Better Informed Judgements: Resource Management in the NHS

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"Resource management" is a crucial ingredient in probably the most significant changes to have affected Britain's National Health Service (NHS) since it was established. These changes result from proposals for an internal market in health care involving both the NHS and the private sector. The central principle was that providers of health services should not be identical to those who are administratively and legally responsible for provision. These reforms, published as *Working for Patients* (DoH, 1989a) were to increase "accountability upwards" and "to provide incentives so that money would flow to those hospitals which treated most patients" (p. 11).

The proposals relied crucially on expanding the Resource Management Initiative (RMI) of the 1980s. This, the Government said, was "the best way to remedy" the chief obstacle to its proposals, namely that the NHS had "only a limited capacity to link information about the diagnosis of patients and the cost of treatment" (DoH, 1989a, p. 16). This information was necessary if the proposals were to mean that money *could* flow to those hospitals that treated most patients.

Similar proposals were also made for the social and community-based services provided by local authorities and voluntary organizations (DoH, 1989b). Together, these proposals were combined into the NHS and Community Care Act 1990. Under this legislation, health authorities and local authorities retain their statutory obligations but shed responsibility for service delivery. Instead, they purchase services from providers who compete with each other (and with private and voluntary providers) for the services they require. Hospitals and community services were encouraged to opt out of the NHS to establish themselves as self-governing trusts (SGTs) and doctors in general practice (GPs) were encouraged to take control over their own budgets. While political and social sensitivities may prevent these arrangements from resembling a "genuine market" (Hudson, 1992), these changes require the ever closer specification of costs and quality of service so that contracts between purchasers and providers can be drawn up. To date, the necessity of these services to develop adequate cost information is underdeveloped (Bryan and Beech, 1991; Lapsley, 1991; Mullen, 1991; Royce, 1993). This is certain to involve everyone in health care, in the NHS and beyond, throughout the 1990s. Earlier experience of the RMI has, therefore, a continuing importance for the 1990s.

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This article is concerned with that experience and its contemporary relevance; exploring the implementation of accounting and management control systems into organizational life. After setting out these themes, the article will outline the development of the RMI and will then examine the efforts made almost independently in the North West Region, where the need to develop resource management was judged equally pressing. It draws on research conducted in this Region during 1985-89. The probability of this experience being repeated in other health districts is reinforced by the experience of an SGT during 1992-93, as the legislation was put into effect. For reasons of confidentiality, this will be denoted by a pseudonym: "Westcountry Health Trust".

Accountability and Health Care

To appreciate the accountability effects of market-based reforms on medical activity, we must be mindful of the fact that medicine has been regarded as a benevolent force in society and has secured important privileges. In particular, rights of clinical autonomy meant the work of doctors could only be assessed by other members of the profession, according to whether it was within accepted standards of treatment and ethics. Decisions to treat, over forms of treatment, and over treatment duration remained relatively free of accountability outside the profession.

Professional autonomy was reinforced by the inability to challenge claims that the profession scrutinized and regulated medical practice. Accountability might justifiably encompass some assessment of *diagnostic* procedures, the *treatments* that follow diagnosis, and the *outcomes* of treatment. Given professional autonomy, however, the only information available that could justify medical intervention were mortality and morbidity statistics.

The construction of these indicators of the need for health care rewards some attention. They depend crucially on clinical diagnoses of physical abnormality. However, diagnosis is but one stage in a complex process where medical practitioners define what is normal functioning. Individuals differ over what they consider "good" health or normal for their age, status, gender, social norms, etc. (Blaxter, 1990). They may wait until they feel compelled or seek medical help as soon as they feel justified. Their decision to seek medical help is affected by work circumstances and domestic responsibilities (Parsons, 1970). Furthermore, employment rates and individual judgements by a doctor over their patient's suitability for work are crucial when sickness notes are a major source of morbidity statistics (Butler and Vaile, 1984). External scrutiny, therefore, relies on statistical information which objectifies the diagnostic process: a process involving social, legal and moral judgements.

Rather more is concealed about the need for medical intervention and health care than this information can reveal. The need for treatment following diagnosis also requires scrutiny. Any decision to treat involves continual judgments over the accuracy of tests, the course of the illness with and without treatment, and the patient's ability (willingness) to be treated. There are risks in

any treatment and, aside from undesired effects or nil effects, the value of a "successful" outcome of treatment will differ for each individual (Dowie and Elstein, 1988). The relationship between treatment and outcome is also rarely subject to effective scrutiny (Fischoff *et al.*, 1980). If vast areas of clinical practice are never subject to outside scrutiny, there is also evidence to suggest that these procedures are rarely scrutinized by the professions involved. Wide discrepancies have been found, for instance, between medical diagnosis and autopsy results but checks on diagnosis are rare (McGoogan, 1984).

With inadequate information about the need for health care, challenges have been made to medicine's claims of effectiveness and benevolence. Its ineffectiveness in dealing with chronic conditions has been well-documented (Kennedy, 1981; McKeown, 1979). Improvements in income, housing, and in working conditions are all considered a greater contribution to decreased morbidity than medicine. Medicine has proved powerless to deal adequately with certain infectious diseases such as AIDs. Medicine's benevolence has been challenged by feminists (Arditti *et al.*, 1984; Ehrenreich and English, 1979; Ehrenriech, 1978), Marxists (Cousins, 1987; Doyal and Pennell, 1979; Navarro, 1980), and those more generally concerned with the degree of professional status in contrast with the precarious status of patients (Elston, 1991; Freidson, 1968; 1970a, 1970b; Illich, 1975; Johnson, 1972).

Despite the broad range of accountability issues raised by these criticisms, medicine has been challenged on the much narrower front of costs by politicians, administrators and health policy analysts. Expenditures have risen over the years, particularly in the acute sector of health care, along with public expectations of what scientific medicine can achieve. Increased costs and expectations have been perceived by successive governments to have risen to ungovernable or crisis proportions (Klein, 1989).

Professional judgement was the sole criterion for allocating health care resources (Crossman, 1972; Ham, 1982; Haywood and Alaszewski, 1980; Hunter, 1979; Parry and Parry, 1976; Wilding, 1982). Government and parliament had little effective means of scrutiny and sanction (Butts *et al.*, 1981; Haywood and Alaszewski, 1980). Nevertheless, medicine's legitimacy to dominate health care decision-making and the rationalities used by medicine were increasingly questioned (Elston, 1991; Phillips and Dawson, 1985).

