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Response to Reviewers: Editor comments

The paper has addressed the comments of the editor and referee quite well so I would recommend it be accepted. I have noticed quite a few grammatical issues though so it needs a very careful proof-reading. To give a few examples: On line 13 of page 3 there is an 'of' missing; On line 22 on page 3 there is a bracket missing; On lines 21 and 25 of page 4 there should be an apostrophe in entities; On line 9 of page 5 there should be an s at the end of stakeholder. There are many other similar minor problems.

We would like to thank you for these comments and we have now been through the paper tidying it up and clarifying the text throughout.

# Accounting for voluntary hospices in England: A business model perspective.

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**Highlights**

- Voluntary hospices in England provide over seventy per cent of palliative bed capacity for end of life patients
- The provision of hospice care can be accounted for within a business model framework of analysis
- Interviews with key stakeholders reveals the changing nature of activities carried out within the hospice business model.
- Financial numbers reveal the impact of stakeholder relations on financial viability.

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## 1. Introduction

Hospices provide palliative care to terminally ill patients and the World Health Organization (WHO) defines palliative care as 'an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual' (WHO, 2002, p. 15). Caring for terminally-ill people is not something new and attempts have been made to trace back the roots of what is known as 'The Hospice Movement'. The term hospice was first associated with the care of dying patients in the 19th century in France and the modern hospice movement often attributed to the efforts of Dr Cicely Saunders who established St. Christopher's Hospice in London in 1967. Approximately 70% of the available palliative care beds in England are managed by voluntary sector organisations and the great majority of these hospices are independent local charities regulated by the Charity Commission. Some larger charities, for example, Marie Curie Cancer Care and Sue Ryder, as well as the National Health Service (NHS), also provide palliative care services (Hospice Information, 2005; The National Council for Palliative Care [NCPC], 2006, 2011). Hospices are often motivated by the original values and vision of founders/trustees but are also subject to evolving regulatory demands covering: health and safety, patient treatment and delivering value for money for local government (see Care Standards Act, 2000; Ellis, 2012; Finlay, 2001, Department of Health [DoH], 2002, 2009; Help the Hospices, 2006, 2009; Kings Fund, 2005, 2006; Palliative Care Funding Review [PVFR], 2011).

The literature on palliative and end of life care is either represented within a fragmented literature on the clinical, social, historical and political challenges facing the development of the hospice movement (Theodosopoulos, 2011; and see also Association of Children's Hospices, 2006; Clark, 1998; Davison, 2010; Denice and Walter, 1996; Kubler-Ross, 1969; Milicevic, 2002; Saunders, 1993, 2001). Or like many activities it is simply subsumed at a macro level, by economists and policy makers, into a Gross Domestic Product (GDP) figure that promotes a singular view of the economy. The GDP national accounting metric 'brackets heterogeneous parts of economic life as alike, on the basis that they all create market income which can be added up by economists' (Moran, et al, 2018 forthcoming).

Providential activities that are socially beneficial, such as hospice palliative care, are either assessed in a partial way because the activity is contextualised within a specific discourse or taken for granted because the activity is consolidated into an overarching GDP measure. Alternatively, Froud et al have argued that a business model framework is a useful investigative device for critical accountants because we can explore how organisations seek to meet the two related conditions of 'stakeholder credibility' and 'financial viability' (Froud et al, 2016). This paper employs a similar business model framing device to construct an interpretative understanding of the development of hospice palliative care using both narratives and numbers (Froud et al 2006). Our narratives are generated from interviews with key stakeholders and numbers extracted from hospice annual financial statements where both narratives and numbers are employed to assess the viability of the hospices business model.

The Literature on business models is grounded in economics and strategy (Chesbrough, 2010; Zott and Amit, 2010; Osterwalder, 2005; Bowman and Ambrosini, 2000; Timmers, 1998) and is normally focused on corporates that generate profit for shareholder value. Our argument is that a business model framework of analysis can also be employed to generate insight into the development and viability of not for profit voluntary hospices that provide palliative care services. Specifically, we employ a business model framing device because it makes visible material stakeholder relations that define the nature of the activities carried out by hospices (Andersson et al. 2010; Andersson and Haslam 2012;Freeman et al. 2004; Haslam et al. 2013, 2015,). Page and Spira (2016) observe that the various approaches to understanding an organisations business model have much in common with Wilson and Chua's broad but useful depiction of the organisation as a 'transformer of contributions from various stakeholders' (Wilson and Chua 1993: 23).

Within accounting there is also an ongoing debate about the objectives of financial disclosure that of informing a narrow group of investors or broader stakeholders about the financial viability of a reporting entity. Zeff (1999) observed that the American Institute of Certified Public Accountants (Trueblood Report, 1973) discussed the use of multiple values to describe organisation performance to a range of stakeholders and also proposed that social goals are no less important than economic goals. The International Accounting Standards Board (IASB, 2013) is still engaged in a process of clarifying the accounting conceptual framework for the

financial statements. However, it is suggested that information disclosed in financial statements should be useful and relevant to a wider group of stakeholders (IIRC, 2013). The European Financial Reporting Advisory Group (FRAG) research report on business models suggested that: 'The need to understand an entity's business model is further increased by development of integrated reporting, which suggests that investors need to rely on a cohesive set of information, encompassing more than only - financial statements' (EFRAG, 2013:12). From a financial reporting perspective the objective has been to employ 'business model reporting' to inform investors about risk and valuations (CFA, 2007). Others are sceptical about the utility of employing a firm's business model to structure financial disclosures and inform investors (Page, 2014). However, Singleton-Green (2015) observes that: each type of activity has its own business model, with its own particular types of market transaction, its own particular types of internal process, and its own particular risks and opportunities (Singleton-Green, 2015: 700). A reporting entities financial results are contingent on the nature of market transactions and risks. Market transactions and risks are the outcome of a reporting entity's interactions with stakeholders where these relationships are contingent upon the nature of the activities carried out to deliver specific products or services. These stakeholder relations are not only embedded in products and services produced but also have an impact upon the financial viability of a reporting entity (Haslam, et al, 2015). For example, changes in hospice regulatory arrangements could modify the way in which services are delivered for patients and these adjustments might, in turn, inflate costs ahead of funding received and thereby compromise financial viability.

In the next section of this article we construct an understanding of the stakeholder network that supports the activities carried out by hospices and which collectively help to broadly define the nature of the hospice business model. These stakeholder relations do not simply affect the nature of activities carried out by hospices but can also have a material impact upon its financial viability.

## 2.0 Framing hospices as a business model

The literature on business models is derived from the discourse of economics and strategy and is employed to explain how a firm positions itself within a value chain to create and capture value (Timmers, 1998; Zott and Amit, 2010). That is, a firm's business model describes how resources are deployed to generate innovative products and services (value creation)

and manipulate value chains to capture value. Haslam et al., (2013) construct an alternative understanding grounded in accounting of a reporting entity's business model invoking Freeman's (1984) work on stakeholder theory (Freeman, 1984; Freeman & Evan, 1990; Freeman et al, 2004). Freeman observes that stakeholders are: *'any group or individual who can affect or is affected by the achievements of the organization's objective'.* Wilson and Chua (1993) depict the organisation as a 'transformer of contributions from various stakeholders' (Wilson and Chua 1993, p. 23). Haslam et al., (2013) take the position that a reporting entity's business model is broadly defined by interactions with key material stakeholders. The European Financial Reporting Advisory Group (EFRAG, 2013) and International Integrated Reporting Council (IIRC, 2013) have suggested that reporting entities should describe their business model as part of the financial disclosure process. A key aspect of business model reporting is to inform investors about financial and non-financial risks in the viability statement. In the UK the Financial Reporting Council (FRC, 2015) amendments to the Corporate Governance Code recommend that: 'The directors should include in the annual report an explanation of the basis on which the company generates or preserves value over the longer term - the business model' (FRC, 2015:16).

