should be communicated to unit heads so that they understand and accept unit goals within the framework of organisational goals. The importance of this, in relation to performance appraisal, needs particular emphasis. The goal congruence objective in a decentralised organisation necessitates that evaluation indicators promote achievement of organisational goals by appraising unit performance on the basis of their contribution to the overall organisational goals. This enables the blending of unit goals with overall goals to achieve the objectives of management control.

(c) The framework of methods and procedures for the performance of activities should be properly formulated. The success of the system, to an extent, depends upon the effectiveness of the formal methods and procedures and their acceptance in the organisation.

(d) The organisation should be managed by professionally trained and motivated managers who can effectively communicate, persuade and inspire the team.

(e) The system should be so designed that controls point out exceptions at critical points. Effective control requires attention of those factors that are critical to the appraisal of performance against a plan. In a simple operating system, all aspects of the activity can be watched and controlled closely. But in a complex system, it may not be possible or necessary or economical to control each and every aspect of the activities. In such cases, controls are to be exercised selectively. A few key or strategic areas or aspects of the activities have to be identified and attention has to be focused on them, the underlying assumption being that the selected key areas or aspects are critical to the survival and success of the system, in the sense of being limiting of bottleneck factors and that by paying attention to them, it is possible to ensure planned performance of the whole operation. The selected key areas for control are variously called key result areas, key success factors, critical points or strategic points. A good understanding of the whole dynamics of the systems to be controlled is needed on the part of the management for purposes of identification of critical points and designing of the appropriate standards of performance and measurement devices. It is obvious that different enterprises will have different key result areas depending on the nature of their operations.

(f) As far as possible, controls should be objective. Where controls are subjective, a manager or a subordinate's personality may influence judgement of performance. Objective controls should be determinable and verifiable even if it is not possible to have quantifiable controls.

(g) Controls should be economical. The benefits derived from establishing a control should be well worth the cost incurred in designing and implementing it. However, economy is relative since the benefits vary with the importance of the activity, the size of the operation, the expense that might be incurred in the absence of control and the contribution the system can make.

THE MANAGEMENT CONTROL PROCESS

In the modern era of planned development and growth, the control-planning linkage is gaining increasing importance. Organisations formulate long range plans and within the framework of these, prepare more crisp and detailed short range ones. It thus becomes an important task of management, to ensure that actual performance is within the range of plans and that short term plans are linked to the long term ones. In fact, one of the definitions of control is that it is an *ante factum* exercise, concerned with the direction of managerial activities in the light of pre-knowledge of, or in anticipation of future circumstances, which is in effect, planning. It is difficult to exercise control over processes or activities which are not planned because, then, there would be no premises against which performance could be measured. This kind of control would thus be ineffective. Similarly, it is meaningless to plan activities over which no control is to be exercised, because in the absence of meaningful comparison, the success of the plans cannot be ascertained.

Many organisations have a formal system to provide a framework to the planning-control link. This system is in effect the management control process, which incorporates and integrates the whole set of control techniques at each stage of its implementation. The information in this system, which is particularly useful in the context on non-profit organisations, consists of (1) planned (or estimated) data and (2) actual data on (a) outputs and (b) inputs. Prior decisions and estimates are made as to what would be the outputs and inputs during actual operations. Records are maintained as to what outputs and inputs actually are. Subsequent to operations, reports are prepared that compare actual outputs and inputs to planned outputs and inputs, and action is taken on the basis of these reports. The principal steps in a typical formal system are as follows[7]:

1. Programming

Representing the planning process

2. Budgeting

3. Operating (and accounting)

4. Reporting and analysis

Representing the control process

Each of these steps leads to the next. They recur in regular cycle.

PROGRAMMING

In the programming phase, decisions are made with respect to the major programmes in which the organisation is to engage in the forthcoming period. These decisions are made either within the context of the objectives and strategies that have previously been decided upon or they represent changes in strategy. In case of the latter, they are part of the strategic planning process rather than the management control process; the two processes merge in the programming phase.

Some organisations state their programmes in the form of a 'long range plan' which shows planned outputs and inputs for a number of years ahead. To the extent feasible, such plans are based on an economic analysis, i.e., the revenues or other benefits estimated from the proposed programmes are compared with the estimated costs. For many programmes in profit oriented companies, however, and for an even larger number of non-profit organisations, reliable estimates of benefits and costs cannot be made. For these programmes, decisions are based on judgement and are influenced by the persuasive abilities of programme advocates and by political and other considerations.

BUDGETING

A budget is a plan expressed in quantifiable, usually monetary, terms and covering a specified period of time. In the budgeting process, the programme is translated into terms that correspond to the sphere of responsibility of those who are charged with executing it. Thus, though the plans are originally made in programme terms, in the budgeting process they are converted into responsibility terms. The end product of the budget is a statement of the outputs that are expected during the budget year and the resources that are to be used for achieving these outputs. Although, this stage of management control process emphasises the budgeting technique, it represents the whole set of control devices, which can conveniently be integrated in the budgeting process. This aspect has been dealt with in greater detail later.

OPERATING AND ACCOUNTING

During the period of actual operations, records are kept of resources actually consumed and outputs actually achieved. The records of resources consumed (i.e. costs) are structured so that costs are collected in a manner that facilitates meaningful comparisons with plans.

Related to the collection of information is the process of internal control. It consists of the procedures that are intended to ensure that the information is accurate and that the opportunities for an undetected departure from plans and policies are minimum.

REPORTING AND ANALYSIS

Accounting information, along with a variety of other information, is summarised, analysed and reported to those who are responsible for knowing what is happening in the entity and for improving their performance. As indicated above, these reports essentially compare planned outputs and inputs with actual outputs and inputs. On the basis of these reports, possible situations requiring action are identified. These situations are investigated and action is taken where appropriate. This action may involve praise for good performance or corrective steps for unsatisfactory performance or it may involve a revision of the plan. This stage, therefore, embodies the performance evaluation process which is one of the objectives of a control system. Effective control can be exercised only if performance is objectively evaluated and necessary actions taken on the basis of the results derived.

NATURE AND CHARACTERISTICS OF NON-PROFIT ORGANISATIONS: MANAGEMENT CONTROL PERSPECTIVE

Non-profit organisations are incorporated or unincorporated bodies which exist primarily to render a service or a range of services without the profit motive. Decisions made by their management are intended to result in the best possible service with the available resources. Their success is measured primarily by how much service they render and by how well they render it. More basically (but unfortunately, also more vaguely) their success is measured by how much they contribute to public welfare.

There are two divergent views on whether the non-profit organisations should generated surplus. According to the traditional view, although a non-profit organisation may indeed report an excess of revenue over expense – which is profit – in a given year, but is should not do so consistently, year after year. If a non-profit organisation regularly shows a profit, then it is presumed that it is not accomplishing its objectives of providing as much service as possible, with available resources. In such a case, either it should provide more service and hence increase its cost, or it should reduce its prices. A non-profit organisation's financial policy should be, at the most, to break-even. In the case of a deficit, i.e., excess of expenses over income, the non-profit organisation should seek funds from other sources, like donations. Deficits are thus acceptable and not an issue requiring priority of the management. It is in fact this traditional approach to the financial viability that is proving to be a threat to the survival of these organisations. Because of the absence of the philosophy of financial self sufficiency, these organisations are unable to finance their growth from their own operations. Thus, they have to rely on external sources like donations and institutional finances which are scarce and not easily available. As a result of this financial crunch, non-profit organisations are unable to adopt new technologies which facilitate better quality and reduced cost. This financial crunch is not faced by their counterpart organisations in the commercial sector who have enough internal resources to fund their growth and development and who are therefore in a position to provide better services at lesser costs.

According to the modern view, the non-profit organisations also need to generate surplus, though for reasons different from those of for-profit organisations. In the commercial context, profit or operating surplus is required for two basic purposes. Firstly, for distribution to the 'owners' by way of dividends or 'returns'. Secondly, it is required for funding the growth of the organisation by way of purchasing fresh capital assets or entering into new ventures and so on. Non-profit organisations do not suffer on the first count because they need not distribute 'returns' to their owners. But they do suffer on the second count, because just like their counterparts in the commercial sector, they need to develop and grow. For this they require funds preferably to be generated from operations. This can be done by having a closer and more critical look at their financial operations and cutting down on costs wherever necessary and, secondly, by having a more rational approach towards their pricing policies. The non-profit organisations, specially those in the private sector, should thus endeavour to recover from operations enough 'surplus' not only to fund its current activities but also to fund its own growth in order that it can ensure its long time viability and survival.

UNSUITABILITY OF PROFIT BASED MANAGEMENT CONTROL MEASURES

Profit provides an overall measure of both efficiency and effectiveness. Furthermore, it is objective and

easily quantifiable. In many non-profit organisations, however, this overall measure is not available. In the case of hospitals, for example, the profit oriented ones have the dominant goal of profitability. The performance of these hospitals is measured in the usual commercial manner, primarily on the basis of profitability. Indicators such as Return on Investment (ROI), net profit ratio, etc., are calculated, supplemented by others like capacity utilisation, average length of stay, etc. just as in a manufacturing concern, profitability serves as the major criterion for evaluating performance while other supplementary indicators are used for measuring operating efficiency. So is the case with the profit oriented hospital, the only difference being that in the former the output is a product, while in the latter the output is a service.

A non-profit hospital is faced with two major consequences where the main goal is the rendering of comprehensive health care service. Since service is a vague term which cannot be quantified, it has to resort to more quantifiable indicators of output like average length of stay, occupied bed days, number of visits per patient, or even the amount of patient charges (subscribing to the view that if the quality of care is inadequate, physicians will not refer patients to that hospital and this will be reflected as a decrease in revenue). However, all these indicators, at best, measure the operating efficiency of service, not the overall objectives. In other words, it is difficult to measure the effectiveness of the hospital, that is, how far the hospital is achieving its overall goals. The second consequence, which is more in the nature of an inherent danger, is that the management may become so obsessed with the goal of patient care that other important aspects including financial considerations may be totally ignored.

Apart from the above most obvious problems, the non-profit organisations also do not have certain important benefits that the profit measure provides. First of all, profit serves as a single criterion for measuring performance, both of the organisation as a whole as well as its individual units. Further, it facilitates quantitative analysis (as profit is the difference between cost and revenue, and revenue is equated to benefits) and permits a comparison of unlike units in an organisation.

The above discussion, however, should not lead one to the conclusion that profit is a perfect measure since it suffers from several limitations. Although, profitability is a primary objective of many entities, it is rarely the sole objective and cannot act as the single criterion for decision making. Secondly, though it measures the success of the organisation as an economic entity, it does not measure its net contribution to society, which is the ultimate test of an organisation. Thirdly, it serves a limited purpose as far as long term implications are concerned. Managers can take many actions that make current profits look good, but which are detrimental to future profits. Fourthly, it serves as an inadequate basis for comparison of actual performance against the performance that should have been turned in. It does not account for missed opportunities or faulty decisions which could have led to sub-optimum performance. There is no absolute standard as there is no way of measuring what profits actually should have been.

Despite these and many more limitations of the profitability measure, it still remains the single most important criterion for performance measurement in profit oriented organisation. In fact the absence of the profit measure is the single most important limitation faced by non-profit organisations, as a consequence of which they are unable to benefit from all the advantages of the most convenient performance measure.

Even if the output in a non-profit organisation could be measured in monetary terms, profit would still not be a measure of performance as the objectives of these organisations are other than earning profit. The issue is further complicated by the fact that many non-profit organisations cannot even measure their outputs in monetary terms. The amount of patient charges in a hospital may not actually be a good approximation of output since, at best, it measures quantity but not the quality of patient care.

In passing, it should be noted that the measurement problems relate to output and not to inputs. With minor exceptions, inputs (i.e. costs) can be measured as readily in a non-profit organisation as in a profit oriented one. The exceptions, such as the problem of measuring the value of volunteers in hospitals, do arise in many situations, but rarely have a significant impact on the control problem.

The absence of the profit measure in non-profit organisations has many other implications. A non-profit organisation has objectives which cannot usually be expressed in quantitative terms. This greatly complicates the problem of decision making since the management team may not agree on the relative importance of various objectives. Secondly, there is no accurate way of estimating the relationship

between input and output. It is difficult to judge what effect an expenditure will have on the objectives of the organisation. Further, many new analytical techniques developed in recent years, which have facilitated the decision making process in profit oriented organisations, assume some causal measurable relationship between costs and benefits. In the absence of such a relationship, these techniques cannot be used in non-profit organisations. However, some of these like linear programming can be used in a limited sense, for example, in minimisation of costs. Thirdly, the principal goal being that of rendering service, the performance of these organisations becomes difficult to measure. Finally, in non-profit organisations, the performance of sub-units having different functions cannot be compared in the light of absence of a single measurement criterion.

LACK OF FINANCIAL DISCIPLINE IN NON-PROFIT ORGANISATIONS

It is generally believed that in most non-profit organisations, there is a lack of financial discipline and absence of a culture of cost effectiveness. This is so in the name of achieving the goal of 'service' and finance is regarded as a secondary issue. It is no wonder that many non-profit hospitals (both government and private) are today facing a very severe financial crunch, which may prove to be a threat to their very survival because of their inability to fund themselves. Donations and institutional financing are after all external sources and not too reliable. As far as government hospitals are concerned, the issue of finance does not really have a priority because the hospital budgets form part of the health plan of the government.

The need therefore exists to develop within the category of non-profit organisations, a culture for financial discipline and optimum utilisation of resources.

DIFFICULTY IN ACHIEVING THE OBJECTIVE OF GOAL CONGRUENCE

Another characteristic of non-profit organisations is the difficulty encountered by the management in blending unit goals with overall organisational goals.

The hospital's goal of patient care is well established. However, since a hospital has various units performing divergent tasks, the main goal of patient care gets permeated into narrow sub-goals of individual units. Therefore, it becomes necessary that the sub-goals of the individual units are so framed that they contribute towards the main goal of the hospital, while, at the same time, providing the respective units a meaningful objective to which their efforts should be directed. For example, an engineer in the maintenance department of a hospital cannot use patient care as a yardstick for his work. A sub-goal needs to be framed for his department which would ultimately lead to better patient care.

This issue is not so prominent in the case of profit oriented organisations because, in their case, the objective of the overall organisation is often also the objective of the sub-units – that is profit – either by way of increased revenue or reduced costs.

FOR-PROFIT vs NON-PROFIT HOSPITALS: THE EFFECT OF THE PROFIT MOTIVE ON THE MANAGEMENT OF OPERATIONS

Does the profit motive result in a better managed hospital that out-performs the non-profit hospital? Are managers of for-profit hospitals better motivated? Do for-profit managers operate their hospitals with lower costs without sacrificing quality? Resolving these questions has become increasingly important because of rising health care costs and the growing proportion of hospital beds owned or managed by for-profit hospitals.

In the following analysis, comparison of 'For-Profit' and 'Non-profit' hospitals has focused on four dimensions: Quality of care, cost of operations, fees charged for services and operating efficiencies.

QUALITY OF CARE

While, on the one hand, there is concern that quality of care may be sacrificed by 'for-profit' hospitals to

enhance profits, on the other hand, it can be argued that these hospitals are in fact more quality conscious because unless they provide quality of care they would be out of business. In the competitive business environment in which they function, it is vital for profit oriented hospitals to create a favourable image by offering quality service in order to attract best of business. On the other hand, an inherent danger exists in the category of non-profit hospitals, that they are less concerned about quality than their counterparts in the profit sector, because they are less subject to the forces of market and are often faced with the problem of overcrowding of patients. As a consequence thereof they are not overly concerned with attracting clients and may tend to neglect quality. As Anthony puts is "(while) in a profit oriented organisation, the new client is an opportunity to be vigorously sought after; in many non-profit organisations, the new client is only a burden to be accepted with misgivings."

This negative attitude toward, clients may have an important bearing on the quality of care provided by these hospitals, especially in the event of overcrowding. It may mean, for example, in the OPD, a doctor may hardly have any time for every patient. For the patient it may mean long hours of waiting in queues. It may mean over fatigued nurses unable to finish their chores within duty hours. It may mean improper 'Span of Control' making it impossible to observe even minimum standard of efficiency. Thus, the very concept of quality may be eroded, defeating the very objective of 'service'.

COST OF OPERATIONS

It is a general belief that profit oriented hospitals are more cost conscious than their counterparts in the non-profit sector. It is also believed that these organisations adapt more easily to modern managerial and technological advances that lead to cost reduction. For example, a manager employing standard costing, responsibility accounting and budgetary control techniques is more likely to succeed in reducing costs than his counterpart who does not employ such techniques. Similarly, hospitals which adopt techniques like group purchasing and other shared services succeed in reducing costs to a large extent.

While managerial techniques are being accepted in non-profit hospitals in many western countries, paradoxically, in India, where resources are inadequate, these are being used sparingly.

In government hospitals, it appears that even where control techniques are applied, so authoritarian and bureaucratic is the style of management that the very objective is lost in the lengthy and cumbersome procedures and inflexible rules which accompany such techniques.

Anthony states: "For many years there was a prevalent attitude to the effect that the differences between government and business were such that government could not use the management control techniques developed by business. Further, so accustomed are these organisations to certain ways of management, that they are reluctant to employ modern management techniques. For example, a government hospital may be so thoroughly accustomed to a certain budget format that it may be reluctant to shift to a new format. Now, the process of budgeting is important enough to affect the whole management control system. In part, this reluctance is based on simple inertia, in part it reflects a suspicion, an unwarranted suspicion – that change is a threat to their own survival, they fear that they may themselves have become outdated".

In private non-profit hospitals the situation is believed to be slightly better, but again, there are no concrete incentives for cost reduction in most hospitals. In profit oriented organisations, cost reduction means increased profits. Since profit is the measure of performance, it provides a definite motivation to reduce cost. Of course, the inherent danger of dysfunctional decision making is always present. But the fact remains the profit measure creates a culture for cost reduction within profit oriented organisation. This culture appears to be sadly lacking in non-profit organisations.

FEES CHARGED FOR SERVICES

Researchers have questioned the premise that for-profit hospitals charge more for services. While there is evidence that for-profit hospitals apply high mark-ups as compared to (private) non-profit hospitals, higher mark-ups do not always mean higher fees. Relative cost must also be considered, that is, if for-profit hospitals have lower costs than non-profit ones, they may still have lower fees even though their

mark-ups are high.

Another factor to be considered is the price mix. Non-profit (private) hospitals are more likely to have differential charges for different categories of clients. They may have free services, subsidised services and services provided at profits. As far as government hospitals are concerned, most of the services are provided free of charge. Their operations are totally funded by government grants and these hospitals do not concern themselves with recoveries.

While considering relative costs, the cost advantage available to non-profit hospitals because of their legal status has to be considered, especially if they are exempted from various taxes and duties. Another reason why for-profit hospitals may not have lower costs and fees is that any savings achieved through better management may have to be used to pay higher salaries and bonuses to managers. This is rarely done in non-profit hospitals.

In India, for-profit hospitals are in a position to charge higher fees for their services as compared to non-profit hospitals due to the high social image they enjoy.

OPERATING EFFICIENCY

Operating efficiency is the final dimension of comparison between for-profit and non-profit hospitals. It has been argued that the operating efficiency of the non-profit hospitals is inferior to that of the for-profit hospitals, because there is lack of business discipline among the managers of non-profit hospitals. In addition, it is often said that for-profit hospitals respond more quickly to changes in demand for patient care than non-profit hospitals as they have staffing standards highly responsive to demands as well as controls to help limit the length of stay.

One point that merits a mention is the criterion for measuring operating efficiencies. In for-profit hospitals which are cost/profit conscious, standards for operating efficiency are believed to be defined against which actual performances are measured. For example, controls like standards for pre-admission tests for particular types of ailments may help enhance efficiency in operations. In most non-profit hospitals, especially government hospitals, such operating standards or controls are generally absent.

It may, however, be mentioned that the actions taken by for-profit managers to increase efficiency and control over operations could be readily adopted by non-profit managers. The fact that more non-profit managers are not using these cost reducing techniques may be partly explained by the lack of an economic incentive for the non-profit manager to have an operating surplus. A study conducted in USA in 1986 concluded that for-profit managers have strong financial incentives to maximise profits, partly through reduced costs which they perceive to be accomplished by using scientific management techniques.

If non-profit hospitals employ similar financial incentives that reward managers for financial performance, would their management practices change? Perhaps not, because of another more critical reason why non-profit managers are slower to use cost reducing techniques. Non-profit managers face a more complex set of goals and constraints than the for-profit managers, which might make a management technique too costly for the non-profit manager. For example, adoption of budgetary control as a management control technique may prove to be more costly in terms of time due to bureaucratic controls than the benefits flowing from it.

The features of a particular for-profit hospital in Indian are worth noting as reported in Business India of December 1987:

1. Optimum utilisation of diagnostic testing equipment.

2. Emphasis on materials management.

3. Hospital shares profits with the doctors.

4. Good systems approach for hospital management.

5. Information to people of available facilities.

MANAGEMENT CONTROL IN A DECENTRALISED ORGANISATION - THE CONCEPT OF RESPONSIBILITY ACCOUNTING

We have discussed in the previous chapter, the nature of the decentralised organisation. For the purpose of the management control function, the individual units of the decentralised organisation could serve as 'responsibility centres', responsible for carrying out specific tasks of the overall organisational function, and enjoying a certain degree of autonomy in their operations.

Viewing the organisation in this context, we would have a chain of responsibility going upward through the organisation, such that every manager is answerable to the man above him.

Since effective delegation can take place only when the organisation is broken down in smaller and more manageable responsibility units, this requires the designing of an overall responsibility structure which, like the organisational structure, is hierarchical in nature. The whole organisation by itself is a large responsibility centre, responsible for the achievement of overall organisational goals and thus has to be viewed in this larger perspective. Within itself, the organisation is subdivided into smaller responsibility centres which may either be 'cost centres', 'profit centres' or 'investment centres'.

A 'cost centre' may be defined as a responsibility centre in which the manager has no control over revenue but is able to control expenditure. The manager is thus responsible and accountable for all the expenses under his control and performance of his unit is evaluated on the basis of the efficiency and effectiveness with which he is able to control these costs.

A 'profit centre' is a segment of an organisation, whose revenue and expenditure can be set apart from the rest of the organisation. The essential feature of a profit centre is that its inputs and outputs are measurable, so that the two can be related. In the case of 'for-profit' organisations the most useful comparisons are those that can be made in monetary terms, so as to reveal a profit figure. The performance of the profit centre is thus measured on the basis of profits generated by these centres.

The measurement of performance of responsibility centres becomes an even more valuable guide in case of profit oriented organisations, if achievements in terms of profit could be linked with the assets employed so that a profit centre can be converted into an 'investment centre'. In this way an appraisal can be made of the segmental rate of return on investment. Since the ultimate objective of the organisation is a high return on investment the linkage of investment or capital employed to the profits of a responsibility centre is a much more effective measure than that of using profit as an isolated criterion.

The measurement indicator most commonly employed for assessing the financial performance of investment centres is the Return on Capital Employed (ROCE). This is a comprehensive measure of financial performance, which enables comparisons to be made between companies and divisions for the purpose of evaluating the efficiency with which the assets are utilised.

The ROCE is calculated as follows:

$$\text{ROCE} = \frac{\text{Net Profit}}{\text{Sales}} \times \frac{\text{Sales}}{\text{Avg. capital invested}} \times 100$$

The formula given above is useful for focusing attention on the important elements which affect the ROCE. It is in this sense that the organisation as a whole is viewed as an investment centre having within itself, a hierarchy of other responsibility centres like profit centres, cost centres and smaller investment centres. Each of these responsibility centres may within themselves have other smaller centres, involved in narrower aspects of the responsibility centre to which they belong. In this manner the whole organisation can be represented in the form of a responsibility structure, comprising various responsibility

centres. The head of each responsibility centre is directly accountable for his operations to the larger responsibility centre.

To illustrate the working of a responsibility centre, let us take the example of a service organisation like a hospital. The activities of a hospital can be broken down into revenue generating activities like laboratory tests, X-rays, etc., and non-revenue generating activities like administration, house-keeping, stores, etc. The former group can be categorised as profit centres (or even investment centres) in case of profit oriented organisations, and the latter as cost centres. Now within the profit centres (or investment centres), there may be further responsibility centres. For example, within the pathology department which is a profit (or investment) centre, there may be several cost centres responsible for costs of individual activities like blood tests, urine tests, etc. Similarly, within the cost centres like housekeeping, several smaller cost centres like linen, general maintenance, etc., can be in existence. These responsibility centres together form a hierarchy with each centre being responsible for its operations to the higher responsibility centre. For example, heads of the linen, and general maintenance cost centres would be directly accountable to the head of the larger cost centre, i.e., housekeeping. The latter, which incorporates the operations of the former, is responsible to, say, the Chief Executive Officer (CEO) who is the head of the largest responsibility centre.

In the preparation of the reports of the hospital, the CEO incorporates results of all the responsibility centres below him. This concept is, in a way, an extension of the concept of delegation, which states that a manager, who delegates some part of his authority to the man below him, still remains responsible to the man above him, for the delegated authority. The manger of a responsibility centre is thus responsible for the functioning of all the responsibility centres under him.

A basic philosophy behind the concept needs to be noted at this point. It is very important that responsibility centre managers be influenced by considerations of long term well-being of the organisation as a whole. Divisional interest must never be permitted to act against the good of the organisation as a whole. Every man charged with responsibility and vested with authority has to be brought to realise that his function is contributory to the accomplishment of a central purpose.

The system of responsibility accounting often plays a key role in motivating managers towards or away from the desires of top management. Targets for various responsibility centres must be evolved keeping in view overall organisational goals. The process of target fixing involves participation of the responsibility centre heads. It also involves their understanding and acceptance of these targets as being contributory to overall organisational targets. One way to achieve this is by incorporating in the performance evaluation process, measures that indicate contribution of the responsibility units in achieving overall organisational goals.

ACCOUNTING UNDER THE RESPONSIBILITY ACCOUNTING CONCEPT

Under the responsibility accounting concept, accounting controls are tailored to the needs of the organisation so that costs are accumulated and reported by the various levels of responsibility within the organisation. Accounting is therefore geared to facilitate management control. Thus, a basic aspect of this concept is that the collection, classification and reporting of accounting data is oriented primarily to organisational responsibilities. The purpose of conventional financial accounting is external reporting, but to facilitate the concept of responsibility accounting, the development of an accounting system designed to control expenditure by directly relating the expenditure to the responsibility centres is necessary. This system results in the preparation of accounting statement for all responsibility centres. The statements are so designed that they can be effectively used by the operating people as aids for controlling their operations and the costs, revenues and investments, as the case may be, thereof.

Responsibility accounting does not involve a drastic change in accounting theory or principles. It represents a change in emphasis from product cost to the control aspect of accounting wherein the statements to management emphasise the control of costs and/or revenue, by reporting and summarising them on the basis of ‘who did it’, before they are adjusted and merged to produce the conventional financial statements.

RESPONSIBILITY ACCOUNTING–AN OVERALL FRAMEWORK FOR CONTROL

Under the concept, inputs are related to outputs and performances are evaluated accordingly. Similarly, physical standards are established and use of all other control techniques like budgeting, standard costing, etc., are incorporated. The concept is in fact an overall structure within the framework of which all other control techniques can be employed and integrated.

In responsibility accounting, each unit head should receive information quickly to make any changes necessary for the achievement of the desired results. This means more than the prompt production of accounting information. It necessitates that the information is conceptually accurate, budgets and standards used for comparison are understood and accepted as appropriate goals, and the variable used to judge performance are controllable.

The application of the concept of responsibility accounting to a non-profit organisation is as important as in the case of profit oriented organisations. It should be remembered that one objective of management control is effective and efficient utilisation of resources. This implies that cost effectiveness is a very important aspect of management control even for non-profit organisations, where resources are scarce and there is no internal generation of surpluses. It should be ensured that each rupee is spent efficiently and effectively. This type of control can conveniently be exercised by applying the principles of responsibility accounting. If each unit head is held accountable for his financial operations and this is made one of the measures to evaluate his performance, it is sure to encourage within the organisation a culture for financial discipline.

It should be remembered that the special characteristics of a non-profit organisation do not permit the use of financial performance as the sole performance evaluating criteria. Therefore, within the responsibility structure, evaluation measures and control variables which instill a culture for service should be incorporated. Only then will both the following objectives of management control in non-profit organisation would be achieved, viz.,

(a) Effective and efficient utilisation of resources.

(b) Provision of maximum level of service within available resources.

MANAGEMENT CONTROL TECHNIQUES

Having discussed an overall framework for application of control techniques in a decentralised organisation, it would be appropriate now to review a few commonly used and effective control techniques.

> "Technical developments in recent years have greatly increased our capacity to design planning and control devices in modern organisations. The emergence of applications of logical and mathematical tools and the advent of computers are two primary sources of these technological developments. The important question is, how do these techniques and tools benefit organisational planning and control in a real sense? One test of these developments must rest in how they improve management control systems. The techniques are only a means to an end. The end is a system that enables managers to make sound decisions as to the efficient and effective allocation of human, physical and financial resources to attain the objectives of the organisations. This is the essence of modern planning and control"[8].

The above words of Joseph G San Miguel describe very accurately the essence of using techniques of management control. In the last one decade many sophisticated techniques based on operations research and mathematical tools have been developed to facilitate the control function. These techniques like Statistical Quality Control, Control Charts, etc., serve as effective control tools that also facilitate managerial decision making. The emergence and increased usage of computers has further enhanced the utility of such techniques. However, these techniques are sophisticated tools requiring quantified data, and can cover only limited aspects in their applications. They, therefore, suffer from two inherent dangers. One, the inability of these techniques to utilise unquantified data, and two, they consider only

limited factors in their application. All the information relevant to the performance of a task or the taking of a decision may not, and in fact cannot, be quantified. If attempts are made to somehow quantify all information, the very essence of the information may be lost. Further, these techniques can consider only a limited application. There may be a number of factors that require consideration before taking a particular course of action. Since these techniques cannot fulfill this vital requirement, their overall usefulness is limited.

The essence of the discussion is that the techniques are not by themselves the control system, but when applied, to the extent that they are relevant in relation to and as a part of an overall integrated system, they become useful in achieving the objectives of management control. As has been very rightly pointed out by Joseph G San Miguel, the techniques are only a means to an end, the end being the ability of the techniques to ensure sound decisions on the effective and efficient utilisation of human, and other resources to attain the objectives of the organisation.