The ability of hospital medical practice and clinical medicine to define health care policy has meant that action to reduce environmental and social aspects of health are almost totally excluded from the NHS. Thus, vast expenditures go on researching cures for relatively minor killers in the full knowledge that any amount of national effort to reduce environmental hazards or social inequalities, particularly child poverty, would reduce illness more significantly (Best *et al.*, 1977; Black, 1988). Ironically, governments have regarded change here as unrealistically expensive (Black, 1988, pp. 1-32).

So, in summary, while health needs are uncertain and medicine's claims to respond are perhaps exaggerated, health care costs have risen and have proved resistant to attempts to restrain them. For UK governments this has been

associated with an inability to direct expenditures within the overall health care programme budget. In turn, this is perceived to be because medical power has unduly influenced allocation and planning mechanisms. Government policy has, therefore, increasingly been driven by the need to challenge medical power through more sophisticated planning and costing systems (Bourn and Ezzamel, 1987; Klein, 1989; Lapsley, 1991).

Health Service Accountability: Finance, Costs and Planning

In the 1950s a department-based costing system was introduced throughout the NHS which expressed expenditures at highly aggregated levels such as nursing, catering, building maintenance, etc. This "functionally-based" mechanism survived throughout the 1960s, 1970s and 1980s.

A variety of experiments with other forms of budgeting and costing, based on specialty costing or patient costing, were tried out on a small scale by individual health districts during the 1970s (Wickings *et al.*, 1983). Further development of these was endorsed by the Perrin report to the Royal Commission on the NHS (1978). As Perrin has noted, the RMI should be seen as one of a number of developments concerned with clinical management budgets, such as Clinical Accountability, Service Planning and Evaluation (CASPE), Financial Information Project (FIP), Körner, and Griffiths (1989). The influential Körner Committee proposed that the NHS should no longer base its cost assumptions on length of stay, but should take account of the different costs associated with patients' health conditions (NHS/DHSS, 1982, 1984). From there, enthusiasm grew in support of using a patient classification system developed in the USA to reimburse hospitals for Medicare patients. This classified patients by their diagnosis into 468 categories known as Diagnostic Related Groups (DRGs). Although the UK has no tradition of patient charging, DRGs were perceived as a useful complement to "improved information about the resource consequences of alternative patterns of care" (Bardsley *et al.*, 1987).

Despite these developments, functionally-based costing mechanisms survived as common practice until preparation began for the NHS and Community Care Act 1990. However, pressure for change had begun in 1982 when the Conservatives effectively broke apart the existing bureaucratic and corporatist structures. Units of Management were established and encouraged to take responsibility for their own budgets within new district health authorities (DHAs). Soon after reorganization, the Government expressed dissatisfaction with progress and set up a review of NHS management. Although this review, chaired by Roy Griffiths, is chiefly noted for proposing that general managers be appointed throughout the NHS, it also proposed to enhance the use of budgeting by managers (DHSS, 1983). Using the term *management budgeting*, it said this was so important that four "demonstration" sites had been established. While these proposals and the Government's acceptance of them six months later (DHSS, 1984) mark the first official interest in the idea, they were based on the specialty costing experiments of the 1970s.

In attempting to forestall objections, management budgeting was launched as a management tool which emphasized the centrality of clinicians. Its over-riding objective was:

> to enable [the NHS] to give a better service to its patients by helping clinicians and other managers to make better informed judgements about how the resources they control can be used to maximum effect. (DHSS, 1983)

Nevertheless, the introduction of management budgeting took place in an atmosphere of increasing tension between management and clinicians.

By 1985, the "demonstration" sites were perceived to have failed. This perception was supported by the Government's interim report which, while claiming progress in establishing the "technical background", indicated problems had been encountered. It emphasized the need to gain the commitment of clinicians and local managers and suggested further development of information systems was necessary (DHSS, 1985). Optimistically, it launched a further nine management budgeting pilot sites, no longer simply "demonstration" sites.

This optimism was short-lived, however, as obituaries on management budgets continued to be published in the professional journals. The difficulties were associated with the inadequacies of the computer systems, or the difficulties of "user budget holders", such as nurses, who were in effect "intermediate budget holders", their costs being recharged to clinicians. Budget holders, in other words, had little influence on the volume of work but were made responsible for costs within their budget.

In 1986, the NHS Finance Director confirmed these reports and admitted mistakes had been made. The problems were explained as relating to the inadequacies of the computer-based systems, especially the clinicians' perceptions of the systems as inaccurate and frequently yielding information that was outdated. Managers, in their turn, regarded the clinicians as obstructive. Noting this discord, he said it was naive to believe that computer-based systems would turn clinicians into "effective resource managers" (Mills, 1986).

The official view expressed by the NHS Management Board was that management budgeting had emphasized systems at the expense of "organizational considerations". Rather than salvage management budgeting, RMI was launched as a new initiative which put the stress on management rather than budgeting (DHSS, 1986). The admission of failure allowed the Government to appear as if it was learning from earlier mistakes. It regretted that opposition and suspicion had arisen among the medical profession: the very actors whose support was vital. Management budgeting was made responsible for tensions where unity was considered necessary. Retrospectively, management budgets were criticized in the Government's monitoring of the national RMI sites for not obliging the service providers to become involved (Buxton *et al.*, 1989). Rather than confront the issue of medical opposition, the issue was stipulated as over whether the RMI was to be "information systems

driven" or "information user driven". Management budgets and the CASPE initiative were the respective models for either approach. In launching RMI, the Government favoured the latter model. Six new pilot sites were established, one of which was a CASPE site (Guy's Hospital) and five of which were among the nine second generation management budgets pilot sites. These six new sites were selected, apparently because they were places where the clinicians were committed to its success: "where doctors and nurses are already centrally involved in the management process".

The Government emphasized that the pilot sites would be making their systems "service-led" (DHSS, 1986). Nevertheless, the RMI had the same stated objective and repeated the same phraseology about "clinicians and other managers" making "better informed judgements" about the "resources they control". But it added the necessity, learned from management budgets, that management arrangements which centrally involve doctors and nurses were a necessary precondition. Moreover, the information provided must be perceived by doctors and nurses as relevant to their work.

The Government's statements represent a partial strategy rather than a closure on what RMI was or would become. The issue of whether RMI was to be systems- or user-driven was still to be decided. As will be demonstrated, RMI was the umbrella for a variety of organizational processes whose meaning was negotiated. A diversity of systems and organizational practices have carried the label "resource management" and it has never been easy to say what resource management is or what it is intended to do.

Intentions, however, or rather assumptions about intentions, have been a central element in attempts made to fix its meaning. For example, at various times, the Government has produced different versions of its intentions. First, in 1983, when the NHS Management Inquiry said that management budgets should be developed (DHSS, 1983), these were to "involve clinicians and relate work-load and service objectives to financial and manpower allocations, so as to sharpen up the questioning of overhead costs". But then, in 1985, when management budgets were being reviewed and indeed were soon to be replaced by the RMI, an official circular re-defined them in terms of what they were not: "Management budgeting should not be seen as an accounting exercise, or as a device for cost-cutting" (DHSS, 1985).

