

Financial Management: A Must in a Hospital Administrator's Skills Toolbox



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It does not require an expert in health care finance to realize how complex the Lebanese hospital system is when it comes to reimbursement policies. Hospitals in Lebanon have had to acquaint themselves with different reimbursement mechanisms (Ministry of Health, NSSF, military funds, etc.) and levels throughout the years. Even recent attempts to unify those have faced resistance based on the argument of organizational and financial sovereignty of funds, as is the case with the NSSF. However, reimbursement mechanisms and levels, although having a critical impact, are not the sole contributor to the financial health of a hospital. There are several financial management strategies that, if properly planned and executed, can lead to state of financial viability, if not prosperity. This article provides an overview of some of these strategies with the aim of raising awareness among hospital administrators - at all levels - of their significance in a hospital operation.

Cost Allocation/Accounting (تحديد الاكلاف)

Cost allocation or accounting is the process by which hospitals estimate the costs of the different inputs/components of the hospitalization (e.g. room and board, operating room costs, diagnostic procedures, cost of L and R [rate units for laboratory and radiology], etc.) with the ultimate goal of determining the cost of the stay. Unfortunately, many hospitals in Lebanon (and in Western countries) do not have a good idea of the costs of services within their institution. Rather, cost accounting methods range from a gross estimation of service component costs (historical figures, overall costs) to a revenue-based cost allocation (driven by payment levels). Determining the cost for a health care institution is critical for setting charges, and more importantly, in negotiating rates with payers, be it public or private. For example, a hospital that has an understanding of its cost structure can better evaluate what would be the impact of rate unification (توحيد التعرفة) that is being decreed/promoted by public payers. Furthermore, the Lebanese accreditation standards dictate (FD 5.1-5.4) that a hospital has clear guidelines regarding its accounting structure. Although a hospital may include such information in its accreditation document, its proved application in hospital operations is what accreditation auditing bodies will be tracking.

There are different approaches to determine costs. However, the first step for such determination is understanding the nature of the cost itself. For example, differentiating between the ability to trace back the cost of staff time spent on an x-ray (traceable=direct cost) and the cost associated with a hospital administrator salary (non-traceable=indirect costs) allows for a better classification of x-ray costs. In this example, an approach has to be devised to allocate part of the hospital administrator salary to the radiology department (and subsequently to an

individual x-ray procedure). Other classifications of costs are also relevant such as operating (related to patient care) vs. non-operating, fixed (does not change with patient volume) vs. variable, marginal (cost of adding one service) vs. average, among others. An understanding of the nature of the costs, i.e. its classification, can aid in the costing exercise.

Delving into the detailed various approaches to cost allocation is beyond the scope of this paper. However, it is worth highlighting that the most common and balanced approach used is referred to as Activity-Based Costing (ABC). The ABC method takes into consideration the categorization of costs as direct and indirect as the basis for standardizing cost inputs. All inputs into the process (e.g. staff time, equipment time, supply expenses, etc.) are standardized to a unit system - resource-value units [RVUs] - classified into direct and indirect costs (e.g. 20 minutes of staff time into performing an MRI equates to 5 resource-value units [RVUs] , 15 minutes of equipment time equating to 3 RVUs, etc.) and added to estimate the total cost of the procedure. The final number would be the cost of a service/procedure to the hospital.

It has to be understood that in the absence of a comprehensive cost accounting system within a hospital, it would be overwhelming to conduct cost accounting for all procedures on an annual basis. However, the exercise should be performed at least once every 3-5 years given the changing nature of costs (inflation, cost of supplies, etc.) and the continuous updates in approach/technology used for procedures. Also, it is important to do costing for every procedure (medical, surgical, radiological) introduced into the institution. Actually, the costing should be part of the decision to introduce such a procedure and is included in the feasibility study.

Budgeting (وضع الموازنات)

Budgeting is translating plans, be it strategic or operational, into monetary values. The level of budgeting can range from capital (e.g. buying a CT scan, building and equipping a new wing, etc.) to departmental and service-level. The standard budgeting approach is to project revenues and expenses in an effort to estimate the total profit or loss (for current services or planned ones). However, the process gets complicated on several fronts. First, the forecasting of volumes - necessary for almost all budgets - is at the end an educated guess. Many market factors could affect volume (e.g. competition, emergencies [outbreaks, wars], etc.). Second, although in Lebanon forecasting revenues is doable, there remains the major issue of accrued revenues, i.e. it is not easy to predict when a hospital will be paid for a Ministry of Health-paid discharge performed. As such, hospital budgets will tend to use accrued revenues more than realized ones. The impact of such a situation is that hospitals would potentially have

to factor in its budgets an interest expense for loans it may take to cover realized expenses - or delaying paying those as much as possible without hurting the reputation and functioning of the hospital. Another issue is what approach to use for the preparation of budgets. Does the hospital use a top-down approach where department's involvement is minimal in the process and they are on the receiving end? If the approach is a bottom-up one, how involved are departments in the budgeting process? Are departments acting as the generator of the raw data for the budget process of their department/ hospital only or are they also involved in the volume and financial forecasting analysis? Obviously, answers to these questions and others help characterize the budgeting process within a hospital. The institution also has to understand/factor in the advantage and disadvantages for each budgeting approach when deciding on a budgeting strategy.

