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Limitations of the HRG Tariff: Local adjustments

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The market forces factor (MFF) is a local adjustment to the tariff which takes 'cost of living' type factors into account for NHS organsiations (Wilson et al 1996). If MFF is so important to provider costs why does it have an insignificant effect on the observed variation between providers at HRG level? Is the MFF due for a radical overhaul?

MFF

With the introduction of 'Agenda for Change' the cost of NHS labour is no longer subject to market forces. Pay bands have been tightly defined and apart from the London weighting all staff in the same band are paid the same irrespective of location. Hence it should come as no surprise that Figure 1 demonstrates that there is no relationship between the cost of an excess bed day (a fundamental measure of organisational costs) and the MFF. The very rationale for the MFF is no longer there! We need to ask the fundamental question - what other forces need to be invoked to explain the differences?

Age

Figure 2 demonstrates that age has a profound effect on the average length of stay for both elective and emergency admissions. Figure 3 demonstrates that the day case rate also declines with age.

While PCTs are (in theory) funded using a formula which takes age into account the provider hospitals are not. Most HRGs do not have any age adjustment and those that do have a crude age divide. Hence each HRG has the assumption of an average age profile specific to that HRG. For those hospitals servicing a population which is older than average the hospital is not reimbursed for the extra bed days arising from this older population. Hence the PCT is unable to reimburse the hospital for its true level of costs – although the PCT is funded for this higher level of cost. Hospitals servicing a younger population are over-reimbursed and the PCT suffers.

This is not rocket science! A MFF-like factor is therefore required to restore the correct balance to both purchaser and provider in terms of costs and funding.

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Economy of Scale

Two comprehensive reviews have established that economy and dis-economy of scale applies to Scottish and Northern Ireland providers (SE 1999, Secta 2003). Are hospitals in England exempt from such forces? Figure 4 demonstrates that economy of scale is no respecter of borders. A specific economy of scale factor is therefore required to correctly allocate resources and to adjust for the consequent effect on the reference costs.

Islands

The Scottish review identified that island-based hospitals have higher costs due to the additional costs of access and their inability to share the emergency demand load with surrounding hospitals (SE 1999). This will affect the hospitals in England based on the Isle of Wight, Isle of Mann and Channel Islands. A specific island factor is required for these providers.

Capital Structure

As soon as a hospital replaces old estate with new its cost of capital as an overhead cost increases. New estate via PFI is even more expensive and has hidden costs due to the prohibitive cost of alterations. The best option for dealing with capital costs would be to add an additional factor which effectively adjusts all hospitals to the average cost of capital. This would effectively remove the drive to move PFI buildings into a 'Charity' in order to avoid the impact of the change in accounting rules. All hospitals would be given an average capital cost based on square meter of buildings or a similar measure and the difference would be met via the capital structure adjustment.

Conclusions

The Department of Health needs to be somewhat more innovative in its thinking if it is serious about encouraging innovation in healthcare provision. You cannot bake a good cake with half of the ingredients missing and it is not a good idea to blame a cook for failure if you are the one only giving them half the ingredients.

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Figure 1: Average cost per excess bed day for emergency admissions for English hospitals (specialist Trusts excluded). Data is from 2006/07 reference cost collection.