It went on to speak of its purpose as improving services "through more effective management at local level". Then, when the RMI was launched, it was described as new accounting procedures and management arrangements which would relate activity levels to their associated costs. So, in four years the Government's "questioning of costs" which would *involve* clinicians had altered to an influence on judgements *made by* "clinicians and other managers". "Better informed judgements" were to be made by different people.

The purpose and effect of these initiatives may be understood and interpreted in a variety of ways. They were introduced at the same time as the Government was sponsoring a range of similar measures (performance reviews, competitive tendering, cost improvement programmes, and value-for-money audits). Like

management budgets, these can be said to be consistent with private sector practices which decentralize management responsibilities (DHSS, 1984). So this may suggest that measures such as RMI result from strategies arising from class relations or the power of society's elites. Alternatively, it may be suggested that such measures are taken up simply because the NHS is a complex, but non-political and non-partisan, organization where the costs of meeting service objectives must be contained (Perrin, 1989).

It is more fruitful, given the experiments that had taken place earlier and the variations that occurred later, if organizational life is regarded as a contested area in which individuals possess considerable autonomy and discretion (Burawoy, 1979; Cooper *et al.*, 1981). While sensitive to the organizational vacuum implied by this voluntarism (Hopper *et al.*, 1987), it is a perspective that affords an opportunity to investigate change and resistance in the introduction of management systems. Thus the Government's support for the development of budget information for medical specialties may be regarded as part of a gradual shift in the balance between a variety of contending forces on the planning and control of clinical activity. In this balance, medical knowledge and practice are clearly important, but so are accounting and management practices.

The Meanings of Resource Management

Thus, "resource management" can be portrayed and interpreted in a variety of ways. It can be advocated as a form of responsibility accounting practice in which budget information facilitates planning and reporting facilitates monitoring and appraisal. As such it might be a decentralized information system designed to make doctors and managers better able to make decisions, or a more centralized form of responsibility accounting where budgeting and reporting are tailored to the needs and responsibilities of specific managers.

However, this pays little attention to the processes by which managerial needs are defined in (by) responsibility accounting. Advocates may ignore the particular difficulties of responsibility for group activities; the imbalance in information between different managers; and the issue of who is responsible when unexpected events occur outside someone's control. It is at the design and implementation stages that such issues are debated and where assumptions are made. Advocates, and those more critical, often assume a connection between accounting, decision-making and performance evaluation but rarely question the role of information in decision-making or the ambiguity of accounting calculations (Burchell *et al.*, 1980). They rarely question whether responsibility accounting will facilitate the planning, monitoring and appraisal that is apparently intended. They ignore the potential for resistance by those whose activities may be monitored.

There are exceptions, however. Foucault's approach to power has been used to highlight the potential for resistance against accounting's systemic effects (Hopwood, 1987; Hoskin and Macve, 1986; Miller and O'Leary, 1987). Indeed, accounting systems are seen as the product of contingent forces, often arising in

other social arenas. Another exception is the adaptation of Callon and Latour's "sociology of translation" to analyse resource management in the NHS (Bloomfield *et al.*, 1992; Preston *et al.*, 1992). This demonstrates that accounting systems are not simply a technical solution to be adopted by health care organizations (from private sector practice, say). These exceptions place considerable emphasis on the constitutive roles of accounting and the effect of forces arising in the accounting arena on non-accounting practices.

This approach enables a critical examination of the general assumptions made about the capacities of RMI to facilitate planning, monitoring and appraisal. Accounting systems are seen as the product of contingent forces in which the potential for people within organizations to intervene is recognized. While separation of provider from purchaser implies a lack of trust in the workforce, their levels of commitment to the (perhaps) mythologised ideals of the NHS should not be underestimated. This commitment is reinforced at a material level: medical professions, nursing and many ancillary occupations would not exist in their present numbers or enjoy their present status levels without the regular funding that a state health service has provided.

However, we need also to question whether resource management is actually designed to facilitate planning, monitoring and appraisal upwards. In the case of government responsibility for public services, at least, there is every incentive to shed responsibilities and to reduce accountability (Culpitt, 1992, pp. 96-139). The RMI appears to enhance accountability by increasing the amount of information, but is very selective in the information it provides. This makes it important to question seriously resource management's capacity to constitute patterns of authority and reporting in organizations; to reinforce and modify organizational designs; and to construct and render visible important aspects of organizational reality. It may be its very ineffectiveness in these areas that makes RMI attractive to government; if "better" information about health care needs is provided, further expenditures might be demanded; if more information about organizational "reality" is provided, further confrontations with clinicians may follow.

While the 1982 reorganization, the introduction of general management, and the market-based reforms of the 1990s can be seen as a continual erosion of the "trust" formerly afforded the medical professions, much is left intact. The ability of doctors to allocate their efforts according to medical definitions of need, combined with peer review, remain important. However, it is within this context that the proposed managerial and budgeting practices introduce important qualifications to clinical autonomy. They imply that admission and treatment decisions should also judge the implications of using resources that might otherwise go towards treating other patients, including those not yet sick.

NHS Accounting Reform in Action

Having reviewed the importance of medicalization within the NHS, and having registered the flexibility that surrounds accounting mechanisms (among which resource management is considered), it is appropriate now to turn to the specifics of its introduction. (Full details of the empirical research referred to in

the following analysis can be found in Bloomfield *et al.*, 1992.) The purpose here is to demonstrate that the introduction of "resource management" was not simply a matter of designing systems which have the support of top managers. The issue is more that of how resource management was constructed and with what purpose by the actors concerned, rather than with how such actors interpreted and implemented it. So, in examining how resource management came into being and in what forms, this article takes a perspective on resource management which, while sometimes usefully regarded as an accounting mechanism, is less than usually concerned with resource management's success in accounting terms.

It has never been easy to say what resource management is, what it is intended to do: its intention and meaning was negotiated. For this reason, it was not easily evaluated. It could appeal to all and yet it would never work first time. There would always be difficulties, "teething troubles", and a diversity of approaches. This made it impossible to approach health districts with a standard methodology. None of the sites adopted comparable means for progressing resource management and, moreover, sometimes they were fairly reticent. Nevertheless, significant variations in progress with RMI can be described here by using three examples from the six national sites.

The National RMI Pilot Sites

The national sites shared a common constraint that they demonstrate the acceptability of RMI and, indeed, its usefulness to local clinicians. The diversity of RMI results from negotiating its usefulness locally.