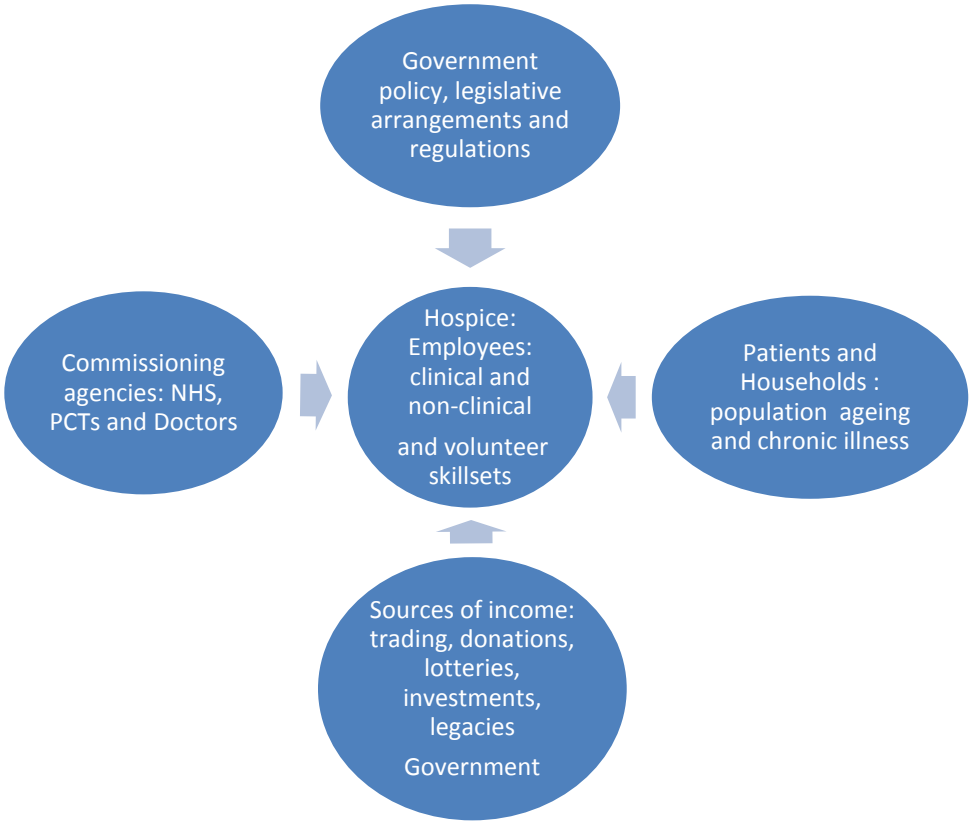
In figure 1 we map out the material stakeholder relations that broadly define the hospice business model. At the centre of the hospice business model are the hospice reporting entity which is subtended within a complex web of internal and external stakeholder relations. These stakeholder relations are also adapting and evolving over time and it is these changes can impact on the activities carried out by hospices and their financial viability.

Hospices are charitable organisations with a general mission to provide palliative care for chronically ill patients around the needs of the communities within which they operate (see Finley, 2001; Johnson, Rogers, Biswas, & Ahmedzai, 1990). In general hospices provide terminal care to cancer patients but this role has progressively migrated into a more holistic approach with hospices providing end of life care to a more diverse group of patients in addition to supporting a patient's family (Addington-Hall, Aspinal, Hughes, Dunckley & Higginson, 2004; CSA, 2000; Monroe and Oliviere, 2003; Payne, 2006; Twycross, 2006; Seymour, Clark, & Winslow, 2005; WHO, 2002). The capacity of hospices to provide chronic patient care is being stressed by an ageing of the population, for example, over the period

1985-2012 the number of people aged 65 and above in the UK increased by 20% and now accounts for 17% of the total population (10.3 million). Additionally, the number of people aged 85 and above has more than doubled during the same period of time and projections show that by 2035 roughly one-third of the UK population will be aged over 65 (Office for National Statistics, 2017).

The governance and stewardship of hospice resources is affected by a variety of dynamic regulatory and institutional demands: the Care Quality Commission (CQC), Charities Commission, NHS commissioning contracts, charity commission and accounting standards. These regulations impact upon the general health care process surrounding patients, professional development and skill-set requirements of staff, and also the financial viability of hospices.

Figure 1: The Hospice Business Model




Source: Authors

The funding model informing the hospice business model has also changed over time from one that was predominantly reliant on donations and legacies towards one that also now includes: government and local government healthcare contracts, lottery income, trading profits from shops and earnings from financial investments. These old and new funding streams are also prone to volatility, for example, in 2011 the UK Healthcare Bill modified the way in which palliative care was commissioned, financed and regulated, for example, giving some LGPs (Local General Practitioners) rather than regional PCT's (Primary Care Trusts) budgetary commissioning powers. Furthermore, the financial climate governing state and local government funding has become increasingly stressed due to funding cutbacks in an age of austerity (Ellis, 2012, King's Fund, 2011; Praill, 2011; Richardson, 2012). A significant amount of income is now generated from shops and trading activities and this not only modifies the nature of activities carried out by hospices it also complicates financial arrangements because shops have to be staffed and stocked, purchased or rented.

In the next section of this article we employ narratives extracted from interviews with 21 senior clinical and non-clinical hospice managers and one director of commissioning from a PCT obtained during the period 2007 to 2016 (See Appendix I). These narrative accounts reveal how changes to stakeholder relations impacted upon and changed the nature of activities carried out by hospices. In the subsequent section of this paper we construct a financial account of the hospice business model employing key financial data extracted from the annual reports of the top thirty-five hospices in England ranked by their total income and covering the period 2004 to 2015[1].

## 2.1 Hospices: Narratives accounts and evolution of the hospice business model

Hospices are non-lucrative voluntary organisations with a reliance on charitable donations but this fundraising has become increasingly complex and now requires skills found in profit-oriented commercial activities. An initial reliance on volunteers has been supplemented with 'professionally' administered teams focused on managing resources and competing for funding and this has led to the recruitment of 'commercially minded' professionals. Interviews with key stakeholders revealed a consensus that the hospice business model has

[1] These are the top 35 hospices in terms of their total income and represent over 50 percent of total hospice income in England in 2015

become increasingly complex in order to maintain its primary activity, namely, providing chronic patient care. Specifically hospices need to respond to changing demands from government and related healthcare agencies involved in the commissioning of palliative end of life care and also strive to continually adjust their funding model. These changes to the hospice business model encouraged a shift towards a more administrative and managerial led medicalization of palliative/end of life care.

Interviews were conducted with practitioners: medical, clinical, administrative and management levels to generate accounts about how the voluntary hospice sector business model has evolved (see appendix A). A medical director at one hospice uses the words 'business-like' and 'model' when constructing a narrative about change in the hospice voluntary sector.

> *'... perhaps it becomes a little bit more professionalized and a little bit more business-like so there is some shift but what we don't want to do is to lose these qualities of this earlier model because it does bring important things to our service so people's commitment is important to us ...'*
>
> Hospice A: Medical Director

It is also recognised that evolving stakeholder interactions are impacting upon the hospice sector and that this has implications for the values and culture of voluntary health care provision. As hospices migrated from their initial charitable financing model to one that has become embedded within a wider system of healthcare funding this adjustment is challenging their traditional independence. This is contextualised in terms of changed relations with the state or local government agencies and associated funding arrangements which are now more contractual and often include meeting targets and achieving regulatory obligations set for the broader National Health Service (NHS).