In the context of non-profit organisations, where output cannot be quantified, the use of mathematical tools is limited. Further, in these organisations actions and decisions are made on the basis of judgement. Since judgement has little place in statistical and mathematical techniques, the applications of these is limited in such organisations. However, there are certain mathematical techniques like inventory control that can be very useful in non-profit organisations, especially hospitals, where materials play a significant role.

Most of the common control techniques such as budgetary control use the monetary data which is generated by the accounting system in an organisation. Thus, the efficacy of the control system depends upon the quality of accounting information. In this context, it is noted that various non-profit organisations, particularly those belonging to Government, follow cash basis of accounting which is not considered a scientific system compared to accrual basis. This aspect being of fundamental nature has been discussed at the outset.

ACCRUAL BASIS OF ACCOUNTING – A PRE-REQUISITE TO CONTROL TECHNIQUES

Accounting Standard (AS) 1 on Disclosure of Accounting Policies, issued by the Institute of Chartered Accountants of India (ICAI), explains the term ‘accrual’ as under:

> “Revenues and cost are accrued, that is, recognised as they are earned or incurred (and not as money is received or paid) and recorded in the financial statements of the periods to which they relate.”

The Guidance Note on Terms Used in Financial Statements, issued by the Accounting Standards Board of the ICAI explains ‘Accrual basis of accounting’ as below:

> “The method of recording transactions by which revenues, costs, assets and liabilities are reflected in the accounts in the period in which they accrue. The ‘accrual basis of accounting’ includes considerations relating to deferrals, allocations, depreciation and amortisation. This basis is also referred to as mercantile basis of accounting.”

The Guidance Note further explains that the accrual basis of accounting, attempts to record the financial effects of the transaction, events, and circumstances of an enterprise in the period in which they occur rather than recording them in the period(s) in which cash is received or paid by the enterprise. It recognises that the buying, producing, selling and other economic events that affect enterprise’s performance often do not coincide with the cash receipts and payments of the period. The goal of accrual basis of accounting is to relate the accomplishments (measured in the form of revenue) and the efforts (measured in terms of cost) so that reported net income measures an enterprise’s performance during a period instead of merely listing its cash receipts and payments. Apart from income measurement, accrual basis of accounting recognises assets, liabilities or components of revenues and expenses for amounts received or paid in cash in past, and amounts expected to be received or paid in cash in the future.

The essential features of accrual basis accounting are:

(i) Revenue is recognised as it is earned.

(ii) Costs are matched either against revenue so recognised or against the relevant time period to determine periodic income, and

(iii) costs which are not charged to income are carried forward and are kept under continuous review. Any cost that appears to have lost its utility or its power to generate future revenue is written-off as a loss.

The concept of accrual is very important from the point of view of management control. Cash receipts in a particular period may largely reflect the effects of activities of the enterprise in the earlier periods, while many of the cash expenses may relate to activities and efforts expected in future periods. Thus, an account showing cash receipts and cash outlays for a short period cannot indicate whether and to what extent the enterprise/division has been successful or unsuccessful. In order to measure efficiency of an enterprise, or for that matter, of various divisions of an enterprise, adoption of accrual system is a must. The accrual system makes the figures of various departments and of the same department over different years comparable. It serves as a foundation for all control techniques. In the absence of this basis, techniques like standard costing, responsibility accounting, budgeting, etc., would lose their effectiveness because where the cost ascertainment of a particular period (which is the first step for the application of any control technique) is not done in a scientific manner and costs of different periods are not comparable, the very essence of control is lost. For instance, if an organisation adopts performance budgeting, but adopts the cash basis of accounting, the control technique would lose its purpose because the accounting system, which is the information base for the control system, does not truly measure efforts (costs) and accomplishments (revenues) relevant to the particular budget period – and essential pre-requisite of a performance budget system.

Though the accrual basis of accounting has got uniform acceptance the world over and has been declared as desirably by all accounting bodies, it has not as yet become a statutory requirement in India, except in some statutes, e.g., the Companies Act, 1956. Other statutory laws like the Indian Trusts Act, 1882, do not have any such requirement. It thus follows that most profit oriented organisations which are incorporated under the Companies Act and some non-profit organisations registered as companies u/s 25 of the said Act, are applying the accrual basis as a statutory requirement. Most of the non-profit organisations which are either unregistered or registered under other statutory Acts like the Indian Trusts Act, may or may not be adopting the accrual basis.

SOME IMPORTANT CONTROL TECHNIQUES

Some of the important control techniques in the context of non-profit organisations are discussed under the following heads:

(a) Ratio Analysis.

(b) Standard costing and variance analysis.

(c) Budgeting.

- performance budgeting.
- planning programmes budgeting.
- zero base budgeting.

Ratio Analysis

Ratio analysis involves the establishment of meaningful relationships between the related components of financial or operating data in order to make useful analysis. In profit oriented organisations, the ratio of profit to investment gives the 'return on investment' which is one of the most significant performance indices. Similarly, the relation of profits to sales gives the net profit ratio, and that of sales to fixed assets gives the fixed assets turnover ratio which signifies the efficiency with which the resources of the organisation have been utilised. A high fixed assets turnover ratio, for example, is an indication of an effective utilisation of the assets. However, an extraordinarily high ratio also indicates that additional investment in fixed assets is required and that the high turnover is achieved on a very thin base of assets. Thus, ratios are indications or particular types of situations and detailed analysis of these ratios would result in vital findings about the operations of an organisation. However, by themselves, ratios are nothing but mathematical calculations and would not be effective unless meaningful analyses of the results are carried out.

Ratios are an important tool of control. When standard ratios for an organisation are fixed, the actual performance can be compared against these, and reasons for deviations analysed. Further, performances can also be analysed against standard norms of a particular industry, for example, 'current ratio' of 2:1, against which the actual ratio can be compared.

To some extent, ratios are also indicative of the strategies of the management in respect of its operations. For example, a stable and high current ratio is indicative of a conservative management and a high assets turnover and debt equity ratio is indicative of a management undertaking a high degree of risk.

Limitations of Ratios

Although, ratio analysis serves as a good and effective control technique to monitor performance, it is not without limitations. It should be remembered that ratios are only indicative of deviations. They should be accompanied by relevant analysis to enhance their usefulness. Secondly, while comparing actual ratios to standards, it should be recognised that the analysis is as good as the standards. If the standards are themselves not scientifically formulated then the analysis cannot be meaningful. Thirdly, while making inter-firm comparisons or trend analysis the difference in concepts, methods of accounting, etc., should be taken into consideration.

Usefulness of Ratio Analysis in the Context of Non-profit Organisations

Ratio analysis as a control technique can prove to be very useful in the context of non-profit organisations. Not only it is a very effective control measure for financial performance, but its application can be extended to the physical operations of the organisations. In the case of hospitals, for example, a ratio of occupied bed days to available bed days would be a useful indicator of capacity utilisation. Similarly, ratios for average length of stay, asset utilisation and other ratios, which measure output of the different departments could prove very useful in improving operating efficiency.

The usefulness of ratio analysis is enhanced in non-profit organisations due to the fact that their service objective is vague and subjective and hence output can be measured only by means of these quantified indicators. Secondly, in such organisations with a culture of inadequacy of financial control, ratios indicative of financial performance can highlight areas of concern and prove very useful in initiating financial discipline. If, for example, in a meeting of the managing committee of a hospital, it is highlighted by the financial officer that direct materials consume 40% of the total expenditure in the hospital, while in another hospital of similar standing, the corresponding ratio is only 25%, it will pass an immediate message that materials management is an area of concern and quick action is necessary.

If the management of a non-profit organisation makes an effort to establish standard ratios for different aspects of its operations and analyse actual operating performances against these standards, it would be largely successful in improving both financial and operating efficiencies. For example, if standards are established in a hospital for cost per visit per patient, etc., such standards would go a long way to improve the efficiency of both financial and operating performance of the hospital.

Standard Costing and Variance Analysis

Pre-requisites of an Effective Cost Accounting System

Earlier, cost accounting systems were used principally for calculating and setting prices. In recent years, organisations have found cost information useful for other control purposes. Here again the accrual concept is a prerequisite of effective cost accounting. The absence of accrual accounting means that cost accounting system is necessarily statistical in nature. Without the discipline that the accrual accounting provides, cost information is likely to be so inaccurate as to be useless.

Another pre-requisite of a good cost accounting system is the presence of a good information system whereby costs can be ascertained and accumulated. Again, accumulation of cost information is of limited use unless it is compared against some standards, reasons of variances, if any, ascertained and corrective action taken.

The Standard Setting Process

'Standards' are measures of efficiency determined by the management which are also used for the purpose of cost control. Standards operate as norms, which the management strives to achieve. They represent the state of affairs which the management would like to prevail in an organisation.

In commercial organisations, physical standards are established by engineers who work out the physical quantity of inputs like materials and labour hours required to produce one unit of output. These physical standards serve as norms against which actual quantities used are compared. Since commercial organisations have a number of technical processes before the input emerges as the final output, physical standards have to be developed for all the processes. To supplement the physical standards for quantities of inputs, standards for cost per unit of input are also determined. With the accumulation of these, standard cost per unit of output can be determined.

Once the standard cost structure for a unit of output is determined, data on actual utilisation of physical inputs and their cost are accumulated and compared to the standards. The variances from standard cost are then analysed and responsibilities are fixed on individuals responsible for them. In this manner, costs of an organisation can be closely monitored and controlled.

The success of standard costing as a control technique is dependent on a number of factors. Firstly, it depends on the manner in which the standards are determined. If standards are too tight and idealistic and the employees feel that they are unachievable, they would not be given too much importance and would be written-off as mere aspirations of the management. Similarly, if standards are too loose and can be attained without much effort, there would be no enthusiasm to strive for them. Ideally, standards should be such that they are attainable with some effort on the part of persons concerned.

Secondly, as has been emphasised earlier, the success of control techniques depends on how the people who are subjected to these controls, feel about them. In the words of Horngren, "Interview results show that a particular figure does not operate as a norm, in either a scorecard or attention directing sense, simply because the controller's department calls it a standard. It operates as a norm only to the extent that the executives and supervisors, whose activity it measures, accept it as a fair and attainable yardstick of their performance. Generally, operative executives are inclined to accept a standard to the extent that they are satisfied that the data is accurately recorded, that the standard level is reasonably attainable and the variances it measures are controllable by them".

It is thus important that the supervisors do not regard this technique in a negative light and also that they be motivated to attain the standards fixed. In fact, the standards fixed should be formulated in consultation with and be accepted by the supervisors/managers concerned. Control should thus become self control, as human beings have more tendency to strive for goals that they have themselves set.

Finally, the recording and accumulation of costs should be done in an effective manner. This implies that

there should be a proper cost accounting system to facilitate comparisons.

Applications of Standard Costing in Non-profit Organisations

The standard costing control technique can usefully be employed in most non-profit organisations, after making appropriate modifications to suit the nature of service organisations like hospitals. Physical standards are not of much use since a hospital does not have any concrete inputs. Further, the output itself, being service, cannot be quantified as in the case of products manufactured in a factory. Similarly, the number of labour hours of doctors, nurses and other personnel, per patient or per patient day, cannot be standardised, because of a very vital difference between a manufacturing unit and a hospital. In a manufacturing unit, extremely complex processes are mechanised and workflows made routine, so that coordination is automatic. Further, since outputs are usually products requiring quantifiable, complete inputs, it is possible to establish physical standard requirements of inputs per unit of output. On the other hand, in hospitals, every patient has to be treated as a separate entity and the care given to him is suited to his requirements. Thus, because the activities and the output of a hospital are non-routine and personalised in nature, the resources required per unit of service cannot be determined, nor can the physical standards be easily set. While in a manufacturing unit, for control of costs, measurement of both input and output is possible for the relative efficiency of a production function and ratio of input to output can be easily calculated; this is not possible in service organisations like hospitals. In such cases it is possible to control inputs alone without a measure of output, because input measures are fairly easy to identify. The resources such as supplies, man hours worked, plant and equipment, and so forth, are measured by long established accounting systems. Now, if these ‘controllable’ inputs can be related to some quantifiable activities of the hospital, some sort of standards may be developed. It is to be noted that the term used is ‘activities’, which may not be completed outputs or patient care services. However, such standards can considerably enhance operating efficiency. An example of Hospital ‘A’ quoted by its ex-Chief Executive Officer, is relevant in this context. Previously, the gauze that was used for dressing wounds etc., was requisitioned in bundles and stored by the ward sister. There was no control over the quantity used per patient and there existed a general tendency of wastage of this expensive material. The then Chief Executive Officer took an initiative in this matter and with the consultation of the ward sisters, determined the standard quantity of gauze used per dressing. It was then arranged with the supplier that, in future, the gauze would be supplied to the hospital in pieces of the required size, instead of being supplied in bundles. As a result of this practice there was now sufficient control over gauzes and number of pieces used could be related to the number of dressings done.

Another experience of the same hospital was in respect of the materials consumed in the operation theatre. Previously, the operation theatre was kept well stocked with all the required materials, which were re-stocked as soon as they reached a particular level. No records of materials used per operation were maintained, nor were the patients charged for these materials. With the help of the operation theatre assistants and a few surgeons, the quantities of materials like cotton, gauze, thread, etc., required for different types of operations were determined and a variety of kits were prepared, containing all the required materials for each kind of operation. The current practice is that just before the operation, when the theatre is being prepared, the relevant kit is placed inside. This practice serves dual purpose. Firstly, there is control over the usage of operation materials and this usage can be related to the number of operations. Secondly, the hospital has worked out the cost for each kind of kit and determined charges to be levied on the patients. This, a small change in the system by introduction of standards enabled not only better control but also increased the income of the hospital.

It is important that while arriving at physical standards, the hospital management seeks the cooperation and assistance of the staff so as to take advantage of their technical expertise, as well as get their acceptance for adhering to standards. However, in some cases, standards may have to be developed by observations and with the help of past data. For example, a thumb rule of average number of lab tests per patient, determined by observations and past records may go a long way in determining whether unnecessary tests are being prescribed by the doctors. For instance, in the case of a government hospital, the radiology and pathology staff was convinced that most of the tests and X-ray investigations required were superfluous and merely a substitute for clinical judgement.

In view of the above, if standards for average cost per patient day, per bed, per laboratory test, per

operation, per meal, per X-ray investigation, etc., can be determined by study and analysis of previous data, these can serve as some sort of norms, against which performances can be measured. It should, however, be remembered that the control can only be as effective as the norm. If the average cost calculations are based on previous year performance, which is by itself not effective, then this would initiate a culture of inefficiency and would do more harm than good. Thus, when past performance is being used to measure efficiency for current performance, it is important to analyse thoroughly the level of efficiency of the past performance and make suitable adjustments for establishing current norms.

Another word of caution is needed at this point. Standards cannot be applied in a rigid manner in a non-profit organisation like a hospital. For example, the norms for number of tests per patient or number of patients examined per hour, may have to be crossed in cases requiring special attention. In the words of Ms Dalal, “Hospitals are constantly geared to emergencies during which there is no time for niceties of rules and requirements. Therefore, strict adherence to standards cannot be insisted upon in such situations”.

To conclude discussion on standard costing and its application to non-profit organisations, it can be said that though the technique cannot be applied with as much effectiveness as in the case of manufacturing units, it does prove useful in enhancing the operating efficiency of non-profit organisation. The concept has to be adjusted to suit the nature of these organisations and sufficient degree of flexibility has to be allowed. In fact, the standard costing technique may be merged with budgetary control, to make budgeting a more effective tool of control.

Budgeting

Budgeting is one of the most common and effective control measures that is being used in both profit oriented and non-profit organisation. The budget is a financial plan which provides a basis for directing and evaluating the performance of individuals and units of an organisation. Through budgets, activities of different parts of the organisation can be co-ordinated and controlled.

Budgets help coordinate and control the activities of the responsibility centres and play an important part in achieving the management control objective of goal congruence. This is because the control variables that are incorporated in the budget and in accordance with which the performance of the responsibility centres are evaluated, can be indicative of the contribution of each responsibility centre towards the achievement of the overall goals of the organisation. Budgets are thus vehicles for formulating and conveying information on plans, establishing performance criteria and allocating resources within the organisation. They are chiefly based on planning and control, with planning being the starting point and control the termination point. This implies that the budget process which starts with planning of strategies and allocation of resources, ends with the control function, which consists of monitoring of activities, measurement of actual performance and comparison thereof with the budgets, analysis of variances and fixing responsibilities for these variances.

Through budgeting is an important process both in profit oriented and non-profit organisations, in the context of the latter it is the most important control device and often the only one. There are several reasons for this.

(a) In a profit oriented organisation, particularly a manufacturing concern, a large fraction of the costs are engineered costs. For example, the amount and quantity of labour required to manufacture a unit of a product are standardised and determined by the specifications of the product and of the manufacturing process. Consequently, little can be done to affect these costs during the budgeting process. By contrast, in most non-profit organisations, where such physical standards cannot be determined, a large fraction of the costs are discretionary, that is, the amount to be spent can be varied within wide limits, according to decisions made by management. The most important of these decisions are made during the budgeting process.

(b) In a profit oriented organisation, a budget is a fairly tentative statement of plans. It is subject to change and such changes, particularly in the level and mix of sales, can occur frequently

during the year. Furthermore, there is general agreement about the manner in which managers should react to such changes. They make contingency plans and flexible budgets, where levels of production are likely to vary considerably. By contrast, in non-profit organisations, conditions are more stable and predictable. A hospital, for example, gears up for a certain number of beds, and although there may be temporary fluctuations in demand, these ordinarily do not cause major changes in the spending pattern. Under these circumstances, the budget can be and should be a fairly accurate statement of what is to be done during the year and of the resources that are to be used.

(c) In a non-profit organisation, or for that matter in any organisation, the budgeting process can very conveniently incorporate other control techniques. For example, the budgeting process can usefully include standards while determining expenditure for the following year. In the case of a laboratory test, if the average standard direct material cost per test is Rs. 3 and it is forecasted that 1000 such tests will be conducted in the following year, the budgeted direct material cost for laboratory would be Rs. 3000. Similarly, other techniques like break-even analysis etc., can be usefully employed while determining the strategy of the following year. For example, if it is anticipated that by reducing the charges per laboratory test from Rs. 5 to Rs. 4, the activity level can be increased from 4000 to 8000 and if the direct expenses per test are Rs. 2, the fixed cost remaining unchanged, the overall profitability position of the laboratory department can be improved to result in increased contribution of Rs. 4000. Likewise, if a new programme is to be initiated, and such an analysis is carried out before planning the strategy for the following year, the results thereof may have an influence on the decisions arrived at.

Budgeting Practices In Non-profit Organisations

As stated earlier, the budgeting process is carried out within the overall organisational design. Thus, where the total system of a hospital is broken down into responsibility centres in the form of different departments and wards like laboratory department, X-ray department, Physiotherapy department, etc., the budget of the hospital, as a total system, is built upon the budgets of these responsibility centres.

In the case of many non-profit organisations, the most important aspect of budgeting is the matching of spendings with available resources. A budget that is prepared without adequate recognition of the resources that are likely to be available to the organisation, is unrealistic and hence of little use to management. In some non-profit organisations, this matching exercise may mean an attempt to increase revenue through revision of charging policy or more aggressive fund raising efforts for the purpose of meeting the budgeted expenditure. In other organisations, the total amount of revenue in the budget year is fixed for all practical purposes. In these ‘fixed revenue’ organisations, the budgeting process is fundamentally different from that in a profit oriented company. A profit oriented company considers both revenues and costs together. It is willing to ‘spend money to make money’, that is, to incur additional costs in order to earn increased profits. A ‘fixed’ revenue organisation must ordinarily take its revenue amount as given. Its approach to budgeting is therefore to decided how best to spend the available revenue. That is, it should budget costs that are equal to revenues in such a way that the maximum output is achieved from available resources.

Since the effective use of budgets in a decentralised environment involves responsibility centres, it is generally believed that the centres’ performances are primarily to be evaluated continually on their ability to meet short term goals set out in their budgets. This narrow view of budgeting has a danger of encouraging dysfunctional decision making since, in such cases, unit heads are concerned only with achievement of short term targets. Now, these targets are nothing but quantified outputs through which alone the effectiveness of the centre cannot be measured nor can the objective of goal congruence be achieved. Thus, in order to achieve the objectives of budgeting, the control variables and evaluation criteria should be based on the long term effectiveness of the unit, in relation to the goals of an organisation. In order to attain this, the budgets, which quantify the goals or targets to be achieved, should be accompanied by efficiency standards and evaluation measures, which promote long term effectiveness and goal congruence. This culture seems to be sadly missing in many non-profit organisations, where

performance achieved in the past years is put forth as targets of the following year after making minor changes. Similarly, revenues and expenses of the past periods are included as proposals for the ensuing years, after accounting for inflation and requests for new sanctions, if any. This type of a budget exercise defeats its very purpose and since budgets play a vital role in controls, the very essence of management control in non-profit organisations is defeated.

Under the conventional budgeting approach, financial resources are allocated on the basis of previous years' allocations. In other words, financing of the future programmes and activities is based on the past years' performance with an arbitrary increment of, say, 5 to 10 percent to the previous years' expenditure for those activities and programmes. Thus, the conventional budgeting focuses on the past performance rather than on what the organisation should do in the succeeding year. The manager concerned undertakes detailed evaluation of only the new activities/programmes since he is required to justify only the expenditure on them.

Thus, the conventional approach to budgeting used by many non-profit organisations, does not provide for any review and evaluation of the ongoing activities. Besides, it fails to answer the following questions specially relevant in the case of such organisations.

1. Are the current activities/programmes efficient and effective?

2. What are the alternative methods to perform them?

3. Should the current activities/programmes be eliminated or their funding level be reduced in order to provide funds for more important new programmes or to improve the quantities/impact of services?

Zero Base Budgeting (ZBB)

In 1962, the US department of agriculture began with a 'ground-up' budgeting technique, which involved re-evaluation of all the programmes of the department. This technique has come to be associated, in the present form and name, with P.A. Phyrr, ever since he presented it in a systematic manner in his article entitled 'Zero Base Budgeting' (ZBB) in 1970. ZBB is, in fact, a reform over all the earlier budgeting systems. It is a tool that can be used to improve planning, budgeting and operational decision making in an organisation.

In the words of Phyrr, ZBB is "an operating, planning and budgeting process which requires each manager to justify why he should spend any money at all. Under this technique, a manager has to rejustify ongoing and new activities and projects of his department and rejustify the proposed expenditure on them in terms of achieving the objectives of the organisation. It enables the manager to make major re-allocation of financial resources for every budget period so as to have the best possible allocation of limited resources available to an organisation."

Since review and evaluation of all the activities and programmes is of central importance in ZBB, the budget unit manager should raise the following questions in this process:

1. Whether the expenditure levels are tied to the achievement of organisational goals?

2. What is the budget request for finance and whether there is any justification for that amount?

3. What are the specific activities and programmes for which funds are required?

4. Are the proposed activities and programmes for which funds are requested, the priority areas?

5. What is the minimum level of scale of the proposed activity that must be performed, to achieve

the organisational goals effectively?

6. Can any of the ongoing activities be eliminated without any adverse effect on the performance?

7. What are the mutually exclusive alternative methods to perform the chosen activities and programmes?

8. Can the activity be done cheaper, faster, easier, safer and better in the sense of greater dignity to people, in some other way?

9. What will be the consequences of eliminating the activity or reducing its funding below the minimum required level?

10. Can we merge two or three activities and still do them effectively? Or, can we make a service unit common to several units, using its services in order to save the expenditures by all the units?

11. On what basis should the expenditure level for an activity be increased or decreased?

12. What will be the additional benefits for incremental levels of efforts beyond the minimum level?

13. What is the total allocation in the ensuing budget year and what will we get for that expenditure?

The usefulness of zero base budgeting is more so, in the case of service organisations (and hence non-profit organisations) than in the case of manufacturing activities. This is because in the case of the latter, costs are worked out after detailed scrutiny of all the relevant data and on the basis of physical standards and as such, no real benefit would flow by applying zero base budgeting. But it is in the case of service organisations that zero base budgeting can be applied successfully. Activities in these areas are usually the most difficult to plan and control, yet these offer the management the greatest lever to influence the costs of an enterprise. For example, in non-profit organisations, discretionary costs - costs for which the optimum amount is not known, and often cannot be known - constitute a relatively large fraction of the budget. Since there is no ‘scientific’ way of estimating the amount of discretionary costs, the budget amounts may often be determined through negotiation. Negotiation is also required, because there is no objective way of deciding which requests for funds, have the highest priority. Various ploys in the form of ‘padding’ of the budgets, adding unnecessary costs etc., ‘in order to be on the safer side’ or ‘present a good picture later on, by showing favourable variance’ can be applied by managers. If the ZBB technique is applied, the probabilities of success of these ploys, will be reduced to a great extent. The detailed analysis which takes place in the process of preparing a zero base budget, is bound to have a cleansing and revitalising effect on any organisation.

Zero base budgeting lays equal emphasis on evaluation of both ongoing and newly proposed activities and programmes. The same rigorous efficiency criterion with which new proposals are appraised, is applied to ongoing programmes. It results in identification of the activities and costs which should be eliminated. Consequently, the limited resources of an organisation/entity get allocated in an optimum manner to achieve the organisation’s goals.

Performance Budgeting

Another shortcoming of conventional budgeting is its tendency to be only finance oriented. Under performance budgeting, budget estimates are prepared in terms of functions, programmes, activities and

projects and the financial outlays are correlated with physical targets. It also attempts to evaluate the effectiveness of the activities of the organisation in terms of costs, and is regarded as an important tool for the management in evaluating the benefits of the activities/programmes.

Performance budgeting requires that the quantitative data for measuring achievements be correlated to the requirements of funds for the purpose of effective decision making.

Planning Programmes Budgeting System (PPBS)

An extension of the concept of performance budgeting is the technique of PPBS, which stands for planning programmes budgeting system. PPBS has three central ideas; first, it is a formal programming system; second, it uses programme budgets; and third, it emphasises benefit/cost analysis.

The PPB system is well described by Charles Schultze.[9]

"As the first step, PPB calls for a careful specification and analysis of basic programme objectives in each major area of (governmental) activity. The key to this part of the operation is forcing (the management) to back away from the particular programmes they are carrying on at the moment, and to look at their objectives. What are they really trying to accomplish? Once this is achieved and the objective clearly specified, the second question is, how best to achieve the objective. Often, the more they learn about how to reach an objective, the more clearly they begin to understand the objective itself.

The second step, under the PPB system, is to analyse insofar as possible, the output of a given programme in terms of the objectives initially specified in the first step. In case of non-profit organisations, as noted before, this is not a very easy task. It is however vital that the overall objectives, which are in the form of broad statements, be broken down into more specific and quantified goals.

The third step is to measure the total costs of the programme, not just for one year, but over at least several years ahead. In the same way, the programme activities should also be forecasted and related to the finances.

The fourth and crucial step is to analyse alternatives, seeking those which have the greatest effectiveness in achieving the basic objectives. It is this competition among alternatives which is crucial as a means of testing the effectiveness and economy of existing and proposed programmes".

The concept of PPBS has not really found its foundation in modern management. It is not widely used and has received a poor acceptance by most organisations.

Even though the PPBS may not be accepted in its original form, a number of important lessons can be learnt from the concept and usefully applied to the budget process, especially in non-profit organisations. It is very important that at the time of the budget review, the objectives of each activity/programme/department be re-ascertained. Further, the management should look 'within' itself and analyse whether these objectives are really being achieved. There is a general tendency for existing activities to keep dragging on and on, until a stage is reached wherein the activities are carried out just because they have been ongoing for a long period, without anybody really knowing the reason or the purpose behind them.

For example, one of the 'action programmes' of a hospital is the immunisation programme. This activity was initiated around twelve years back, at the time of the inception of the organisation, which was at that time run by a small Board. At that time, the incidence of morbidity and mortality amongst children was high and the activity was initiated with the objective of considerably reducing this by the process of immunisation. At that time, health education level in the target group was low, therefore, the workers were involved in the actual monitoring of doses to ensure complete immunisation. The performance of this activity was evaluated on the basis of number of doses administered, which considering the strategy of the management at that time, was a suitable measure of performance.

Over the years, the organisation grew in size and from a small Board of volunteers it became a limited

company incorporated u/s 25 of the Companies Act. It employed more and more professionals and its activity grew in range as well as in quantum. However, the immunisation activity went on and on without any change either in its objective or in its methodology.

Each year, the targets (for the number of doses to be administered) were revised and performance evaluated on the basis of the percentage of the target doses achieved. No effort was made to find out the immunisation coverage of the target group, (i.e. the percentage population of the target group who have completed their schedule of immunisation). Neither was any effort directed towards updating records of immunisation by adding new births, deleting the children who have completed their schedules, enlisting the defaulter children and taking necessary action to see that they complete their schedule. The most important issue overlooked by the management was to change the strategy in implementing the programme. The fact that due to increasing awareness amongst parents, they were making efforts to immunise their children on their own and that there was now no need for the workers to involve themselves in the administration of the doses, was overlooked. A mere activity of monitoring and updating of the records could have served the purpose as well, while using less than half the resources.

Finally, the need to review the basic purpose for the activity to be carried on was overlooked. Whether there was a need any more for the existence of the activity? Whether the changed circumstances warranted the utilisation of scarce resources to more meaningful activity? All these issues were never raised.

Even for the activity which was going on, the vital questions were not asked, e.g., are the objectives with which the activity was initiated being fully met? What has been the impact of the activity over the years? How many people have benefited from the activity? What is the cost per beneficiary? How does this cost look when compared to that of other organisations carrying on similar activities? If the management had analysed the answers to all these questions and had come up with frank conclusions, they would have easily realised the need to either change the strategy or the very essence of the activity.

This is a typical example of sub-optimal utilisation of resources by an organisation. Such examples are not at all uncommon in non-profit organisations. Hence, the need for a very serious reviewing exercise by these organisations at the time of the budget process.

As has been emphasised earlier, budgeting is perhaps the strongest control device in the case of non-profit organisations. Further, it can incorporate other techniques like standard costing, break-even analysis, etc., so as to represent one single integrated control device and a very useful one at that. Added to this, the concepts of zero base budgeting, performance budgeting and programming techniques can greatly enhance the usefulness of budgeting as a control technique.