At Newcastle's Freeman Hospital, the large number of patients from outside the district (57 per cent) was identified as a problem that required the development of costing mechanisms. RMI was offered as the solution. It was portrayed as enabling "effective planning and control" of the pattern and cost of care. The system developed was able to represent graphically where patients were drawn from.

Management communications with staff focused on the system's ability to provide information that started with the need to know the financial impact of workload. This was because they wanted "to establish the belief that staff can influence the amount and quality of services under their control..." (Freeman Hospital, 1988). Support was also encouraged by moving medical records staff (and the classification of patients by DRGs) from their offices and into the wards. Freeman's strategy was hailed as "evolutionary" and widely regarded as "a runaway success". The NHS Board's progress review judged clinical and non-clinical managers to be "working well" (DHSS, 1987).

At Huddersfield Royal Infirmary, RMI was not conceived as a system allowing the presentation of management and accounting information. Instead it was aimed "at exploring the clinical and management advantages of comparing details of actual patient care against treatment norms". It was called a Clinical Information System. Huddersfield's manager thought their RMI was "maverick" and that the NHS Board members might regard them as "loony".

Nonetheless, they thought their efforts were recognizably resource management.

While all the national pilots relied on clinical diagnosis, Huddersfield provided a model for assessing the outcomes of treatment: medical audit. Nevertheless, medical audit was intended to be under medical control. Huddersfield was working at "changing the culture" so that clinicians would integrate their use of menu-driven computer systems into their management of clinical activities.

Management change was minimal and decision making more akin to pre-1982 reorganization days when clinical priorities were decided by Medical Executive Committees (MECs), elected forums for clinicians to iron out their difficulties. However, in Huddersfield, this was extended by a management forum which included managers, doctors and nurses, and another forum where discussion centred on medical audit. The first of these was felt to resemble most closely the kind of management change envisaged by Government under the RMI.

Unlike Freeman, where the RMI was portrayed as a solution to a common problem, very few consultant-grade clinicians received regular reports from Huddersfield's CIS. Although it was technically possible for each doctor to use CIS to monitor colleagues' practice, this was potentially threatening and not allowed. Instead, consultants were allowed access to information relevant to their own patients. An individual patient's treatment could be compared with expected care using a standardized diagnostic classification. Unlike other health authorities, Huddersfield was not using DRGs but an earlier, more disaggregated system, known as the Read Clinical Classification. This was regarded as easier for clinicians to use and more administratively useful. Huddersfield was less concerned with costing, more concerned with clinical needs as defined by the need to manage clinical work. DRGs were thought inadequate for medical audit where Huddersfield considered itself ahead of other health authorities.

While management change at Huddersfield was minimal, at the Royal Hampshire Hospital at Winchester, the RMI was dependent on management arrangements based on clinical directorates. These were an idea imported from Johns Hopkins University Hospital at Baltimore and then developed by Guy's in Lewisham. Winchester claimed its RMI was more than just financial and technological: it was allied to introducing "total quality management". It was not directed at case-mix management, although case-mix was "bolted on", but at encouraging staff to "own" the Region's computer-based management system covering patient administration, pathology, nurse management and dependency. This system, known as RISP, became the subject of a police fraud investigation three years later and little was said about it when we interviewed. Instead, the emphasis was on defining roles and relationships between management teams, doctors, nurses and support staff. The district general manager (DGM) was talking to clinicians aiming at consciousness-raising. We

	Freeman	Huddersfield	Winchester
Stated purpose	Information on costs of workload in order to charge neighbouring areas.	Information to compare details of patient care against treatment norms.	Management change and a common culture. Case-mix information was "bolted-on" to provide vocabulary
Management arrangements	Evolutionary: budgetary systems, based on diagnosis, to be compatible with management structure	Medical priorities still determined by MECs. Additional forums: (a) management issues and (b) medical audit	Clinical directorates established
Information distribution	Widespread access to information about patient administration, pathology, and nurse management	Clinical Information System: information was restricted to medical staff's own patients	Clinical directorates had information on patient administration, pathology, and nurse management

Table I.
Three RMI Sites

were told the motivation for this was to get clinicians to concentrate on their NHS work as opposed to their private work. The diversity of these three RMI sites is summarized in Table I.

The diversity demonstrated at national level results from local encounters under the common constraint that RMI's usefulness and its acceptability to clinicians be demonstrated. Different strategies and different outcomes resulted from local interpretations of what could be gained. The RMI was an umbrella term for a variety of organizational activities, including medical audit, in which people struggled to construct something worthwhile.

Because the national sites were operating under common constraints and under considerable scrutiny, the variations were rarely discussed. Justification of one strategy might imply criticism of another and criticism might harm the initiative. Nevertheless, the diversity demonstrated at national level encouraged further flexibility of interpretation over the purpose and means of resource management when it was tried elsewhere. This can be illustrated by considering the experience with resource management in the North West region, prior to the reforms of the 1990s.

Resource Management at Local Levels

While most health districts have only experienced resource management with the market-based reforms of the 1990s, the North West region saw a necessity to follow national developments from early 1985. This was because it conceived that the whole organization of health services could be expressed with money. Financial information could then be used to express the relationship between

productivity and the cost of producing health services. The Region was so convinced of this that it sponsored its own unique initiative despite opposition from the medical profession and a Government wary of the profession.

The initiative amounted to (1) the incorporation of resource management progress within annual reviews of district managements and (2) the establishment of a District Support Team (DST) within its administration. During 1985/86, the DST had a staff establishment of ten, although this complement was diminished significantly when staff began to leave after a new Regional General Manager was appointed at the end of 1986. The DST provided training materials aimed at middle-management and individual technical expertise for the Region's districts.

The strategy implicit in the Region's initiative was thrown into disarray several times by national developments. The first time was when the "negative" news from the initial four management budgeting demonstration sites fostered inertia at a time when districts were creating financial information systems and nominal budgets. Second, the launch of RMI, with its emphasis on management and organizational change, caught Region unexpectedly going in the "wrong" direction, although some districts were clearly less out of line than others. The head of the NHS's RMI directorate told us it would be better if the Region did nothing rather than pursue a systems-led RMI (management budgeting) as before. Third, the NHS review (1988-89) plunged Regional activity again into the doldrums: its support staff diminished to two in number.

The Region's initiative resulted in health districts pursuing a variety of resource management initiatives of their own. These district initiatives were observed from early 1986 through to late 1989 when publication of *Working for Patients* brought activity on resource management to a halt. This article concentrates comparison on two of these districts which, for reasons of confidentiality, are referred to as "Osgood" and "Hartford".

