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High efficiency or unfair financial gain?

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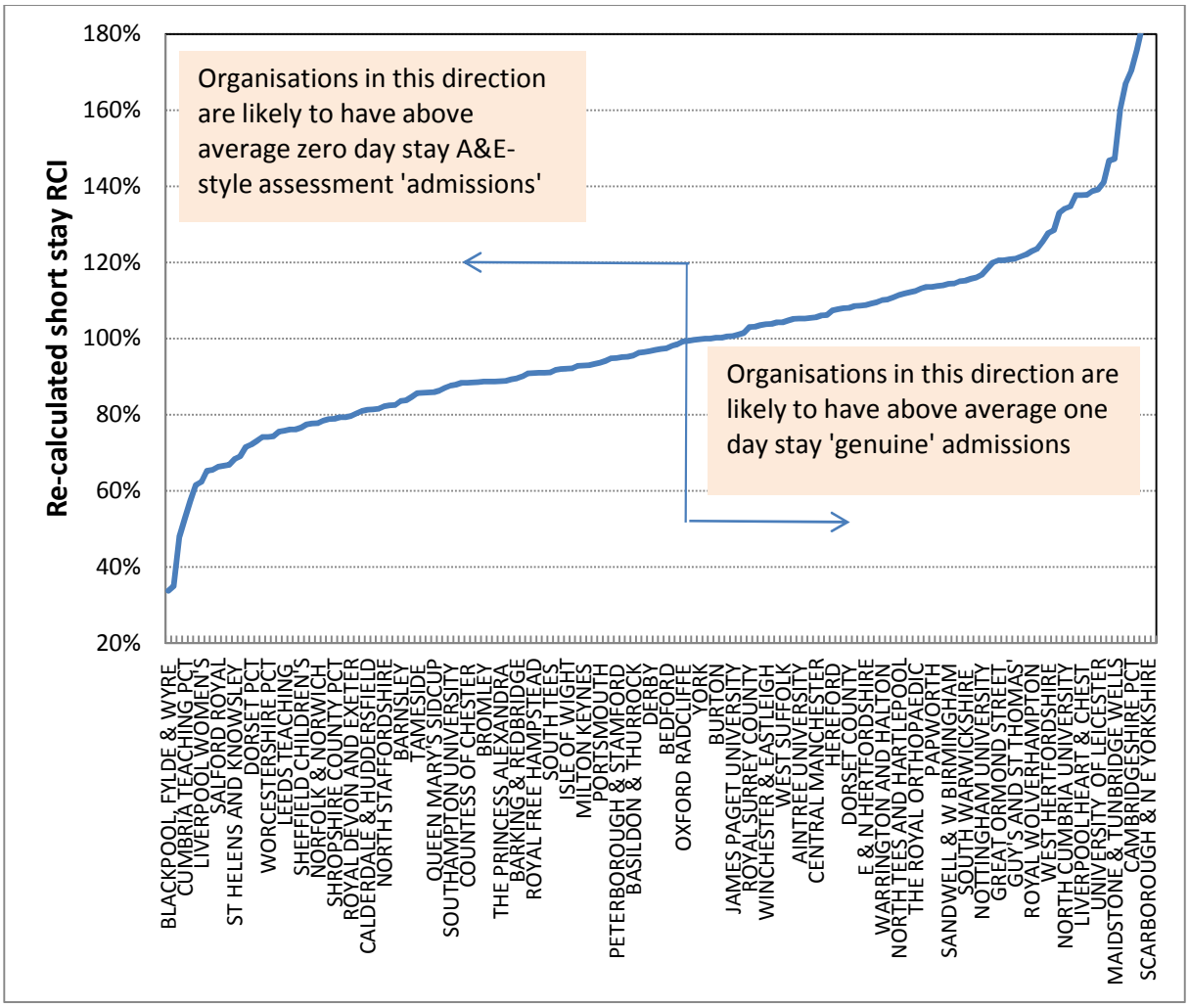
Key Words: Reference Cost Index (RCI), hospital efficiency, short stay tariff, emergency admissions, limitations of the HRG tariff, NHS, UK, reference costs, counting and coding

In this edition of BJHCM the adequacy or otherwise of the short stay tariff for emergency admissions is discussed in some detail (Jones 2010). The basic conclusion is that the short stay tariff is fundamentally flawed because it seeks to create an average price for two different classes of patient contacts within acute care; namely; emergency assessment and genuine inpatient admission with a single overnight stay

Fig 1: Apparent Reference Cost Index (RCI) for short stay emergency admissions



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Footnote to Fig. 1: Only every third organisation name is shown on the x-axis. 2008/09 national reference costs were obtained from the Department of Health website http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111592 Reference costs were recalculated as HRG-Specialty combinations and applied to the Trust-based reference cost data to obtain the re-calculated short stay RCI.

If the ratio between these two classes were constant then an average price could indeed be applied but the central argument is that the ratio is unique to each hospital (Jones 2006, 2007). This creates large imbalances in the financial landscape of the NHS where NHS Trusts and PCT experience unjustified income/expenditure pressures.

Is it possible to prove that such large imbalances exist? Figure 1 presents a re-analysis of the 2008/09 reference costs collected from all NHS provider organisations. The costs have been recalculated as unique HRG-Specialty combinations to remove the bias in costs which arises when the contribution of specialty to within-HRG cost variation is ignored (Jones 2008, 2009a-c). This adjustment strips out the contribution of anomalies in the tariff to reveal the underlying contribution arising from variation in the ratio of the two categories within the short stay tariff. A reference cost index (RCI) of 100% is the supposed national average cost while a more 'expensive' hospital would be expected to have an RCI above 100% (Jones 2009b).

Genuine variation in efficiency could possibly account for ± 10% variation in the re-calculated RCI, however, as can be seen the majority of organisations fall outside of these limits. We e therefore left to conclude that apparent 'efficiency' is largely driven by the ratio of zero day and one day stay admissions and that the criticisms levelled at the current short stay tariff are justified. If one may observe, this is an entirely unsatisfactory situation and one which should never have been allowed to occur as it totally violates every principle of how a good tariff should work.

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