The value of budgeting has also been highlighted by including it a whole section in the accreditation guidelines (FD 2.1-2.8) to the existence, structure and use of budgets in hospitals at various levels. In all instances, it is advisable to use two budget process enhancement strategies. (1) Sensitivity analysis, using various volume, revenue and expense levels when budgeting to factor in variations and plan for the different financial scenarios; (2) Variability analysis, routinely checking how far the projected/budgeted estimates are from actual figures in an effort to introduce process improvement strategies before it is too late.

Financial Analysis (التحليل المالي)

Many hospital administrators (at all levels) consider financial analysis to merely be the bottom line (profit/loss analysis). However, the approach to financial analysis goes beyond that to include many strategies. One of these strategies that is under-used but extremely valuable in analyzing all aspects of a hospital operations are financial ratios. These are formula-driven figures that assess financial performance ranging from how well inventory is managed to the ability of a hospital to cover its debt obligations, and many things in between. The ratios are classified into four categories: liquidity, profitability, asset efficiency and capital structure. Each of the categories includes several ratios that assess different aspects of that category. For example, liquidity ratios include the current ratio (current assets/current liabilities), days cash on hand ratio (how long can an operation meet its obligation is cash receipts were discontinued) among others.

The advantage of using financial ratios to assess a hospital's financial performance is that they provide an analytical snapshot of the various aspects of the operation. Alternatively, a hospital administrator would have to examine in some detail various financial statements including the balance sheets, income statements and cash

flow statements which sometimes can be misleading or confusing. However, it has to be noted that the employment of these ratios as a financial analysis strategy does not preclude using other strategies, such as profit/loss analysis, asset analysis, etc. However, the use of financial ratios was highlighted due to its underutilization in many hospitals.

Inventory Management (ادارة المشتريات)

Materials or inventory constitute a noteworthy proportion of the assets of any hospital. Hence, its proper management can have a favorable impact on reducing expenses. Describing the detailed specific approach for proper materials or inventory management strategies is beyond the scope of this article. However, it has to be noted that material in a hospital can be divided into patient care (e.g. surgical kits, IV bags etc.) and administrative (computers, office supplies, etc.). Further, key inventory management strategies include (1) estimating the total costs of the inventory, comprised of purchasing costs, ordering costs, holding or storage costs, opportunity costs (costs associated with not investing the money in something else), (2) determining the economic ordering quantity, the amount in units which is associated with the least total costs and (3) estimating the reorder point of materials, taking into consideration the lag time to delivery and the hospital's rate of inventory use.

Proper planning and execution of these three strategies would ensure the efficient use of inventory as a key asset within a hospital.

Conclusion

These four financial management skills are considered key skills in today's health care market. However, there are many other skills such as procurement or purchasing, management of accounts receivable, capital budgeting, managing working capital among others that contribute to the proper financial performance of a hospital.

Most hospital administrators would state that the financial performance of their organization is one of their top priorities. As such, although it is not expected that a hospital administrator be aware of the mechanics of each of the skills, he/she has to have enough knowledge to ask the right questions of his management team. Also, there is a misconception that only top management or financial managers have to understand and acquire such skills. It can be easily argued that if such skills are acquired by administrative (and even clinical) department directors, the communication and financial functioning of a hospital can be greatly enhanced.

Half of babies born in rich world will live to 100

Increasing numbers of very old people could pose major challenges for health and social systems, but the research showed that may be mitigated by people not only living longer, but also staying healthier in their latter years.

"Very long lives are not the distant privilege of remote future generations -- very long lives are the probable destiny of most people alive now in developed countries," Kaare Christensen of the Danish Aging Research Center wrote in October in a study in the *Lancet* medical journal.

The study used Germany as a case study and showed that by 2050, its population will be substantially older and smaller than now -- a situation it said was now typical of rich nations. This means smaller workforces in rich nations will have to shoulder an ever-greater burden of ballooning pension and healthcare requirements of the old.

Many governments in developed nations are already making moves toward raising the typical age of retirement to try to cope with aging populations.

The researchers said this was an important strategy, and added that if part-time work was considered for more of the workforce, that could have yet more benefits.

"If people in their 60s and early 70s worked much more than they do nowadays, then most people could work fewer hours per week," they wrote. "Preliminary evidence suggests that shortened working weeks over extended working lives might further contribute to increases in life expectancy and health."

LIVING BETTER?

Christensen and colleagues said huge increases in life expectancy -- of more than 30 years -- had been seen in most developed countries over the 20th century.

And death rates in nations with the longest life-expectancy, such as Japan, Sweden and Spain, suggest that, even if health conditions do not improve, three-quarters of babies will live to celebrate their 75th birthdays.

"But should life expectancy continue to improve at the same rate, most babies born in rich nations since 2000 can expect to live to 100 years," they wrote

The researchers, who pooled and analysed data from several international studies, said they wanted to explore "a common view" that a big rise in the proportion of older people would come as a result of helping an increasing number of frail and ill people survive longer -- with huge personal and societal costs.

But they found that even though many people who live to age 85 have chronic diseases such as diabetes and arthritis, they have only become frail and disabled at a later stage, essentially postponing frail old age instead of extending it.

"This apparent contradiction is at least partly accounted for by early diagnosis, improved treatment, and amelioration of prevalent diseases so that they are less disabling," they wrote.

"People younger than 85 years are living longer and, on the whole, are able to manage their daily activities for longer."

But for people older than 85, the situation is less clear, the researchers said. Data are sparse, and there is widespread concern that exceptional longevity -- with ever larger numbers living to 100 and more -- could be grim for the people themselves and the societies they live in.