Against a continuing belief among management and accountants that some form of relating clinical activity to resource-use was necessary, commitment varied in practice. Nevertheless, the Region's strategy meant that local health districts were obliged to take resource management seriously. Under the name "resource management", very different strategies could coexist: Osgood established formal committee structures while other districts did not. In one district, similar activities took place but the terms "management budgets" and "resource management" were avoided entirely.

Local medical co-operation was necessary but opposition was anticipated. Because each adopted a different "strategy", the issue of whether resource management should be information-driven or user-driven was never resolved, as such, but addressed differently. These local differences, summarized in Table II, required different approaches to be taken in our empirical research. At Osgood, it was possible to observe the process by attending formal meetings in addition to conducting interviews and examining documentation. Elsewhere we had to rely more on interviews. Also, some districts initiated the process much earlier than others, and we could not observe the process over a comparable

time. Changes in policy at a national level affected these districts differently, according to how well advanced their own initiatives were.

Resource Management in Osgood and Hartford

Although interconnected, comparison of local variations can be considered under (1) the strategies adopted for making progress, (2) the debates over the construction of costing systems and systems of reporting, and (3) the meaning and purpose of resource management.

Strategies. In Osgood, formal arrangements were made to introduce resource management in one Unit of the district. This involved regular meetings and support from the DST. Despite some progress towards developing the system, it was a shoestring operation and there was no-one to input the data except a member of the Region's DST. When this person left and Region refused to replace them while the NHS review was underway, Osgood's progress slowed to a halt. Hartford committed even less in the way of resources to the operation. It sought no Regional assistance nor established any formal procedures for making progress.

In Osgood, the problem all along was perceived as how to devise an information system that local clinicians would accept as accurate. Clinician reports of activity were necessary but clinicians were unwilling to make sufficient effort while they perceived the system was inaccurate and out-of-date. Despite all the national and Regional statements to the contrary, Osgood's managers regarded resource management as an accounting exercise. Continual worries over whether their efforts were compatible with national initiatives were tempered by a perception that management budgets and RMI had failed. The national initiatives were thought never likely to be sophisticated enough for management and planning. They thought that without adequate and accurate information, Osgood's doctors would never accept that managerial changes could be linked to the system. It was therefore systems-led and its purpose was clearly to enable efficiency savings to be identified: "less for less money" as one manager expressed it. Developing a system that would use the FIP software in conjunction with Region's Enhanced Budgetary Control System (EBCS) used elsewhere was the major aim. However, the budget headings were to be left vacant for fear of upsetting local medical opinion.

In contrast, Hartford did not perceive management budgeting and resource management as simply about cash. Instead, the issue was about intervening in people's behaviour. However, in order to avert opposition, Hartford's doctors were never told about management budgets and resource management, although district managers and chairmen had to convince Region they were making progress. Normally, the information was only shared with doctors when there was a specific aspect of their clinical behaviour that the Unit General Manager (UGM) wanted to influence. When organizational changes were made in the district, doctors were to be involved in the new structure with the MEC as its main focus. However, this formal structure was to be supplemented by informal links between managers and clinicians. Seven

Assistant UGMs were employed for each specialty. Nationally, clinicians were described as the "natural managers" (DHSS, 1986) but at Hartford, clinicians would generally only have access to cost/workload information through their UGMs/Assistant UGMs. There was no expectation that the clinicians would be drawn into the management, only that the communications between them and management would be more "information rich".

The construction of costing systems and systems of reporting. While the first task tackled in Osgood was the identification of the cost of every treatment, the system introduced by Hartford was devised to use existing information.

Osgood's concern over the accuracy of its information meant that time and flexibility was required to implement "pilot budgets". Consultation over the setting of budgets was also required at every stage but cash shortages forced considerable urgency on their efforts. Moreover, the launching of RMI put additional pressure on Osgood so that it entered into a commitment towards producing specialty costing. This introduced further concerns over accuracy because specialty costing averages out across all consultants within each specialty. Many consultants preferred specialty costings because it would not expose any individuals. So, while some managers wanted the system to produce information which recorded the work of individual consultants, this was thought unlikely to be acceptable. The computing resources required would also be considerable. Nevertheless, individual managers were devising systems based on the activities of individual consultants because they thought only this level of detail would provide the accuracy necessary to sway their doctors.

Hence Osgood adopted a compromise where specialty costings were reported but where individual clinicians were left to decide if they wanted more detail some time in the future. While individual doctors were interested if explicit budgets might gain them extra funds, most were unwilling to see resources go on administrative staff and computing. Rather than express any concerns over the impact of management budgets on clinical freedom, opposition centred on the inaccuracies of the system. Most discussion centred on how financial information should be presented to clinicians. Any progress that was made in Osgood was therefore obscured from the clinicians whose suspicions might undermine the system.

These contradictory pressures meant that progress was modest. It was limited to *ad hoc* purchases of computing equipment and relevant software. Osgood remained reluctant to spend big money on equipment when the system's credibility was low. Considerable efforts were made to ensure that these systems could communicate with each other but there was little confidence in retaining staff to input the data, so paper records were also used as a back-up to the communication between systems. Nevertheless, by April 1988, systems were all established for in-patient and out-patient activity, pathology, radiography, ECG and theatres. This all coincided with the start-up of a new machine, a gift from IBM, who also provided training staff to run it.

Hartford's decision to use information that was already available was crucial to development of its "resource management". Information about the staff time

used in operating theatres was already available on paper, for instance, and so could be easily computerized. Microcomputers were therefore used extensively and Hartford's own software was introduced to replace the EBCS software initially supplied by Region. The information was ward-based. Consultants received information about medical/surgical activity but the cost information was made available to the UGM alone. Any decision to alter this so that consultants would have access to this information was made conditional on future organizational change so that clinicians would be involved in the management process. Otherwise, there were no plans to disaggregate the budgets below specialty. The decision to produce ward-based information, as opposed to specialty-based information, had a crucial effect in that it placed all the emphasis on an administrative unit rather than a clinical one. This effectively removed the "natural managers" from the system: ward-based accounting places managerial responsibility in the line management hierarchy. It was therefore accepted that the system would be of more interest to the nursing staff. It was also accepted that their clinicians felt no particular loyalty to the NHS, regarding the main hospital as they might regard a private hospital as a source of work, and had no interest in managing the local NHS's services.