In the implementation of the budget process, the behavioural aspect is very important, more so in the case of non-profit organisations, where measures of output are not quantifiable and evaluation techniques are not well developed. In such situations, it is only motivation that can induce units to strive for goal congruence. Where it is difficult to ensure quality of care in a formal manner, it is only the dedication of personnel and their attitude towards their work that can ensure quality. For example, in a hospital, it is difficult to relate in quantifiable terms, the extent to which it is meeting the overall objective of patient care. How is one to know whether the laboratory department, whose output is the number of tests conducted, is meeting the objective of patient care? How is one to ensure the quality of care given by nurses to patients, when their attitude towards the patients, their communication with them (which are indicators of patient care), cannot be quantified? Thus, the only way to achieve overall organisational goals and quality of service is to have a well motivated and dedicated team of workers. Performance evaluation measures have an important role to play in the motivational aspect. As stated earlier, unit managers tend to act in a manner which makes their performance look good at the time of evaluation. Thus, if evaluation measures are such that they promote goal congruence and quality of care, these would by themselves act as motivational factors. Performance evaluation is thus the result and purpose of management control, and is inbuilt in all its techniques in order to achieve the objective of effective and efficient utilisation of organisational resources to achieve its overall goals.

NOTES

1. "Management Control Systems – Text and Cases", Robert N. Anthony and John Dearden.
2. "Management Control Systems in Non-profit Organisations", Robert N. Anthony and Regina Herzlinger, p. 12.
3. Ibid., p 19.
4. Rensis Likert of the University of Michigan, USA, carried out extensive research on management and leadership patterns in a large number of organisations. Likert evolved four models of management which he termed as 'Systems to Management'. He assigned numbers 1 to 4 to his conceptual models to indicate the stages of evolution in the patterns and styles of management in organisations. These systems are:

System	1	Exploitative – Authoritative
System	2	Benevolent – Authoritative
System	3	Consultative
System	4	Participative – Democratic

   Likert found from his research that system 1 oriented organisations scored very poorly in relation to performance characteristics like productivity, employee turnover and absenteeism, quality control and resource wastage and scrap losses. On the other hand, system 4 oriented organisations scored very creditably.
5. "Inter Organisational Power Considerations for Designing Information Systems", Martin. L. Bariff and Jay R. Galbraith.
6. "Management Control Systems in Non-profit Organisations" Robert N. Anthony and Regina Herzlinger, p. 32.
7. Ibid., p. 16.
8. "The Behavioural Sciences and Concepts and Standards for Management Planning and Control", Joseph G. San Miguel, p. 214.
9. Quoted in "Management Control Systems in Non-profit Organisations", Robert N. Anthony and Regina Herzlinger, p. 188.

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THE CONCEPT OF A HOSPITAL

To a layman, a hospital even today is an institution associated with only the curative aspect of health care - a function which starts with the admission of a patient into the hospital and is completed on his discharge. This is a very narrow view. In the world of medicine, hospitals are being increasingly seen as the major part of a total and a far reaching health care system. Apart from this, they are also seen as community institutions serving community needs. Hence, the socio-economic conditions of the community, its level of education, its disease pattern, age and sex distribution, etc., are factors which affect the community expectations of the hospital.

The World Health Organisation defines the modern hospital as follows:

> "The (Modern) hospital is an integral part of a social and medical organisation, the function of which is to provide for the population, complete health care, both curative and preventive and whose out-patient services reach out to the family in its home environment. The hospital is also a centre for training of health workers and for Bio-Social research".[1]

The above definition portrays the hospital as a part of a total social and medical system. Thus, it has to view its existence as contributory to this system. More specifically, its functions are to provide a whole range of health care services, according to the needs of the community it serves.

"Today, (therefore) the hospital is more than just a place of treatment for the sick. It constitutes a comprehensive system of preventive and curative medicine, devoted not only to in-patient care but also to ambulatory and domiciliary care"[2].

HOSPITAL – A COMPLEX ENTITY

That a modern hospital is an extremely complex organisation is evident from the fact that it provides essential services which must be available round the clock, throughout the year. Moreover, the hospital's facilities must be ready on demand, thus increasing certain stand-by costs. Obviously, hospitals differ from other organisations in that they continuously deal with problems of life and death. Hospital staff has to deal with the consumers of health services - and sick consumers at that, who are often very demanding of the staff and highly dependent on it.

Viewed in the light of change that have taken place in organisations in general, over the years as a result of increasing complexities and technological advances, some of the characteristics that feature in the management of a modern hospital are common to all organisations. Routinisation of tasks, differentiations along department lines and their integration is a management function, which has to be performed in all organisations. But being a service organisation and characterised by a basic constraint of difficulty in performance measurement, the hospital is faced by a unique set of issues and characteristics. These characteristics, in the Indian context, are attempted to be analysed in the following paragraphs.

A. The complexity of a hospital is characterised not only by its diverse activities, but also by the personalised nature of its services. The hospital provides by way of patient care, highly specialised medical and surgical procedures as well as simple hotel facilities. There is a difference in the complexity of an industrial organisation and the hospital organisation. In industry, extremely complex procedures are generally mechanised and workflows made routine so that co-ordination is achieved automatically. But in a hospital, every patient has to be treated as a separate entity and the care given to him suited to his requirements. Thus, the functions and procedures in a hospital cannot be made totally mechanical. Each patient is like a special product, only much complex because he is not an object.

B. While workflows in hospitals cannot be made routine, controls, rules and regulations also cannot be imposed in a rigid manner. Further, hospitals are constantly geared to emergencies during which there is no time for the niceties of rules and regulations. Therefore, medical personnel cannot always be reprimanded for breaking rules. In such a situation, authoritarian patterns of organisation become inappropriate because they are not flexible enough to fit all the intricacies of patient care. In many an emergency, everything depends on the readiness of the people to help each other.

C. The hospital as an organisation, tends to be dominated by the medical profession, which forms the major proportion of personnel at higher and middle level management. This feature is a characteristic of almost all service organisations. A danger of this situation is that the organisation may tend to be run in the interests of those working in it, rather than that of its objectives. The medical professional is able to intervene in many places in the hospital and justify this on the grounds of a medical emergency. In the hospital, the medical profession is thus dominant, both in terms of prestige and authority. The medical profession's knowledge about illness conditions and their handling is readily accepted as definitive. It is also granted autonomy, atleast in respect of medical techniques if not in organisation. It can command resources and exercise control over non-medical aspects. Undoubtedly, the definition by one professional of a "medical emergency" may not be shared by his colleagues who also seek control over scarce organisational resources and facilities. But, it is only a fellow professional who will generally be in a position to reject particular claims. Medicine is thus an autonomous profession in that it alone evaluates the work and judgement of its members.

D. Another widely recognised feature of a hospital is its dual pattern of authority, that is, there are two main lines of authority in a hospital – one professional and the other administrative. The professional line is controlled by the physicians whose authority is based on technical knowledge and prestige. The other line is controlled by the administrator who derives his authority from his position in the organisation.

This dual pattern of authority in a hospital can be related with the staff and line managers in a commercial organisation. While the line managers are the ones who are directly concerned with the activities of the organisation, staff managers are technical experts in specialised fields whose basic function is to support the line managers. The conflict between the two categories is a common feature in commercial organisations. Line managers feel that the staff people are theoretical in their outlook and do not understand or appreciate the practical constraints and stress under which they (the line managers) work all the time. The staff managers, on the other hand, feel that the line managers are too rigid in their outlook and do not appreciate sound and useful advice on their working.

A similar conflict exists between the medical professionals and the administration in a hospital. The authority of the professional is based upon his 'granted and protected autonomy', while that of the administrator is formal authority by the virtue of his position. The two are oriented to different sets of values, one emphasising the maintenance and the smooth working of the organisation and the other emphasising the provision of services to the patient as the paramount institutional goal. Each group feels the other to be unreasonable.[3]

E. One major characteristic of hospital management is the over emphasis of medical care, which may override the financial considerations. This may result in a distortion of management principles and their application to hospitals as compared to other undertakings. In normal commercial ventures, the product or service produced, no matter how socially useful it may be, assumes a lesser importance than the production of profit which ensures the continuous existence of the venture. But in the hospital, it is the service provided which is of paramount importance and that takes precedence over questions of profitability or even solvency. In the long run chronic and insoluble financial problems do assume a critical significance for the hospital, but in the short run they are less important even for the profit oriented hospital than for commercial enterprises.[4]

F. Coming to the operating costs of the hospital, they are not only high but also increasing by the day. In the words of Dr. K C Ojha.[5] "A hospital must provide facilities round the clock and throughout the year. These facilities have to be created though they are seldom fully utilised. Steep rise in prices, high rate of interest, advancement in medical technology, production of fast responding medical drugs, advancement

in surgery, etc., continue to push up continuously the cost of running a hospital".

Besides the above, a hospital must replace obsolete and uneconomic equipments and also acquire the latest equipments made possible by improvements in medical technology. Accordingly, necessary financial reserves should be created for this purpose.

Apart from the above, a hospital also needs working capital for its day to day operations and to keep stock of consumable materials and other expenses. Because of the steep rise in prices of commodities, services and salaries and wages, the working capital requirements in monetary terms of a hospital keep increasing and provisions for impending increase in prices needs to be made.

G. Quality of a product or service is an important parameter for an industry or service organisation to evaluate its performance and this is equally true for a hospital, which is accountable to the community as well as to the provider of resources.

In early nineteenth century, the quality of product became an important factor for the industries to survive and this lead to major thrust in the form of initiation of quality control programmes in every industry. The product oriented quality control measures were slowly applied to the total system and quality control was replaced by quality assurance, which is basically the application of the systems approach. Service organisations like hospitals were slow to respond to the concern for quality due to a variety of internal and external pressures, including the unquantifiable nature of the outputs.

A related aspect of quality is the formation of explicit objectives against which the quality of hospital care can be evaluated. Few hospitals appear to have taken the first step in this direction. The American Public Health Association offers the following conceptual and operative definition for evaluation.[6]

> "It is the process of determining the value or amount of success in achieving a predetermined objective. It includes at least the following steps.
>
> (a) Formation of the objectives.
>
> (b) Identification of the proper criteria to be used in measuring success.
>
> (c) Determination and explanation of degree of success.
>
> (d) Recommendation for further programme activity".

As mentioned earlier, only a few hospitals have taken the first step in this direction. Actually, there is a hierarchy of objectives in evaluation. For example, at the top, the hospital attempts to improve the health of the community, that is, complete physical, mental and social well being. While measurements are difficult, health status indices are being developed that can be used operationally to measure changes in health. Is the hospital attempting to return the sick to maximum potential healthfulness? Measurement of outcome of care would help to evaluate success in achieving the objective.

Another aspect of quality of care is that is evaluation should be made after examining the environment in which it takes place. "It is concerned with matters like adequacy of physical facilities, the qualification and organisation of the medical staff, the fiscal organisation and deals on the whole with fairly concrete accessible information".[7]

A very sound the contrasting standpoint has been taken by Batistella and Chester.[8] They argue that health and other similar concepts are non-operational and non-quantifiable. In treatment of patients, there are no standard uniform measures of output and no way of standardising and controlling the quality of care. It is not practicable that clearly defined goals can be formulated for different health authorities and professional groups. Thus, quality assurance and its evaluation against predetermined objectives is an extremely difficult task.

H. In any hospital, management must give considerable attention to 'operating discipline', in respect of functions such as admitting a patient, billing and scheduling nursing personnel and if the relevant systems

are properly established, they would have built-in evaluation and control mechanisms.

Unfortunately, operating disciplines are sometimes established haphazardly and may function for long periods of time without any controls at all. The admissions system may be functional, but can still result in unfilled beds, unnecessary transfers and surgical cancellations. Bills are rendered without recording all charges. Nursing personnel are scheduled with excess personnel on slack days or insufficient staff on peak days. The most common indication of inefficient operating disciplines is management engaging in repetitive 'fire fighting'.

Most non-profit organisations, including hospitals, are characterised by lack of attention given to this important function. It is needless to mention that this factor plays a very important role in the quality of services provided by the hospital.[9]

I. A concept closely related to the quality of patient care is that of measurement of the output of the hospital. Each department in a hospital and the hospital as an organisation is responsible for some output, whether it be services to the patients or to the other departments. Output is a cause of growing concern in terms of quality, quantity, availability and costs. Measuring output is an inescapable result of this concern and all systems using these measurements are limited by their success at this basic level.

Measurement of output in hospitals is a very complex task, since all departments have multiple purposes, many of which are personal services, individualised for each patient. This issue has already been discussed in Chapter 2, in the context of non-profit hospitals.

J. Although the rising costs of hospital services is a matter of growing concern both for the people and the government of the country, there is great scope for reduction of costs in hospitals. If every manager in every hospital were to judge each expenditure request in terms of question 'What will happen to the health of community if he says "No"? and then say "No", whenever the answer was "nobody knows", "nothing" or "not much", the result would be a tremendous drop in health care costs. It might be a good beginning to contain costs but the question is oversimplified and needs to be approached with care. The single question is hardly enough. Cost reduction is frequently effected through changes brought about by other means, e.g., through planning of facilities and services, scheduling of patient and patient services, medical control over utilisation, quality and administrative control of manpower.

In general, the most significant potential area for cost reduction appears to be planning and control of physical resources. Significant operating cost savings as well as capital investment reduction are also often possible. According to John R. Grifith, savings by merging emergency services, excess surgery and anesthesia capacity are possible. Opportunities also appear to exist for profitable sharing or merger of laundry, computer services, and laboratory. Regarding occupancy considerations in cost reduction, many industries have a capacity benchmark or load factor and express their activities relative to it. The principle one in hospitals is the occupancy rate, i.e., occupied beds divided by available beds. Occupancy can be maintained at quite a high level but it is frequently uncontrolled. Some trustees seem to regard it as an evidence of divine providence rather than of management performance. Occupancy can in fact be regulated by admission scheduling, i.e., systematic planning of the admission patterns in the hospital. The admission scheduling system presents another possibility, viz., the reduction of in-patient stay through pre-admission testing.

Attitudes favourable to cost reduction, particularly at medical staff and supervisory levels, is a pre-requisite for effective cost reduction. People have a constant temptation to spend. They feel less anxiety over quality of service if extra laboratory tests and X-rays are ordered. Hospital staff may get pressures from some patients and families to prolong patient-stay. Similarly, an increase in occupancy cannot lead to reduction of cost if manpower and supplies costs increase more than the workload. Reduction in the number of tests ordered per patient does not decrease average laboratory cost per admission unless laboratory costs reduce proportionately. Mergers in physical facilities may avoid capital investments, but can reduce operating costs only when individual departments reduce expenditures for manpower and supply.[10]

THE ROLE OF A MODERN HOSPITAL

"Increasing sophistication in the concepts and techniques of medicine in recent times has altered the functions of the modern hospital. Specialisation in the medical services is reflected in the wide range of services which a modern hospital provides. The increasing importance of preventive and social medicine and its practical applications to entire populations in the great public health movements in recent times, have also had an impact on the role which a general hospital is expected to play in community".[11] The concept of a hospital has thus changed significantly over time, and so has its role in modern society.

Broadly, the role of a modern hospital has two major aspects, viz.,

1. The Restorative Aspect
2. The Preventive Aspect.

THE RESTORATIVE ASPECT

The restorative (curative) function of a hospital still remains its most important and best appreciated service. This function involves diagnosis, as an out and in-patient service. Early diagnosis and prompt treatment are of prime importance not only for the individual patient but also for the general health and medical care system as well.

Complexities of modern technologies have greatly increased cost of hospitalisation. Further, modern diagnostic procedures require sophistication in equipments and technical expertise in personnel, which results in further increase in costs. The restorative function is thus one of the most expensive of the hospital's functions, which accounts for the maximum utilisation of its resources.

The restorative function also includes, apart from diagnosis and treatment, rehabilitation of patients who are cured, but left with residual handicaps. Rehabilitation, which means helping the physically and mentally handicapped to resume their normal roles as useful members of society, is a relatively modern concept.

THE PREVENTIVE ASPECT

In a developing country with a large population, the importance of the preventive aspect of health care cannot be undermined. With its culture of unhygienic conditions, malnutrition, high rates of morbidity and mortality, the economy has to make major investments in this vital aspect of health care.

The scope of the preventive aspect of health care extends to outreach services, which include health education, hygiene and immunisation. In a developing country, a bulk of preventive work needs to be decentralised and carried out by health centres situated at the periphery of health services, as a majority of the population lives in rural areas. The role of the modern hospital in this context would be to act as a referral base for the health centres and their outreach activities.

FUNCTIONS OF A HOSPITAL

Broadly, the functions of the hospital can be divided into hospital care, patient care and medical care. What do these terms mean? Hospital care is nothing but hotel care for in-patients, the only difference being that the hotels receive the healthy and the hospitals receive the unhealthy. Patient care and medical care cannot be done without hospital care. Just as in hotels, particularly the starred ones, take professionally trained persons for their management, hospitals are also supposed to do likewise.

Next is the patient care. Relatively speaking, this is a new concept – an area which lies between hospital care and medical care. It consists of physical and other facilities provided by the hospital to cater to patient's well-being and includes diagnostic services. The third function is medical care. This is related to the actual scientific needs of the patient. The spectacular advances in medical technology have made the area quite complicated to manage. It cannot be one man's job but has to be carried by a whole lot of

medical professionals.[12]

The total hospital services can be divided into two broad categories, viz., the clinical services and the support services. In the former are included those categories of services which are rendered directly to the patients in the form of medical care and which also can be conveniently demarcated from one another. Examples of such services include Pathology services, Pharmacy services, Radiology services, Physiology services, Ultrasonography, ECG, Operating room facilities, etc. These services can very conveniently be demarcated from one another and can also be directly traced to the individual patients benefiting from them. The range of these services vary from hospital to hospital, depending upon a number of factors including the size and the nature (general or speciality/superspeciality) of hospital.

The other category of services, i.e., support services, are those which are necessary to facilitate the provision of the clinical services. These are services like housekeeping and dietetics, which are necessary for the provision of in-patient facilities, and administrative and finance services, which are necessary for the maintenance and upkeep of the hospital. Generally, these services do not have potential for generating revenue.

The clinical services of the hospital may be provided either in the form of in-patient or out-patient services. The latter comprises services the provision of which does not necessitate the stay of the patient in the hospital. In most cases, in-patient services also include various kinds of surgeries, the range of which is dependent on the nature of the hospital. An individual patient may use one or more of these clinical services, depending upon his needs. If his needs are limited to out-patient services without necessitating his stay in the hospital, he may use the diagnostic services of the hospital. If his needs go beyond out-patient services and extend to surgical operations or close surveillance, he may avail of the in-patient facilities offered by the hospital.

The out-patient department of a hospital is a bridge between the hospital and the community. It is very important in the context of the hospital having a limited bed capacity, thus resulting in overcrowding of hospitals. Modern out-patient departments (OPDs) have the facility of screening the patients, especially in large hospitals. The conventional OPD is now giving way to polyclinics/ diagnostic centres organised as part of the out-patient complex of the hospital.

The in-patient wards of a hospital are like temporary homes for the patients and all factors including hygiene, minimal chances of cross infection and the comfort of the patient have to be ensured by the hospital management. Apart from general wards, the in-patient department of a hospital has several categories of special wards for catering to the needs of patients requiring specialised nature of care. Example of these are the pedeatric wards, maternity wards, psychiatry wards and intensive care units.[13]

The more common services rendered by a hospital are discussed below.

CLINICAL SERVICES

Radiology

Until recent years, the objective of the department of radiology was considered fairly simple, namely, the safe diagnosis of disease by the passage of X-ray from an external source through the body and the recording of the results on X-ray films. The word ‘safe’ is used because the indiscriminate use of radiation can be dangerous to the operator and undesirable for the patient.

In the past few years, X-ray departments have increasingly tended to include nuclear medicine (the internal application of ionising radiation) and the non-radiological modalities of ultrasound and in very recent times, nuclear magnetic resonance. Consequently, some are now called Departments of Diagnostic Imaging. The result is that no single definition currently covers the scope of radiology departments, although many small hospital departments, continue to deal exclusively in diagnosic X-ray.

The structure of a radiology department varies according to the size and complexity of the services. A small community hospital will have one or two rooms managed by a single X-ray technician working

under the supervision of a radiologist, who will visit the department once or twice a week and interpret the X-ray examination. In the more complex departments the techinician will be assisted by an administrative assistant, who may have been assigned administrative responsibilities.[14]

Physiotherapy

The purpose of physiotherapy is to restore and/or to prevent and minimise disability resulting from disease, injury or congenital disorder, taking into account patient as a whole, including primarily the physical but also the emotional, psychological and social needs.

The functions of a physiotherapy department include assessment and treatment in the following principal areas: neurological and neuro-surgical, respiratory, cardio-vascular, pre and post-natal care, pedeatrics, burns, pain management, geriatrics and preventive health care. This encompasses the rehabilitative stages and both in-patient and out-patient populations. Non-clinical activities cover administration, education, research and consultation.[15]

Pathology

The end towards which all of the laboratories' activities are directed, is the quantitative and/or qualitative analysis of body substances for diagnostic and treatment purposes. Over the last fifteen to twenty years, laboratories have experienced increased demands upon their services for a number of reasons. New developments in the management of illness and diseases have led to a higher utilisation of laboratories. Increased complexity of laboratory medicine has resulted in a greater degree of specialisation by laboratory physicians and technical staff. The advent of automation has improved the accuracy and precision of laboratory results and reduced the time required to produce these results.

The organisational structure of a pathology department will depend upon a number of factors, viz., the size and complexity of the laboratory, the degree of specialisation and the historical development of the laboratory. Basically, the structure will range from all activities in one common laboratory in a small primary and secondary care general hospital, to specialised divisions of activity and designated laboratory areas in large tertiary care teaching hospitals.[16]

Nursing

The nursing philosophy reflects the overall institutional philosophy to achieve the purpose of the hospital. Nursing functions often begin when the patient first enters the hospital and continue till the patient is discharged. They include direct functions like assessing the patients' condition, providing physical or psychological care, etc. indirect care functions of nursing include those of co-ordinating all actions performed for, by and to patients. Another important indirect function performed by nurses is that of patient advocate. Nurses are usually with the patient for the longest period. All other personnel come and go but nurses are always there. Because of this nurses are in the position of knowing the patient best. They have thus assumed the role of making other of the health care team aware of the patient's need on behalf of the patient and ensuring that appropriate actions are taken.

Nursing departments have been structured traditionally in a hierarchical system with strong autocratic leadership. The nursing leader usually reports directly to the hospital Chief Executive Officer.

Except in very small hospitals, nursing department is divided into smaller units or sub-parts to carry out the many activities that must be achieved and co-ordinated to meet the goals of the department. These smaller units called nursing units or nursing wards, facilitate communication, delegation of authority and the direction and control of activities performed to meet the goals. Number of patients, needs of patients, number of staff (span of control), speciality functions, geographical relationships or physical facilities may be the criteria used to determine individually or in combination, what constitutes a nursing unit. In any hospital there could be as few as one or as many as 50 or more nursing units.[17]

Each of the clinical departments of the hospital provide their services on in-patient and out-patient basis.

SUPPORT SERVICES

Dietetics

The term dietetics has been described as a unit specifically designed, staffed and equipped to provide food service to meet the normal and therapeutic nutritional needs of patients and staff. The provision of high quality food and nutrition services by the department of dietetics is and essential and integral part of the function of the total health care facilities.

Administration of the system and food services for patients and staff involves the establishment of departmental policies and procedures related to financial control, menu planning, purchasing of food and its handling, in order to provide the services of nutritious high quality and safe meals along with the effective utilisation of al resources including personnel, layout and equipment.[18]

Housekeeping

A hospital housekeeping department has two major objectives.

1. To provide a standard of sanitation and cleanliness throughout the hospital conducive to good patient care, to assist in the prevention of infection and to create an atmosphere which is clean, giving a sense of safety and care to both staff and patients.

2. To ensure that all public areas are kept clean and attractive so as to reflect the standard of cleanliness applied throughout patient areas.

The laundry in a hospital exists to supply the patient with adequate, clean, freshly laundered linen. In a smaller hospital the function is often merged with that of the housekeeping department.[19]

Materials Management (Stores)

The concept of store-keeping is now fairly common. Under stores or materials management, the following functions are included:

1. Purchasing
2. Receiving
3. Inventory Control
4. Internal Distribution

Increasingly, hospital administration is recognising that materials management can make significant contribution to economic and efficient operations.[20]

Pharmacy

The ultimate function of hospital pharmacy can be described by the term ‘drug-use control’ which has been described as that system of knowledge, understanding, judgements, procedures, skills, controls, and ethics that assures optimum safety in the distribution and use of medication. The general objective of a hospital pharmacy is to maintain high professional pharmaceutical services that complement and support the hospital medical service.

The organisational structure of the pharmaceutical service will vary depending upon the location, size,

complexity of the hospital and number and ratio of professional/non-professional personnel in the pharmacy. Complexity of the structure of the department will depend on.

1. Whether the department serves both in-patients and out-patients.
2. The total number of patients served daily.
3. Whether the pharmacy performs a manufacturing function.
4. Whether the pharmacy procures and dispenses medical supplies and laboratory items.
5. Hours of service.
6. Type of drug distribution system.
7. Type of hospital, i.e., general, chronic, psychiatric, teaching, etc.[21]

Finance and Accounting

The objectives of a hospital finance department may include the following:

1. To collect and record the hospital's revenue and to pay and record its expenses; to maintain records of assets and liabilities, and; to prepare financial statements of the hospital.

2. To provide expertise in planning, organising and controlling the financial aspects of the organisation.

3. To report financial data to the hospital's Board/Management Committee, funding agencies and community.

The organisation of a hospital's finance and accounting function is, to a great extent, dependent upon the size of the hospital. In most hospitals, there is usually a Chief Financial Officer who is responsible for the hospital's financial functions. Smaller hospitals may employ a book-keeper who maintains the hospital's books of account, leaving the planning and control functions to the hospital's Chief Executive Officer. Thus, the organisational and individual roles of an accounting department very with the size of the hospital.[22]

ORGANISATION OF A HOSPITAL

Just as in any other organisation, a hospital normally has a hierarchy of managerial levels. The top management normally consists of trustees (in a private hospital) and the Chief Executive Officer is involved in taking strategic decisions. The latter is primarily responsible for the smooth and efficient operation of the hospital.

In order to assist the Chief Executive Officer in the administration and finance functions, the hospital generally has a Financial Controller and an Administration Officer. In small hospitals, both these functions may be entrusted to the same person. On the clinical side, a hospital may have a Medical Director to head all its clinical facilities.

Under the Chief Executive Officer, a dual line of authority commences in the organisation of a hospital: One is the administrative line and the other is the clinical line. On the administration side, we have the general administration function, the finance function, the house-keeping function and other related activities. On the clinical side, we have the various operating departments, the diagnostic services and the nursing functions. Each of the two lines of authority is headed by professional experts in the respective fields.

In the administration line, under the Administrative Officer, one may have various functions like stores, purchasing, housekeeping, dietetice etc., being performed, each of which may be organised in the form of

functional departments. On the clinical side, various operating activities like radiology, pathology, physiotherapy, sonography etc., are being performed. Each of these functions are organised in the form of operating departments and are headed by technical experts in the relevant fields. Each department is organised as a separate unit of the hospital having an organisational structure suited to its own requirements.

CATEGORIES OF HOSPITALS

Having studied broadly the general organisation of a hospital, let us now discuss the different categories of hospitals. Generally, hospitals can be divided into two broad categories, viz., the commercial hospitals, i.e., the profit seeking hospitals and the non-profit hospitals which exist basically for the service motive. The latter category may be further divided into private and government hospitals. In government hospitals, normally, all services are offered free of charge or at highly subsidised rates. This is because all the costs of these hospitals are borne by the government by way of inclusion of these in its health plan. The hospital is thus not charged with the responsibility of recovering even a part of its costs as these are funded by the government by way of grants to the hospital.

In the context of the private charitable hospitals, the word 'non-profit' has a different meaning altogether. The fact that these are 'non-profit' implies that they do not exist for the profit motive. They do not wish to accumulate surpluses with the object of its distribution to their owners. But almost all of these organisations have an objective of their long term financial viability and that of their being financially self sufficient. Thus, these hospitals necessarily have to break-even and recover at least their operating costs. This implies that all their services may not be offered free of charge or at subsidised rates. Instead, there would be a price mix followed by the management of these hospitals. This means that while a part of their services would be provided free of cost or at subsidised rates, a part may be provided above costs. Similarly, services may be provided free or at subsidised rates to a particular section of society and at a profit to another section, the overall aim being to recover total costs. The objective of the management in these hospitals would be, first, to maintain the level of resources (to run the hospital) and then, use them efficiently and effectively to achieve the organisational goals of health care.

The organisation and management of the different categories of hospitals would be essentially very different. This is because their objectives are different and the environment within which they function are also different. Government hospitals function within the relevant rules and regulations. The type of management in such hospitals would be bureaucratic, emphasising procedures and rules and the environment would be like that of a typical government organisation. These hospitals would be affected by the developmental plans of the government.

On the other hand, the private hospitals would be governed by a board of trustees or a managing committee which would form broad policies and strategies for the functioning of the hospitals. The management and environment of these hospitals would thus be influenced by the philosophy of the Board and the direction of their thinking.

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In this chapter, an attempt is made for an in-depth study of the existing scenario in two hospitals belonging to the two categories of non-profit hospitals, namely, government and private.

THE PRIVATE NON- PROFIT HOSPITAL (HOSPITAL 'A')

OVERALL ORGANISATION

The private non-profit hospital in respect of which this study was conducted, has been registered under the Bombay Public Trust Act, 1950, by a company limited by guarantee and registered under section 25 of the Companies Act, 1956. This company is involved in the provision of preventive, promotive and curative health care services, and the hospital acts as a referral base for implementing these functions. The Managing Council of the hospital is appointed by the Board of Directors of the Indian company. The Indian company in turn, is a subsidiary of a foreign company. The foreign company has its nominee directors on the Board of the Indian company. These directors are technical experts in the fields of finance, management, health and hospital care. The linkage between the hospital and the Indian company is provided through the President of the hospital, who is a director of the company. He represents the interests of the hospital at the Board meetings of the company and is the implementing agent for all decisions arrived at in these meetings.

Brief History

The hospital was established in June, 1945, as a small 16 bedded hospital in a rented flat in Bombay. It was established by a devoted group of volunteers with the sole objective of providing free medical care to members of a particular community. The new hospital, in its present organisational form, was inaugurated in 1957. It then had 54 beds including the nursing section. In 1958, the hospital was thrown open to all communities and also, there was a shift from a purely free service to mixed pattern of free as well as

paying service, leading to financial stability. The hospital continued to grow in size, range of service and clientele. A new private wing was added in 1969 with a view to increase number of private beds. However, by this time, the hospital was beginning to loss money at progressively higher rates. This, combined with low fees, increasing costs, increasing competition and an acute shortage of professional management, led to fall in standards of hospital services and demoralisation of staff.