> *'I think that they see themselves as independent organisations, and I think they want to maintain that independence, but I think they also recognise that they … to carry, in terms of the public services they provide, would need to be able to carry the NHS brand'*
>
> PCT: Director of Commissioning Palliative Care

> *'There is less freedom to work in isolation or "do our own thing". We are expected to evidence what we do more thoroughly than ever before. H&S, infection control, HR, outcomes, working time directive, Cost in the £ etc. We are inspected more than ever before and the general public also want to know*

*where their money goes. On one hand this is a good thing but it now means hospices are having to employ experts in these fields which takes funds away from core services'*

Hospice E: Managing Director

*'I think it's having to become… I won't say more professional, I'd probably say more institutionalized, and NHS-ized ... And I don't think that's… it has some good features, but actually I think it's something that I'm very suspicious of'*

Hospice B: Medical Director

In addition there are changes driven by the type of treatment, length of stay for care, and need to provide palliative care to a broader group of patients such as non-cancer patients and this has led to increased complexity and sophistication of palliative care provision.

*'... I would say that the way in which the patients have changed and become more complex and their illnesses with co-morbidities, everything, actually it's not an easy option to work in a hospice anymore...'*

Hospice D: Nursing Director

Stakeholders reveal that the development of a more complex hospice business model for palliative care provision has been associated with the 'professionalization and medicalization of palliative care'. There is now more specific training for palliative care clinicians, as well as professional development and specialisation.

*'When I first started ten years ago, on the ward, there were very few treatments given on the ward. There was no, we weren't giving blood transfusions. It was much more low-key. It wasn't medicalised as such ...'*

Hospice A: Community Nurse Specialist

*'Now medical training is very rigid, it follows the same pattern as specialist training in any other specialty, so then it's a very different group of people coming through, it's a little bit more like a sausage machine you get the predictable product at the end. Whilst in the early days we had a wide mixture of people, mostly with very strong personal motivations on this work ...'*

Hospice A: Medical Director

There is also increased competition for funding among hospice charities and the need to manage expectations of those making donations

*'And so we have to be a lot more professional, a lot more aware and a lot more able to present ourselves against other charities when, from my perspective, we're looking for money and we're actually sourcing funds'*

Hospice D: Appeals Coordinator - Fundraising

In the following section we focus on three material elements that are impacting on the adaption and evolution of the hospice business model: funding arrangements, employee skills and population demographics. Responses from key stakeholder interviewed revealed how these elements of the hospice business model are also interconnected because changes in one element are conjoined with often ambiguous and contradictory impacts elsewhere. For example a regulatory change might have implications for employee expenses or need to employ additional staff which might then compromise financial stability.

## 3.0 Sustaining the hospice business model

Our interviews with hospices stakeholders revealed three interconnected threats to its sustainability: securing funding to cope with increasing demand for services; recruiting appropriately skilled employees and pressures arising from an ageing population.

### 3.1 Hospice funding

Hospices now receive a substantial share of their funding (roughly one-third) either directly from government or indirectly from related funding agencies such as the NHS or local doctors. This source of income is not only viewed as a key risk that has the potential to undermine hospice financial viability but also that this funding comes attached to contracts that demand value for money (VFM).

*'The more the NHS funds you, the more they expect from you, but at the same time, they actually want it dirt cheap. So what the PCT would like is to have most palliative care delivered by generalists ... but the specialist units have to have a certain lower level of funding to enable them to provide the services that they do'*

Hospice B: Medical Director

*'As DOH budgets decrease and increased scrutiny around fundraising governance is introduced and different contractual arrangements are introduced. More focus on core service is expected and less focus on seeing the patient as a whole, which is the basis of hospice care, anything that isn't nursing or medicine will not be funded'*

Hospice D: Hospice accountant

The voluntary hospice business model is being absorbed into the NHS management and regulatory regime through contracts.

> *'... there might be a lot of reasons that we might not want to come under government funding because then we get involved in all the competition for funding with other specialties and we also get involved with huge bureaucracy which is the NHS and that's not very attractive, at the moment we have our independence we are self-determined to some extent ...'*

Hospice A: Medical Director

There is also the challenge of becoming too dependent upon government funding agencies especially when cutbacks in public spending transmit financial risk and instability into the hospice business model.

> 'So, at the moment, of course, the problem is the hospice is in a crisis, the government has run out of money, they've got to make savings in the NHS, so the NHS passes on the financial cuts, if you like, through the PCT'

Hospice D: Hospice Accountant

Hospices are also reliant on funds from donors from within a local community from: lotteries, legacies (from a persons will upon death), charity trading shops, and general fundraising events. Donors rarely adjust their contributions in line with inflation and so hospices are under additional financial pressure to find new funds to cover inflated expenses, such as employment costs.

> *'They're used to donating £10. It's their level, if you like. They'll buy £5 worth of raffle tickets and then £5 of raffle tickets every year. They don't buy £6 the year after and £7 the year after that because our costs are going up. They're contributing at the same level so we have to find more contributors, if you like'*

Hospice C: Finance Manager

> *'Salary costs are on the increase but the general public do not understand this. It is no longer enough to care we need to now prove how, why etc. Money is not going to be just handed over anymore, we have to evidence everything and we do not have the infrastructure to do this which means spending more on staffing – it is a vicious circle.'*

Hospice E: Managing Director

Diversification of funding streams away from traditional donors has been a significant development to the hospice business model. Shifting from individuals to corporate donors and setting up fundraising events brings with it new income streams but also new uncertainties and demands.

> *'... we need to start looking outside of that and really concentrate on the business sectors, and getting people involved and doing things like that, because people only have so much money to give'*
>
> Hospice C: Fundraising Director

> *'With the present economic climate it's very difficult for us to attract money from corporates so, and that's something that's been in a sort of a decline at the moment'*
>
> Hospice D: Appeals Coordinator - Fundraising

The hospice business model has not only become more complex in terms of its funding model there are also pressures on hospices to maintain and recruit new staff.

3.2 Hospices: Recruitment, retention and skills

Recruitment, retention, and training of qualified clinical personnel is also a significant issue raised by stakeholders and affects hospices' capacity to sustain current levels of care and/or extend palliative care. For example, a scarcity of relevant skills at a national level and competition between NHS hospitals and neighbouring hospices impacts adversely on hospices' operating capacity.

> *'Okay. Seeing we're talking about staffing, I mean, great plans, the end-of-life care strategy, lots of good stuff in it. But they've starved the people to do it at a general level, let alone at the specialist level'*
>
> Hospice B: Medical Director

As hospices offer wider palliative care services to cancer and other chronically ill patients they need adequate expertise at both generalist and specialist levels and this also presents a strain on resources.

> *'I think we're finding them a challenge in terms of our knowledge* (referring to non-cancer patients). *Because although we're sort of, at end stage, ... sort of,*

*our skills should be applicable to anybody. It's still concerns, you know, we're not trained as respiratory nurses, we're not trained as, you know, renal nurses. So we're just concerned about that the, sort of, challenges of knowledge and being skilled enough to do it"*

Hospice A: Community Nurse Specialist

Scarcity of adequately qualified and experienced professionals has already led to a general inflation of remuneration packages because hospices need to match NHS and private consulting pay scales. Matching these pay rates inflates hospice expenditure levels and this, in turn, imposes additional pressure on fundraising.

*'Our main competitors are the neighbouring hospices and the neighbouring hospitals but mainly the neighbouring hospices. I remember back two years ago we were fighting over one doctor where to work, we wanted the doctor, we also knew that two other hospices wanted that doctor, so we interviewed the same person, you know, for the three jobs and unfortunately we didn't get her'*

Hospice D: Medical Director

In addition to the challenge of recruiting and retaining qualified clinical personnel, scarcity of relevant expertise in fundraising is a significant issue especially recruiting fundraisers at a senior level.

*'I think just from a fundraising perspective, yes, I'm looking for people with sales and marketing skills. These people could be earning a lot more money elsewhere, so what are you ending up with in a recruitment pool?'*

Hospice A: Fundraising Director

3.3 Hospice palliative care: Changing demands and ageing population

Hospices are under increasing pressure to provide end of life care to patients with non-malignant conditions. Interviewed stakeholders expressed a general concern about how hospices' will cope with the complexity of chronic illnesses that new types of patients bring into the system where also life expectancies are increasing.