Internal debates over what costs should be included under what headings were a significant element in the local construction of "resource management". In Osgood, it was decided that only direct variable costs should be reported. Although these excluded staff time and so were only a fraction of the costs incurred, managers did not want to have to explain to doctors that a cutback in activities (X-ray tests for example) – while saving money – did not amount to any real efficiency saving. This was a great deal more complex in Hartford where, once paper records of staff time had been incorporated, much effort was then needed to include ward-usage of medical/surgical equipment. Food and cleaning costs were not to be included because they were judged to be outside of ward control. A plan to include pathology and radiology costs had to be abandoned because the Region's Patient Administration System (PAS) was inadequate. Considerable efforts were made to include pharmacy, not because it was any easier to incorporate in ward-costs than either pathology or radiology but because it was judged to be demand-led. Consultants were persuaded to alter their reporting so that information on diagnostic tests could be included. However, similar plans to include physiotherapy activity had to be abandoned because the Chief Physiotherapist was supporting her professional body's opposition to resource management. Because both consultants and physiotherapists were discharging the same patients, she was also concerned over "re-charging" because patient discharge information was being repeated in the system

Variations in the meaning and purpose of resource management. To some degree, local attempts to fix the meaning of "resource management" were affected by interpretations of what was happening elsewhere at national and regional level. Resource management was a goal in each of the districts but, against this motivation, activity was restricted according to Regional and

national support, calculations made about medical co-operation, available finances, and the local understanding of technology. The Region tolerated variety and saw no reason why the national pilot sites should serve as a model. Medical support was sometimes forthcoming locally, even though the DoH's Resource Management Directorate urged caution in the Regions because it feared systems-led, budgets-led activity would prevent medical support.

The links between the national scene and the local scene were far from direct, let alone mechanistic. At every stage, "messages" from the "top" were interpreted and either ignored or used locally for local purposes. Resource management at the local level bore very little resemblance to the national RMI, and even that differed enormously. The local variations took place against a background of interpretation, but where no one could point to any Governmental or Regional text which defined what resource management was. Over time, local actors were confronted with a variety of incommensurate views on the situation. As a result, managers were sometimes identified as budget holders but at other times clinicians or nurses were identified as the individuals who were responsible for decisions. Resource management implied that clinicians were already taking decisions but on the basis of inadequate knowledge, at other times it was proposed they were the "natural managers". Fluidity in resource management's meaning was experienced: an accounting technique could become a means for changing organizational culture. The high-tech imagery was matched by shoestring computing facilities.

Discussion over the purpose of resource management in Osgood was consistently framed by worries over the future direction of the national initiative and then the NHS review. Meetings were dominated by discussions over what the latest developments elsewhere might bring and how they might affect their own resource management efforts. A decision at national level to use "bed-occupancy" as a measure would create problems because this idea had been dropped in Osgood because cuts in beds actually increased throughput levels and activity. Similarly, cash-load targets was rejected because districts would then be driven by cash limits. Activity, money and standard of care, were all the essential elements of measuring services, but there were few controls over activity levels.

Osgood represents an example of systems-led resource management. Once committed to the purposes it saw as inherent in "management budgeting", it could not easily change direction when RMI was launched. So, after four years progress in getting the systems to work, Osgood faced a new challenge over how the system was to influence clinical behaviour. By the time *Working for Patients* was published, less and less was happening. A chasm had opened up between the Unit General Manager (UGM) and the rest of his management simply because he was in daily contact with clinicians. This made him suspect and, in turn, sympathetic with medical suspicions over the capabilities of the system.

Hartford displayed far less concern to take any cues from the Regional initiative. However, as elsewhere, progress was halted by national

developments but, in addition, there was a change in the District General Manager(DGM) who did not place resource management at the top of his priorities. Staff were never made available in sufficient numbers to support the work and the system provided few reports. Resource management only surfaced among the DGM's priorities after he had been reminded of it by our research interest. Following an interview aimed at re-establishing our access, he set up a review of resource management progress. As a result, the emphasis switched away from the provision of financial information and moved towards persuasive efforts aimed at bringing the doctors into general management roles. Further structural change was anticipated but held in abeyance during the NHS review. As in the Royal Hampshire Hospital at Winchester, this district began to concentrate on "total quality management", but the DGM's interest in this was met by doctors who were defining "quality" rather differently from himself. He claimed, however, that their initial suspicions had faded. For the accountant and information officer, budgets were nothing to do with cash limits but the more important task of "influencing doctor behaviour". They were as involved in "politics and psychology as much as in accounting". The DGM was far less concerned with relating costs to workload than with communications with the clinicians and with gaining their "commitment" to local services. This may have been well judged: Hartford's clinicians were highly suspicious of resource management, regarding it as having "eroded" clinical freedom.

Progress with resource management placed Hartford in a familiar dilemma – whether to get the whole system "up and running", so that doctors could be presented with credible information about their workload, or whether to move ahead with dialogue first. In choosing the latter option, various meetings had been set up between managers and clinicians, designed to discuss how "quality", for example, should be defined. Out of discussions such as these, another initiative was taken: the production of an explicit mission statement entitled *Purpose, Vision, Values: A Statement of Direction*. While this encountered indifference and derision from clinicians, the DGM continued to attach greater importance to establishing communications with clinicians than he did to developing information systems. He wanted to see doctors "participating" and "integrated into the planning process", not just reacting to cash shortages by "shroud-waving", "poking at each other" and by demands for more clinicians.

So, even within this one district, resource management had no consistent meaning. There was no clear strategy for its "implementation". At different times and according to different people, it was a computing exercise, an accounting exercise, or subsumed within management's determination to justify its financial decisions. Resource management was conceived as merely a conversation point in the management's stormy relationship with its clinicians: a relationship which only deteriorated as financial restrictions meant the reduction of medical services. It was only in this respect that clinicians began to demand reliable financial information. Their support for resource management was a local creation, rather than an adaptation of Regional or national

	Osgood	Hartford
Stated purpose	Systems-led accounting exercise: emphasis on accuracy of financial information relating to costs	Organizational change, cultural change. Information was to be used, along with more informal activities, to foster spirit of co-operation among doctors and managers
Management arrangements	No change attempted. Once accuracy was achieved, a limited amount of financial information would be made available in order to get doctors to accept managerial change	Attempt to bring doctors into management roles
Information distribution	Specialty-costing information only available Budget headings deliberately obscured	Doctors were not told about the work on management budgets and resource management. Information was only shared with doctors in specific cases to highlight discrepancies

Table II.
Osgood and Hartford DHAs

initiatives, and its purposes were locally defined as a tool for staying within cash limits. One new system development, for instance, was a "ward sister development programme" aimed at getting nurse managers to influence admissions directly. In taking on such responsibilities, especially where conflicts with clinicians might be encountered, this programme would need to be supported by management. System operation, in Hartford, was regarded as intersecting directly with organizational management and development.