In 1974, a team of consultants was appointed for a management study of the hospital. Based on the recommendations made by the team, a five year hospital upgradation plan was prepared over the period 1976-1981. This upgradation included:

(1) Appointment of professional managers.

(2) Establishing administrative and financial systems, procedures for recording, reporting and internal control procedures, stores purchase system, hospital information system and production of periodic activity/financial performance reports and annual budgets.

(3) Upgrading of medical services by appointment of suitable medical/para-medical staff, updating medical technology and diagnostic services, strengthening of ancillary services.

(4) Renovation of physical facilities, plants, furniture and other fixtures, patient facilities and staff amenities.

(5) Improvement in staff remuneration, working and living conditions.

(6) Changes in bed mix and strength in response to market demands and financial needs.

(7) Establishment of intensive cardiac care unit.

(8) Renovation, redesigning and re-equipping of operating rooms.

(9) Extension of out-patient wing.

(10) Improved catering services.

(11) Opening of physiotherapy department.

(12) Addition of a private wing with 11 private rooms.

Further to these, in 1983, an automatic blood cell counter, an automated chemistry analyser and Endoscopes were purchased. In 1984, dental treatment unit, emergency power generators were acquired and sophisticated monitoring equipments in intensive cardiac care unit were purchased. In 1985, a special ‘well baby clinic’ was established for providing care for babies upto the age of 5 years. Subsequently, further purchases of sophisticated diagnostic equipment and an X-ray generator were made.

The hospital has 110 beds and is running at over 95% occupancy. The intensive care unit is equipped with state of art monitoring and life support equipments, as are the operating rooms equipped for major surgery, gastrointestinal endoscopy, endoscopic urinary surgery and micro-surgery. The pathology lab has been automated and there are semi-automated chemistry analysers and blood cell counters. The dental clinic is equipped with the latest equipments as in the physio-theraphy clinic. The radiology department has been upgraded with the installation of an image intensifier close circuit TV unit. New diagnostic service for ultrasonography and echo-cardiography and treadmill for cardiac stress testing, with state of art equipments, have been added.

A large volume of free and subsidised care is provided. 44% of total beds are earmarked for free and/or subsidised care and 40% of all out-patients are provided free diagnostic services. The hospital has major plans for further expansion and has prepared a development plan which is under review.

The Organisational Structure

Since we have already reviewed the linkage of the hospital to the Indian company, and the parent foreign company, we will directly go into the details of the internal organisation of the hospital.

Figure 4.1 depicts the organisational structure of the hospital.

The organisational structure of the hospital is explained below:

1. The Managing Council, which is at the top of the internal organisation and hierarchy of the hospital, is responsible for taking policy decisions and laying down the strategies for the functioning of the hospital. It is also responsible for formulating, approving and initiating medium and long term strategic plans of the hospital, as also the annual operating, capital and cash flow budgets.

The Managing Council has established various operating committees, each headed by a member of the Council and responsible for separate aspects of its functions. The hospital has formulated and approved terms of reference for the Managing Council, as well as the standing committees appointed by it. The following standing committees are established;

(i) An Executive Committee, comprising the President, the Hon. Joint Secretary and the Chief Executive, who is responsible for monitoring of day-to-day operational activities.

(ii) The Finance Committee to advise on financial policies and issues.

(iii) The Strategic Planning Committee.

(iv) The Quality Control Committee.

The Chief Executive Officer is an ex-officio member of all the Committees of the Managing Council. In addition, the Managing Council has formed a task force and has entrusted certain additional areas like the estate development, the North Bombay project (a new hospital proposed to be constructed in North Bombay), fund raising, renovation and volunteer services to individual members.

2. Below the Managing Council and directly responsible to it is the Chief Executive Officer who is responsible for the efficient functioning of the hospital within the framework of policies and strategies laid down by the Managing Council.

The broad responsibilities of the Chief Executive Officer have been classified as:

(a) Achievement of hospital objectives.

(b) Planning and organising.

(c) Ensuring quality of medical care.

(d) Allocation of resources.

(e) Monitoring and evaluation of policies, plans and procedures.

(f) Compliance with regulations.

(g) Promotion of hospital.

(h) Conflict resolution.

(i) Maintenance programmes.

(j) Asset security.

(k) Human resource management.

(l) Training, education and research.

(m) Supervision.

The Chief Executive Officer is, therefore, an overall charge of the governance of the hospital.

3. Below the rank of the Chief Executive Officer, the line of authority in the hospital splits up into the clinical and administrative aspects.

Administration of the hospital is currently headed by the Chief Financial Officer, who looks after various administrative aspects like accounting, purchasing, materials management and general administration.

The clinical aspect of the hospital's services is organised in the form of various departments providing a specialised range of medical care services like radiology, pathology, physiotherapy, sonography and nursing services. All these departments are headed by departmental heads who have their own staff as per the requirements of their departments. Each department has its own formulated missions, goals and objectives within the framework of which it is required to function. One of the most outstanding features of the hospital is that all the heads of the clinical departments, namely the medical professionals, are honararies who spend limited time in the hospital.

There also exist activity parameters for each department in the hospital. As far as level of autonomy to departmental heads is concerned, there is no formal delegation of authority. But informally, the departmental heads enjoy full autonomy in their day to day clinical operations. When it comes to administrative and financial autonomy, these are centralised functions in the hospital in which the departmental heads do not have significant role. The absence of financial and administrative autonomy to departments can be explained and attributed to the fact that the departmental heads are honararies, devoting limited number of hours in the hospital due to which they are constrained from undertaking administrative and financial responsibilities.

Delegation of Authority through the Organisational Structure

The Managing Council of the hospital has the full authority to take all the policy decisions concerning the hospital as also to set its long term directions.

Below the Managing Council and directly accountable to it is the Chief Executive Officer who has been delegated full authority to manage the day-to-day functioning of the organisation within the framework of the policies and strategies laid down by the Managing Council.

As far as the departmental heads are concerned, as mentioned earlier, there is no formal delegation. Informally, although they have autonomy in their clinical operations, they do not have definite financial authority for the functioning of their departments. The complete financial and administrative authority is currently delegated by the Chief Executive Officer to the Chief Financial Officer, who monitors the approved budget and sanctions expenditures. The existence of such a situation implies that the departmental heads are involved only in the clinical operations. All other aspects are looked into by the top administration.

As a conclusion, it can be said about the organisational set up of the hospital that even though the hospital, as an organisation, is decentralised in that its overall functions are broken down into

subfunctions and managed by separate individuals, decision making is highly centralised and delegation of financial authority is minimal except at the top management level. This inference has been drawn from the following facts pertaining to the hospital:

(1) Initiation and approval of new programmes is made at the top management level.

(2) Utilisation of the approved budget is sanctioned by the top management.

(3) Appointment/removal of personnel is handled by the top management.

(4) Financial budgets are prepared and approved at the top management level.

Behavioural Aspects of the Delegation of Authority

In response to a query on the existence of the present situation in the hospital whereby departmental heads are almost unconnected with the financial operations, it was explained that departmental heads did not understand finances and they were happy to restrict themselves to their clinical operations, so long as all their requirements were looked into by the management. As far as reactions of the departmental heads in this context were concerned, it was influenced by the fact that most of the departmental heads in the hospitals were honararies who did not work full time in the hospital. Thus, naturally, whatever time they were present in the hospital they were involved in clinical activities, and most of them would like to maintain the prevailing situation due to the sheer constraint of the time factor.

FORMULATED MISSION, GOALS AND OBJECTIVES OF THE HOSPITAL

The hospital has formulated and documented missions, goals and objectives for the hospital as a whole as well as for its various departments.

Mission

To provide comprehensive health care through a multi speciality acute care general hospital.

Goals

(1) To cater to health care needs of the community at large.

(2) To provide high quality comprehensive care comparable to other similar hospitals at reasonable prices.

(3) To ensure long term financial viability of the institution.

Objectives

(1) To provide modern high quality diagnostic therapeutic and rehabilitation services.

(2) To ensure short term and long term financial viability.

(3) To extent out-patient, primary care and outreach programmes to the community.

Missions of the Departments

Documentation pertaining to the individual departments first elaborate the overall mission of the department, followed by its specific goals. While the mission is an overall and general statement, the goals specify more concisely the directions which the department should pursue in terms of quality, communication, upkeep of equipment, provision of services, etc. This is followed by a description of the organisation of the department and its monitoring.

The broad missions of certain individual departments are given below to give an idea of the overview of the functions of the department.

Mission of the Administration Department

The mission of the administration function is to ensure that the objectives of the hospital are achieved most effectively, economically and to the satisfaction of the Managing Council, patients, medical staff and employees.

Mission of the Finance Department

To manage all financial activities and keep the administration informed of the financial condition of the hospital for purposes of planning, operating and control.

Mission of the Radiology Department

To provide diagnostic radiology including ultrasonography services of the highest quality possible within the available resources.

Mission of the Pathology Department

To provide the physicians practising in the hospital and within the referral areas, with the highest quality of pathology services achievable within the available resources.

Mission of the Nursing Services

To provide quality nursing care, collaborating with physicians, paramedical personnel, the patient and his family, in an effective manner.

The process of nursing will include:

- Assessment of the patient's needs.
- Planning patient care in accordance with this needs and the physician's plan of treatment.
- Periodic evaluation of care rendered with redesigning of the nursing plan if necessary.
- Quality of care to be maintained in a therapeutic and safe environment in which the physical, emotional, social and cultural needs of each patient are recognised and dealt with in a preventive, restorative or curative manner.

Mission of the Housekeeping Department

- To maintain the hospital in a clean, sanitary, orderly and attractive condition for providing a healthy and pleasant environment for patients, physicians, visitors and employees.
- To evaluate and employ update techniques to ensure a modern department operating within budgetary provisions and contributing to the overall success of the institution.

The missions of the hospital and its departments put together give a very definite picture of the services provided by the hospital. One observation pertaining to the missions and goals of the hospital and its departments is that though one of the goals of the hospital is that of ensuring long term and short term financial viability, this does not form a goal of any of the operating department.

Behavioural Implications of the Missions, Goals and Objectives of the Hospital and Its Departments

Out of the six heads of clinical departments who were administered the questionnaire to analyse the behavioural implications of the various aspects of management control in the hospital, four departmental heads responded. These responses have been used to study the behavioural implications of the system.

In view of the responses of the questionnaire, it is apparent that the overall attitude was in favour of the missions, goals and objectives. Further, the departmental heads felt that the overall organisational environment was encouraging and the top management supportive. This attitude, alongwith very favourable responses on the understanding and acceptance of the goals of other departments, gave an impression that the departmental heads were well motivated as far as this aspect of management control is concerned.

GENERAL FUNCTIONING OF THE HOSPITAL

a. Capacity

The private non-profit hospital under study, as mentioned earlier, is a 110 bedded one, having an average occupancy of 95% and an average out-patient attendance of 36000 patients per annum. In respect of the year under study, the budgeted total number of available bed days were 30629 and the actual occupied bed days were 30069.

b. Sources of Revenue

The main source of revenue for the hospital, as far as its operations are concerned, is the income which it generates by way of in-patient and out-patient charges. The hospital generated a cash surplus in respect of the year under study (after adding back depreciation). In the forthcoming years, the hospital is expected to generate an operating surplus. However, as far as the capital and developmental costs are concerned, the hospital has to rely on donations and external institutional financing. This is because at the current activity level it is just about self-sufficient in its operational functions but not in its growth and development.

c. Pricing Policy

The pricing policy adopted by the hospital comprises a range of charges which vary according to the type of services provided and the financial status of the patients. For example, the hospital has a bed mix which comprises the following categories of beds:

(1) ‘A’ deluxe (AC)

(2) ‘A’ deluxe (non-A/C)

(3) ‘A’ single occupancy

(4) ‘A’ twin sharing

(5) ‘B’ Class

(6) ‘C’ Class

(7) Free Class

(8) ICCU: ‘A’ Deluxe

(9) ICCU: ‘A’ Class

(10) ICCU: ‘B’ Class

(11) ICCU: 'C' Class

The rationale behind the charges in the in-patient wards is that the 'A' deluxe and 'A' categories are charged above cost, 'B' category at break-even and the 'C' category beds are charged below cost. For the free category, no charges are levied. At the time of the study, the hospital rendered around 40% of its total services at free and subsidised rates.

The current charges have been brought up to this level by making market surveys of charges levied by other similar hospitals. Previously, the services were heavily subsidised, resulting into heavy cash losses. The current charges are fixed more on the basis of market competition than on costing considerations.

According to the chief financial officer, for any new service initiated, charges are fixed only after working out break-even levels and attaching a margin of profit. However, in many instances, cost considerations have to be sacrificed in order to compete with the other hospitals in the area. This is due to two reasons – First, the overheads of the various hospitals vary due to a number of reasons including size, cost structure, activity levels etc. Secondly, the costing method followed by each hospital is different. While one could be using direct costing, the other could be using the full costing method for cost accounting purposes. Generally, therefore, market forces play an important role in the determination of charges in the hospital.

d. Cost Classification

For the purposes of accounting and management control, the financial records in the hospital are collected and reported in two types of broad classifications.

1. The first type of classification is done by dividing the departments into revenue generating and non-revenue generating ones, as follows:

(i) In the revenue generating departments, the income and direct costs of the general beds, maternity beds, ICU, pathology, pharmacy, physio-therapy, radiology, ultra-sonography, ECG and operating rooms as well as out-patient clinics like dental, opthalmic, psychiatry and others are accumulated. In the non-revenue generating departments, the direct costs of departments like housekeeping, administration, finance and catering are accumulated.

(ii) The indirect costs like electricity, maintenance etc., are allocated to both the revenue generating and non-revenue generating departments on pre-determined basis.

(iii) As a next step, the costs of the non-revenue generating departments are allocated to the revenue generating ones.

(iv) After the total costs of the revenue generating departments are thus determined, these are divided by the activity levels of the departments, to arrive at the cost per unit of activity for each department.

(v) These unit costs are then compared with the unit income of the departments to calculate the revenue (deficit) per unit of activity, for each department.

2. The second classification used by the hospital is that on in-patient and out-patient services provided by each of the revenue generating departments.

(i) As a first step, the income generated by way of room rent, pathology, pharmacy, and other revenue generating activities from the various categories of in-patient beds like a 'A' Deluxe, 'A', 'B' and 'C' are accumulated to arrive at the gross revenue generated by these beds. Similarly, the income from the revenue generating out-patient activities are also determined to

arrive at the gross revenue of each out-patient department.

(ii) The next step is to determine the expenditures of each category of in-patient bed and out-patient services. This allocation is made on the basis of the records maintained by each department of the number of in-patients and out-patients served by them.

(iii) As a result of this exercise, the hospital is able to determine the net surplus/deficit for each category of service provided by it.

Implications of the Costing System in the Hospital.

It is evident from the description of the costing system that the hospital follows full costing, whereby, inter alia, the costs of service centres are allocated to the revenue generating departments.

1. While this facilitates calculation of full costs of services of revenue generating activities, the system is constrained by the fact that it does not facilitate the control of cost at the point of incurrence. This kind of control can be possible only if the system of charging costs to the departments responsible for their incurrence is followed.

2. The costing system in any organisation has implications on the behavioural and motivational aspects of management. A system wherein individuals are made responsible for costs incurred by them would positively motivate and lead to a more effective control on costs, rather than a system that merely accumulates costs. As a result of this system, the departmental heads cannot be held responsible for all the components of costs allocated to their departments, as they do not have any control on them.

3. An advantage of the full costing system is that it gives information of full costs, which can be useful for making pricing decisions. But as we have noted in our discussion on the pricing policy adopted by the hospital, cost considerations are not very prominent as far as pricing decisions are concerned. Other considerations like competitors' prices, play a more prominent role in such decisions.

4. It is important to note that since the same costing system is adopted both for the purposes of planning and monitoring, i.e., for making budgets/plans as well as preparing accounts, both these activities are constrained by the above mentioned limitations of full costing system.

Having had an overview on the cost accounting method followed by the hospital, it appears that the revenue/non-revenue generating departments can in fact be its responsibility centres. The revenue generating departments could be termed as profit centres and the non-revenue generating ones as cost centres. Further, each of these departments have their own missions, goals and objectives and are headed by experts in the relevant fields, thus meeting with some basic pre-requisites of a sound responsibility structure. In fact, the infrastructure for the implementation of a responsibility accounting structure already exists in the hospital. The departmental organisation, the formulated missions, goals and objectives of the hospital as well as those of the individual departments, the formulated and documented policies and procedures, all could very well facilitate the successful operation of the responsibility accounting system.

e. Communication

The Managing Council of the hospital meets every month to discuss the matters falling under its purview. The Chief Executive Officer prepares a monthly activity report for discussions at these meetings. Apart from this, monthly accounts are also prepared and submitted to the Managing Council for discussion and approval.

The various operating committees meet more often to discuss the matters delegated to them.

Recommendations of these committees are submitted to the Managing Council for approval before they are implemented.

The Chief Executive Officer is an ex-officio member of all the committees. He provides an important link and acts as a coordinating agent in the overall functioning of the Managing Council. Apart from this, he is also responsible for implementing the decisions of the Council. All matters discussed and decisions made at the Council meetings are made operational through the Chief Executive Officer who translates the philosophy and directions of the Council into actual results. Further, the Chief Executive Officer also acts as the communication channel between the top management and the other levels of management.

The budgets and the quarterly appraisal reports are discussed and approved at special meeting of the Managing Council held for the purpose. Other than the minimum required formal reports, communication is very informal in nature. Given the size of the hospital and the departments being at close proximity to each other, there appears to be no need to the management for resorting to formal communication channels like circulars, letters, notices, etc. Instead, communication is effected through informal meetings with the departmental heads.

This informal channel of communication is effected in all directions. Just as the top management uses this means to communicate with the other levels, so does the latter communicate with the higher management. The Chief Executive Officer is accessible for the whole day to discuss grievances and difficulties. Formal communication channels are resorted to only in case written guidelines are to be circulated or policy decisions of the Managing Council are to be communicated all through the hospital.

Behavioural Implications of the Communication System

The Communication system seems to have positively motivated the departmental heads in the hospital. They are involved in all formal meetings and discussions pertaining to their specialised fields. Similarly, informal communication being free and open within the hospital, problems/issues are resolved immediately. The most important factor is that the departmental heads being honoraries, enjoy a very unique position of respect from all concerned, including the Managing Council.

All departmental heads responded positively when questioned about the communication system in the hospital. They felt it was open and worked both ways - upwards and downwards.

f. Documentation

Guidelines on the general administration of the hospital are provided by way of four volumes of manuals covering different aspects of the hospital's administration. The contents of these volumes are as follows:

1. The first volume, called the operating manual of the hospital, covers information pertaining to the following aspects of the organisation:

(i) Office routine.

(ii) Patient routine.

(iii) Missions, goals, objectives of the various departments – clinical and administrative.

(iv) Organisation chart.

(v) Terms of reference of the Managing Council and its various standing committees.

(vi) Job descriptions for each category of personnel.

(vii) Proformae of appointment applications, forms, appointment orders, renewal of appointments etc.

(viii) Other appointment documents like interview records, appointment offer conditions, general employment conditions, show cause notices and warning letters.

(ix) Job approval and evaluation formats.

2. The second volume on hospital accounting gives an elaborate and detailed explanation of the accounting procedures followed by the hospital, including specimens of asset record cards, depreciation calculation and property records as well as 'hospital activity analysis' which is in fact a proposed management audit framework which has been received from the foreign parent company of the hospital.

3. The third volume is the budget and status report manual and management information system guidelines containing the following details:

Section I

(i) General budget guidelines

(ii) Budget editorial checklist

(iii) Guidelines for new project proposals

(iv) Workplan for formulating the budget document

(v) The budget manual

(vi) Budget time-table and approach

(vii) Budget contents

(viii) General points for budget presentation

(ix) Specimens of

- Operating budgets
- Working capital budget
- Capital budget
- Balance sheet
- Funding sources

Section II

(i) Guidelines for preparing monthly/quarterly status report

(ii) Specimens of

- Editorial for the status reports
- Financial sections of the status reports

4. The fourth volume on financial and management audit guidelines contains the information on functional areas of audit, audit questionnaires for management, internal and financial audits.

The hospital is required to operate within the framework of the guidelines provided in these manuals, which are, in fact, the norms for its functioning. The manuals are a collection of guidelines received from the foreign parent company of the hospital.

THE EXISTING CONTROL SYSTEM

Planning

The culture of planning, both long range and short range, has been instilled in the management of the hospital for at least a decade now. The hospital prepares its five year development plan within the

framework of which its annual plans are prepared. The development plan document lays down in detail the goals to be pursued by the hospital, the strategies to be adopted, the policy changes to be made and the projections of activities in the next five years. Most important of all, the plan document contains the financial projections for the five years. It contains, in detail, the resources that would be required to attain the goals of the management and the sources of these resources. In short, the development plan document contains the direction which the hospital would pursue in the next five years, as also the efforts required of the management to attain the desired direction.

The annual budgets of the hospital are formulated within the framework of this plan. In fact, the annually budgeted activities and finances are compared with those planned and variances analysed and justified.

To supplement the development plan a strategy paper is also formulated in a series of meetings of the Managing Council, in which the exercise of (a) scanning the external environment for opportunities, (b) reviewing changes that are taking place in medical technology, (c) forecasting the changes that may take place in future, etc., are reviewed. The paper then recommends the strategies that the hospital should pursue to meet the challenges of the future as mentioned earlier. This paper is a supplement to the development plan and guides the management through the years relating to the plan period. The hospital is expected to follow the approved strategy as recommended by the strategic paper over the plan period.

Approval Procedure for the Development Plans

The strategic paper and the developmental plan are first approved by the Managing Council. Next, these duly approved documents are submitted to the Board of the Indian parent company for approval. The latter reviews the documents in the context of its overall health plan, before approving the same. These, along with the plans pertaining to other activities of the Indian parent company, are submitted to the Board of the foreign parent company. It is at this level that final sanction is accorded to both the development plans and the strategic papers of the hospital. These then become the formal documents of the organisation within the framework of which it is expected to operate.

Behavioural Implications of the Development Planning

The development plans within the hospital are prepared on the basis of the ‘philosophy’ or the ‘thinking’ of the Managing Council, with inputs from departmental heads with respect to the expertise in their specialised fields. However, the financial implications thereof are solely worked out by the financial officer with minimal inputs from the clinical experts, namely, the departmental heads.

As mentioned earlier, the departmental heads were happy with the existing situation and as long as they had a say in their clinical activities and development thereof. They were, thus, satisfied with the developmental planning exercise in the hospital.

Budgeting

The budget exercise in the hospital takes place within the framework of the budget guidelines approved by the Managing Council, particularly, with regard to the following:

(1) The budget preparation procedure.

(2) Budget contents.

(3) Budget approval procedure.

(4) Monitoring of the budget.

(5) Budget flexibility.

(6) Behavioural aspects of the budgeting process in the hospital.

(7) An overview of the budgeting process.

(1) The Budget Preparation Procedure

The budget preparation procedure in the hospital is initiated in the month of June for the submission of the draft budget in the month of August.

(i) The guidelines on budget time table and approach state:

> "In view of the tremendous amount of work involved in preparing and reviewing budgets and in consolidating them, it is essential that the budget exercise is commenced early and the pre-arranged time tables are adhered to. Shortly after a budget has been submitted and approved, work can commence on preparation for the next year's budget. Formats can be set up, previous year's actual and present year's budget figures can be filled in, staffing schedules can be produced, graphical illustrations can be redesigned, historical information can be gathered and updated and so on. This is an on-going process.
>
> By the middle of the year, sufficient information should be available to be able to gauge the progress made in each programme and to identify problem areas. At this time, thoughts should be given to the likely achievements or strategies which are proposed for the following year."

(ii) In the hospital, the budget preparation stage starts with a series of 'budget meetings' held by the Managing Council to discuss the plans and strategies for the following year. At these meetings, elaborate discussions are held, pertaining to the performances of the current year and the strategies to be adopted for the following year. Similarly, the prospects for introduction of new activities or changes in continuing ones, are reviewed. Need for changes in strategies are also reviewed and alternative strategies studied. Departmental heads are involved in discussions pertaining to their areas of operation.

The guidelines in the Manual, pertaining to this thinking process, state the following: "What are the components of the thinking approach? In essence, it is a review of direction and speed. These were both set out in the plan, and both need to be reviewed annually in the light of the following questions:

1. Have there been changes in the environment in which we operate?
2. Have new opportunities arisen?
3. Are there new challenges to be met?
4. What lessons can be learnt from the previous year's performances and from the early part of the current year?
5. Can we move faster than we expected to when we prepared the plan?
6. Are some of the strategies in the plan proving inappropriate and so needing to be reworked?
7. What remedial action should be taken to correct past under-performance?

These and other related questions should all be addressed before we start to think of figures. The outcome of the thinking process should be a prioritised statement of objectives for the year ahead, which can be the starting point for staff work on the preparation of the programme component of the draft budget".

(iii) A lot of groundwork is done by the hospital itself, namely the Chief Executive Officer and the Chief Financial Officer for the purpose of the budget meetings. Information pertaining to previous years'

performance, both in the context of activity and finances, is provided and compared with the projections in the development plan. Similarly, the actual levels of activity and finances upto the mid year, namely June, are provided and expected levels for the year, determined. Variances, if any, are highlighted and justified.

(iv) It is at these meetings of the hospital that the need for resources for the operations of the organisation in the following year are determined, and their sources identified. Similarly, needs for capital investments are established and justified and if members decide that a major capital investment is required for updating technology etc., a separate procedure is required to be initiated- that of identifying a suitable funding agency to finance the investment.

If the Managing Council of the hospital decides that such a request is required to be made to a funding agency and if the proposed venture falls within the purview of the objectives of the latter, the Chief Executive Officer is instructed to initiate the process of preparing a project proposal for submission to the funding agency. The details of the new proposed activity are required to be included in the draft budget alongwith the proposed source of finance to be disclosed, subject to the approval of the project proposal.

(v) Once, all the policy matters are discussed and decided upon at the Managing Council level, the actual work on the preparation of the budget is initiated by the Chief Executive Officer and the Chief Financial Officer. The formats and the contents of the budget are pre-determined and the document has to be submitted in the prescribed manner to the sanctioning authorities.

(vi) All budget related functions are performed by the Chief Executive Officer and the Chief Financial Officer, with inputs from the departmental heads, as and when required. These include reviewing of on-going activities, setting of targets and the financial projections. This is done on the basis of past performances and the Managing Council's projections about the future. The operating departments and their heads are not involved in the preparation of the financial budgets, except where they specifically require some change or replacement in their equipments etc., in which case they approach the Chief Executive Officer with their requests.

As mentioned earlier, the size of the hospital being small and the departments being situated at very close proximity to each other, the situation as prevailing in the hospital is such that the Chief Executive Officer and the Chief Financial Officer know about all the happenings, the issues, the problems and the requirements of the individual departments. Thus, according to them, no difficulties exist in projecting the activities and the finances of the operating departments.

(2) Budget Contents

One very important feature about the budget document of the hospital is that it does not contain the budgets of the operating departments as separate sections of the overall document. Instead, the budget of the hospital is portrayed as a single proposal. This implies that the departments are not viewed in the context of the responsibility structure.

Another point to be noted is that the budget for the following year is supplemented with the performance appraisal of the current year's activities. This is done in the following manner.

The draft budget for the following calendar year contains the review of the actual performance upto June and the expected performance for the current year. These are compared to the budgets for the current year and variances, if any, justified.

The final budget for the following calendar year contains review of actual performance upto September and the excepted performance for the year, which is compared with the budgeted performance for the year and variances, if any, justified.

The budget in its final form contains the following schedules in standard formats.

(i) Editorial.

(ii) Overall summary.

(iii) Operating income summary, supported by detailed schedules.

(iv) Operating cost summary with detailed schedules for:

- Supplies cost.

- Support and administrative cost.

- Staff cost.

(v) Working capital budget.

(vi) Maintenance expenses budget.

(vii) Capital expenditure budget.

(viii) Projected balance sheet.

(ix) Hospital utilisation indicators for each activity.

In addition to the above schedules, the budget document also contains a schedule of performance relative to the development plan. In this schedule, the actual annual performance (both programme and financial) for all the expired years of the development plan as well as expected performance for the unexpired years are compared to the projected performance in the plan. Variances, if any, are justified.

The overall summary contains the financial position of the hospital as a whole, giving details of the actual financial performance of the previous year, expected performance of current year and the proposed performance of the following year.

Each part of the overall summary is required to be substantiated by detailed summaries. Thus, the overall income figures appearing in the overall summary have to be substantiated with details of incomes received from each category of services like bed charges and various clinical activities. An important point to note is that the hospital first accounts for the total income on the basis of full charges and then deducts therefrom rebates and remissions to arrive at its net figure. Just as the income summary gives details of income from each category of services, the supplies cost summary gives details of direct supplies cost of each of the departments, the totals of which appear in the overall budget summary. Similarly, the support and administrative cost summary contains specific details of all the costs like maintenance, upkeep etc., that make the total support and administration cost appearing in the overall summary. The staff cost summary gives the details of each department which totals to give the figure of staff cost appearing in the overall summary. Thus, details are not provided according to the activities of departments, but by broad expenditure heads. It is only later, at the time of working out departmental costs, that these are allocated to different departments. For the purpose of the budget, no such allocations are made. In fact, as mentioned earlier, departmental budgets do not form separate sections of the budget document but are incorporated as part of the overall summarises.

Besides all the above schedules and summaries, the hospital also gives the following additional information pertaining to its activities:

1. Pertaining to the budget for the following year

- Proposed Bed Mix.

- Proposed occupancy in percentage for all categories of beds.

- Proposed activities in terms of –

(a) Available bed days and occupied bed days.

(b) Admissions.

(c) Average length of stay.

(d) Proposed departmental activities in terms of in-patients and out-patients attendances.

(e) Proposed pricing policy.

2. Pertaining to performance review of the current year.

(a) Schedule of average bed occupancy (in percentage) for all categories of beds.

(b) Diagnostic support service utilisation for all clinical operations.

3. Hospital Utilisation Indicators

For Bed Utilisation

(a) No. of beds

(b) Available bed days

(c) Occupied bed days

(d) Discharged bed days

(e) Average bed occupancy %

(f) Average daily bed occupancy

(g) Average length of stay (days)

The above information is provided for all the categories of beds as well as for the total number of beds in the hospitals.