'*We're looking at doing non-malignant work, so that's putting a huge increase, that's, you know, doubling potentially the amount of patients that there are going to be, although I'm not convinced whether hospices should be prime*

*movers in non-malignant palliative care, or whether they should just be advisory'*

Hospice B: Medical Director

*'… and the other thing is, with the end of life care and the all the sort of proposals of what other patients we might be taking other than cancer patients, we could be opening the floodgates, I would imagine, to lots of referrals'*

Hospice D: Voluntary Services Manager - Fundraising

*'I think the demand from people, there just going to be an increasingly ageing population, so you are going to have to deal with more people, with more complex conditions'*

Hospice A: Managing Director

*'The challenge would be on trying to make places available for those patients, but also to run our policies alongside them'*

Hospice A: Day Hospice Leader

The capacity to provide hospice end of life care is being stressed by both an ageing population and compounded by the need to treat non-cancer patients or patients with multiple chronic health care needs.

*'Because the difficulty can sometimes be, particularly from myself in day hospice, that despite the fact that they've got on going chronic illnesses the length of their life may actually still be longer than a cancer patient, and therefore can we accommodate places for perhaps periods of years as opposed to periods months?'.*

Hospice A: Day Hospice Leader

Our interviews with key stakeholders engaged in the hospice business model reveal how its sustainability is being challenged. The need to raise funding requires additional staffing in both managerial and administrative tasks. Changes in patient care establishes the need for high skilled nursing and clinicians that can help manage more complex chronic illnesses. An ageing population, coupled with broader healthcare problems, will increase the number of patients seeking chronic palliative care. The hospice business model is being stressed by these

challenges and in the following section we employ hospice financial statements to generate narratives about whether the hospice business model is financially robust or fragile.

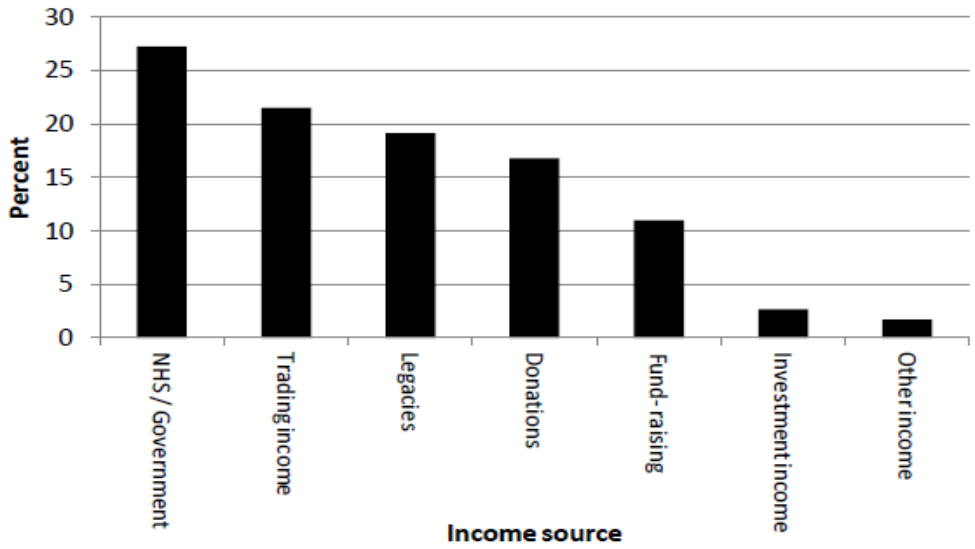
## 4. The hospice business model: assessing financial viability

The UK Charity Commission's website reproduces the Statement of Recommended Practice (SORP, 2005) which outlines the financial information that should be disclosed by hospices (as charities) in their main financial statements and notes providing guidance on the treatment and recording of income, expenditure and balance sheet line items. Help the Hospices (a UK umbrella organisation) provides specific SORP guidance for hospices (Help the Hospices, 2010; Hospice UK, 2014). The financial information disclosed by hospices provides an additional 'numbers' resource that can be employed to generate interpretative narratives about the financial viability of the hospice business model. Our financial analysis employs financial data extracted from the top 35 hospices in England ranked by their total income. This financial analysis is made possible by changes in charity Statement of Recommended Practice (SORP) which extended disclosure obligations. The sample of thirty-five hospices used to construct our financial analysis account for just over half of all hospice income in England in 2015. At the top of the list is St. Christopher's Hospice that received £19.5 million of income in 2015, and at the bottom of our group of hospices is the Butterwick Hospice with an annual income of £5.2 million whilst the average total income for this group of hospices was £10.4 million

### 4.1 Hospice Income: Fragmented and volatile

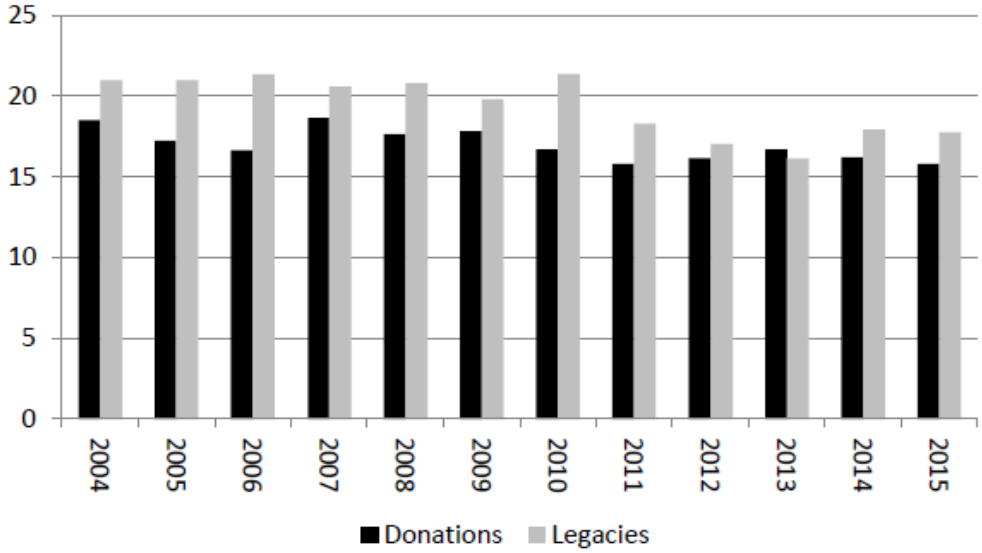
Hospices raise income from a complex array of stakeholders with varying motivations and commitment to funding. The average hospice will generate income from: legacies arising upon the death of a donor, individual or corporate donations made on a regular or irregular basis, specific fund raising events, lotteries, shops, investment income, NHS and Local Authority funding, and other income (such as from educational courses). This diversity of income streams presents a number of challenges because some of these account for over 20 per cent of hospice income but can be volatile (see Figure 1 and 2). Figure 1 reveals that income from NHS/Government sources accounts for 27 percent of an average hospice total income followed by trading income, legacies and donations.