In summary, although the Region supplied support staff and training materials, the districts were never required to take one particular line on resource management. Variations in regional commitment to the project made that impossible. Instead, districts were more or less free to interpret resource management according to their own perceptions of what was needed. Debates concerned the emphasis given to the system in promoting change; some districts adopted a systems-led approach more in tune with the earlier management budgets initiative while Hartford concentrated on organizational change. However, Hartford's approach got nowhere near the RMI approach with its insistence on local clinical interest. Aside from deciding what strategy to adopt, variations occurred as debates ranged over such matters as how to charge activities against budgets, when often activity loads were outside the control of the person controlling the budget, or how they should account for staff salaries or use of pharmaceuticals.

Another debate concerned the role of clinicians; one district successfully brought its clinicians into the development, providing weekly reports to over 100 budget holders, but elsewhere (in Osgood and Hartford) this was regarded as a near impossibility. Managerial assumptions about the value of resource management led them to believe that doctors would see its value also, provided the information was accurate and well presented. However, this was matched by a suspicion that doctors would misunderstand the figures reported to them. Managerial activity was therefore devoted to convincing those doctors who showed any interest that resource management would not be as dangerous as opponents feared. But there was a reluctance to advance claims for the systems that might incur derision. They had to satisfy Region that progress of some sort was being made, while adopting a soft approach with their doctors until the stage was reached where accurate reports were feasible.

Having highlighted the unresolved issues experienced nationally and in the North West Region, it is appropriate to examine its contemporary relevance.

The NHS Review: Resource Management and Market-based Reform

As has been seen, the distinctiveness of the RMI at national level was of considerable interest to local health authorities elsewhere. Resource management had implications for future investment in computers and in managerial effort. The diversity became at least one reason for doing nothing, although clearly something needed to be done if managers were to control medical use of resources.

On the other hand, this diversity allowed the BMA to accept resource management after the Government's review of the NHS and its proposals for an internal market (DoH, 1989a). The BMA noted Resource Management had "considerable scope... to develop in ways which reflect the preferences and conditions of the hospitals concerned" (British Medical Association, 1989).

Nevertheless, the Government's proposals for market-based reform were made crucially dependent on a version of resource management which related costs to individual patient episodes. The Government therefore proposed to extend RMI to 50 acute hospitals during 1989, building up to 260 hospitals by the end of 1991/92. The review, and the proposals that resulted, therefore had a profound affect on local efforts to develop resource management, as well as once again acting to establish RMI as a particular kind of financial control mechanism. And here the contradictions must be stressed, for there was no accomplished RMI ready and waiting to be imported into the new structure. As experience at the national pilot sites and elsewhere demonstrates, there was considerable variation in the development, meaning and purpose of resource management.

In the BMA's resistance to *Working for Patients*, it adopted resource management – because of the variation it noted was allowed – as a worthwhile and valuable initiative. In short, the BMA rallied to the forms of RMI being excluded by the impetus of the Government's new proposals, as part of its resistance to that impetus. Thus the profession gave its partial and grudging

acceptance to RMI provided it was defined as incorporating doctors within the management system. Provided, also, that RMI produced "credible information geared to clinical needs" (British Medical Association, 1989). These, of course, are significant provisos but – still referring to the pilot sites as "experimental sites" – this was the first public and positive acceptance of RMI by the BMA.

Aside from the BMA's acceptance of resource management, the profession's response to the reforms as a whole are rather more mixed (Driscoll, 1991; May, 1991; Sherman, 1991). There were benefits for many. In particular, GPs were given considerable powers over the flow of finances within the NHS and many have reacted favourably to the opportunities presented.

At this point it is appropriate to highlight several questionable aspects of the claims made for RMI by the Government. As will be apparent, these will continue to be of pressing concern to those developing resource management locally throughout the 1990s.

First, the emphasis placed on the particular relationship between cost and diagnosis excludes other relevant relationships which may be of more significance. The relationship between diagnosis and treatment and between treatment and outcome are examples. Although diagnosis, treatment and outcome are underevaluated, the efficacy of clinical diagnosis was implicitly assumed in the Government's RMI proposals. RMI ran into medical opposition and to have suggested any further scrutiny would have threatened clinical autonomy more. It would have increased the likelihood of confrontation.

Second, market-based reforms will require judgement over the right mix of service, their appropriate levels, and with what priority. This will be the major strategic task for managers of hospital and community services throughout the 1990s. While knowledge of the costs of treatment would be an essential ingredient in these judgements, it would not allow comparisons over the value of treating separate categories of patient or of offering different types of service.

Third, even if the government's claim is accepted that the RMI was "the best way", this cannot imply that RMI had proved itself able to fulfil the task then asked of it in *Working for Patients*. The RMI was itself born of previous initiatives whose success had been questioned. The problems those earlier initiatives had run into had not been reduced. Nor had they evaporated.

Finally, a diversity of systems and organizational practices have carried the label "resource management". Many of these appeared experimental. As market-based reforms came into effect, it was as difficult as ever to say what resource management is, what it is intended to do, and what it will actually do. With the *NHS and Community Care Act 1990* on the statute books, "resource management" continues to be subject to reinterpretation and renegotiation. RMI could never be the adoption of established practices because RMI and "resource management" more generally had simply never been established. Both Government policy statements and experience of the RMI demonstration sites serve to stress that there was no one thing called resource management. Resource management is what it is to particular people at particular junctures: it is reconstructed at separate moments. Moreover, if there had been such a

thing it still faced unresolved problems. As previously noted, the Government had been forced do an about turn on whether the "questioning of costs" would *involve* clinicians or be *made by* "clinicians and other managers". This meant that there would be every possibility that questions over what "better informed judgements" might be would be negotiated locally. The idea of resource management was further altered by people at a local level who saw it as instrumental to their own purposes and did so within their local constraints.

For this reason alone, the implementation perspective on accounting is clearly too deterministic to describe resource management adequately. It does not deal with the problems and real dilemmas encountered in designing something for which there is, in any case, no standard template. Nor does analysis of resource management as responsibility accounting encompass the negotiations involved when deciding, identifying and defining who was to be responsible. The clinicians do not appear as a fixed item in the manager's landscape, being neither wholly against nor wholly for the goals of resource management. They also demonstrate a variable inclination to become "responsible", to control themselves rather than (or in addition to) being controlled by others. The differences encountered do not simply reflect the influence of local conditions but, rather, a negotiation of the meaning of "management" in general and "resource management" in particular. Neither of these is given a priori in, say, Government circulars. It is actively and intentionally constructed through the social and political contingencies of each site.

The fabrication of resource management at different sites represents a dynamic negotiation of management/doctor relations. Its development will continue to involve the building of alliances between various actors, including individuals and groups but also machines, software, or accounting reports. Knowledge about computing, accounting, management, medicine, or of the attitudes of medical staff, will continue to be mobilized to persuade others what resource management should do. For the development to be regarded as successful, each of these actors has to be convinced that they shared a common cause or interest. This involves the attempt to persuade others what their interests are. As in the past, resource management's future will depend on its ability to produce data which are perceived to be accurate, valid and relevant – however these are to be defined.