For Clinical Services

(a)	Out-patient clinic visits	
(b)	Pathology	- in-patients - out-patients
(c)	Radiology	- in-patients - out-patients
(d)	Ultrasonograpy	- in-patients - out-patients
(e)	Treadmill	- in-patients - out-patients
(f)	Physiotherapy	- in-patients - out-patients
(g)	E.C.G. Examination	- in-patients - out-patients
(h)	Operating rooms	- in-patients

		- out-patients
(i)	Total Operations	- Major Operations - Minor Operations
		- Available Operating Room Hours. - % Operating Room Hours Utilised.

4. Financial Indicators

(a) Bed charges income per day (Income from bed charges or in-patient income per day.)

(b) Total income from clinical activities per patient attendance (including in and out-patient income.)

(c) Income per unit of clinical activity, e.g., income per radiology attendance, pathology etc., per patient (Separately in terms of out-patients and in-patient income).

(d) Overall in-patient income per patient day (i.e., Total income per in-patient per day, including for services like radiology, pathology etc.)

(e) Overall out-patient income per out-patient attendance (i.e., Total income from out-patient activities like radiology, pathology etc., per patient.)

(f) Pharmacy gross profit % (i.e., percent of profit from sale of drugs.)

(g) Medical and surgical supplies cost/patient day.

(h) Food and beverage cost/patient meal.

(i) Cost per unit of clinical activity like cost per pathology test, per X-ray etc.

5. Each standard format contained in the budget is required to give information in the following manner:

Draft budget for the year 1996 would contain

January to June 1995
Budget\Actual\ % Variance
Calendar year 1994
Actual
Calendar year 1995
Budget/Expected/ % Variance
Calendar year 1996
Budget/ % Variance (from the expected of the calendar year 1996)

6. The editorial of the budget contains the following details:

(a) Performance Appraisal

- A brief commentary on the performance of the current year, analysing activities, supplemented with tables comparing expected performance with the budgets and highlighting any diversion from the current year's budget.

- A commentary on the financial results as well as the utilisation of the hospitals services during

the year.

- Changes, if any, in the Managing Council and key personnel officers.

(b) Proposed Budget

The next aspect of the editorial is the proposed budget for the following year. It covers the following aspects:

- A commentary on the general strategies to be adopted in the following year, highlighting deviations from the plan and justifying any new proposed activity, if any.

- The basis for the budget proposals, the assumptions on which they are based and the basic aim of the budget are also highlighted. For example, the budget document of the hospital for a particular year may state that it is a budget proposed and based on past performance and approved policies. It is aimed at survival along with maintenance of quality care, optimum resource utilisation, minimising the capital investment, controlling costs and being sensitive and responsive to market needs and demands.

- Next, the editorial gives the details of the proposed bed mix as well as those of the proposed pricing policies. It states the proposed fee increases and explains how they have been calculated. Where fees are not to be increased, it gives the reasons thereof. It also states the implications of the changes proposed in the fees.

- The editorial also gives a commentary supported by tables showing the proposed activity levels.

- A commentary on the capital budget, including a statement that the capital expenditure is consistent with the hospital's objectives and is included in the long term plan. Exceptions are duly explained. Where there is a new capital project the reason for the expenditure together with brief details on the payback period is given. For replacement capital expenditure, the details of the asset being replaced and its replacement value is mentioned.

- Changes in staff number, their calibre and salary structure, particularly senior or middle management staff is mentioned.

- A brief commentary on the donations expected to be raised and the efforts of the Managing Council in this direction.

-A commentary on the progress made by the hospital against the development plan and the extent to which the objectives of the plan have been achieved. Deviations duly explained and justified.

As mentioned earlier, the budget document represents the sum total of all activities to be performed in the following year. It contains details of the activities to be undertaken by utilising own funds or internal resources as well as those to be undertaken with the help of the external fundings, through donations and institutional financing. The budget document includes the proposals for which requests have been made to funding agencies, but have yet to be sanctioned. In all such cases, where approval is not yet received, the budget document contains the alternative strategy to be adopted in case the project proposals are rejected by the funding agencies.

Cash Flow Statements

After the budget is duly sanctioned, the hospital is required to submit a cash flow statement indicating the monthly requirements and sources thereof. Similarly, a workplan is required to be submitted, indicating the monthly break-up of activities over the budget period. The cash flow and the activity workplan form the basis for evaluating the quarterly performances projected in the status reports.

The guidelines formulated on the presentation of budgets are as follows:

1. Every budget must be preceded by an editorial which should state the objectives, policies and assumptions that form the basis of the budget.

2. Statistical and financial information should be shown and the relationship between the two indicated.

3. The currency used must be clearly shown and figures rounded-off preferably to the nearest thousand.

4. Summaries of historical information which is meaningful and informative should be included in the budget as back-up material, either in figures or in pictorial or graphical forms.

5. The use of graphs, bar charts and other means of visual presentation is emphasised for easier comprehension or when it is wished to draw attention to a particular point not easily seen in figures alone.

6. Current and budgeted performance must always be measured against the long term plan, where there are significant variances between plan and current or budget year performance, whether for the current year alone, or cumulative. The variances must be explained and details given of corrective action to be taken, if any, in order to meet the plan targets.

7. If an activity which is traditionally self-supporting is budgeted to have a deficit, then details must be given of how and when the same will again reach self-sufficiency.

8. Donated supplies or services must be valued and included in the budget for the purpose of accountability. Similarly, remissions or rebates given in income earning activities must be measured and included as income and then shown as deductions from income.

9. Cost/benefit ratios must be calculated wherever meaningful. The term cost/benefit sometimes causes confusion and should therefore be read as the total cost of services provided, divided by the number of beneficiaries.

10. The accrual concept of accounting must be applied.

11. When a capital project is expected to extend over more than one year, the full cost, together with an annual cash flow forecast, should be included in the request and updated as necessary in the budget submissions. However, only the relevant cash requirements should be introduced into the budget. A brief progress report should be given for each capital project every year until completion, along with the reasons for delays, if any, in completion.

12. Approved budgets cannot be carried forward from one year to the next. This is of particular importance in the context of capital expenditure budgets.

13. Actual figures for the previous year should agree with the annual accounts. Budget figures for the current year should agree with, or be reconciled with, the grant letter.

Procedures for New Projects/Capital Ventures

As mentioned earlier, many capital ventures of the hospital are funded through institutional financing. For the purposes of requesting funds from the funding agencies, a detailed project proposal is required to be submitted giving justification for spending the funds and the benefit that would be derived therefrom. Even otherwise, for making any capital investment, the hospital has made it a practice to make cost-benefit analysis and work out the pay back period or return on investment on the venture.

The foreign parent company of the hospital under study has prescribed certain guidelines for the framing

of project proposals, some of which are reproduced below to give an understanding of the procedure that is required to be undertaken for starting a new project. Though most requests made by the hospital pertain to acquisition of capital assets, these may sometimes also relate to the initiation of a new activity like starting of an outreach service or a health centre in a nearby area as part of its health care programme. In all cases, however, a proper justification for spending of funds is necessary. The guidelines state:

"The major purpose of writing a proposal is to provide sufficient information to enable a decision to be made about funding and to convince potential founders of the viability of the project and its approach. Any attractive proposal would include the following elements:

- a clear statement of the problem to be tackled by the project.
- A precise statement of the objectives in measurable terms; a brief description of the project and the specific features that make it both creative and likely to succeed.
- A detailed work plan identifying the activities to be undertaken.
- An explicit description of the management and staffing of the project.
- A budget for the resources required and the monetary costs over the life of the project, including cost sharing plans.
- Information about funding already in hand".

The sections to be included in a new proposal are as follows:

(a) Identification and description of the Problem

- Definition of the problem
- Concrete (quantitative) information on its activity
- Causes of the problem
- Existing local efforts to solve the problem
- Knowledge and experience from efforts elsewhere
- Summary of why a new initiation is necessary

(b) The proposed project

- Brief description of the project
- Statement of project objectives in terms of results
- Why is the proposed solution appropriate
- Identification and rejection of other alternatives
- Expected impact of the project: direct, economic, spin-offs, staff development

(c) Plan of action

- Narrative description of activities
- Time table

(d) Management and staffing

- Organisation design (including lines of authority)
- Description of functions and responsibilities
- Identification of personnel and/or recruitment criteria
- Staff development activities

(e) Budget

- Budget summary
- Detailed breakdown of inputs required
- Financial commentary

(f) Expected funding sources

- Proposed sources and amounts for initial funding
- Possible other sources of assistance
- Plan for long term financing of recurrent expenditures

If the project happens to be a multi-year one, then financial and activity projections for at least five years have to be supplied giving details of both operational and capital costs. Besides, it should show the throughput of the project in terms of cost-benefit analysis to make it attractive and appealing.

(3) Budget Approval Procedure

The procedure for the approval of the annual budget is similar to that for the approval of the development plans and the strategy papers. The budget document of the hospital is presented and approved in two stages.

The hospital is first required to prepare a draft budget which is discussed at levels of the Managing Council and the Board of the Indian parent company. The document is discussed in detail by the Council and the Board and the suggestions for changes are asked to be incorporated and submitted in the form of the final budget document. The draft budget is usually submitted and discussed in the month of August for the sanctions pertaining to the next calendar year. After the suggestions of the Board are incorporated in the draft budget document, it is re-presented before the Managing Council and the Board of the Indian parent company in the form of the final budget, in the month of October. Once the final budget of the hospital is approved by them, it is forwarded to the Board of the foreign parent company for approval. The budgets are normally presented by the Chairman of the Indian company, who is invited to attend the budget meeting of the foreign parent company. Once the budget is approved at this level, it becomes a formal approved document, which governs the operations of the hospital in the following year. This approval is normally accorded in the month of November for sanctions pertaining to the next calendar year. The Board of the foreign company sends formal budget sanction letters, which elaborate the funding requirements of the hospital and the sources thereof. The budget approval procedure is completed when the grant letters are received by the hospital and the acknowledgement thereof sent back to the foreign company.

(4) Monitoring of the Budget

Close monitoring of the budget is done primarily by the Chief Executive Officer and the Chief Financial Officer. The Managing Council of the hospital is also involved in the monitoring process as a consequence of the formal requirements laid down by the foreign parent company. These requirements are described in the following paragraphs.

A quarterly review report known as the status report is required to be submitted by the hospital within the framework of prescribed guidelines and formats. The following deadlines have been determined with respect to the submission of this report:

Reporting Period	*Deadlines for Submission*
January-March	15th May
April-June	15th August
July- September	15th November
October-December	15th February

Further, the reports for the months of April to June, and the others following it, would include summaries and information pertaining to the periods that have already expired as well as that pertaining to the expected performance for the year. For example, the status report for the period April-June would contain commentaries on the performance from January to June as well as details of expected performance for the

year.

The status report prepared jointly by the Chief Executive Officer and the Chief Financial Officer is to be submitted first to the Managing Council of the hospital. Here the performance of the hospital is reviewed, variances are analysed and necessary course of action determined to correct deviations.

Once the status report is discussed at the Managing Council level, the same is required to be submitted at the Board meeting of the Indian parent company, where it is discussed again and suggestions made for improvements.

Contents of the Status Report

The status report has essentially three components:

- Editorial
- Financial section
- Key indicators section

The editorial to the status report gives a commentary on the performance of the hospital highlighting deviations from physical targets and reasons thereof. It also contains the plan for proposed corrective actions, if trends are disturbing. The financial section contains details of significant financial variances and reasons therefor, while the key indicators section outlines the details and changes in the key variables contained in the budget.

The information contained in the status report and the schedules attached to it, is similar to that contained in the budget. Further, this is presented in a similar manner to allow easy comparison. The following are briefly and guidelines provided by the foreign parent company of the hospital in respect of the variances in the status report.

1. Variances in excess of 10% between the present year's budgeted and expected figures must be explained, whether statistical or financial. Where, however, a variance is directly related to another variance, which has been explained, it is not necessary to repeat the explanation. For example, a drop in in-patient activity in a hospital will affect income and costs in many departments. Having explained the drop in in-patient activity, it is not necessary to explain also that pharmacy income has dropped as a direct consequence. Similarly, having established changes in activity and a rate of cost inflation, it is not necessary to explain all variances resulting from these two easily identifiable factors. It is, however, essential to explain all other variances.

2. Variances are to be compared as a percentage of budgeted figures to the actual figure. They are to be rounded off to the nearest whole number and shown in brackets, if adverse.

(5) Budget Flexibility

The foreign parent company of the hospital under study has proposed a budget flexibility policy within the framework of which the hospital is required to operate. However, this policy has not yet been approved at the Board level of the parent company and so the hospital, at present, does not comply with the requirements of the policy. Under the present situation, the hospital administration explains the reasons for all variances in excess of 10%. Technically, the hospital is not allowed to spend funds in addition to the approved budget. However, in case of increase in costs due to increased activity or such other reasons, the Chief Executive Officer or the Chief Financial Officer, can sanction such extra spending provided they can be funded through generation of extra income. Other over- expenditures on operations have to be approved by the Managing Council before funds can be expended. As the major source of finance for the hospital is the generation of its own income supplemented by donations, the

excess funds required are to be generated by any one of these sources.

Major requisitions for overspending on capital items or operational activities funded through institutional financing have to be approved by the Boards of both the Indian company and the foreign parent company as well as the institution funding them.

(6) Behavioural implications of the various aspects of the budget.

Having reviewed in detail the various aspects of the budgeting process in the private non-profit hospital, the behavioural implications of each aspect of the process are dealt with hereinafter.

Budget Approval Process

One of the most important implications of the budget approval procedure is that whatever the involvement of the departmental heads in the budget exercise, the departmental budgets are not formally presented by them at the meeting of the parent company, where the budget is first presented and approved. Instead, the document is presented by the Chief Executive Officer who responds to all the queries of the members. He is supported by the Chief Financial Officer who provides information/explanations for the financial implications of the proposed budget. As a result, there is no formal commitment of the departmental heads to meet the requirements of the budget. However, even the departmental heads feel that the Chief Executive Officer is a sufficient representation of the hospital at the Board meeting where the budget is first approved.

Budget Preparation Process

AS mentioned earlier, although the departmental heads provide their inputs on the proposed activities pertaining to their departments, the actual targets and financial requirements are prepared jointly by the Chief Executive Officer and the Chief Financial Officer. This results, as mentioned earlier, into a lack of formal commitment on the part of the departmental heads to meet the activity and financial targets. The departmental heads on their part are not too concerned with budget targets and are happy as long as they have a say in policies relating to the clinical activities. For this, they have an opportunity in the pre-budget meetings before the preparation of the actual budget document.

Contents of the Budget

As mentioned earlier, the budget of the hospital is an overall document as far as its financial proposals are concerned. The proposed financial operations in terms of income, expenditure and contributions of individual activities/department are not reflected separately. Further, no physical standards are formally used while preparing the budget and these, thus, do not form part of the budget contents. The implication on the budget process is that the budget performs a limited role as a control mechanism as, firstly, it does not highlight the financial performance of individual departments and, secondly, provides no relationships between inputs and outputs pertaining to individual activities. The departmental heads are hardly aware of these shortcomings of the budget and all of them feel that the budget of the hospital is a complete and comprehensive document.

Monitoring of the Budget

One important point to note is that since the budget targets are in fact prepared by persons other than those who are involved in their implementation, no action can be taken by management for under-performance that has already taken place. This is because the persons presenting the budgets, namely, the Chief Executive Officer and the Chief Financial Officer are not the implementing officials and have no control over clinical activities. The persons who do have this control, namely, the departmental heads, are neither involved in the preparation of the budget targets nor are responsible to achieve proposed performance. Hence, the only control that the status report facilitates is that it highlights shortcomings that have already taken place so that corrective actions can be taken to avoid such shortcomings or make up for them in the remaining period of the budget.

When the Chief Financial Officer of the hospital was asked how activities were monitored, (when in fact the administration had no control over the physical activities), he explained that the activity targets were fixed on the basis of previous performance, with provisions made for anticipated increases in activity levels. Thus, when the activities of a particular department were below that of the previous year, he asked the departmental heads for the reasons. The same reasons were then given in the status report as justifications for negative variances.

Budget Flexibility Policy

According to the Chief Financial Officer, in normal circumstances, the costs of the hospital do not exceed the budgets. This is because they are prepared on the basis of the actual expenditures of the previous year with due provisions being made for inflation. It is only due to unforeseen circumstances, like a sharp rise in staff cost due to an agreement signed with the labour unions and other such developments that flexibility needs to be resorted to. Moreover, in those cases where flexibility does need to be resorted to, it is available without too much difficulty with the ratification by the Managing Council. The behavioural implications of the budget flexibility policy are minimal due to two reasons. Firstly, flexibility is hardly ever resorted to and, secondly, the departmental heads, who are in any case not too involved with the preparations of estimates, can hardly be expected to be affected.

(7) An overview of the budgeting process adopted by the private non-profit hospital.

Generally speaking, the budgeting process adopted by the hospital is fairly good. It applies most of the modern ideas and principles recommended by management experts for the budgeting exercise. The budget of the hospital is prepared within the framework of a well formulated budget manual which contains detailed guidelines on its preparation. It is prepared within a time-table and is approved through a formal process after which the grant letters are issued. Thirdly, it is prepared within the framework of the long term development plan and explains deviations, if any, from the plan. The contents of the budget too are rather elaborate making it a complete and comprehensive document. It has separate components like the operating budget, the capital budget, the cash budget, and the maintenance budget. The income budget, supplies cost budget, support and administration cost budget, staff cost budget, activity budget, hospital utilisation budget, working capital budget, fixed assets budget, projected balance sheets, key management financial indicators, etc., are also prepared along with many other schedules. Further, the document at a glance provides the information pertaining to the previous year as well as the expected performance of the current year. Finally, the monitoring of the budget and the review of performance against targets is again in the form of the formal document, presented in a manner which facilitates comparisons and highlights major deviations.

However, despite the infrastructure and the framework of the budgeting process being fairly good, the essence of the whole process is not complete in the physical contents of the document. Its utility in the context of achieving the objectives of management control is limited as discussed in the following paragraphs.

1. The first shortcoming of the budgeting process in the hospital is that it does not prepare departmental budgets representing separate aspects of the overall budget. Though all information pertaining to departmental activities and finances is given in the document, it is presented in a manner which does not facilitate the analysis and review of different departments as separate activities of the hospital. The whole hospital is treated as one single unit, without highlighting the activities of its decentralised sub-units.

   The editorial of the hospital budget also does not contain commentary on individual activities. Neither does it highlight future prospects and long term plans for the individual activities.

2. As a consequence of the above practice, it becomes very difficult to control departmental costs. Since the hospital budget does not provide for separate information pertaining to the

departments, the objective of controlling costs at the point of incurrence is lost. Although, at the end of the year, the costs of the hospital are presented in the form of department financial statements (on the basis of full cost accounting), the utility of the same is lost in the absence of their meaningful comparison with budgets.

3. The hospital budget process is a highly centralised activity. The complete process right from the accumulation of information for the preparation of the budget to the monitoring of activities and providing justification for deviations is carried by the Chief Financial Officer and the Chief Executive Officer. The people actually carrying out the activities of the hospital and controlling them are not really involved in the budget process.

4. The current procedures place too much responsibility on, and grant too much authority to, the two key personnel of the organisation, viz., Chief Executive Officer and Chief Financial Officer. The Chief Financial Officer, for example, is responsible for the preparation as well as the monitoring of the budget. He has the full authority to spend funds upto the sanctioned limit. Sound management principles caution the bestowing of excess authority on any one individual.

5. The budget of the hospital, inspite of the elaborate procedures for preparation and approval, is still based on the actual performance (both activity and financial) of the previous year and the expected performance of the current year. Like-wise the projected income and expenditure are also based on financial performance of previous years. Thus, the soundness of the base years, on the foundation of which projections are made, is by itself weak. There are no physical or financial standards for working out budget projections. The concept of Zero Base Budgeting gaining increasing popularity in many organisations is also absent in the hospital.

6. As explained above, since the budget document is prepared taking as its base the activity levels of the previous year, the proposed finances are also based heavily on the financial performance of the previous year. Although, there are no formal standards or norms for costs per level of activity, nor physical standards for input per level of output, the hospital does have some key financial indicators which give some idea about the cost/income per unit of activity. However, these indicators have limited usefulness as they are simply derived by making some mathematical calculations after all the budget proposals are already prepared. They thus only serve a limited purpose of highlighting major deviations from the previous years.

   According to the Chief Financial Officer, some physical standards do exist in an informal manner. He quoted, for example, that number of X-ray films per patient, number of laboratory tests per in-patient etc., are informally established by the departmental heads, who monitor their activities against these norms. However, these norms are not as such formally established nor is formal information collected and reported, to facilitate comparison against the norms. Further, performance of the departments is monitored against these norms, and no incentives are provided to departmental heads to adhere to these norms. These informal norms thus serve a very limited purpose and cannot as such be said to be facilitating effective control.

7. The control objective of budgeting, in its true essence, is not being served by the current budgeting process in the hospital. For example, in the status report for a particular period, it was reported that referrals to treadmill were below the targeted level by 92% in in-patients and by 79% in the case of out-patient attendances. Similarly, in the case of electrocardiogram procedures, the shortfall was 62% in in-patient and 51% in out-patient attendances. It was simply reported that this was due to faulty projections and consequently the expected targets for the year were reduced. Given the budget procedure, it was not possible to hold any one person responsible for the shortcoming since the persons performing the activities were not involved in the target setting. Perhaps, if they had been involved in the budget process, the target setting would not have been faulty. Thus, the management in the current situation is not in a position to take any action for shortcomings. All that it can do is take corrective actions for future performance. The same situation holds true in the case of finances. If there exists a case of

overspending of funds, the same is reported in the status report and justified, while the Managing Council just ratifies the overspending after the funds are already spent.

In summary, it can be concluded that though the budget process is fairly sophisticated in the hospital, yet, it needs to be strengthened and streamlined to be more useful and meaningful as an integrated control technique.

ACCOUNTING AND AUDITING

The legal status of the private non-profit hospital under study being that of a charitable trust registered under the Bombay Public Trust Act, the statutory audit of the hospital is conducted as per the provisions of the said Act.

Apart from the statutory audit, the hospital also has a system of internal audit which is carried out at the end of every financial year. The internal auditor is required to give a detailed report to the management on the internal controls operating in the hospital and also recommend changes or improvements in the system.

The accounts of the hospital are maintained on accrual basis and as per the provisions of the Bombay Public Trust Act. They are maintained in a manner that facilitates the preparation and monitoring of the budget. The accounting system provides the information base for the preparation of the status reports that are submitted by the hospital on a quarterly basis. Thus, the account heads and the general system for the maintenance of the accounts is in consonance with the budgets.

Funds are spent within the framework of the approved budget after approval and sanction of the Chief Executive/Chief Financial Officer. The payment of salaries as well as for supplies and administration overheads is centralised.

MATERIALS MANAGEMENT

All supplies, both medical and general, are purchased centrally by a storekeeper. This implies that the purchasing and storing functions are the responsibility of the same authority. It is interesting to note that even while purchasing and monitoring of stores is the responsibility of one individual, the budgeting for supplies is the sole prerogative of the Chief Financial Officer, without any involvement of the former. Projections for stores are made as per the previous year's expenditures of the various departments after making provisions for inflation or any additional requirements in the forthcoming year. The storekeeper is, therefore, required to work within the framework of the budget in which he has had no part to play. He merely makes the purchases by getting sanctions before spending the funds. To be more clear on this aspect, the storekeeping function in the hospital is discussed in detail hereinafter.

The storekeeper maintains around 2-3 months' stock of drugs and other utility items on hand, depending on the value of the items as well as their requirements in the hospital. There are no minimum and maximum stock levels or re-order quantities. The hospital has basically two stores; a central store and a sub-store. The central store is used to stock the major and bulk items which are held in stock mostly for future use. The sub-store is used to stock the immediate requirements or the near future requirements of the various departments. Stocks are transferred from the main stores to the sub-store on a weekly basis or earlier, if required.

Disbursements are made to the various departments on the basis of the indents received from the departmental heads. The departments maintain minimum levels of stores of drugs/other items, which are reimbursed on their exhaustion by the stores. Thus, primary records for stock utilisation are maintained at departmental level.

Orders are placed for the purchase of drugs/other stores by the storekeeper, with regular suppliers, who are finalised after inviting quotations from 3-4 suppliers. Before the orders are actually placed, they are duly submitted for sanctions of the Chief Financial Officer. This facilitates the monitoring of the supplies

budget by the latter.

Conclusion

As mentioned earlier, the hospital under study has a fairly good management control system. However, in the implementation of the system, the purpose of management control is not completely achieved in all respects.

Since there are no formal efficiency or effectiveness measures, it is difficult to ascertain whether resources are being utilised in that manner. Moreover, apart from activity levels, which are quantitative measures, no indicators are applied to ascertain the performance of the individual departments. Thus, it is not easy to ascertain that the departments work towards the achievement of organisational goals. Even the motivational aspect of management controls is not recognised by the management in a formal manner. Motivation is provided to an extent by personal interaction and close informal relationship of the departmental heads with the top management.

THE GOVERNMENT NON-PROFIT HOSPITAL (HOSPITAL 'B')

BROAD FRAMEWORK OF THE ORGANISATION

Sub-section (g) of section 61, of the concerned Municipal Corporation Act (MC Act) defines one of the obligatory duties of the Corporation as follows:

"Establishing and maintaining hospitals and dispensaries, and carrying out other measures necessary for Public Medical relief."

In the fulfillment of this obligatory duty, the Municipal Corporation (MC) has established an infrastructure of Health Care Services, ranging from preventive and promotive to curative and tertiary care in the form of general and speciality hospital.

The Government Non-Profit hospital under study in one of the three teaching hospitals established by the Corporation under the framework of the MC Act.

THE MUNICIPAL CORPORATION – ITS OVERALL ORGANISATION

The Municipal Corporation has two basic wings - The deliberative wing and the executive wing. The deliberative wing is in effect the Corporation itself, which is an overall planning, policy making and sanctioning body, exercising overall control on the management of the Corporation. It comprises certain statutory committees – like the Standing Committee, the Improvement Committee, the Education Committee etc., which are elected bodies whose appointments, powers and functions are laid down by the Act itself. Each of these committees is headed by a chairman, elected by the members. These committees also have their own sub-committees.

As the name suggests, the executive wing of the Municipal Corporation is in charge of execution of the decisions of the deliberative wing. It is headed by the Municipal Commissioner, who is assisted by the Additional Municipal Commissioner and the Deputy Municipal Commissioner. The latter has under him, the heads of all the departments of the Corporation, including the Health Department, the Education Department, Housing Department, and so forth.

The Health Department is headed by the Health Officer, who is responsible for vaccinations, dispensaries, primary health care, maternity homes, peripheral hospitals, health licensing for nursing homes, private hospitals and so forth. The Dean of the hospital has a position parallel to that of the Health Officer. The Dean is thus the point of link between the hospital and the Municipal Corporation.

HISTORY OF HOSPITAL 'B'

The year 1946 will be remembered throughout the world as the year of peace after the horrifying World War II came to an end and peace prevailed. The event had a direct bearing on the origin of the hospital under study. After the war, an Indian Military hospital became surplus to the defence force. The Municipal Commissioner seized the opportunity, opened negotiations and succeeded in securing the hospital buildings for a sum of Rs. 4,45,000. This facility was acquired to meet the acute medical relief need of the fast expanding suburb.

The hospital was initially placed under the control of the Dean of another municipal teaching hospital and on 2nd December 1947, it was thrown open to the public with an initial capacity of a ward with 50 beds and an outdoor dispensary which served as a miniature OPD. From April 1948 onwards, the hospital had its independent existence with out-patient services, in-patient services, and casualty departments like any other general hospital to provide medical relief to the people of Bombay. It was staffed by specialists who were employed as full time staff without permission for private practice.

In 1950, the hospital was affiliated to a college for diploma in gynaecology and obstetrics. In 1953, it was recognised as a teaching hospital and in 1964, it had its own college.

By 1959, all the major speciality departments like pathology, anesthesia, ophthalmology, dermatology, ENT, dentistry, occupational theraphy, physiotherapy, pediatrics and psychiatry had been set up and were in full operation. In 1962, a general training school was started and in 1964, a flying maternity squad was established to attend to difficult maternity cases.

In 1964, a Poor Box Charity Fund was started which collected donations for the hospital and in 1951, for the first time, a paying ward 50 beds was started. This has now increased to a paying ward with 72 beds. A mobile accident service and a mobile coronary case service was also put into commission with effect from 29th April, 1978, in the hospital under the centralised ambulance service for Greater Bombay.

The hospital has made efforts to keep pace with the all-too-rapid developments in medical technology as is evident from the number of specialities and sub-specialities which have developed within the framework of the older departments of medicine and surgery. There has also been considerable physical expansion in terms of new buildings and increase in beds. This has, however, not kept pace with the rapid growth of population in the area. Over-crowding is one of the most outstanding features of the hospital.

The hospital had also demonstrated its role as a community organisation and has not been impervious to new ideas in the field of medical care. However, for its operations, it is dependent on grants from the State or Central Governments, or even international organisations like the World Health Organisation.

The hospital under study had a staff strength of 2,647 (excluding college), during the financial year under study: it had 54,570 in-patient admissions with the total number of in-patient days coming upto 4,11,464. In the same period it served 4,68,702 out-patients and conducted 55,311 major and minor operations.

SOURCES OF REVENUE

The significant source of finance for the hospital is the municipal sanctions received from the Corporation. The MC finances all the activities of the hospital through its own revenues comprising taxes, duties and fees under the provisions of the MC Act. Apart from this, the hospital has small inflow of donations from private individuals and organisations and some donations in kind like milk powder, vaccines, medicines, etc., by health organisation like WHO, CARE, etc.

There is, in addition, a small income generated by the hospital from the selling of registration forms and from the few paying wards in the hospital. Such income, however, constitutes about 1% of the total operating expenditure and is thus insignificant as a source of finance.

There is the Poor Box Charity Fund, which comprises donations from patients through collections in boxes placed in wards, OPDs etc.

In the year under study, the total expenditure on in-patients and out-patients, excluding new works,

amounted of Rs. 9,52,99,270. Of this, total income contributed Rs. 13,67,894 (1.43%), while collection in the Poor Box Charity Fund contributed Rs. 18,05,858.95 (1.89%), towards the expenditure. Grants from the Corporation, therefore, funded 96.68% of the total expenditure.