Figure 1: Hospices average income share by source (Aggregate Data 2004-2015)




Source: Data obtained from UK Charities Commission website. The data refers to the top 35 hospices ranked by income in England in the year 2015

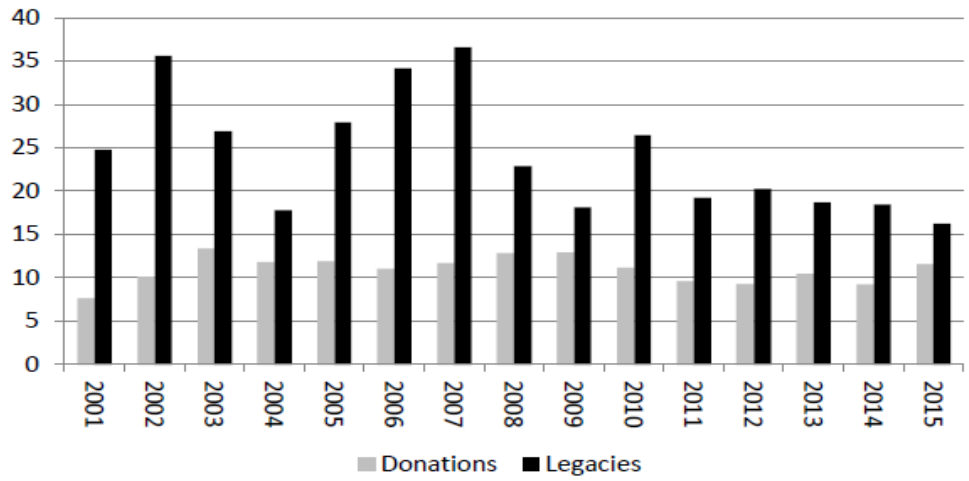
Figure 2: Hospices income from donations and legacies (Aggregate Data 2004-2015)




Source: Data obtained from UK Charities Commission website. The data refers to the top 35 hospices ranked by income in England in the year 2015

Income from legacies and donations tends to be more volatile than that for other components such as from trading (shops) and also government/NHS income received. We can also observe that, in aggregate, the share of an average hospice income from donations and legacies is either falling and/or volatile.

Figure 3: Pilgrims Hospice income from donations and legacies (Aggregate Data 2004-2015)




Source: Data obtained from website: [http://www.pilgrimshospices.org/about-pilgrims-hospices/annual-accounts/](http://www.pilgrimshospices.org/about-pilgrims-hospices/annual-accounts/)

In the specific case of Pilgrims Hospice (see figure 3) there is considerable volatility in the pattern of income received from legacies and donations. In response to this volatility in income hospices have sought to modify their business model to incorporate new forms of stakeholder income generating activities. One significant change to the hospice business model has been the considerable investment in shops located in towns and cities that trade donated goods and now generate roughly one-fifth of an average hospice's total income (see figure 1). Hospices generally locate these trading and retail activities in separate subsidiaries and consolidate profit into their main set of accounts.

> 'St. Rocco's Shops Ltd. is a wholly owned subsidiary of the Hospice. During the year (2013) the company's net income was £613,034 (2012: £603,161). This equates to just over 20% of the total income of the Hospice. We have, in addition, generated gift aided donations through our Furniture Shop of £48,175.'
>
> St. Rocco's Hospice Annual Report (2013, p. 10)

Table 1 reveals that, for the group of 35 hospices the share of trading income in total income increases from 19 percent to more than 24 per cent over the period 2004 to 2015.

Table 1: Hospices trading income in total income (%)

| Years | Trading income in total income (%) |
|---|---|
| 2004 | 19.1 |
| 2005 | 19.6 |
| 2006 | 18.3 |
| 2007 | 19.7 |
| 2008 | 18.5 |
| 2009 | 20.0 |
| 2010 | 20.8 |
| 2011 | 21.3 |
| 2012 | 24.2 |
| 2013 | 24.2 |
| 2014 | 23.3 |
| 2015 | 24.3 |

Source: Data obtained from UK Charities Commission website. The data refer to the top 35 hospices by income in England.

Another significant source of income for hospices arises out of contracts with local and national health agencies but this injects additional complexity into the hospice business model because of the need to deliver value for money (VFM) and efficiency savings. Public sector contracts with voluntary hospices require compliance with a value for money audits. In the past NHS funding for hospices been a relatively stable component of total income (see Table 2) but there is increasing concern that, in an era of austerity, funding levels will reduce.

> More than two thirds of hospices have had their statutory funding frozen or cut by NHS commissioners for 2014/15
>
> Almost three-quarters (74%) of hospices in England surveyed expect their funding to be either cut or frozen again during this financial year (2015/16). With 59% expecting a funding freeze and 15% anticipating a cut in funding
>
> Hospice UK (2015 p. 5)

Table 2 reveals that after peaking at 30 percent of total hospice income in 2011 funding from the UK Government/NHS has fallen back to 26 percent of income n 2015.

Table 2: Hospices income from NHS / Government contracts as a share of total income 2004 to 2015

| Years | Income from NHS/ Government as a share of total income (%) |
|---|---|
| 2004 | 26.8 |
| 2005 | 27.3 |
| 2006 | 25.3 |
| 2007 | 25.5 |
| 2008 | 26.9 |
| 2009 | 26.3 |
| 2010 | 28.0 |
| 2011 | 30.3 |
| 2012 | 27.8 |
| 2013 | 27.4 |
| 2014 | 27.2 |
| 2015 | 26.1 |

Source: Data obtained from UK Charities Commission website. The data refers to the top 35 hospices ranked by income in England in 2015.

4.2 Hospices: Changes to operating costs

Table 3 reveals the average cost structure for our sample of hospices and it shows that the average hospice increased its share of total income used to buy-in purchases and services from 23 to 27 percent of total income. This reduced retained income[2] available for internal uses from 77 to 73 percent. In 2015 the average hospice deployed over 90 per cent of these internal funds to cover employment expenses compared to 80 per cent in 2004. This increase in both the share of external costs and internal employment expenses out of total income squeezed the cash surplus which was down from roughly 15-20 percent of total income in 2004 to 8 percent in 2015. Smaller hospices such as St Ann's record considerable volatility in

[2] Retained income is all total income minus all internal costs (employment costs and cash surplus - earnings before interest tax and depreciation EBITDA)

their annual net funds (total income minus expenses) and when these funds are negative this can then have an adverse impact on balance sheet reserves.

Table 3: Hospices external and internal cost structure 2004 to 2015

| | Total Income | Total External Costs Share of Income | Total Income Retention | Employment Costs out of Retained Income | Cash Surplus from Income |
|---|---|---|---|---|---|
| | £000's | % | % | % | % |
| 2004 | 187,923 | 23.6 | 76.4 | 80.7 | 19.3 |
| 2005 | 198,268 | 23.1 | 76.9 | 85.1 | 14.9 |
| 2006 | 225,340 | 25.7 | 74.3 | 82.2 | 17.8 |
| 2007 | 231,353 | 23.7 | 76.3 | 83.0 | 17.0 |
| 2008 | 261,864 | 23.8 | 76.2 | 79.0 | 21.0 |
| 2009 | 260,967 | 26.7 | 73.3 | 89.6 | 10.4 |
| 2010 | 279,352 | 24.0 | 76.0 | 86.0 | 14.0 |
| 2011 | 300,071 | 24.1 | 75.9 | 84.9 | 15.1 |
| 2012 | 304,722 | 26.6 | 73.4 | 91.9 | 8.1 |
| 2013 | 323,813 | 26.5 | 73.5 | 91.1 | 8.9 |
| 2014 | 365,640 | 26.8 | 73.2 | 85.4 | 14.6 |
| 2015 | 364,630 | 27.0 | 73.0 | 91.6 | 8.4 |

Source: Data obtained from UK Charities Commission website for the top 35 hospices by income in England. Notes: External costs found by deducting all internal costs (employment expenses and cash surplus) from total income. Total income retained is after deducing all external expenses.

Table 4: St Ann's hospice total costs and cash surplus 2004 to 2015

| | Total Income | Total Expenditure (External plus Labour Costs) | Net Funds Movement |
|---|---|---|---|
| | £000's | £000's | £000's |
| 2004 | 6,418 | 7,271 | -853 |
| 2005 | 6,754 | 8,143 | -1,389 |
| 2006 | 8,431 | 6,870 | 1,561 |
| 2007 | 7,999 | 7,531 | 468 |
| 2008 | 9,794 | 7,227 | 2,567 |
| 2009 | 8,788 | 9,351 | -563 |
| 2010 | 9,673 | 8,975 | 698 |
| 2011 | 10,083 | 11,171 | -1,088 |
| 2012 | 9,449 | 8,296 | 1,153 |
| 2013 | 11,066 | 9,015 | 2,051 |
| 2014 | 9,817 | 9,324 | 493 |
| 2015 | 9,675 | 10,151 | -476 |

Source: http://www.sah.org.uk/about/documents-and-leaflets/annual-reviews-and-accounts

4.3 Hospices: Balance sheet assets and reserves

In table 5 we summarise the asset structure of our sample of hospices. This reveals that the value of investments are a significant and material item on balance sheet and include: bonds, equities and cash deposits. These investments in financial assets are important because they will eventually be liquidated to provide funds to modernise or replace tangible assets such as buildings and equipment. However, the value of these financial investments can be affected by the vagaries of the capital markets which can generate holding gains but also losses. We also find that hospices are investing more funds into stock and debtors associated with their increased shop related trading activities.

