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A maximum price tariff

Dr Rod Jones (ACMA)
Statistical Advisor & Chartered Accountant
Healthcare Analysis & Forecasting
www.hcaf.biz

The Department of Health (DH) has indicated that from 2011/12 the tariff will become an upper maximum rather than the unique price for each HRG (DH 2009). The need for such cost containment measures needs no discussion. However in spite of over 15 years of development the tariff still contains a long list of fundamental flaws (Jones 2009). The most fundamental flaw is that the true average price within almost every HRG is highly specialty dependant. In general this means that the cost of whatever falls within the remit of each HRG rises as the complexity of the specialty/unit delivering the HRG increases. What appears to be the 'same' HRG will therefore cost more in Neurosurgery than Anaesthetics or in Geriatric Medicine than in General Medicine. Recall that each HRG is the amalgam of a range of procedures or diagnoses and a range of crude age splits and assumptions around 'average' case mix within the HRG. On this basis the true cost of the 'same' HRG is quite rightly not the same at different hospitals. Hence on particular occasions PCT's can rightly and fairly negotiate a lower price. This will be especially true for the wide range of outpatient tests and minor procedures (injections, etc) along with a range of regular day attendances which have been labelled as a 'day case' in particular acute trusts (Jones 2007).

However such freedom comes at the price of fundamental violation of the principle of fairness because on other occasions the acute provider of more specialised than average services will often rightly deserve a far higher price than the national average (and now maximum) price for the tariff dictates. In order to carry the (real) loss incurred on these procedures such providers cannot afford to offer lower prices in other areas.

Indeed this whole issue raises the very thorny question around how accurately does anyone in the NHS know the real cost of anything? Fig. 1 illustrates this issue by recalculating all HRG prices at specialty level and then using such specialty-specific HRG prices to calculate the apparent reference cost index for every specialty at every hospital and PCT across England. As can be seen there is an exponentially increasing error margin as size reduces which is due to the role of sampling error, i.e. smaller specialties are more exposed to non-average patient characteristics such as local age or acuity score than that implied by the national 'average'. Add in ambiguity in coding and bias in apportionment at specialty level and you have the ingredients for a national situation where it is very difficult to know who is and is not genuinely 'efficient' – all within the limitations of length of stay apparent efficiency imposed by the effectiveness (or otherwise) of the surrounding primary and social care network (Davis et al 1998, Davis & Lowell 1999).

Indeed scrutiny of examples of low apparent RCI, i.e. units lower than the general cluster, reveal they are either gross errors of the costing process or are PCT run units who appear to offer a simple case mix within the wider case mix of each HRG, i.e. the equivalent to cost creaming.

On a more positive note Fig. 1 does offer powerful insight into issues such as the role of size in financial stability and when a regional unit may be a better option than smaller local units. It could also indicate that the policy of plurality may have fundamental economic limitations and be highly

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susceptible to creaming within a HRG; which is obviously not a desirable outcome. This figure also suggests that size is a fundamental factor in understanding apparent cost efficiency and the related issue of financial stability, i.e. the majority of specialties operate in the area of high cost uncertainty below 10,000 admissions per annum (Jones 2006).

As some recent spectacular failures have demonstrated low cost is not necessarily an indication of true efficiency or effectiveness. Where does this leave us? Basically any hospital with a large surplus is likely to have partly (emphasis on partly) gotten there via inadvertent benefit from the flaws within the tariff and a bit of homework by the PCT should uncover a range of HRG where prices can rightly be negotiated down. On the other hand certain (more specialist) Trusts should be able to present a robust case to show that they have been the inadvertent casualties of the flaws in the tariff. Obviously the latter is no excuse for complacency as both efficiency and effectiveness are goals in their own right.

At the end of the day remain civil toward one another as it can rightly be said – in healthcare, nothing is ever as simple as it first appears to be. Indeed the impending financial pressures that all must jointly face are a result of another industries catastrophic failure to be both efficient and effective.