One limitation faced by the MC, which is the major source of finance for the hospital, is that its own expenditures are dependent on and limited by its revenues. Further, the funds have to be utilised in the areas requiring top-most priority at a given point of time. The implications of this situation on the finances of the hospital under study are many. Firstly, it is not ensured of stable budget sanctions from year to year. In the years of low revenue generation or when the Corporation has other priority areas to expend its funds, the hospital budgets may be slashed down to any extent. Secondly, the hospital may become susceptible to political considerations.

ORGANISATIONAL RELATIONSHIPS

The government hospital under study does not have a formal organisational structure to depict organisational relationships. However, various activities of the hospital are explained below in brief.

(a) Broadly speaking, the overall functions of the hospital can be divided into three categories namely, clinical, teaching (college) and administrative functions. The overall responsibility for all these functions rests with the Dean of the hospital who is its Chief Executive Officer. He is usually a medical professional, whose appointment is made on the recommendation of the State Public Service Commission.

(b) The clinical function of the hospital is carried through 21 operating departments, in-patient wards and a number of operation theatres. The 21 operating department are enumerated below.

1. Medicine
2. Surgery
3. Obstetrics and Gynaecology
4. Pediatrics
5. Radiology
6. Casualty
7. Orthopaedic
8. ENT
9. Ophthalmic
10. Skin and VD
11. Blood bank
12. Psychiatric
13. Pharmacy
14. Intensive Care Cardiac Unit
15. Occupational therapy/Physiotherapy
16. Dental

17. Cardiology

18. Dispensary

19. Laboratory Service

20. Social Service

21. Anesthesia

(c) The in-patient wards are also of a wide range including general wards, paying wards, maternity wards, pediatrics etc.

(d) The 21 operating departments render in-patient as well as out-patient services.

(e) The heads of these operating departments are also the heads in the relevant areas in the college.

(f) The in-patient wards have two aspects to their management, namely, the clinical and the administrative aspects. While the former is looked into by the medical and nursing professions, the latter is the joint responsibility of the nursing and administrative departments.

(g) The nursing profession thus has a dual role to play in in-patient wards. In addition to their professional responsibilities towards medical and patient care, they are also required to perform certain administrative functions like maintenance of records, drug management in wards, etc. They are assisted in their administrative tasks by the administrative units like diet, linen, general stores, medical stores, repairs etc., as all these are centralised functions in the hospital.

(h) The medical profession is responsible for the purely clinical aspects of in-patient wards. These comprise day-to-day medical care of the patients as well as specialised care which includes minor and major surgeries. The day-to-day medical care involving routine kind of work is done by the resident Medical Officers and junior doctors, the specialised care activities involve honorary consultants as well as heads of the operating departments, depending upon the nature of surgery. Thus, for surgeries in specialised areas like ophthalmic, ENT etc., the heads of the respective departments as well as other specialists and consultants in the concerned fields are involved.

(i) Similarly, for in-patients requiring diagnostic and other services like radiology, laboratory tests etc., the respective operating departments render the service.

(j) The general administrative functions are centralised and looked into by as many as 22 head clerks, each responsible for a specific are like medical stores, general stores, diet, linen etc. All these are centralised services, carried out for the hospital as a whole.

(k) Just as there is no formal organisational structure, similarly there is no formal delegation of authority in the hospital. Instead, the administrative and financial powers of the individual positions in the hospital are communicated by the Corporation, from time to time, in the form of official circulars. The latest circular from the Corporation, prior to the conduct of the study, which currently governs these aspects, outlines the powers delegated to the various hospital authorities in the following areas:

(i) Power of incurring expenditure.

(ii) Power of making purchases (separate limits have been outlined for different types of purchases like stationery, clothes, medical stores etc.).

(iii) Disposal of different categories of movable properties.

(iv) Departmental work.

(v) Authority to invite and open tenders.

(vi) Disposal of unserviceable articles.

(vii) Appointment of personnel.

(viii) Increments.

(ix) Promotions.

(x) Punishments.

(xi) Resignation of employees.

(xii) Power of granting leave.

(xiii) Routine correspondence.

(xiv) Sanctioning advances from provident fund.

(xv) Signing of bills of contract (of different types).

(xvi) Indenting of scheduled and non-scheduled items.

(xvii) Breakage loss written off report.

(xviii) Acceptance of donations.

(xix) Signing of bonds of service.

(xx) Granting of overtime allowance.

An interesting point to note is that even while the above powers are delegated, they are subject to the rules and regulations already laid down by the Corporation in these respects. For example, although powers for making purchases have been delegated, the purchases are to be made only through scheduled suppliers/contractors of the Corporation with whom rate contracts have already been entered into.

(m) The authority for the powers mentioned above is delegated to personnel at various levels throughout the hospital, within prescribed limits, mentioned in the circular. These levels range from that of the Dean down to the departmental heads, implying that some administrative powers are delegated to the clinical departments. It has been mentioned earlier that general administration is a centralised function in the hospital. However, certain administrative authorities pertaining to the departmental functions like those of sanction for spending of funds (within budget limits), leave to departmental staff etc., is granted at departmental levels. Thus, departmental heads do have a certain level of administrative authority for some administrative aspects pertaining to their departmental activities.

As far as autonomy in clinical functions is concerned, although there is no formal delegation, the departmental heads are more or less incharge of the activities in their departments. No standard framework of authority limits has been prescribed by the Corporation and the hospital as well as all its clinical departments are autonomous as far as the medical aspects of its ongoing activities are concerned.

(n) Over the years, organisational relationships have evolved in the hospital as a result of and in keeping with the functions of the various categories of personnel. In this manner, general job descriptions, again informal in nature, have evolved in the hospital. Thus, there is no formal manual for this purpose, making it difficult to get a picture of detailed organisational relationships.

Implications of the Existing Structure

The implications of the organisational structure as existing in the hospital are many as discussed in the following paragraphs.

(a) Due to the absence of clearly defined areas of responsibilities there is bound to be some overlapping jurisdiction over certain areas and personnel. Such a situation has an inherent danger of creating confusion and provides opportunities for shirking responsibility. Further, most matters which can be settled at lower levels have a tendency to go up to the Dean.

(b) Official circulars are not enough to deal with the infinite variety of situations that are bound to

arise in the day to day working of the hospital. Thus, quite often a situation arises that the Dean himself is not equipped with adequate authority to take decisions pertaining to the hospital's operations, especially in administrative matters like personnel management, which is governed by means of rules and regulations set by the Corporation. These rules and regulations confer considerable authority regarding personnel management outside the hospital, while, in fact, personnel management is an issue which should preferably be tackled at the hospital level itself to enable the Dean and other hospital authorities to be effective. Thus, many matters which could be tackled at the hospital level have to be referred to the municipal commissioner causing undue delay.

(c) One very important implication of this structure is that it leads to lack of involvement of employees, which in turn is responsible for low morale, minimal commitment and inadequate flow of information, both upward and downward. Most of the hospital personnel, including some departmental heads and administrative staff had no idea whatsoever of the organisational relationships in the hospital. Their knowledge concerning the hospital was limited to their own narrow role and duties.

(d) Another implication is the danger of multiple subordination, for example, in the absence of clearly defined relationships, as intern receives orders from resident doctors, senior doctors and clinical professors. He also gets orders and directions from administrative departments and the ward sister may well tell him what he may or may not do in the ward.

(e) As far as the responses of the department heads were concerned, certain interesting observations were made. Out of the twenty two operating departments, responses were received from 13 thus making it a 59% representation.

The analysis that can be made from the responses is as follows:

Although there was no well established organisational structure, the departmental heads did not feel too comfortable in the hospital. The reason for this could be that the departmental heads were very senior medical professionals, highly respected in their fields. They got much satisfaction out of the practice of their profession and, therefore, so long as they were allowed high degree of autonomy in their clinical functions, they were happy. This was also evident from the fact that even though the administrative and financial authority delegated to them was limited, most of them felt that it was adequate. They substantiated this view by emphasising that administrative functions obstructed their basic function.

MISSION, GOALS AND OBJECTIVES

The organisational structure of the hospital, as mentioned earlier, and its mission and goals, have not been formally laid down in any official manual of the Municipal Corporation. However, as is evident from its strategies, the hospital has the goal of rendering general and specialised health care services to the people residing in surrounding areas. It specifically caters to the needs of people living in the nearby slums, where the hospital also runs several health centres. It is also involved in outreach health care services for which it has specific immunisation and health education activities. It, thus, aims at providing preventive, promotive and curative health care services to the people whose needs it caters.

Just as the hospital does not have a formal mission statement, it also does not have formulated goals and quantified objectives. It, therefore, moves towards its health care mission in a rather informal manner.

The inference that can be drawn from the responses is that although the mission, goals and objectives are not formally laid down, the informal objectives are well recognised and well appreciated amongst the departmental heads.

AN OVERVIEW OF THE EXISTING MANAGEMENT CONTROL SYSTEM IN THE GOVERNMENT HOSPITAL

Before going into the details of the control system prevailing in the hospital, it is important to have an overview of the system by reviewing:

(a) The objectives of the management control system.

(b) The overall scheme of control.

The objectives of the control system

An important control concept in the Municipal Corporation is that being a public body utilising public funds, it prime responsibility is to ensure that authority is not concentrated in the hands of a few. This has also become the basic philosophy and objective that governs the control system in the hospital. As a result, a situation prevails that no individual, including the Municipal Commissioner, has an absolute authority in operations. This has been achieved by dividing authority in such a way that beyond a certain limit, decisions pertaining to an activity can only be taken by a higher authority. This situation is true all through the hierarchy in the Corporation as well as in the hospital.

Even within the framework of the authority limits formulated by the Corporation, individual institutions are required to operate as per the overall rules, regulations and procedures of the Corporation. For example, while the Deans of the Municipal hospitals are empowered to make purchases upto Rs. 30,000/-, these can only be made through scheduled contractors with whom the Corporation enters into rate contracts for the consolidated requirements of all the hospitals under its purview. Similarly, recruitment of personnel can only be made within the framework of rules and regulations pertaining to their appointments, pay-scales, promotions, increments, leaves, punishments and dismissals, as formulated by the Corporation.

The overall structure of control

The overall scheme of control as existing in the Corporation and hence the hospital is as follows:

(i) Budgetary control ensures that the funds utilised by the hospital are within the sanctions accorded to it by the Municipal Corporation during a given period.

(ii) The internal accounting information system of the hospital is geared to monitor the expenditure against budget sanctions.

(iii) A wide range of audits like internal audit, stock audit etc., have been introduced to monitor the performance of the hospital in its various aspects.

(iv) A wide range of internal control procedures have been introduced to ensure that authority (both administrative and financial) is not concentrated with a few. Besides, rules and regulations have been enforced within the framework of which the hospital is expected to operate.

Let us review each aspect of the control system to have an overview of its effectiveness.

Budgetary control

Budgetary control is the overall control technique employed by the Corporation to provide a framework within which the hospital is required to operate.

The discussion on budgetary control in the hospital has been divided in the following broad heads:

(a) Introduction

(b) Forms of budgets

- Financial
- Performance

(c) Financial Budget

- Overall process
- Contents of the budget
- Procedure for preparation
- Basis for preparation
- Monitoring of the budget

(d) Performance Budget

- Overall process
- Contents of the budget
- Procedure and basis for preparation
- Monitoring of the budget

(e) Budget flexibility

(f) Motivational aspects of the budget – An overview and appraisal.

Introduction

The budget of the government hospital under study forms part of the overall budget of the Corporation, which, in turn, is a consolidation of the proposals received from all the institutions falling under its purview. The entire budget estimate of the hospital appears as one consolidated figure under the Corporation's budget for Medical Relief and Education, which under Part A is devoted to hospitals and sub-section 4 mentions the name of the hospital along with its consolidated requirement for the budget period. However, as far as the hospital is concerned, it is required to submit a comprehensive document to the Corporation for the purposes of monitoring actual expenditures.

Form of Budgets

Traditionally, the Corporation and hence the hospital has been adopting the conventional financial form of budgets, mostly restricted to financial aspects of operations. Recently, the Corporation has introduced the concept of performance budgeting in the hospital, which highlights the level of activity that is proposed to be achieved in the budget period, and its relation to the proposed expenditure. Both the above documents are submitted as separate proposals, with the financial budget preceding the performance budget.

Financial Budget

Overall process The financial budget of the hospital is prepared by the various departments/sections of the hospital, presented to the Dean and finally approved by the Municipal Council. The process has been given by way of a flowchart in **Fig. 4.2**.

Once the proposal is received by the Chief Accountant of the Corporation, it is merged with those of other institutions to form a consolidated budget proposal of the Municipal Corporation. This is a comprehensive document covering the application of funds over the range of services provided by the Corporation.

The Chief Accountant also prepares revenue estimates for the following year and along with a statement showing the revenue and expenditure of the Corporation, submits these to the Municipal Commissioner. As mentioned earlier, since the projects and programmes of the Corporation are dependent on its revenues, changes in these may have an impact on the grant allocation of the Corporation.

The Municipal Commissioner submits the consolidated budget document of the Corporation to the standing committee. In the course of reviewing the budgets of the various institutions, the standing committee can revise the estimates as presented by the Commissioner. After the approval of estimates by the standing committee, the budget is presented to the Municipal Council which is an elected body charged with the responsibility of approving the budgets.

As a rule, the Corporation first estimates the consolidated requirements for the following year and on the basis of these, estimates and formulates its revenue requirements and sources thereof. However, since the Councilors are an elected body, they rarely agree to increases in taxes. Therefore, in cases of tight revenue situations, the Councilors may reduce or change the budget allocations of the institutions. However, these changes are rarely made to the routine operation expenditures. They are made in non-routine or other major heads. In any case, as far as the hospital under study is concerned, over 55% constitutes staff cost which is of a fixed and committed nature. Similarly, most of the other expenditures have necessarily to be incurred in order to enable the hospital to operate. In this case the usual tendency is to allow for the existing levels of expenditure with minor increases to cover inflation.

The budget as approved by the Corporation becomes the formal sanction within the framework of which the Corporation and, thus, the hospital is supposed to operate.

The approved budget of the hospital is handed over to it and becomes the official document, duly sanctioned by the Corporation. This approval usually comes in the month of March for the financial year beginning from April.

Contents of the Budget The financial budget of the hospital contains elaborate details pertaining to the various categories of expenditure in prescribed formats. The following details are provide for each category of expenditure:

(i) Actual expenditure for the three immediately preceding financial years.

(ii) Budget grant for the current year.

(iii) The budget sanction required for the forthcoming year.

The figures for all the above years are compared and if there exist major variations in the proposed budget, from the sanctioned budget of the current period, reasons thereof have to be stated. An important characteristic of the budget exercise is that the budgets of the hospital and the college have to be submitted as separate documents.

The budget document of the hospital is divided into a number of sections representing various categories of services rendered by it. These sections are as follows:

(i) Hospital Services (including in-patient and out-patient services).

(ii) Physiotherapy Centres.

(iii) Mobile Accident Service.

(iv) Urban Health Centres and Wards.

(v) Lumpsum Provisions for Emergency Wards of Intensive Care Unit (ICU).

Each of these sections contain the details of various categories of costs pertaining to them.

The details of expenditure required to be provided for each section is as follows:

(i) Establishment:

(a) Supervisory and Subordinate
(b) Overtime Allowance
(c) Stipends
(d) Other Allowances
(e) Labour – Technical and Others

(ii) Contingencies:

(a) Printing
(b) Stationery
(c) Advertisement
(d) Miscellaneous
(e) Books and Dead Stock
(f) Ground Rent and Taxes
(g) Washing and Linen Charges

(iii) Equipment and Apparatus.

(iv) Medicine and Instruments:

(a) Drugs, Medicine, Surgical Dressings etc.
(b) Instruments.

(v) Diet

(vi) Stores:

(a) General
(b) X-Ray
(c) Clinical and Ward Laboratories
(d) Clothing

(vii) Repairs and Maintenance:

(a) Building
(b) Appliances
(c) Special Repairs
(d) Repairs and Maintenance of Road
(e) Maintenance of Garden
(f) Maintenance of Electricity Installations
(g) Electric Energy and Lighting Installations

(viii) Gymkhana

(ix) Transport

(x) Lumpsum provision for expenses of deputation of officers in India and abroad for conferences

(xi) Lumpsum provision for research/special investigations

(xii) New works

(xiii) Assistance for attending international conferences

Procedure for Preparation The budget exercise in the hospital begins in the month of June-July when

the Chief Accountant of the Corporation issues a circular to the hospital, enlisting the details required for preparation of the Corporation budget. The circular gives general guidance for the preparation of the budget proposal and outlines the deadlines for its submission.

On receipt of the circular, the Expenditure Section of the hospital starts the preparation for the budget proposal. The budget for the hospital is prepared partly by the operating departments and partly by the administrative sections, before it is finally consolidated. The role of each of these bodies is as follows:

(i) There are certain services in the hospital which are centralised for the purpose of economy and convenience. Such services include (a) general administration, (b) purchases, (c) establishment (staff), (d) stores (which are further bifurcated into general stores, medical stores, diet and linen), and (e) engineering (including repairs and maintenance). Budgets for these centralised services are prepared by the head clerks in-charge of each these services. The user departments of these services are not involved either in their formation or in their monitoring. Similarly, the budget sanctions of these services are not allocated to the user departments. The head clerks responsible for the framing of these budgets are also responsible for their monitoring.

(ii) In case any of the departments require any special items like equipments for their departments, extraordinary supplies, special repairs and so forth, which are outside the purview of regular requirements, they are required to make special requests and submit these to the concerned section for the purpose of inclusion in their respective proposals.

(iii) All the respective sections like establishment, stores, purchases and so forth send the proposals of their sections to the expenditure section, where the hospital budget proposal is finally consolidated for submission to the Chief Accountant.

(iv) The entire process of preparation and consolidation is completed by the month of July for the forthcoming financial year and submitted to the Chief Accountant in the same month. The preparation process has been given by way of a flowchart depicted in **Fig. 4.3**

Basis for Preparation The basis of preparation of each aspect of the budget has been briefly explained below:

(i) The general administration budget of the hospital includes the administration overheads of the operating departments. This budget is prepared by the head clerk (expenditure) on the basis of the previous year's expenditures after making allowances for inflation. Departmental heads are not involved in the preparation of administration overheads for their respective departments. This is a centralised service directly under the control of the administrative officer.

(ii) Personnel or establishment budget is prepared by the head clerk in charge of establishment. This section first prepares the establishment schedule showing details of staff, category-wise and department-wise. The number of posts for each department as well as their categories and grades (or scales) are predetermined by the Corporation and the budget proposals are prepared on this basis. The pay sheet for the month of July forms the basis on which the establishment budget of the following year is prepared. Since the budget proposals are made in the month of August, actual figures for July are already available. Increments in the hospital are governed by the rules of the Corporation and are given on the basis of the pay scales formulated for each category of personnel. For the sake of convenience the Corporation formulates and circulates each year, a ready reckoner which provides the basis for this calculation. Since the scales and allowances are fixed for each category, there is no ambiguity or difficulty in formulating the establishment budget.

    The budget of the Municipal Corporation contains a special document which forms an appendix to the main budget. This appendix contains the detailed particulars of positions and scales for each institution. Thus, the section on the hospital under study contains in detail the particulars of every post that is sanctioned for the hospital. This complete list then constitutes the scheduled posts as sanctioned for the hospital by the Corporation. The hospital cannot employ even one additional employee outside the purview of this list.

The establishment budget of the hospital is prepared taking into consideration the total number of scheduled posts sanctioned by the Corporation. No recognition is given to the fact that some of these might remain vacant in the course of the budget period.

Establishment costs constitute a major proportion of the total expenditure of the hospital. At the time of the study, over 55% of the total budget of the hospital was allotted to staff cost. The hospital employed over 2,600 persons (only for hospital activities), and together with the college staff, the total staff force was 3,979.

(iii) The budgets for the requirements of different categories of stores like general stores, medical stores, diet and linen, and engineering and repairs are prepared and submitted by the individual head clerks responsible for their purchasing/monitoring. However, requirements of special nature of each department/ward are submitted separately by the concerned wards/departments before a consolidated budget is prepared for the relevant category of stores.

The stores section prepares its requirements on the basis of the average consumption in the previous year after making provisions for inflation etc. It is to be noted that stores in the Corporation are divided into two categories, i.e., for scheduled and non-scheduled items. Scheduled items are those which are used commonly and in large quantities by all the institutions under the purview of the Corporation. These are thus purchased centrally by the Corporation to avail the benefit of economy of scales. Each institution is required to submit in advance its requirements of such scheduled items for one year in case of general stores and two years in case of medical stores. On the basis of the consolidated requirements, rate contracts are entered into by the Corporation. The rates as well as names of the approved contractors for each category of items are circulated to the institutions, which place order as per their requirements, with the approved contractors, at the approved rates. The non-scheduled items, constituting items either not commonly used by all institutions or not used in large quantities, are left to be purchased by the individual institutions.

Once the requirements for each category of the scheduled items are determined by the concerned stores section, the approved rates which are valid for one or two years, as the case may be, are applied to get the consolidated budget amount for the particular category. However, if in case the rate contracts are scheduled to be renewed in the budget year, an approximate percentage increase in rate is calculated before arriving at the budget amount. Similar calculations are made to arrive at budget estimates for the non-scheduled items.

The budgets are approved in the same sub-heads as they are submitted, in order to facilitate effective monitoring of actual expenditure.

The budgets for all categories of stores, including general stores, medical stores, linen, and repairs and maintenance are prepared in similar fashion and submitted to the expenditure section. The head clerk of the expenditure section is responsible for consolidating the overall budget of the hospital as also for the monitoring of actual expenditures against budgetary sanctions.

Capital budgets In case a capital expenditure is proposed or an amount exceeding Rs. 50,000/- is sought to be spent for fresh works, the same can not be provided for in the budget of hospital unless a prior sanction of the Municipal Commissioner is obtained. In case this amount exceeds Rs. 3,00,000/-, the sanction of the Standing Committee is required before processing the matter further. For obtaining these permissions the hospital has to justify the proposed expenditure and establish the need for the acquisition of the capital item/undertaking of the fresh work. This exercise is to be carried well in advance of the budget submission date for the purpose of inclusion in the budget proposal.

Once the permission of the competent authority is obtained, the hospital is charged with the responsibility of processing the matter further. It has to invite quotations/tenders for the articles, tabulate details, select the suitable contractor and finalise the deal, before the inclusion of a capital provision in the budget.

Most of the capital expenditures of the hospital are multi-year projects for which the total costs are determined at the initiation of the project by the engineering section. In case of these projects, the provisions unutilised at the end of the year are carried forward to the following year after obtaining the

permission of the Municipal Commissioner or the Standing Committee, as the case may be.

Monitoring of the Budgets The monitoring of the overall budget takes place at three levels within the hospital. Primarily, the monitoring of departmental sanctions is done by the individuals responsible for their preparation. For example, the monitoring of budget sanctions of general stores is the responsibility of the head clerk (general stores). In his section, a liability register is maintained which contains the particulars of budget sanctions under each head relevant to general stores. On the incurring of the liability, under a particular head, the same is noted against the sanction. It is the duty of this head clerk to see that the actual liabilities do not exceed the sanctioned provisions. The departmental sanctions for special expenses pertaining to individual departments are monitored by the respective head of the departments. All the sections/departmental heads send monthly reports of liabilities noted against their sanctioned budgets to the head clerk (expenditure), who already has records of liabilities noted against all sanctioned budgets (as all bills are scrutinised by him before they are finally passed for payment to the accounts section). The head clerk (expenditure) reconciles the reports received from various sections/departments and sorts out differences, if any. He then proceeds to prepare a consolidated report of liability noted against each budget head and submits the same to the Dean. The Dean monitors the overall budget spending and discusses the same with the departmental heads at the periodic meetings held with them. As far as the Corporation is concerned, the monitoring of institutional budgets is done through assistant accountants placed at each institution. All indents are passed to them for pre-audit before the orders are placed. If, at that time, there is no provision for funds under a particular head, the assistant accountant would simply refuse to admit the liability unless further sanctions are sought. Similarly, after the liabilities are noted by the concerned authorities at the hospital, they are passed to him for recommending the payment to the Corporation.

Performance Budgets

Overall process As mentioned earlier, the Municipal Corporation has recently introduced the concept of performance budgeting in the hospital with a view to highlight the various activities proposed to be performed and their relation to the financial budgets. As in the case of financial budgets, the process of performance budgeting starts on the receipt of circular from the Chief Accountant, giving guidance and deadline for the submission of the same. On receipt of the circular, the same is sent to the medical records office, which acts as a data base for the hospital and wherein all the records pertaining to the activities/operations of the hospital are maintained. The medical records officer prepares and consolidates the performance budget and presents the same to the Dean for review. The Dean in turn submits the same to the Chief Accountant and from this point onwards, the process for approval is similar to that of the financial budget.

Contents of the budget The performance budget gives the following details for both the finances and operations of the hospital:

(a) Actuals for the immediately preceding year.

(b) Budget estimates for the current year.

(c) Revised budget estimates for the current year.

(d) Budget proposals for the forthcoming year.

The contents of the performance budget are as follows:

1. Financial requirements

    (a) Classification of amounts under various activities.
    (b) Objective classification of amounts under various account heads (as per financial budget).
    (c) Sources of finance.

2. Programme/Activity Workload Summary (giving details of in-patient and out-patient attendances for each activity).
3. Personnel summary
   (a) Category-wise.
   (b) Activity and category-wise
4. Revenue (from the hospital)

Procedure and basis for preparation The following is the procedure and basis for preparation of the performance budget.

(a) The activity targets are determined by the medical records officer on the basis of actual activity levels of the preceding year.

(b) The Medical records officer usually makes activity estimates by providing a two percent increase in the current activity levels. On being asked for the rationale behind making these additions, he explained that previously he used to provide for five percent increase, but it was observed that the hospital was unable to meet the resultant targets. He, therefore, started providing for two percent increase and surely now the hospital is comfortably able to meet its targets. The conclusion that can be drawn on studying the performance budgeting procedure and basis thereof is that the concept is not being applied in the hospital in a very scientific manner. There is no involvement of the clinical departments in establishment of their targets, nor is there any scientific basis for its preparation. Such a budget cannot serve as a meaningful control device in any organisation. In effect, it becomes a mere formality which has to be complied with because it is required by higher authorities.

Monitoring of the budget There is no formal system of monitoring the performance budget of the hospital by way of periodic reports, variance analysis, etc. However, informal appraisals are carried out by the Dean at review meetings with the heads of the departments.

Informal control is also exercised by the Corporation in its periodic meetings with the deans of the three teaching hospitals, wherein important issues relating to the hospital's activities are discussed. Similarly, the overall direction for the hospital is determined at these meetings. For example, if an epidemic has struck in the area to which the hospital caters, the plan of action for the hospital is formulated at these meetings. Similarly, new activities of the hospitals are discussed and the Municipal Commissioner's sanction is taken before further action for their approval is taken by the hospitals.

The Dean of the hospital exercises similar control at the periodic meetings with his departmental heads. Monthly reports pertaining to the activities of each department submitted to the Dean are deliberated upon at these meetings and plans of actions determined.

Budget Flexibility

The hospital enjoys considerable flexibility in its budgets by way of the following mechanisms.

(a) Internal transfers of budget sanctions

(b) Drawing upon saving reserves.

(c) Unexpired grants.

(d) Submission of revised budgets.

The above mechanisms are discussed in detail as follows.

Internal transfers While technically the hospital cannot incur any expenditure unless there exists a budget grant under a specific budget head, there is some flexibility available for making internal adjustments in the budget sanction. For example, the Dean has the authority to transfer provisions from one budget head to another within the overall budget sanctions of the hospital. However, his authority is limited to Rs. 5,000/-. Beyond this amount, any transfer in budget heads has to be sanctioned by the Standing Committee. No transfers are, however, allowed between the budgets of the hospital and the college.

Drawing from saving reserves. One feature of the hospital budget is that there exists a provision for compulsory saving of 10% under each head of the sanctioned budget. This implies that the hospital is allowed to spend only 90% of the sanctioned budget under each head. This saving is allowed for use by the hospital in case the provision of 90% proves to be inadequate, after obtaining the sanction of the Municipal Commissioner.

Unexpired grants The following points are worth noting in this regard.

(i) The municipal grants are available for utilisation by the hospital in the year of sanction. In the case of capital works which are to be completed over a number of years, the unutilised sanctions of the budget period can be carried forward with the permission of the Municipal Commissioner in case the works remain unfinished during the year. Even in the case of one time capital expenditure like purchase of equipment etc., if for a particular reason the delivery is delayed or the placement of the order itself is delayed due to the lengthy procedures, the grants can be carried forward after justification and obtaining of the permission of the Municipal Commissioner.

(ii) In the case of operational grants also, the budget provisions lapse at the expiry of budget period. However, in an indirect manner, the utilisation of these provisions can be made during the next two years after the expiry of the budget period. According to the rules of the Corporation, the grant is deemed to have been utilised in the budget period if the liability for spending the amount is placed in the same period. This implies that if the indents for the incurrence of the expenditure are placed in the budget period, the amount can be actually spent within the next two budget periods under the category of 'renewed grant'. This indirectly allows for the utilisation of a sanction upto three years, in the first year as a sanctioned grant and in the next two years as renewed grant.

(iii) Even though technically no expenditure can be incurred without the budget grant to cover it, a wayout exists in which it is possible to utilise funds in the budget heads which have inadequate provisions or where no provisions exist. This can be done by debiting the payments to an account called 'sundry advances' account. It is expected that provisions for such payments would be made in the following year and the amounts to the debit of the sundry advances would be wiped off.

Revised Budgets. The Municipal Corporation Act provides that the Corporation, on recommendation of the Standing Committee, may, during the year, increase the amount of budget grant or make an additional budget grant. Thus, on the basis of the actual expenditure in the first eight months of the budget year, a revised estimate of the budget may be submitted to the Corporation if it is felt by the hospital authorities that the actual expenditure would deviate substantially from the original budget sanctioned. It should be appreciated that the budget estimates are made very early, i.e., in the month of July, at which time it is difficult to forecast accurately the expenditures of even the current year. The revised estimates have to be sanctioned by the Corporation before they can be utilised by the hospital.

Motivational aspects of budgeting in the hospital

Having reviewed the various aspects pertaining to budgeting in the hospital, the motivational aspects have been discussed by analysing what the departmental heads felt about the budgeting exercise at the hospital.