Table 5: Asset structure of 35 hospices in England

| | Tangible Assets | Investments | Stocks & Debtors | Cash and Deposits | Total Assets |
|---|---|---|---|---|---|
| | £ 000's | £ 000's | £ 000's | £ 000's | £ 000's |
| 2004 | 129,029 | 88,380 | 13,342 | 74,232 | 304,983 |
| 2005 | 130,982 | 103,615 | 14,875 | 76,913 | 326,385 |
| 2006 | 140,890 | 125,632 | 17,296 | 84,519 | 368,337 |
| 2007 | 149,383 | 139,494 | 16,162 | 89,791 | 394,830 |
| 2008 | 164,404 | 136,327 | 19,991 | 114,152 | 434,874 |
| 2009 | 190,000 | 122,123 | 23,403 | 96,195 | 431,721 |
| 2010 | 200,224 | 146,680 | 28,635 | 94,850 | 470,389 |
| 2011 | 213,258 | 161,733 | 27,542 | 98,904 | 501,437 |
| 2012 | 223,601 | 162,836 | 27,890 | 93,953 | 508,280 |
| 2013 | 227,438 | 175,424 | 30,465 | 96,361 | 529,688 |
| 2014 | 238,168 | 179,845 | 41,435 | 95,602 | 555,050 |
| 2015 | 237,863 | 202,686 | 37,043 | 97,154 | 574,746 |
| Share of Assets % | | | | | |
| 2004 | 42.3 | 29.0 | 4.4 | 24.3 | 100 |
| 2005 | 40.1 | 31.7 | 4.6 | 23.6 | 100 |
| 2006 | 38.3 | 34.1 | 4.7 | 22.9 | 100 |
| 2007 | 37.8 | 35.3 | 4.1 | 22.7 | 100 |
| 2008 | 37.8 | 31.3 | 4.6 | 26.2 | 100 |
| 2009 | 44.0 | 28.3 | 5.4 | 22.3 | 100 |
| 2010 | 42.6 | 31.2 | 6.1 | 20.2 | 100 |
| 2011 | 42.5 | 32.3 | 5.5 | 19.7 | 100 |
| 2012 | 44.0 | 32.0 | 5.5 | 18.5 | 100 |
| 2013 | 42.9 | 33.1 | 5.8 | 18.2 | 100 |
| 2014 | 42.9 | 32.4 | 7.5 | 17.2 | 100 |
| 2015 | 41.4 | 35.3 | 6.4 | 16.9 | 100 |

*Source: Data obtained from UK Charities Commission website and for the top 35 hospices by income in England.*

A significant challenge facing hospice trustees is that of maintaining reserves in the balance sheet because these provide a financial buffer when income reduces and / or costs inflate during the financial year. All hospices are required to operate with a specific reserves policy which is decided upon by the trustees, for example, St Rocco's hospice has a reserves policy that balances the possibility of uncertain revenues and expenses (free unrestricted reserves) and reserves available to rebuild and update facilities (restricted reserves)

> 'The Trustees annually review the Reserves Policy of the charity. This review encompasses the nature of the income and the expenditure streams, the need to match variable income with fixed commitments and the nature of the reserves. The review concluded that to allow the charity to be managed efficiently and to provide a buffer for uninterrupted services, a free reserve equivalent to approximately nine months of expenditure should be maintained. During the year the charity's total consolidated reserves increased from £8,853,973 to £8,927,668 of which £4,140,786 is held in tangible fixed assets'
>
> St. Rocco's Hospice Annual Report (2013, p. 11)

Free reserves are those that are available to cover a deficit arising out of changes in income and expenditure and these are held by hospices for a number of reasons: 'in a charity which relies on voluntary sources for half to two-thirds of its income and renegotiates NHS funding every year, it is important that there are reserves held to enable the hospice to continue charitable work effectively and seamlessly if income levels were to fall' (Hospice UK, 2014, p. 19). The average 'free reserves' held by hospices was equivalent to roughly eight months of hospice expenditure but nine out of our 35 hospices held free reserves that were equivalent to less than two months of annual income in 2015. Hospices must also maintain reserves that are designated and set aside to redevelop or update facilities. These reserves, as we have noted, are held as financial investments but this exposes hospices to capital market risk. For example in St Margaret's hospice in 2013, a deficit adjustment on invested funds was in the region of £445K.

> In addition we strive to maintain our investment portfolio, our main reserves, so that we can have confidence when undertaking operational planning. The investment portfolio generated a gain of £309k in the year (2012: £2,042k). Charitable companies are obliged to report gains and losses on investments as part of the annual result consequently, we report a total deficit in the year of £445k (2012: £772k surplus)

St Margaret's Hospice Annual Report (2013, p. 15)

Changes in the fair value of investments can have an adverse impact on reported surplus for the year, for example St Columba's Hospice noted in their 2015 annual financial report that:

> The deficit for the year for Companies Act purposes comprises the net outgoing resources plus realised gains and losses on investments less taxation and amounted to £1,649,613
>
> St. Columba's Hospice Annual Report (2015, p. 17)

This change in the market value of financial investments at St Columba Hospice was equivalent to a 23 percent reduction in total income and these losses impacted negatively on the value of restricted reserves set aside for infrastructure replacement and modernisation. Capital market risk is heightened in the hospice business model because investments are now roughly one-third of an average hospice's total assets (see table 5).

The financial operating characteristics of the hospice business model are now more complex and there are considerable uncertainties on both the income and expenditure side as there are also with balance sheet valuations. Income is derived from a complex range of stakeholder arrangements where donors have variable motivations and behaviour and so these segments of total income are uncertain and often volatile. Hospice managers are motivated to maintain expenditure levels because this preserves their capacity to provide chronic care for patients and so it is also important to maintain discretionary reserves to absorb any financial instability that might threaten the continuity of services. In addition to discretionary reserves hospice will also maintain designated reserves to finance new equipment and buildings but the valuation of the investments that sit in these reserves are exposed to capital market uncertainty and value at risk.

## 5. Summary

The objective of this paper has been to construct a descriptive business model for voluntary hospices in England and employ this framing device to reveal the challenges of sustaining palliative end of life care. Our argument is that a reporting entity's business model can be broadly specified as resulting from dynamic stakeholder relations. These stakeholder relations not only broadly describe the activity characteristics of a reporting entity's business model

they also support or frustrate financial viability. In this paper we have drawn upon 'narratives' from key stakeholders involved in the hospice business model to understand how activity characteristics are changing. We have employed 'numbers' extracted from hospice financial statements to reveal how changes to stakeholder relations governing the hospice business model modify its' financial condition.

Our interviews with 21 clinical and non-clinical directors from five hospices and one director of a commissioning Primary Care Trust (PCT) reveal the changing nature and challenges facing this complex business model. Three key aspects are identified: first the complexity of the funding model; second, the scarcity of appropriately skilled staff for clinical, nursing and fundraising work, and finally the extended demand for hospice care driven by population demographics. The interview narratives reveal that the voluntary hospice care business model is becoming, '*more business-like'* and this is evident from interviews with participants. And, that the drivers of this change, are the demands on hospices to provide an extended range of clinical support which has to be secured from innovative income generating initiatives.