The differences that were apparent over what resource management should be and what it should do relate to conflicts over how the activities of a hospital should be represented. Thus discussion over the appropriate level of aggregation of data (patient-based or DRG, for example) are crucial to the design of an information system. Similarly crucial were discussions over what costs should be included and how to categorize them into fixed costs or variable costs. Unsatisfactory resolution of these issues can lead to distrust of the information system, and yet some compromise was often necessary. The compromise result was not a system that could reveal or objectively represent the hospital's activities as they are. Rather, it makes visible a partial view of

activities. The choices inherent in the design of the categories which define an information system are not obvious but negotiated between the various groups building the system.

Despite all the variations observed and still likely to be encountered, there are common features to be noted. General managers have sought information systems in order to discharge the management function. There is general agreement about the need to involve doctors and nurses. Assessment of whether health care needs are being met is assumed to be adequately defined by reference to clinical diagnosis. Other similarities stem from the common use of computing hardware and software. (IBM has a major stake in the majority of national pilot sites.) And then, there is a move towards standardization of data handling (Körner and DRGs). These commonalities must be kept in mind as this complex variety of developments is analysed. Moreover, central government, particularly the NHS's Resource Management Directorate, and the comparability required by market-based reform will ensure further similarities.

Nevertheless, in 1993, Westcountry Heath Trust still operated a computerized system, under the heading "Resource Management", that deviated in important respects; unlike most of the national and local initiatives reported above, pay was regarded as just as much a variable as non-pay expenditures; costs were based on length of stay, not DRGs; budgets, based on previous spending levels, were set for facilities which might include a number of wards and specialties.

As market-based reform came into effect during the early 1990s, resource management still provided little indication as to how people might use information in making resource use judgements. Whatever resource management was and whatever "better informed judgements" might be, were still to be negotiated locally. Resource management's purposes was still to be interpreted at a local level in ways that were instrumental to local purposes and within local constraints.

Resource management provides no necessary logic for determining what good judgement is. Neither does it provide guidelines as to how organizational practices that might enhance better judgement should be established. The information provided to Westcountry's Mental Health Directorate, for example, enabled managers to identify areas of overspending. They could achieve a reduction in their own overspending but were powerless to prevent overspending in other areas of the SGT. Perverse incentives were operating because these other areas might continue to overspend and, indeed, soak up the money saved by the Mental Health Directorate. As their management accountant said to them "Under-achieving is rewarded – over-achieving is punished". Cash loads were dictating resource allocation. Despite separate budgets and the separation of provider and purchaser, checks on its expenditure were inadequate, so institutionalized hospital medicine continued to take precedence. Resource management provided very little assistance to managers attempting to make better informed judgements.

Conclusion

When mimicking markets is the main device for ensuring efficiency and effectiveness, reliably comparative information about costs and the need for health care is required. While judgements are "better informed" in the strictly limited sense that there is more information flowing, resource management has offered and continues to offer little guidance to those who must judge whether to fund new developments or reduce existing services.

Despite the vast organizational efforts being made to mimic the market, there has been no adequate assessment of resource management's practical application. The whole effort towards management budgets and RMI appears a classic case of doing something in order to avoid doing something else. The efforts have generally focused on accounting systems rather than tackling the need to make medicine more accountable. So, resource management can only be expected to justify what has already been decided on or has emerged from an overspend.

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Corporate Accountability and Rorty's Utopian Liberalism

Tom Mouck

Accounting, Intelligence, Philosophy

Addresses the lack of any coherent intellectual perspective for establishing a theory of corporate accountability that is neither extreme right-wing nor anti-liberal. Insights derived from Rorty's *Contingency, Irony and Solidarity* are employed to develop a new perspective on the relationship between corporate activities and the public interest. This perspective is then joined with Dewey's view of social intelligence and Barber's notion of *Strong Democracy* to argue for an expansion of corporate social accountability.

Job Satisfaction, Organizational Commitment, and Turnover Intentions of United States Accountants: The Impact of Locus of Control and Gender

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Accountancy Profession, Gender, USA, Women

Investigates the impact of locus of control and gender on the experiences and practices of accounting professionals. Also considers the impact of role overload, inter-role conflict, and coping behaviour on these attitudes. Suggests that a complex set of forces creates differences in the extent to which an individual encounters, and is successfully able to contend with, both role overload and inter-role conflict. Gender differences were observed in the accountants' expressions of housekeeper role overload, volunteer role overload, and inter-role conflict between work and spouse. Locus of control differences were present in the perceived conflict between work and self. Locus of control and gender interacted to produce differences in accountants' expressions of overload and leisurite role overloadexpressed less satisfaction with their current positions and greater intentions to search for alternative opportunities. Suggests that the accounting environment may still be inhospitable for certain women attempting to realize multiple work and family obligations.

Absorbing LMS: The Coping Mechanism of a Small Group

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Financial Management, Local Management of Schools, Schools

While the original proposals of Local Management of Schools (LMS) had a wide-ranging agenda for management change, the actual outworking has tended to emphasize the management of devolved financial resources. Looks at the way these new financial responsibilities are handled. Empirical insights suggest that the dominant approach is through a small group of staff, invariably dominated by the headteacher, to absorb the management tasks involved. Draws from a wide range of theoretical literature to highlight the nature and function of the small absorbing group. Uses these theoretical insights to inform the empirical analysis which explores the nature and diversity of the small group "doing LMS" in 24 different schools from three local education authorities. Highlights the importance of the headteacher both in the functioning of this small group as well as providing pointers to its underlying character and nature. Presents a range of critical comments about the strengths, weaknesses and dangers of this handling process as well as providing some wider evaluatory points concerning the value of LMS more generally for the education service.

Better Informed Judgements: Resource Management in the NHS

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Healthcare, National Health Service, Resource Management

The Resouce Management Initiative (RMI) is a central ingredient in plans to instil market-based relationships in health care and medicine. However, these plans have not benefited from any adequate assessment of "resource management". Demonstrates how earlier experience with resource management provides little guidance as to how it might be made to work. While resource management implies that measures of cost and activity were to be related to each other, its purposes are confused and confusing. While seemingly offering a variety of advantages, resource management is characterized by struggles and negotiations over its operational substance. Moreover, the initiative failed to resolve crucial issues over how to account for activities. Experience of tackling these issues as market-based relationships came into effect during 1992-3 demonstrates that resource management provides limited assistance to managers of the service.