The inferences that can be derived from the responses of the departmental heads, on the budgeting system, are as discussed below.

On making a broad analysis, it can be said that the departmental heads were happy with the role they played in the budgeting exercise, although it was limited. This might be because, being professionals, they, in any case, did not wish to get too involved with administrative aspects of hospital management. They felt that their role was sufficiently active and they were generally able to meet their financial targets. They enjoyed enough flexibilities in case they faced a financial crunch.

The responses are further analysed by comparing the total positive responses with the negative ones, ignoring neutral or no responses.

	Positive	*Negative*
On overall budgeting process	4	8
On extent of participation in budgets	12	-
On easy attainability of targets	8	5
On controllability of expenses	3	9
On importance of cost controls	4	8
On availability of budget sanctions	4	5
On 'cuts' in budget sanctions	1	10
On their satisfaction with their performance	11	1

On the whole, the departmental heads seemed to be happy with their participation in the budget, the attainability of their targets and with their own performance. However, when it came to the process of budgeting, the responses were inclined towards being negative, particularly with respect to the controllability of expenses allotted to their departments. They also felt that cost control was not a priority, especially in a hospital where according to them, service should be the only motive and goal. They were, thus, critical about the 'cuts' in the budget sanctions.

In a way, the reactions of the departmental heads were typical of the profession to which they belonged. While attaching tremendous importance to the contribution of their profession and their own to the hospital, they were critical about the finance related aspects of hospital management, resenting any constraints like cost control measures and budget 'cuts' in their departments.

As a conclusion, it may be said that the departmental heads were 'self motivated', that is, they were motivated by their own profession and the importance attached to it in the hospital. They were, thus, as stated earlier, satisfied with the limited role they played in the financial budgeting process in the hospital.

An Evaluation of the Budgeting System

Let us now analyse whether the budgeting system itself has been designed effectively so as to meet the objectives of Management Control. This is very vital because as concluded in Chapter 2, not only do the departmental heads need to be motivated, but this motivation should necessarily be in the right direction, i.e., towards making effective and efficient utilisation of the organisational resources towards the achievements of its overall objectives. Let us therefore analyse whether budgeting system promotes the achievement of these objectives of management control.

1. The very system of budgeting followed by the Corporation is conventional. It lays stress only on financial aspect and that too in the traditional form, emphasising control according to operating account heads like establishment, contingencies, etc. It does not give enough importance to control, activity-wise or department-wise. For example, the Corporation sanctions a certain amount for contingencies like supplies, etc. The allocation of this provision between the different activities or departments is left largely

to the hospital. Further, there is no effective co-ordination between the financial budget and the performance budget in that the two are prepared and viewed at separately. Finally, there is no meaningful linkage between the two, in terms of analysis for expenditure per unit of activity and so forth. Thus, as a concept, the system of budgeting is not scientific.

2. The budgetary control system emphasises more on procedures rather than ensuring efficient and effective utilisation of resources. No efficiency measures like input-output ratios or standards are formulated to ensure financial efficiency. The estimates for the following year are formulated on the basis of the current year's budget and actual expenditure of previous years. There are no standards or measures on the basis of which estimates are formulated. Moreover, there are no indicators to ensure that the current year estimates and the previous year's expenditures which form the bases for the formulation of the budget are, by themselves, justified and form a true measure for indicating future requirements. All these aspects and requirements of effective budgeting are not possible in the type of budgeting adopted in the hospital.

3. Once the budgets are sanctioned by the Corporation, it does not have an effective mechanism for their monitoring as no formal reports are prepared showing variances and reasons thereof. Instead procedures are established to ensure that the budgetary provisions are not exceeded. Moreover, within the framework of the sanctioned budget, there is no mechanism to measure the efficiency with which the moneys are spent.

4. The funding requirements of the hospital are not related to the activities or their levels. The performance budgets which are prepared by the hospital are not really understood or appreciated by the personnel. Even the person responsible for its preparation did not know the source of the information which went into the preparation of the performance budget. Further, the involvement of departmental heads in the preparation and monitoring of the performance budget is practically non-existent.

5. The involvement of the departmental heads in the preparation of the budgets is limited. Firstly, the major proportion of the departmental budget which constitutes 55% of its total cost, namely, the staff budget, is centralised. The departments have no say either in the number of persons employed in it or in their performance evaluation and/or in their increments. All the above aspects are dealt with, as per the established rules and regulations of the Corporation. Further, budgets for the administration costs or the departmental overheads are prepared centrally as general administration is a centralised service. Similarly, supply requirements like general stores, medical stores, etc., are also centralised services, which have different divisions or sections looking after them. The budgets submitted by the operating departments are limited to specialised items required by them.

6. The budget system in the Corporation does not serve as a tool to measure departmental performance and neither does it serve as a motivating factor for departmental heads to strive towards achieving organisational goals. All that the budget does is to lay down limits beyond which moneys cannot be expended unless certain additional procedures are followed. Even this basic purpose is not achieved effectively. This point can be highlighted in the illustration of the typical reaction of departmental heads in the case of stockouts. This example was recited by one of the departmental heads of the hospital. If, in a particular year, the budget provisions for medical stores are either 'slashed' by the Corporation or prove insufficient and it is expected that the existing supplies will last only for eight months instead of one year, all that the department does is that upto eight months it supplies medicine to patients on a first come first served basis and at the end of the eight months declares a 'stockout'. All the patients coming after this period will be told to purchase medicine from their own sources. Thus, even if the budget provision falls short, it does not affect the department in any way, because its performance is not evaluated and its actions are not questioned. Thus, there is no incentive for departmental heads to perform. This is evident from two facts regarding the hospital budget. One is that the budget does not have an inbuilt mechanism to evaluate the performance of the departments. Therefore, when the performance is not subject to evaluation there is no concrete incentive to perform. Secondly, whatever the performance, the increments or monetary incentives are predetermined. When these are not based on performance, there is absence of incentive to work.

7. The concept of planning and its importance in the budget process is not recognised. In the hospital, neither is there a long term plan, nor does the annual budget cover important aspects like reviewing

ongoing activities, their usefulness and their effectiveness. In fact, even the finances of the hospital are not forecasted beyond the following year. The hospital thus exists on a year to year basis, without a concrete direction towards the achievement of objectives/goals. Its priorities keep on changing from year to year and it is involved more in overcoming immediate crisis rather than framing long term plans of action. In the words of Ms. Dalal, "To say that in India, public hospitals betray a conspicuous absence of planning is an understatement. In every branch of hospital administration, whether it is preparation of budgetary estimates, management of stores, indenting of drugs, maintenance and upkeep of costly equipment, personnel polices, patient care, or training of nurses, there is a neglect of planning and systems. The initiative for expansion has to be taken by hospital authorities and proposals communicated to the Commissioner, who places them before the Standing Committee, or the estimates are submitted to experts. This causes undue delay and sometimes leads to increased costs. Although expansion schemes may be planned, it is still done in an ad hoc fashion and overall lack of a system of planning, which takes into account routine as well as extraordinary development, persists".

8. Even when the budget estimates are incorporated in the budgetary proposals, these are incorporated almost exactly as they are sent by the various institutions. This style of budgeting is not appropriate for an organisation with such huge financial transactions.

9. Budgeting, in order to be a meaningful and useful technique, needs to be a co-ordinated activity, which enjoys the sponsorship and active involvement of all those who are a party to the process. In the hospital under study, budget estimates are prepared and consolidated by the clerical staff, with limited involvement of the departmental heads. The Dean is a little more than merely the presenting authority of the budget. Ideally, the budget making process should be carried out under the supervision of a financial officer, who exercises overall control and coordinates the budgeting process. In the hospital, even while the process is carried out by clerical personnel, it is fragmented to such an extent that the person preparing one part of it is not aware how the other parts are prepared. Hence, there is no overall supervision.

10. There is, to some extent, the presence of a tendency on the part of departments to 'pad up' the budgets. This was admitted by a departmental head who said that though in the past there was a tendency to pad up budgets upto 100%, this had now reduced to a great extent. As a consequence, a considerable amount of unutilised grants remins from year to year. Yet, the budgets for the forthcoming years are always proposed in relations to the budgets for the current/immediately preceding year, without considering the trend of actual expenditures, thus resulting into unutilised grants from year to year. While there could be a number of reasons for such a situation, going deeper and analysing the responses of the departmental heads on their perception of the 'cuts' in their budget requests (which is a psychological reason for padding up), it was found that many departmental heads felt that there was considerable cuts, with 40% feeling that these varied between 10-20% and 50% feeling that they varied between 20-50%.

11. Finally, the policy of flexibility, especially pertaining to the usage of unutilised grants for long periods beyond the budget year is detrimental to the budgetary control system. This, coupled with other loopholes in the policy, like the availability of sundry advances account for debiting non-budgeted expenditure and so forth, makes it appear as if the flexibility policy is more of an 'way-out' to bypass the system, rather than the built-in flexibility in the system itself. The question that arises at this point is whether this kind of flexibility is intended in the system design itself or it is a reaction to the system. The inference that can be drawn, favours the former possibility because as far as the usage of unutilised grants is concerned, it is a loophole in the Act itself, which provides that the items for which liability has been booked, can be expended in future periods. In fact, one can go to the extent of stating that the overall budget exercise does not in fact serve its purpose. One of the basic control purposes of the system - namely to compare and analyse variances - is not fulfilled. The formula followed by the Corporation is simple. Negative variances are simply not allowed because the Corporation would not release funds in excess of the approved budget. Positive variances in the form of under spending are welcomed by the Corporation. Thus, budgeting as a control device, is not very effective in the hospital.

ACCOUNTING CONTROL

(a) One of the most prominent features about the Corporation and thus the hospital is that it maintains

its accounts on 'cash' basis. Thus, all expenditures are accounted for in the year of payment and all incomes in the year of receipt. The Administration Reforms Committee appointed by the relevant State Government (viz., Maharashtra) some years back justified this 'cash' basis by commenting "A strict compliance (with the cash basis) is necessary to enable Government accounts to be closed annually and determine the surplus/deficit of the year. If this cash basis of accounts were not to be observed, the only other alternative would be to write them up on the basis of assets and liabilities which would be a very complicated and time consuming process. The accounts of any year, will have in that case to be kept open for years together."

(b) Another feature about the accounts of the government hospital under study is that it does not have an independent accounting entity:

(i) The statutory accounts of the hospital, as also all bills and vouchers, are maintained by the Chief Accountant of the Corporation.

(ii) Even at the Corporation level, no separate accounts are maintained for the hospital. Instead, these are merged with the accounts of other institutions, so as to formulate and present consolidated accounts of the Corporation. Similarly, all the assets owned by individual institutions are merged in order to present a consolidated assets statement of the Corporation. This implies that assets of capital nature, purchased by the Corporation for its institutions, and accounted for as and when paid (on cash basis) are merged and reflected as the assets of the Corporation.

(c) Since the hospital has no separate accounting entity, no separate records are maintained for its assets and liabilities. It is, therefore, very difficult to find out the total investment in the hospital in terms of its immovable and movable assets.

Implications of the Accounting Policy

By following the cash basis of accounting the Corporation has weakened the very foundation of its control system. In an earlier chapter, the merits and importance of the accrual concept have already been discussed. In its absence, it is not possible to get a correct picture on the state of affairs of the hospital, nor is comparison from year to year possible as the expenditures reflected in the accounts are not pertaining to a single accounting period.

The implications of the system on the motivation of employees is also significant. The hospital authorities are not in a position to determine and analyse the costs from year to year. Control is thus virtually impossible. This has the danger of promoting a tendency of indifference amongst hospital authorities towards cost effectiveness. The instrument of purposeful control is thus taken away from the hospital authorities defeating its very purpose.

Another implication of the accounting policy is that since depreciation is not included in costs, the total costs of the hospital are understated as depreciation would comprise a major cost component, considering the huge value of assets being used. In fact, as mentioned earlier, the total investment in the hospital is also not determined, thus making the task of forecasting replacement/maintenance costs from year to year a difficult exercise. Even the internal accounting information system adopted by the hospital loses its effectiveness as a control device in the absence of the accrual system of accounting.

In fact, for effective implementation of a performance budgeting system, accrual basis of accounting is a pre-requisite. Thus, in its absence, the performance budgeting system in the hospital seems like a mere formality.

In short, the accounting policy in the hospital does not provide a proper control base as it fails to adopt the accrual system of accounting, which as mentioned earlier, is the foundation for various control techniques.

AUDIT CONTROL

(a) The statutory audit of the hospital forms part of the statutory audit of the Corporation as a whole. The statutory auditor of the Corporation is appointed according to the provisions of the relevant Municipal Corporation Act wherein he is termed as the Municipal Chief Auditor. He audits the consolidated accounts of the Corporation and as far as the hospital is concerned, he conducts test checks to verify the accounts maintained by the Corporation.

(b) Apart from statutory audit, the Municipal Corporation also conducts internal audits of all institutions under the control and supervision of the Chief Accountant. This audit consists of a 100% check of the hospital's transactions. Amongst other things, the following details are verified:

- There exist budget provisions for utilised funds, duly authorised by competent authorities.
- Expenditures conform to relevant provisions of the Municipal Corporation Act and rules thereunder.
- Financial rules/regulations made by the Commissioner are adhered to.
- There exist sanctions accorded by competent authorities for authorising expenditures.

The internal auditor submits monthly reports to the Chief Accountant.

(c) A new concept recently introduced by the Municipal Corporation is that of Stock Audit. This concept is an extension of internal audit but deals specifically with inventories which constitute a major proportion of the Corporation's assets. Inspectors visit the institutions on surprise basis and check the records maintained to reconcile them with the actual stocks in hand. They also verify whether the systems as formulated by the Corporation are being adhered to by the institutions.

(d) Another aspect of audit introduced by the Corporation is in the area of quality control. This audit is also conducted on a surprise basis for a limited sample of the Corporation's transactions. A particular transaction is scrutinised in detail from its initiation to completion. The need for the expenditures, the purchase procedure, the allotment of tender, the quality of material received etc., are studied in detail. Amongst other things, it is also ensured that there exists no vested interest of any individual/s in making the purchase of a particular equipment or from a particular supplier. The audit team consists of a group of experts in all fields including finance, engineering, medicine, etc. This audit is conducted by a Central Quality Control body which operates at Corporation level.

AN APPRAISAL OF THE MANAGEMENT CONTROL SYSTEM IN THE HOSPITAL

A critical appraisal of the control system in the non-profit government hospital under study has been attempted hereinafter. Firstly, overall environment in the hospital, which is a pre-requisite of the control system, is discussed below.

(a) The hospital functions in an environment which is typical of a government undertaking, with its rigid rules and regulations and bureaucratic management.

(b) The hospital does not have a formal organisation structure, nor are there formulated job descriptions existing for the various categories of staff. The organisational relationships are thus unclear and to some extent there is overlapping of responsibilities.

(c) The hospital as an organisation does not have formulated mission, objectives, goals and strategies. There is no culture for long term planning for the overall direction for the hospital. Thus, the basic per-requirements of an effective management control system, namely structured organisational relationships, well formulated job descriptions and a defined set of objectives are absent in the hospital.

(d) Coming to the system itself, an important drawback is that there are neither indicators nor a formal system, for evaluating performances of the different departments and their contribution to the overall organisational goals. As a result of this, there is an attitude of indifference on the part of departmental heads towards their contribution to the organisation. Consequently, the

patients, especially those from a lower socio-economic background, who are the recipients of the hospital services, suffer.

An example of how such a situation can act upon the motivation of employees is narrated by Ms. Dalal as follows: “Evidence indicates that the professional staff do not offer their service in a uniform manner to everyone who presents himself, but make judgements about the worthiness of the person and the appropriateness of his demands and takes these judgements into account when performing the service. The majority of patients in the hospital OPD and in the wards as well, come from lower socio-economic background and some even from streets. How does that affect the doctor – patient relationship? A resident medical officer in the psychiatric OPD casualty observed that while electroshock therapy was frequently given in OPD, educated patients were generally given anesthesia prior to the treatment. When asked the reason for this differential treatment and why others were excluded from being given anesthesia, he casually replied that anesthesia was in short supply.”

It is because of the absence of a performance evaluation system that hospital employees can afford to adopt such a behaviour.

The above discussion reflects the general quality of services rendered by the hospital. It is, however, important to view the issue in the context of the constraints within which the hospital is required to function. For example, one indicator of measuring quality of service rendered is the death rate in the hospital, which is admittedly higher in the public hospitals rather than in the private hospitals. However, on this basis, it would not be proper to conclude that the municipal hospital provides ineffective service. The issue has to be seen in a different light. Private hospitals sometimes refuse to admit accident cases or cases where chances of survival of the patient are dim. All such cases are admitted in the municipal hospitals which being public bodies cannot refuse to take up such cases. It is not, therefore, surprising that the death rate in municipal general hospitals is high. Similarly, patients in the municipal hospitals are of the lower socio-economic section of society. They find even the hostel services provided at the hospital a luxury compared to those available in their homes. Getting these services free of charge, they are reluctant to vacate their beds and try to prolong their stay as long as they possible can. On the other hand, in the private hospitals, where the patients are paying for each day and every aspect of their stay, they are anxious in vacating their beds at the earliest. This psychology of the patients in each category plays an important role in the incident of highest stay periods in the government hospitals as compared to private ones.

Let us now look into the issue of the extent to which the system in the municipal hospital meets with the objectives of management control as discussed in a previous chapter, which is to ensure that the resources of the organisation are utilised effectively and efficiently towards achieving the overall organisational objectives. The characteristics of the control system in the hospital are first summarised below:

1. All the pre-requisites of an effective management control system are missing in the hospital.
2. There are no standards or input/output ratios to keep a check on the inputs per unit of output. Nor are there quality norms or any other indicators to evaluate performance.
3. There are no techniques like zero base budgeting or other techniques for relating the performing to the level of expenditure.
4. The basic foundation of any management control system, namely, the accrual basis of accounting is not adopted in the hospital.
5. Control techniques in the hospital lay more emphasis on procedures rather than on the purpose of the procedure.
6. The control activities are fragmented into a number of activities each one being handled by a head clerk. None of these clerks know what the others do and there is no responsible co-ordinating body to consolidate and monitor the budgets.

The implication of these occurrences, on the objectives of management control are as follows:

(a) The non-existence of efficiency or input/output ratios make it difficult to determine whether resources are being utilised in an efficient manner.

(b) Even the existing controls like budgeting are exercised in a conventional manner, wherein there exists no scientific basis for their formulation. Admittedly, a large proportion of the total financial requirements in the hospital is of a fixed nature, with 55% of its total cost being represented by establishment cost. But whether in the first place such a huge burden of staff cost is justified and, secondly, whether it is being efficiently utilised is a question which has very important consequences. Whether a staff strength of about 4000 is justified for a 1048 bedded teaching hospital, whether it is kept usefully employed in the organisational services, whether their performance is being monitored to ensure achievement of organisational goals? These are all very important questions to be considered. Further, the activity levels are neither monitored nor related to the financial requirements. The newly introduced concept of performance budgeting has a very limited role to play. The financial requirements are monitored against the sanctioned budget but no one looks into whether the activities were performed or not.

(c) The procedures established by the corporation do not necessarily ensure efficiency. As an example, let us look into the materials management in the hospital.

Poor inventory control often leads to either huge inventory blocked up in stocks or a situation of stock out. Though the hospital does have some kind of reorder levels and reorder quantities, the stores clerk himself admits that they are not of much use and are not adhered to by the hospital.

Wastage of drugs due to spoilage and expiry is another common issue in municipal hospitals. It is very important that drugs be issued by the stores to the ward and by the ward to the patient on a first-in, first-out basis. In the absence of this, the prevalence of wastage and huge quantities of expired medicine is inevitable.

The important lesson to be learnt from the above example is that just establishment of procedures is not enough. There should be enough monitoring and supervision to ensure that the procedures are properly implemented. What is even more important is that the employees should be motivated enough to follow the procedures for the sake of the purpose behind them. A situation where the procedure by itself becomes the purpose should be avoided.

Coming to the question of whether the control system achieves the objective of motivating all the departments towards working for the overall organisational goals, it is enough to say that the control techniques adopted by the municipal corporation are generally viewed as mere procedures which are required to be followed and have become little more than formalities that the hospital personnel fulfill because they do not have a choice.

As a conclusion, it can be said that a lot needs to be done with respect to making the management control system effective in the hospital. More importantly, the changes need to be effected right at the very top, namely, at the Municipal Corporation. Further, these changes represent strategic and policy changes that need to be made in order to have a more effective management control system not only in the hospital under study but in all the individual institutions and in the Municipal Corporation as a whole.

Comparative analysis of the two hospitals

The environment in the two hospitals is different. While the government hospital is characterised by a typical bureaucratic organisational environment, the private hospital is characterised by an informal environment. While the former has lengthy and rigid procedures covering each aspect of its management, the latter has minimum procedures and an environment in which decision making is quick. While delegation of authority is sometimes ineffective in the government hospital due to the fear of

concentration of authority in the hands of few, in the private hospital, there actually prevails a situation of concentration of authority in the hands of a few executives at the top level. While the private hospital is managed by a Board of Trustees and is influenced by its philosophy, the government hospital is in effect managed just like any other Government department.

HOSPITAL 'A' – ORGANISATIONAL STRUCTURE

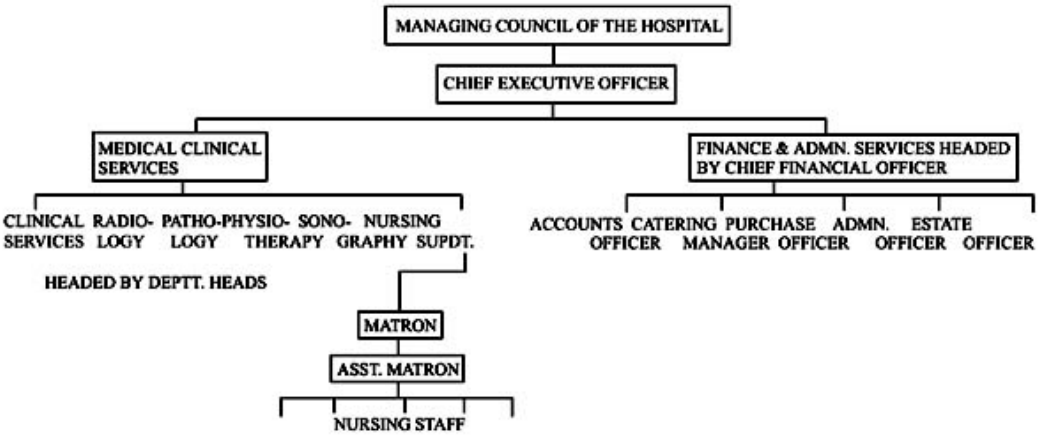

Fig. 4.1

THE BUDGET PROCESS

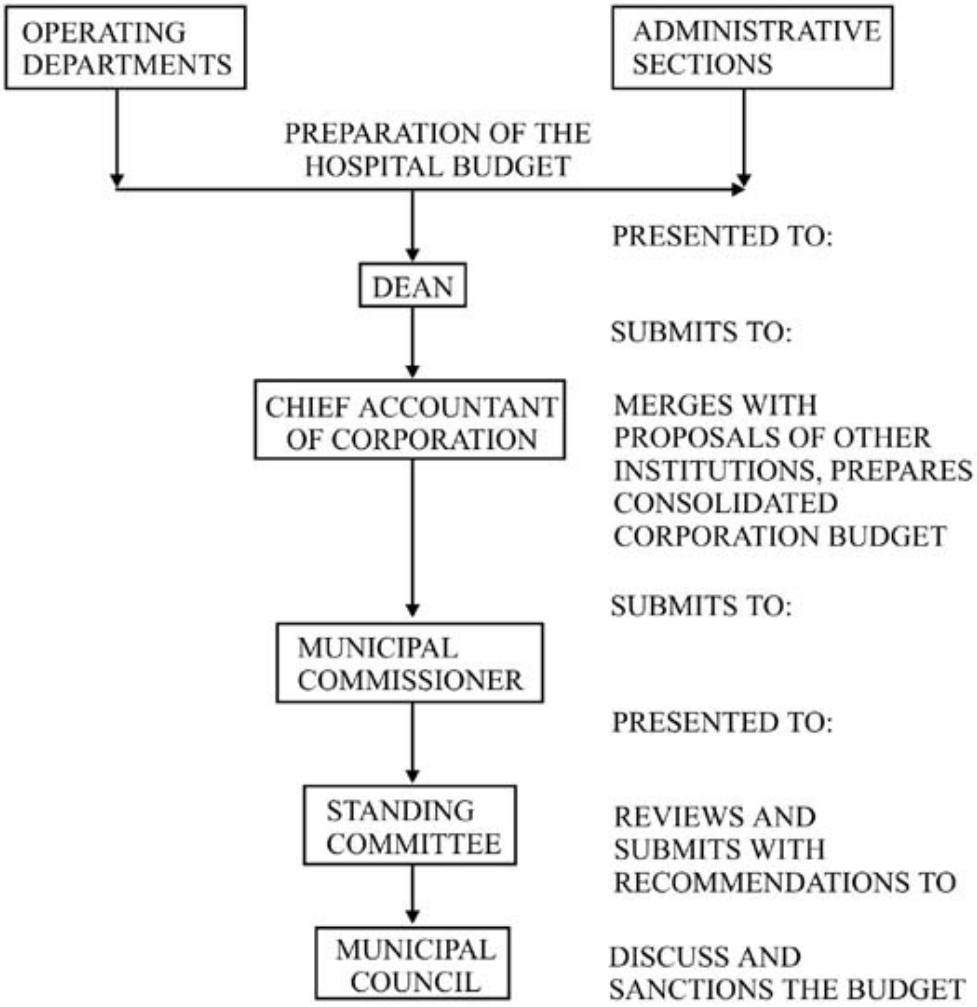

Fig. 4.2

PROCEDURE FOR PREPARATION OF BUDGET

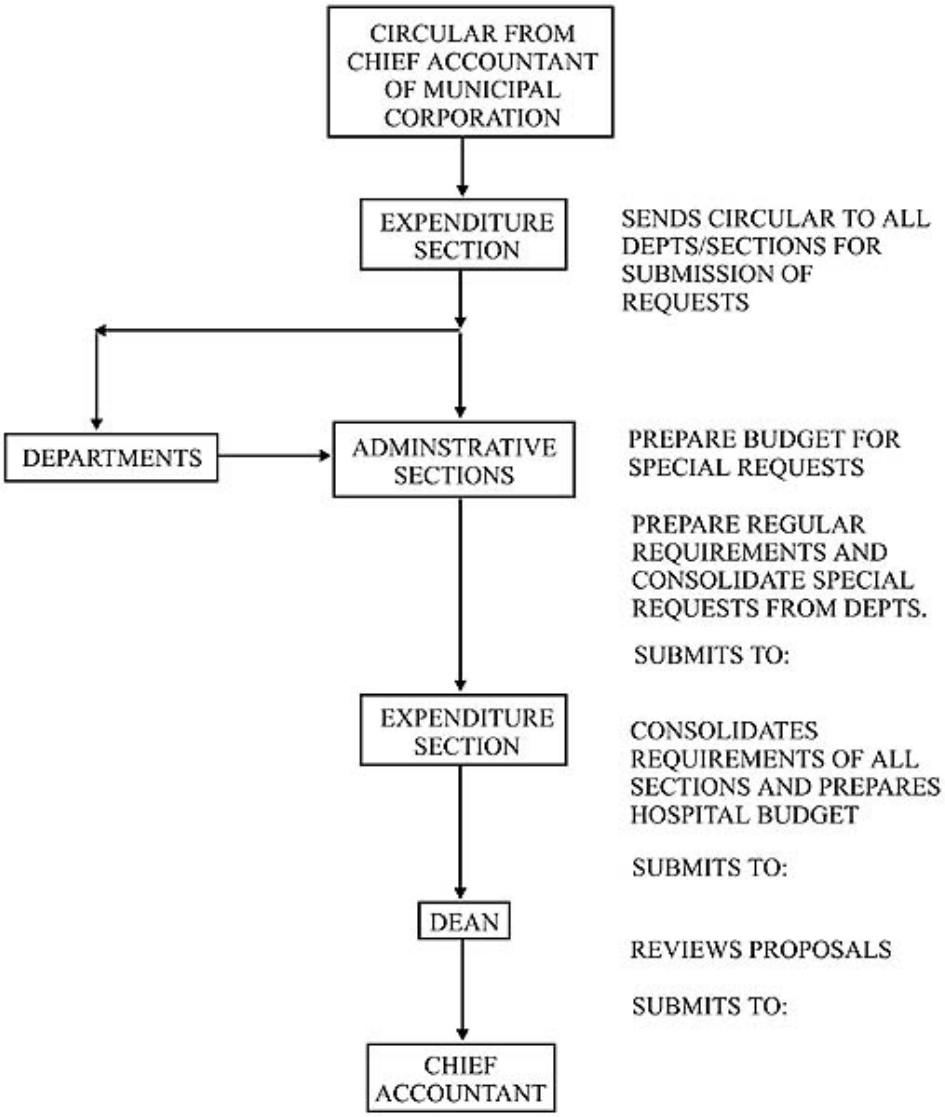

Fig. 4.3

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Management Control Systems in Non-Profit Organisations
With Special Reference to Hospitals

Contents > Summary and Conclusions

5
Summary and Conclusions

PART A: SUMMARY OF FINDINGS

PART B: SUGGESTIONS FOR IMPROVEMENT IN THE CONTROL SYSTEMS IN NON-PROFIT HOSPITALS

This chapter has been divided into the following two parts.

Part A: A summary of findings.

Part B: Suggestions for improvements in control systems in non-profit hospitals.

PART A
SUMMARY OF FINDINGS

The study was undertaken on the premise that non-profit organisations suffer from inadequate management control systems. A summary of findings on the basis of the study and available literature is produced below.

I. Non-profit hospitals in India can be divided into two broad categories, namely, the private and the government owned/supported hospitals. Although, most of the hospitals under both these categories come under the umbrella of non-profit hospitals, they are generally very different in the context of their organisational relationships and management. Both are, however, characterised by a feature common to most non-profit organisations, namely, inadequate management controls.

II. Hospitals are, by their very nature, a very complex group of organisations. They are generally characterised by the following features:

(i) Increasing sophistication in the concepts and techniques of medicine in recent times, resulting in a wide alteration in the scope of functions performed.

(ii) A consequent rise in the exceptions of society from modern hospitals.

(iii) Rapid progress in medical technology at such a pace that current procedures and technologies fast become outdated.