Annual financial reports are a useful 'numbers' resource that can be employed to assess the financial viability of the hospice business model. These financial reports are much more informative after changes in disclosure requirements set out in the Statement of Recommended Practice (SORP) for charities. Hospice annual reports now provide a rich information resource that can be employed to reveal changes in hospice funding from a variety of stakeholder perspectives: trading from shops, individual and corporate donations, legacies, lotteries, general fund-raising and holding gains (or losses) from funds invested in financial markets. These financial disclosures help to specify the nature of the hospice business model (Singleton-Green, 2015) and can be employed to critically inform policy makers about how changes in stakeholder relations promote or frustrate the financial viability of a specific business model (Haslam et al, 2015; Froud et al, 2016).

Our objective has been to reveal how the hospice business model has become increasingly complex as new stakeholder relations not only impact upon the activities undertaken by hospices but also the financial viability of this business model. A UK Hospice report (2015) revealed that forty percent of UK hospices were in deficit in 2015 and are drawing down on their reserves. This financial uncertainty adds to the difficulty of sustaining and growing the hospice business model to meet the challenges that will arise from an increasingly ageing

population seeking palliative/end of life care. The UK Government's end of life care strategy will need to draw upon the capacity of voluntary hospices to sustain the provision of palliative care in England as the population ages. UK Government policy interventions need to be critically informed by a descriptive hospice business model grounded in accounting rather than economics because this alternative framing reveals the impact of a reporting entity's stakeholder(s) on viability.

Appendix A

| List of interviewees and role | | |
|---|---|---|
| Employer hospice | Interviewee's role | Interview time |
| Hospice A | Medical Director | Apr-07 |
| Hospice A | Fundraising Director | Feb-08 |
| Hospice A | Community Nurse Specialist | Apr-07 |
| Hospice A | Nursing Director | Apr-07 |
| Hospice A | Day Hospice Leader | Apr-07 |
| Hospice A | Managing Director | May-16 |
| Hospice B | Medical Director | Nov-08 |
| Hospice B | Support Services Director | Nov-08 |
| Hospice B | Fundraising Director | Nov-08 |
| Hospice B | Nursing Director | Nov-08 |
| Hospice C | Fundraising Director | Dec-08 |
| Hospice C | Medical Director | Dec-08 |
| Hospice C | Finance manager | Dec-08 |
| Hospice D | Medical Director | Oct-09 |
| Hospice D | Nursing Director | Oct-09 |
| Hospice D | Voluntary Services Manager Fundraising | Oct-09 |
| Hospice D | Senior Administrator | Oct-09 |
| Hospice D | Appeals coordinator Fundraising | Oct-09 |
| Hospice D | Hospice Accountant | Oct -09 & Mar-16 |
| Hospice E | Managing Director | Apr-16 |
| PCT | Director of Commissioning Palliative Care | Jul-09 |

References

Addington-Hall, J. M., Aspinal, F., Hughes, R., Dunckley, M., & Higginson, I. J. (2004). *Project to Improve Management of Terminal Illness: Summary of findings from PROMOTE*. London: National Council for Palliative Care.

American Institute of Certified Public Accountants. (1973). 'Objectives of financial statements' (Trueblood Report): New York. http://3197d6d14b5f19f2f440-5e13d29c4c016cf96cbbfd197c579b45.r81.cf1.rackcdn.com/collection/papers/1970/1973_1001_TrueBloodObjectives.pdf

Andersson, T., & Haslam, C., (2012). The private equity business model: On terra firma or shifting sands? *Accounting Forum,* 36(1), 27-37. doi:10.1016/j.accfor.2012.01.002

Andersson, T., Gleadle, P., Haslam, C., & Tsitsianis, N. (2010). Bio-pharma: A financialized business model, *Critical Perspectives on Accounting,* 21(7), 631-641. doi:10.1016/j.cpa.2010.06.006

Association of Children's Hospices. (2006). *Annual Review 2005/2006*. Retrieved from http://www.childhospice.org.uk/sections/aboutus/documents/ACH002B_AReviewFinal.pdf

Bowman, C., & Ambrosini, V. (2000). Value creation versus value capture: towards a coherent definition of value in strategy, *British Journal of Management,* 11, 1–15. doi: 10.1111/1467-8551.00147

CSA 2000 (Care Standards Act 2000). Retrieved from http://www.legislation.gov.uk/ukpga/2000/14/contents

CFA (2007). A Comprehensive Business Reporting Model, CFA Institute Centre for Financial Market Integrity. http://www.cfapubs.org/doi/pdf/10.2469/ccb.v2007.n6.4818

Chesbrough, H. (2010). Business Model Innovation: Opportunities and Barriers. *Long Range Planning,* 43(2-3), 354-363. doi:10.1016/j.lrp.2009.07.010

Clark, D. (1998). Originating a movement: Cicely Saunders and the development of St. Christopher's hospice, 1957–1967, *Mortality*, 3, 43-63. doi:10.1080/713685885

Davison, S. N. (2010). End-of-life care preferences and needs: perceptions of patients with chronic kidney disease, *Clinical Journal of the American Society of Nephrology*, 5, 195-204. doi: 10.2215/CJN.05960809

Denice, C. S., & Walter, B. F. (1996). *Hospice and Palliative Care Concepts and Practice.* Massachusetts: Jones and Bartlett.

DoH (Department of Health, 2009). *End of Life Care Strategy: First Annual Report* (London: Department of Health). Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136486/End-of-Life-Care-Strategy-Fourth-Annual-report-web-version-v2.pdf

DoH (Department of Health, 2002). *National Minimum Standards and Regulations for Independent Health Care,* Norwich: Department of Health. Retrieved from http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4085259

EFRAG (European Finance Research Advisory Group, 2013).The role of the business model in financial statements. Retrieved from https://www.efrag.org/Assets/Download?assetUrl=%2Fsites%2Fwebpublishing%2FSiteAssets%2FBusiness%2520Model%2520Research%2520Paper.pdf

Ellis, J. (2012*). Funding for Palliative Care Is Vital.* Retrieved from http://www.helpthehospices.org.uk/media-centre/press-releases/funding-for-palliative-care-is-vital-says-hospice-sector/

Financial Reporting Council. (2015). The UK Corporate Governance Code, London, UK. https://www.frc.org.uk/Our-Work/Publications/Corporate-Governance/UK-Corporate-Governance-Code-2014.pdf

Finlay, I. (2001). UK strategies for palliative care, *Journal of the Royal Society of Medicine,* 94, 437–441.

Freeman, R. E. (1984). *Strategic Management: A Stakeholder Approach.* London: Pitman.

Freeman, R. E. & Evan, W.M. (1990). Corporate governance: a stakeholder interpretation*, The Journal of Behavioural Economics*, 19, 337-359. doi:10.1016/0090-5720(90)90022-Y

Freeman, R. E., Wicks, A. C. & Parmar, B. (2004). Stakeholder Theory and The Corporate Objective Revisited, *Organisation Science,* 15(3), 364-369. doi:10.1287/ orsc.1040.0066

Froud, J, Johal, S., Leaver, A and Williams K. (2006). Financialization and Strategy: Narrative and Numbers. Routledge, Taylor and Francis, London

Froud, J., Tischer, D and Williams, K. (2016). It's the business model...Reframing the problems of UK retail banking, *Critical Perspectives on Accounting,* 42, (1), 1-19. http://www.sciencedirect.com/science/article/pii/S1045235416300168

Haslam, C., Andersson, T., Tsitsianis, N., & Yin, Y. P. (2013). *Redefining Business Models: Strategies for a Financialised World*. Routledge.

Haslam, C., Tsitsianis, N., Andersson, T., & Gleadle, P. (2015). Accounting for Business Models: Increasing the Visibility of Stakeholders, *Journal of Business Models,* 3(1), 62-80. doi:http://dx.doi.org/10.5278/ojs.jbm.v3i1.1066

Help the Hospices (2005) *Hospice and Palliative Care Facts and Figures 2005,* London: Help the Hospices.