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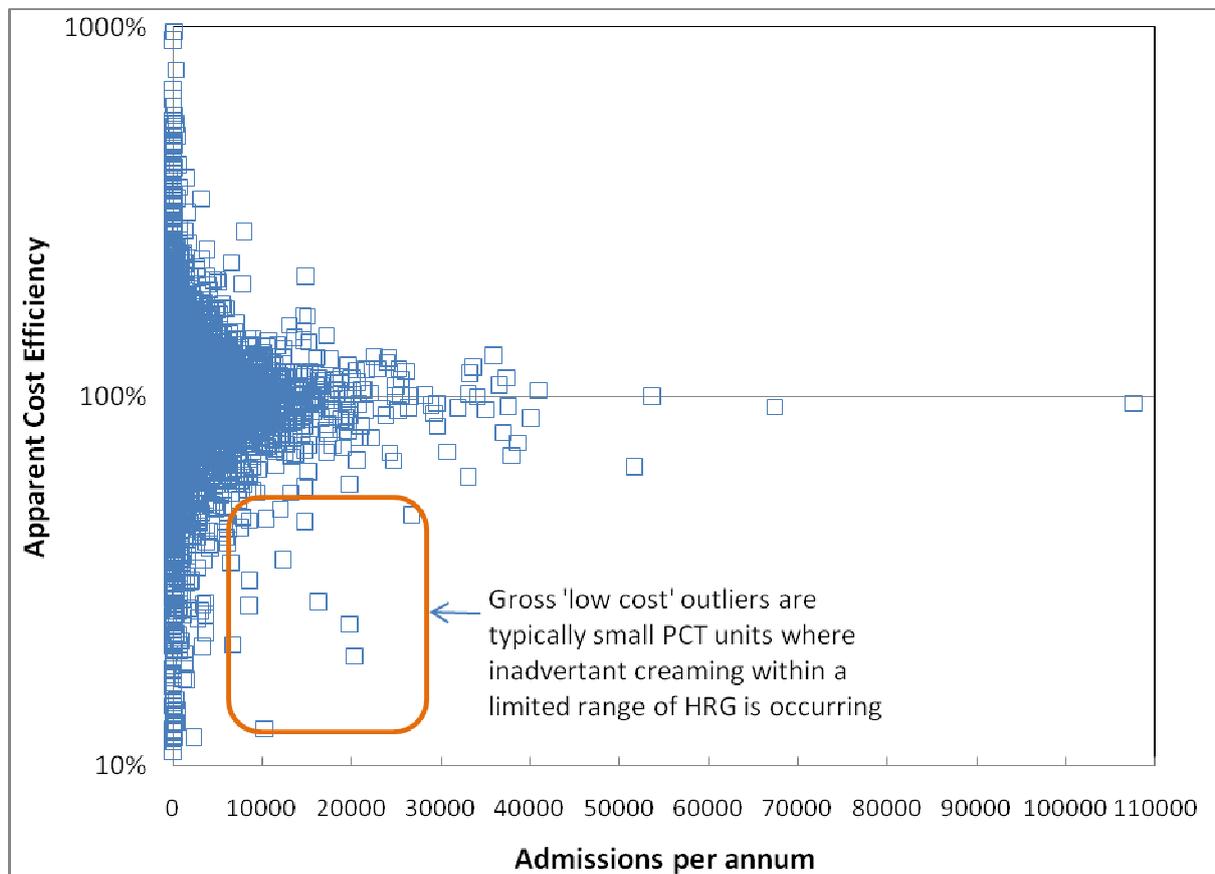
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Fig 1: Unavoidable uncertainty in specialty costs



Footnote: Data is from the 2007/08 reference costs. The Y-axis is a logarithmic scale. Note that the uncertainty in the apparent cost efficiency increases exponentially as size and hence turnover reduces. If the data is re-plotted as turnover there is evidence for an economy of scale function up to a size of £10M followed by dis-economy of scale above £20M, i.e. optimum size is in the region £10M to £20M.