(iv) A consequent demand for increasing investment in the hospital industry, to meet the challenges of rapid advancements.

(v) Personalised nature of hospital services - the need for constant gearing to emergencies.

(vi) The existence of multiple goals.

(vii) The dominance of the medical profession.

(viii) The dual lines of authority.

(ix) Difficulty in evaluating quality of care.

(x) A lack of financial discipline and overemphasis on “service” in many non-profit hospitals.

III. Indian hospitals in the non-profit category are generally characterised by a number of unique features (which are in fact constraints) administrative and financial in their operations. Some of these which were found to be common in the private and government hospitals are as follows:

(a) Informal management; absence of formal organisational structures and ineffective delegation of authority; a general tendency of “Management by crisis”.

(b) A general absence of financial discipline and cost effectiveness. The dominance of the medical profession, their exaggerated emphasis on “service”, and the very fact that the organisations are “non-profit” in nature, go a long way in contributing to the prevalence of such a situation.

(c) Inadequate internal control systems contributing to ineffective management of resources.

IV. In the government hospital, the main characteristic is that it functions as a government department with similar procedures and regulations. The main constraints faced by such government hospitals are:

(1) Overcrowding.

(2) Inadequate and ineffective delegation of authority.

(3) Lengthy and cumbersome procedures.

(4) An attitude of indifference in the employees.

(5) A generally low morale amongst employees.

(6) A typically bureaucratic management and environment.

(7) Ineffective communication.

V. A single outstanding feature in the private hospital covered in this study is the threat to its financial viability. The inadequacy of such organisations to fund their development and growth is a result of faulty pricing policies, underutilised resources and inadequate management control.

VI. In the government hospitals the following were the observations in respect of existing scenario of management control systems.

(a) A basic factor adversely affecting the foundation of management control system is the cash basis of accounting which is not a sound basis, since it is not scientific. Thus, absence of accrual basis is one of the reasons for lacks of effective management control system.

(b) A general lack of planning was observed in all respects:

- Absence of long term planning in the development of the hospital (strategic planning).

- Absence of budget related planning.

- Absence of administrative planning like capacity scheduling, work load scheduling, pre-admission tests etc., which is essential to meet the challenge of overcrowding (Operational planning).

(c) Existing controls are implemented through lengthy procedures and rigid rules which cause unnecessary delays and inconvenience.

(d) The essence of control is lost. Most procedures are followed because they exist; the purpose behind the procedures being neither known nor appreciated.

(e) The organisation of the hospital is structured in a manner that makes effective control and coordination difficult.

(f) Inadequate involvement of departmental heads in the control process.

(g) It is generally felt that there is lack of monitoring and no accountability of performance.

(h) There are no formal appraisal techniques to evaluate performance and performance based incentives do not exist. Consequently, there is no motivation to perform.

(i) No norms or standards for quality or cost effectiveness.

(j) Generally inadequate administrative control.

In the private hospital studied the following were the findings:

(a) There is under-utilisation of facilities of the costly equipments in the hospital.

(b) Informal management.

(c) Concentration of authority in the hands of a few personnel.

(d) Inadequate internal control.

(e) Inadequacy of formal appraisal techniques.

(f) No operational planning in the form of pre-admission tests, capacity scheduling etc.

PART B
SUGGESTIONS FOR IMPROVEMENT IN THE CONTROL SYSTEMS IN NON-PROFIT HOSPITALS

Suggestions for making improvements in the management control systems in non-profit hospitals are briefly outlined below:

(A) A sound management control system should be preceded by sound strategic planning within the framework of which an integrated management control system should be operated.

(B) The management control system in a hospital should be implemented within the framework of a responsibility structure, constituted by well defined responsibility centres comprising cost as well as profit centres. The requirements for a responsibility structure to be effective are: -

- systems approach
- clear definition of the objectives of each responsibility centre
- effective delegation of authority
- controllability of costs as a basis for charging to responsibility centres.

(C) Having defined a framework for the implementation of a management control system, the performance of the hospital as well as the individual responsibility centres should be evaluated. Effective evaluation requires the measurement of both quantity and quality of outputs, as also cost effectiveness thereof. Each of these aspects are briefly dealt with below.

Quantification of Services

(i) A number of indicators are available for measuring the output of the individual responsibility centres as well as those of the hospital as a whole. Many of these can be conveniently adopted by the management of a medium sized hospital.

(ii) Apart from the above, there exist certain 'key' indicators like bed occupancy rate, inpatient admissions, outpatient attendances, number of operations and so forth, which can be used to closely monitor the overall activity levels in the hospital.

Quality of Care

(i) As far as quality of care is concerned, there are three aspects, viz.,

- Quality of physical facilities, both at responsibility centre and hospital levels, e.g., adequacy of space, level of hygiene and cleanliness, bed to personnel ratio and so forth.

- Quality of (technical) health care for which a number of criteria exist for the hospital as a whole as well as those suited to the technical nature of each responsibility centre like radiology, pathology and so forth. The concept of medical audit has emerged as an overall measure, covering a number of aspects to determine the adequacy or otherwise of the quality of medical care offered by a hospital.

- Quality of care includes factors like access to care, general attitude towards patients, arrangements such as patient scheduling to avoid patient waiting time and so forth.

Cost Effectiveness of Services

(i) This can be achieved by laying down, to the extent possible, cost effectiveness standards and establishing input-output relationships in a number of areas such as supplies cost with respect to cost per laboratory test, per bed day and so forth.

(ii) Apart from these and in cases where standards cannot be practicably applied, costs can be effectively monitored by applying good financial management principals and control techniques like zero base budgeting.

(iii) Capital costs must be closely monitored by having standard procedures for sanction as well as utilisation of funds.

(D) Having identified indicators to measure the quantity, quality and cost effectiveness of services, it is essential to integrate all these indicators so as to formulate an overall performance evaluation model in keeping with the objectives of management control in a hospital. The performance indicators should be balanced in a manner that ensures that no single aspect receives undue weightage due to any reason. This can be achieved by adopting a rating system that gives appropriate weights to the individual indicators.

(E) Having formulated the framework of the system by way of the responsibility structure and designed a performance evaluation model for the same, what remains is to establish an integrated control system. In this context, budgeting was found to be the most potent techniques, which can be designed in a manner that incorporates other control techniques like standard costing and break-even analysis. Various budgeting techniques like zero base budgeting and performance budgeting further enhance its utility as an overall control device.

The following further aspects in this regard may be kept in mind.

(i) Budgeting as a concept needs to be implemented within the framework of a long range plan which may extend upto five years.

(ii) The preparation of the annual budgets should be preceded by well defined budget guidelines and time schedules for various activities.

(iii) Furthermore, the actual preparation process should commence only after a review of existing performance and determination of the overall objectives and direction for the following year.

(iv) The preparation, review and approval procedures should be agreed upon in advance, to facilitate the administration of the budget process.

(v) The contents of the budget should include the following analysis for each responsibility centre and the consolidation thereof for the hospital as a whole:
- Objectives and targets
- Performance review
- Following years' targets and plan of action
- Detailed budget
- Future plans and projections

(vi) The contents should also include performance indicators proposed for the following year against which actual performance can later be evaluated.

(vii) The review of the budget should be made using, where possible, the principles of zero base budgeting, performance budgeting and break-even analysis.

(viii) Monitoring of the budget should take place by periodic reporting in prescribed formats which facilitate comparisons with the budget.

(ix) There should also exist a well formulated flexibility policy within the frame work of which the hospital should operate.

(F) The last and most important part of any management control system is the performance appraisal. Within the framework of the evaluation model, the performance of each responsibility centre and the hospital as a whole should be evaluated and mutually agreed incentives/disincentives may be granted.

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Appendix

QUESTIONNAIRE FOR CHIEF EXECUTIVES

A. General

1. How are non-profit hospitals different from profit seeking hospitals particularly in the areas of:

   a. Clinical operations.

   b. Organisation structure and relationships.

   c. Financial management.

   d. Adaptation to technological changes.

   e. Any other.

2. In what ways are these hospitals affected because of their non-profit nature, particularly in areas of:

   a. Quality of care.

   b. Cost of operations.

   c. Fees charged for services.

   d. Operating efficiency.

   e. Motivation of employees.

   f. Any other.

B. Overview of the hospital

1. Give a brief history of your hospital. Include a summary of important policy level/strategic changes that have taken place over the years and major achievements of the organisation.

2. Give a brief description of facilities available in the hospital. Also give details of

   a. Total number of beds.

   b. The bed mix viz., the classes of beds.

   c. What is the legal status of the hospital?

C. Mission, objectives of the hospital

1. What is the mission of the hospital?

2. What are its long term objectives?

3. What are the current (short term) issues faced by the hospital?

D. Organisational relationships

1. Give the organisation chart of the hospital. To what extent is the management and decision making process decentralised?

2a. Clearly defined the responsibilities and authorities delegated to various departments in the areas of:

   a. Clinical operations

   b. Finance

   c. Personnel management

   d. General administration of the departments

   e. Others

2b. Is there any overlapping in the responsibilities of different departments?

3. What are the goals of the individual departments in the hospital?

4. To what extent are departmental heads involved

   a. In the framing/reframing of these goals.

   b. In policy matters pertaining to their departments.

5. What are the incentives offered to departmental heads to achieve their goals?

6. What are the communication channels at different levels of management? Specify

   a. Formal channels like reports, periodicals, meetings, formation of committees etc.

b. Informal channels like grapevines, etc.

E. Staffing patterns

1. Enumerate the different categories of personnel in the hospital.

2. Are formal job descriptions and job specifications existing for senior officers/all departmental heads/managers?

3. Is on the job training provided to new recruits in the above areas?

4. Are there facilities for ongoing training and education in the form of seminars, deputation and conferences etc.?

5. What are the basis for promotions, increments etc.?

6. To what extent are problems of staff turnover and absenteeism prevailing in the organisation.

F. General functioning

1. Outline the patient routine in the hospital.

2. What is the capacity of the hospital in terms of available bed days?

3. What is the average occupied capacity in terms of occupied bed days?

4. What are the average activity levels of the different OPD departments?

5a. What is the average length of stay of patients in hospitals and how does this compare with those in other hospitals?

5b. What are the average number of visits per patient per day?

6. What is the break-even point of the hospital at present?

7. What percentage of expenditure does the hospital recover at present?

8. Give the performance level of the hospital of the last year in terms of

a. Comparative expenses

b. Comparative income

c. Comparative surplus (deficit)

d. Comparative occupied bed days

e. Comparative occupancy

f. Comparative admission

g. Comparative average length of stay

h. Comparative outpatient visits

i. Comparative staff position (Comparison of budget with actuals).

G. Managing committee

a. Give the size and composition of the committee.

b. How is appointment of committee members made?

c. How often does the committee meet?

d. Which are the various sub-committees formed?

e. What are the matters generally dealt with by the committee?

f. What are the reports received by the committee?

g. To what extent are the members involved in the day to day functions of the hospital?

G. Evaluation of performance

1. What are the social and other indicators to measure the impact of services rendered by the hospital?

2. On what basis are the performances of the different departments measured? Specify the criteria used.

3. What are the input/output ratios used for the different departments?

4. What are the measures taken by the management to ensure quality of care at all levels?

5. Is the quality of care different for paying and non-paying patients?

6. How does the management arrange for feedback from patients on their perception of the services provided by the organisation?

7. How does the hospital measure the effectiveness and efficiency of its performance in the following areas:

   a. Capacity utilisation

   b. Cost effectiveness

   c. Quality of care provided

   d. Assets management

   e. Clinical efficiency

   f. Human resources management

   g. Administrative performance

8. At what level are standards of performance ascertained and who initiates changes?

9. How does the organisation ensure that the individual departments work toward achieving overall organisational goals?

SUPPLEMENTARY QUESTIONNAIRE FOR CHIEF EXECUTIVE OFFICERS

1. What phrase most accurately describes the hospital's values with respect to the outside world?

   a. Don't rock the boat.

   b. Roll with the punches.

   c. Plan ahead.

   d. Dream ahead.

2. How does the hospital react to advances and changes in management techniques?

   a. Does nothing.

   b. Rejects or resists changes.

   c. Adapts to changes.

   d. Seeks changes.

   e. Anticipates changes.

3. What phrase best describes the hospital's position with respect to keeping abreast of advances in medical technology?

   a. Does not attempt to keep pace with new advances.

   b. Lags behind other hospitals.

   c. Follows the leader.

   d. Responds quickly to new technology and is usually the leader in the market.

4. What is the hospital's financial strategy?

   a. Seeks new sources of revenue through diversification.

   b. Seeks institutional financing.

   c. Seeks local donations.

   d. Any other (specify).

5. What is the hospital's growth strategy?

   a. Exists gracefully.

   b. Maintains the present position.

   c. Increases the market share of present services in its traditional service area.

   d. Grows selectively, specialises in certain services, or caters to different markets.

   e. Diversifies by adding new services.

   f. Pursues vertical integration, e.g., more primary care, outreach services, long term care.

g. Converts the hospital as underutilised capacity to another use.

h. Closes the facility.

6. What are the two/three most drawing forces behind the hospital's present direction?

a. Traditions and past success.

b. Outside sanctions and incentives.

c. Results (e.g. finance, quality of care).

d. Services offered.

e. Market forces including keeping up with competition.

7. Which three resources are key to the hospitals success?

a. Medical staff.

b. Managerial expertise.

c. Finances.

d. Physical plant/facilities.

e. Reputation.

f. Political clout.

g. Community support.

8. What are the basis for determining quality of care at the hospital?

a. Adequacies of facilities and equipment.

b. Quality of nursing care and performance.

c. Quality of medical staff and physician performance.

d. Organisational coordination and management.

e. Overall patient care and patient reaction.

f. Comparable overall care when compared to other hospitals.

9. In what research activities is the hospital involved?

a. No research activity.

b. Limited clinical research.

c. Broad array of basic and clinical research programmes.

d. Cooperates with a university or research institute.

QUESTIONNAIRE FOR FINANCE OFFICER

1. What are the techniques used in your hospital to ensure financial control?

Budgeting

1. Are the following types of budgets prepared by the hospitals?
    a. Master Budget.
    b. Cash Budget.
    c. Staff Budget.
    d. Purchase Budget.
    e. Income Budget.
    f. Administration Budget.
    g. Capital Expenditure Budget.
    h. Activity Budget, e.g., capacity utilisation in bed days, activity level at OPD etc.
    i. Performance Budget.
2. Is the budget prepared within the framework of
    a. Budget manual?
    b. Budget time table?
3. Outline the procedure for the preparation of the budget.
4. What are the basis for fixation of targets for the following year?
5. At what level in the organisation are performance standards fixed?
6. Are department budgets prepared by departmental heads and approved by a budget committee?
7. On what basis are incomes and expenses of individual departments determined?
8. How are department budgets reviewed?
9. Are there major budget cuts? If yes, why?
10. Is the technique of zero based budgeting recognised while reviewing budget proposals?
11. Are expenses/incomes related to units or activity?
12. What are the checks introduced to ensure cost effectiveness by departmental heads?
13. How are requests for fresh investments/programmes reviewed?
14. Are cost benefit analysis carried out?
15. Are programme budgets for multi year proposals prepared?

16. How are budgets of service/non-revenue generating departments reviewed?

17. In final stages of review are budgets “negotiated” with departmental heads?

18. Is the overall budget evaluated against long term plans of the hospital?

19. Does the budget committee scan the environment for opportunities before finalising the budget?

20. How often are actual performances reviewed against budget targets and by whom?

21. What are the incentives offered for favourable variances and disincentives for unfavourable ones?

22. What level of flexibilities are allowed within the framework of the approved budget?

Responsibility Accounting

1. Outline the overall responsibility accounting structure of the hospital.

2. Give the design of the overall plan and indicate whether responsibility centres are cost centres, profit centres or investment centres.

3. Which are the expenses directly charged to the individual centres?

4. How are they determined?

5. Which are the indirect expenses allocated to individual centres?

6. What are the basis for allocation?

7. Are distinctions made between controllable and uncontrollable costs while

   a. allocation/charging of expenses.

   b. evaluating performance of the centres.

8. Are the centres made accountable only for controllable costs?

9. On what basis are performances of individual centres evaluated?

10. How are inter-unit services priced?

11. Are break-even points for individual centres determined?

12. If yes, how are fixed cost, variable costs and semi variable costs demarcated?

Accounting, Auditing and Internal Control

1. (a) What are the various books of account maintained by the hospital and (b) what is the basis of accounting?

2. What is the billing procedure followed by the hospital.

3. How are expenses approved for payment?

4. Are the heads of accounts formulated in a way that facilitates comparisons with budgets?

5. How are purchases made?
6. How are inventories controlled? Is VED analysis carried out periodically?
7. Which are the financial statements prepared?
8. Are monthly accounts submitted to the Managing Committee?
9. How are incomes of various departments accounted and recorded?
10. Are cross checks made to ensure proper accounting of income/ expenses?
11. Is internal audit carried out? If yes, briefly describe its scope and manner of its conduct.
12. What are the reports submitted to the management?
13. What is the scope of the statutory/ financial audit and what are the statutory reports prepared?

Pricing of services and sources of funds

1. What is the overall philosophy of the pricing policy of the hospital?
2. What percentage of services are provided?
   a. above cost
   b. at cost
   c. below cost
   d. free.
3. What are the basis for giving free/ subsidised services?
4. To what extent and what "relevant" costs are taken into account while determining charges?
5. Is the use of Cost Volume Profit analysis made while effecting pricing decisions?
6. Is the quality of service different for paying and non-paying patients?
7. What percentage of expenditure is funded by income?
8. To what extent is the hospital dependent on donations as a source of fund?
9. Does donation as a source of fund have an impact on the pricing policy?
10. Whether the hospital has a long range plan to improve its financial viability?
11. Whether the hospital uses institutional financing as a funding source? If yes, to what extent? What are the limitations of this source of funds?

QUESTIONNAIRE FOR DEPARTMENTAL HEADS

Please answer each of the following questions to show how you feel about the various characteristics of your organisation. You can do this by encircling the answer which best describes your opinion.

1. To what extent do you understand the goals of the organisation?

a. To a very large extent.

b. To a large extent.

c. To a fairly good extent.

d. To some extent.

e. I do not understand at all.

2. To what extent do you accept the goals of the organisation?

a. To a very large extent.

b. To a large extent.

c. To a fairly good extent.

d. To some extent.

e. I do not accept at all.

3. To what extend does each member of the organisation feel the responsibility for achieving the organisational goals?

a. Personal at all levels feel the responsibility to implement the goals.

b. Substantial portion of personnel feel.

c. Higher management feels only, middle and lower none.

d. Middle management feels only, higher and lower none.

e. Lower management feels only, higher and middle none.

4. You feel that the goals of your own department are

a. Extremely well defined.

b. Very well defined.

c. Well defined.

d. Not too well defined.

e. Not at all well defined.

5. Your participation in framing the goals of your department is

a. Extremely active.

b. Very active.

c. Active.

d. Not too active.

e. There is no participation.

6. Your involvement in policy decisions pertaining to your department is

   a. Extremely active.

   b. Very active.

   c. Active.

   d. Not too active.

   e. There is no participation.

7. When you think of the total organisational environment you feel it is

   a. Free, supportive, respect for differences.

   b. Somewhat free and supportive.

   c. Little restrictive, some pressure.

   d. Restrictive, some pressure for conformity.

   e. Restrictive, pressure for conformity.

8. The top management knows and understands the problems faced by the departments

   a. Strongly agree.

   b. Agree.

   c. Don't know.

   d. Disagree.

   e. Strongly disagree.

9. In solving problems, top management generally tries to get the departments' ideas and opinions and makes constructive use of them

   a. Strongly agree.

   b. Agree.

   c. Don't know.

   d. Disagree.

   e. Strongly disagree.

10. How good is the management at handling people in general?

    a. One of the best.

    b. Better than most.

    c. About average.

d. Not as good as most.

e. One of the worst.

11. How well do you understand and accept the goals of other departments?

a. Understood, accepted, coordinated and supported.

b. Understood, accepted, coordinated but not supported.

c. Understood, accepted but not coordinated and supported.

d. Understood but not accepted, coordinated and supported.

e. Neither understood nor accepted.

12. How well informed are you kept about what is going on in other departments?

a. Very well informed.

b. Relatively well informed.

c. Quite well informed.

d. Not very well informed.

e. Not at all well informed.

13. The departmental heads have a lot of respect for each other

a. Strongly agree.

b. Agree.

c. Don’t know.

d. Disagree.

e. Strongly disagree.

14. The departmental heads know and understand problems faced by each other

a. Know and understand very well.

b. Know and understand relatively well.

c. Know and understand quite well.

d. Have some knowledge and understanding.

e. Have no knowledge and understanding.

15. The direction of information flow in our organisation is

a. Downward.

b. Mostly downwards.

c. Always downwards.

d. Down and up.

e. Down and up and with peers.

16. Extent to which downward communications are accepted by departmental heads:

a. Always accepted and followed.

b. Generally accepted.

c. Accepted with some resistance.

d. Accepted but strongly resisted.

e. Mostly resisted.

17. The management insists that departments follow standards ways of doing things in every detail

a. Never.

b. Seldom.

c. Sometimes.

d. Frequently.

e. Usually.

18. The management gives recognition and credit for good performance

a. Strongly agree.

b. Agree.

c. Undecided.

d. Disagree.

e. Strongly disagree.

19. How much trust and confidence do you think the top management has in departmental heads?

a. Complete confidence and trust in all activities.

b. To a large extent.

c. Some, but management keeps control on decision.

d. Like that of a master servant.

e. Has no confidence and trust.

20. How hard do you think the organisation is trying to improve its ways of doing things?

a. As hard as it possibly can.

b. Quite hard.

c. Fairly hard.

d. Not very hard.

e. Not trying at all.

21. How do you feel after making a suggestion to other departmental heads?

a. Very good. They always consider my ideas carefully.

b. Fairly good. They show real interest.

c. Good enough. They show some interest.

d. Not too good. They show little interest.

e. Pretty bad. They seem to resent suggestions.

22. How well do you think the management knows the workings of the departments?

a. Thoroughly.

b. Quite well.

c. Well enough.

d. Not too well.

e. Not well at all.

23. To what extent do you feel you have autonomy in the clinical operations of your department

a. Complete autonomy.

b. Relatively high degree of autonomy.

c. Moderate degree of autonomy.

d. Not too much autonomy.

e. No autonomy at all.

24. The authority delegated to you in the financial operations of your department is

a. More than adequate.

b. Adequate.

c. Undecided.

d. Relatively inadequate.

e. Very inadequate.

25. The administrative responsibility, e.g., periodical budget reports, pertaining to staff etc., delegated to

you is

a. More than adequate.

b. Adequate.

c. Undecided.

d. Relatively inadequate.

e. Completely inadequate.

26. How many functions do you perform, which you consider relatively unimportant or unnecessary?

a. Most of them.

b. Quite a few.

c. Few.

d. Very few.

e. None.

27. The performance of your administrative responsibility obstructs the performing of your own basic functions

a. Strongly agree.

b. Agree.

c. Don't know.

d. Disagree.

e. Strongly disagree.

28. How often do you feel you are using your full capability in the performance of your job

a. Almost always.

b. Very often.

c. Often.

d. Not very often.

e. Almost never.

29. How much say do you have in the overall operations of the department?

a. Unlimited amount.

b. Very large amount.

c. Large amount.

d. Very little.

e. None.

30. How frequently has your department achieved recognition for its achievement?

    a. A great many times.

    b. Very often.

    c. Quite often.

    d. Seldom.

    e. Almost never.

31. The organisation gives a lot of opportunities for learning and personal development

    a. Strongly agree.

    b. Agree.

    c. Don't know.

    d. Disagree.

    e. Strongly disagree.

32. These are amply rewarded?

    a. Strongly agree.

    b. Agree.

    c. Don't know.

    d. Disagree.

    e. Strongly disagree.

33. The equipments in your department are technologically updated

    a. Strongly agree.

    b. Agree.

    c. Don't know.

    d. Disagree.

    e. Strongly disagree.

34. The equipments in your department are underutilised

    a. Strongly agree.

    b. Agree.

    c. Don't know.

d. Disagree.

e. Strongly disagree.

35. The quality of care provided in your department is as good as that in other hospitals

a. Strongly agree.

b. Agree.

c. Don't know.

d. Disagree.

e. Strongly disagree.

36. In general, the level of performance in your department is upto the mark

a. Strongly agree.

b. Agree.

c. Don't know.

d. Disagree.

e. Strongly disagree.

37. The measures applied to evaluate the performance of your department are, well defined and correctly assess the performance

a. Strongly agree.

b. Agree.

c. Don't know.

d. Disagree.

e. Strongly disagree.

38. The management motivates the departmental heads to achieve organisational goals

a. Strongly agree.

b. Agree.

c. Don't know.

d. Disagree.

e. Strongly disagree.

39. Your departmental goals sometimes conflict with overall organisational goals.

a. Strongly agree.

b. Agree.

c. Don't know.

d. Disagree.

e. Strongly disagree.

40. You are generally happy with the budgeting process in the organisation

a. Strongly agree.

b. Agree.

c. Don't know.

d. Disagree.

e. Strongly disagree.

41. Your participation in setting the targets for your department is active

a. Strongly agree.

b. Agree.

c. Don't know.

d. Disagree.

e. Strongly disagree.

42. The targets set for your department are easily attainable

a. Strongly agree.

b. Agree.

c. Don't know.

d. Disagree.

e. Strongly disagree.

43. Are standards fixed for income/expenses per level of activity

a. Always.

b. Almost always.

c. Quite often.

d. Not too often.

e. Never.

44. The expenses allotted to your department, e.g., supplies, staff cost etc., are directly controllable by you

a. Always.

b. Almost always.

c. Quite often.

d. Not too often.

e. Never.

45. Cost control is part of your departmental goals

a. Strongly agree - It always is.

b. Agree - But it is not a priority issue.

c. Don’t know - I can’t understand costs.

d. Disagree - It is the job of the finance department.

e. Strongly disagree - Costs are unimportant when service is the motive.

46. Requested budget sanctions are easily accepted

a. Strongly agree.

b. Agree.

c. Don’t know.

d. Disagree.

e. Strongly disagree.

47. Are budget requests thoroughly reviewed by you and justifications prepared before onward submission?

a. Always.

b. Almost always.

c. Quite often.

d. Not too often.

e. Never.

48. Are cost-benefit analysis carried out before requests for fresh sanctions are made

a. Always.

b. Almost always.

c. Quite often.

d. Not too often.

e. Never.

49. Are budget proposals jointly reviewed by you and the top management before approval

    a. Always.

    b. Almost always.

    c. Quite often.

    d. Not too often.

    e. Never.

50. Do you find it difficult to restrict your costs within the framework of your budget

    a. Always.

    b. Almost always.

    c. Quite often.

    d. Not too often.

    e. Never.

51. Are ‘cuts’ made by the management from the budget requests submitted by you

    a. Always.

    b. Most often.

    c. Quite often.

    d. Not too often.

    e. Never.

52. How big are the cuts

    a. None.

    b. Around 10%.

    c. Between 10-20%.

    d. Between 20-50%.

    e. More than 50%.

53. Are you allowed “flexibility” in the budget sanctions granted to you

    a. Most always.

    b. Most often.

    c. Quite often.

d. Not too often.

e. Never.

f. If as per rules, specify.

54. How often do you compare actual performance with budgeted targets

a. Every week.

b. Every month.

c. Every quarter.

d. Half yearly.

e. Only at the end of the year.

55. How often do you submit report of variances to the management

a. Every week.

b. Every month.

c. Every quarter.

d. Half yearly.

e. Only at the end of the year.

56. How often are you satisfied with the performance of your department

a. Always.

b. Most often.

c. Quite often.

d. Not too often.

e. Never.

57. How often does your department meet its targets

a. Always.

b. Most often.

c. Quite often.

d. Not too often.

e. Never.

58. Does management provide incentives for favourable performance and disincentives for unfavourable

a. Always.

b. Most often.

c. Quite often.

d. Not too often.

e. Never.

59. Does provision/non-provision of incentives affect the working of the department in any way

a. Always.

b. Most often.

c. Quite often.

d. Not too often.

e. Never.

60. Achievement of targets proves a motivating factor for the working of your department

a. Strongly agree.

b. Agree.

c. Don't know.

d. Disagree.

e. Strongly disagree.

BUDGET BEHAVIOUR VARIABLES - ENCIRCLE THOSE APPLICABLE TO YOU

1. I start preparing the budget for my unit before I am asked to.
2. I spend time outside of normal working hours preparing the budget for my unit.
3. I am not able to spend as much time as I would like, preparing the budget for my unit.
4. I work with my subordinates in preparing the budget for my unit.
5. I work with other unit heads in preparing the budget for my unit.
6. I work with financial staff in preparing the budget for my unit.
7. I am consulted about special features I would like to have included in the budget prepared.
8. New budgets include changes I have suggested.
9. The budget is not finalised till I am satisfied with it.
10. Preparing the budget for my unit requires my attention to a great number of details.
11. I am reminded of the importance of meeting the budget for my unit.

12. I am evaluated on my ability to meet the budget for my unit.
13. I have difficulty in meeting the budget for my unit.
14. I am shown comparisons of actual and budgeted performance of other units.
15. My explanation of budget variance is included in performance reports.
16. I go to my superior for advice on how to achieve my budget.
17. My methods of reaching budgeted performance are accepted without questions.
18. My superiors call me to discuss variations from the budget.
19. My superiors express dissatisfaction to me about results in my units when budgets have not been met.
20. My superiors mention budgets when talking to me about my efficiency as a Manager.
21. I ask for assistance from staff departments concerned with budgeting.
22. I am required to submit an explanation in writing about causes of large budget variances.
23. I use the budget to plan activities in my unit.
24. I personally investigate budget variances in my unit.
25. I am required to trace the cause of budget variances to groups or individuals within my unit.
26. I am required to report actions I take to correct causes of budget variances.
27. I find it necessary to stop some activities in my units when budgeted funds are used up.
28. I find it necessary to charge some activities to other accounts when budgeted funds for these activities have been used up.
29. I have to shift figures relating to operations to reduce budget variances.
30. Budget matters are mentioned in informal conversations.
31. I express my opinions on budget matters.
32. I offer suggestions for improvement of budget systems.
33. The budget system is changed in accordance with my suggestions.
34. I discuss budget matters when problems occur.
35. The budget enables me to be more flexible.
36. The budget enables me to be more innovative.
37. The budget enables me to keep track of my success as a manager.
38. The budget enables me to be a better manager.

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