Help the Hospices, (2006). *Hospice Accounts: Analysis of the Accounts of English Adult Independent Voluntary Hospices 2002-2005,* London: Help the Hospices.

Help the Hospices, (2009). *Hospice Accounts: Analysis of the accounts of UK independent voluntary hospices 2005-2008,* London: Help the Hospices

Help the Hospices, (2010). Guidance for member hospices on the Charity, March. Retrieved from http://www.hospiceuk.org/docs/default-source/finance/guidance_for_hospices_on_the_charity_sorp.pdf?sfvrsn=2

Hospice UK, (2014). Hospice Accounts: Analysis of the accounts of UK independent voluntary hospices for the year ended 31st March 2013. Retrieved from http://www.hospiceuk.org/docs/default-source/default-document-library/hospice-accounts-report-2014.pdf

Hospice UK, (2015). Commissioning and statutory funding arrangements for hospices in England Survey results 2015. Retrieved from http://www.togetherforshortlives.org.uk/assets/0001/1502/Hospice_commissioning_and_funding_survey_results_2015.pdf

International Accounting Standards Board (IASB). 2013. *A review of the conceptual framework for financial reporting*. Discussion paper DP/2013/1 http://www.ifrs.org/Current-Projects/IASB-Projects/Conceptual-Framework/Discussion-Paper-July-2013/Documents/Discussion-Paper-Conceptual-Framework-July-2013.pdf

International Integrated Reporting Council (IIRC), (2013) *Consultation draft of the international <IR> framework,* London: IIRC. Retrieved from http://www.theiirc.org/consultationdraft2013/

Johnson, I. S., Rogers, C., Biswas, B., & Ahmedzai, S. (1990). What do hospices do? A survey of hospices in the United Kingdom and Republic of Ireland, *British Medical Journal,* 300, 791-3. doi: http://dx.doi.org/10.1136/bmj.300.6727.791

King's Fund, (2005). *Palliative Care Perspectives on Caring for Dying People in London,* London: King's Fund. Retrieved from http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/palliative-care-perspectives-dying-people-jenni-burt-cathy-shipman-julia-addington-hall-patrick-white-kings-fund-1-march-2005.pdf

King's Fund, (2006). *Future Trends and Challenges for Cancer Services in England,* London: King's Fund. Retrieved from

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/future-trends-challenges-cancer-services-england-review-of-literature-policy-rebecca-rosen-alex-smith-tony-harrison-kings-fund-24-august-2006.pdf

King's Fund, (2011). *Issues Facing Commissioners of End-of-Life Care,* London: King's Fund. Retrieved from http://www.kingsfund.org.uk/sites/files/kf/issues-facing-commissioners-end-of-life-care-report-september2011.pdf

Kubler-Ross, E. (1969). *On Death and Dying.* New York: Macmillan Publishing Co.

Milicevic, N. (2002). The hospice movement: history and current worldwide situation *Archive of Oncology*, 10, 29-32. doi:10.2298/AOO0201029M

Monroe, B., & Oliviere, D. (2003). *Patient Participation in Palliative Care. A Voice for the Voiceless.* Oxford: Oxford University Press.

Moran, M., et al. (2018 forthcoming). 'The Foundational Economy', Manchester University Press.

NCPC (The National Council for Palliative Care, 2006) *National Survey of Patient Activity Data for Specialist Palliative Care Services MDS Full Report for the Year 2005-2006,* London: NCPC.

NCPC (The National Council for Palliative Care, 2011) *Commissioning End of Life Care,* London: NCPC. Retrieved from http://www.ncpc.org.uk/sites/default/files/AandE.pdf

Page, M (2014) Business models as a basis for regulation of financial reporting, Journal of Management and Governance 18 (3):683–695.

Page, M., & Spira, L. F. (2016). Corporate governance as custodianship of the business model, *Journal of Management and Governance,* 20, 213–228. doi:10.1007/s10997-016-9343-7

Osterwalder, A., Pigneur, Y., & Tucci, C. L. (2005). Clarifying business models: origins, present, and future of the concept, Communications of the Association for Information Systems, 16(1), 1-25. Retrieved from http://aisel.aisnet.org/cais/vol16/iss1/1

Office for National Statistics (ONS) Overview of the UK population: March 2017 https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/overviewoftheukpopulation/mar2017

Palliative Care Funding Review, (2011). *Funding the Right Care and Support for Everyone,* Retrieved from https://www.gov.uk/Government/uploads/system/uploads/attachment_data/file/215107/dh_133105.pdf

Payne, M. (2006). Social objectives in cancer care: the example of palliative day care, *European Journal of Cancer Care*, 15, 440 – 447. doi:10.1111/j.1365-2354.2006.00686.x

Praill, D. (2011). *Help the Hospices Response to the Palliative Care Funding Review,* Retrieved from http://www.helpthehospices.org.uk/media-centre/press-releases/palliative-care-funding-review/

Richardson, H. (2012). *Help the Hospices Responds To New Report On The Role Of Social Workers In End Of Life Care,* Retrieved from http://www.helpthehospices.org.uk/media-centre/press-releases/social-workers-play-vital-role-in-end-of-life-care/

Saunders, C. (1993). *Oxford Textbook of Palliative Medicine.* In Denice, C. S., & Walter, B. F. (1996). *Hospice and Palliative Care Concepts and Practice.* Massachusetts: Jones and Bartlett.

Saunders, C. (2001). The evolution of palliative care, *Journal of the Royal Society of Medicine*, 94, 430–432.

Seymour, J., Clark, D., & Winslow, M. (2005). Pain and palliative care: the emergence of new specialities, *Journal of Pain and Symptom Management.* 29(1), 2–13. doi:10.1016/j.jpainsymman.2004.08.008

Singleton-Green, B. (2014). Should financial reporting reflect firms' business models? What accounting can learn from the economic theory of the firm? Journal of Management and Governance 18 (3):697–706

The Charity Commission, (2005). *Accounting and Reporting by Charities: Statement of Recommended Practice,* Retrieved from http://www.charitycommission.gov.uk/Library/guidance/sorp05textcolour.pdf

Theodosopoulos, G. (2011). Voluntary hospices in England: A viable business model? *Accounting Forum*. 35, 118-125. doi:10.1016/j.accfor.2011.03.003

Timmers, P. (1998). Business models for electronic markets, *Electronic Markets*, 8(2), 3-8. doi: 10.1080/10196789800000016

Twycross, R. (2006). *A Tribute to Dame Cicely Saunders,* Retrieved from http://www.stchristophers.org.uk/page.cfm

Wilson, R., & Chua, W. F. (Ed. 2). (1993). *Managerial accounting: Method and meaning.* London: Chapman Hall

WHO, (The World Health Organization, 2002). *National Cancer Control Programs Policies and Managerial Guidelines.* Geneva: World Health Organization. Retrieved from http://www.who.int/cancer/media/en/408.pdf

Zeff, S. A. (1999). 'The evolution of the conceptual framework for business enterprises in the United States'. Accounting Historians Journal, 26, 89-131.

Zott, C., & Amit, R. (2010). Business model design: an activity system perspective, *Long Range Planning*, 43, 216-226. doi:10.1016/j.lrp.2009.07.004

Editor comments

The paper has addressed the comments of the editor and referee quite well so I would recommend it be accepted. I have noticed quite a few grammatical issues though so it needs a very careful proof-reading. To give a few examples: On line 13 of page 3 there is an 'of' missing; On line 22 on page 3 there is a bracket missing; On lines 21 and 25 of page 4 there should be an apostrophe in entities; On line 9 of page 5 there should be an s at the end of stakeholder. There are many other similar minor problems.

*We would like to thank you for these comments and we have now been through the paper tidying it up and clarifying the text throughout.*