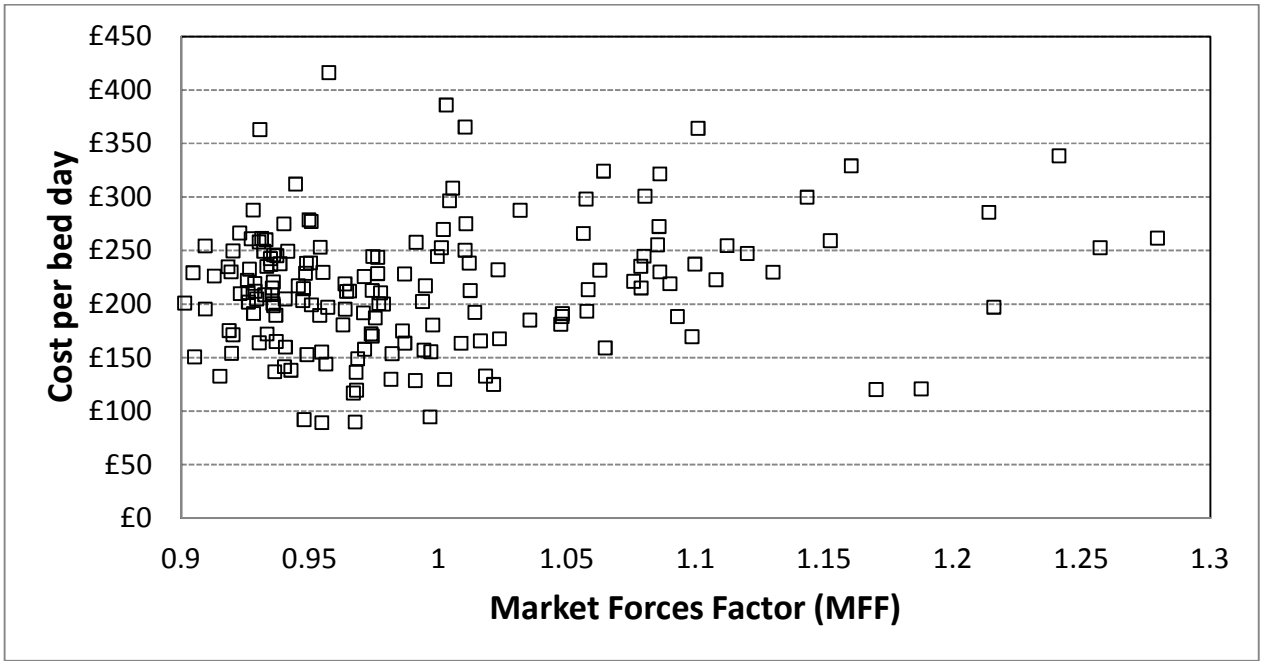

Figure 2: Effect of age on average length of stay (LOS) for admissions to General Surgery

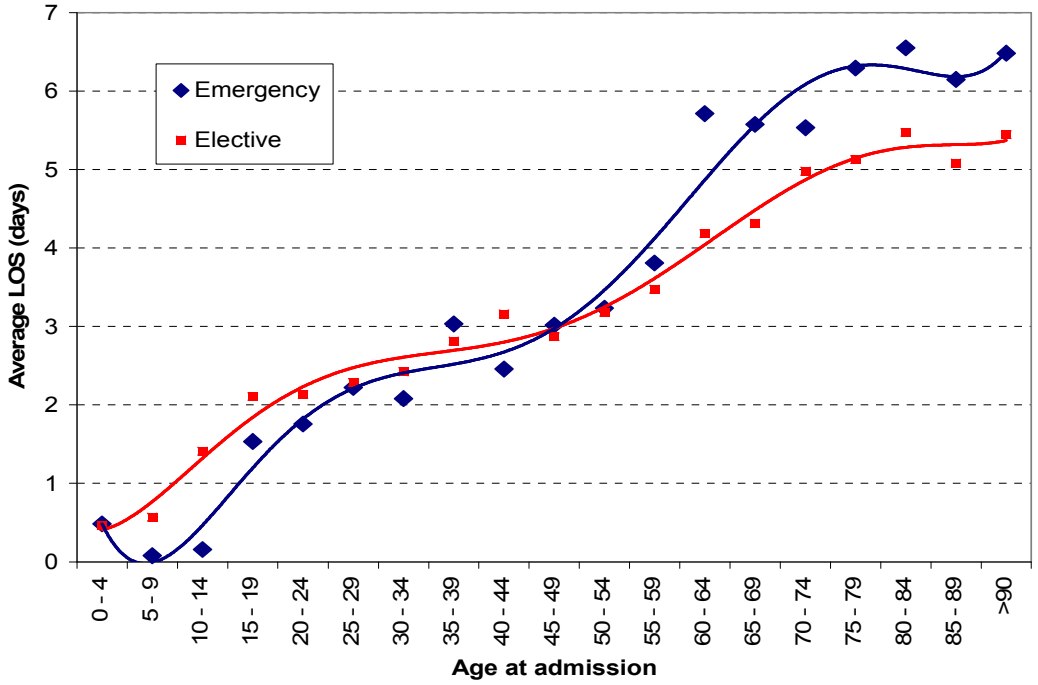

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Figure 3: Effect of age on the proportion of General Surgery elective admissions conducted as a day case.

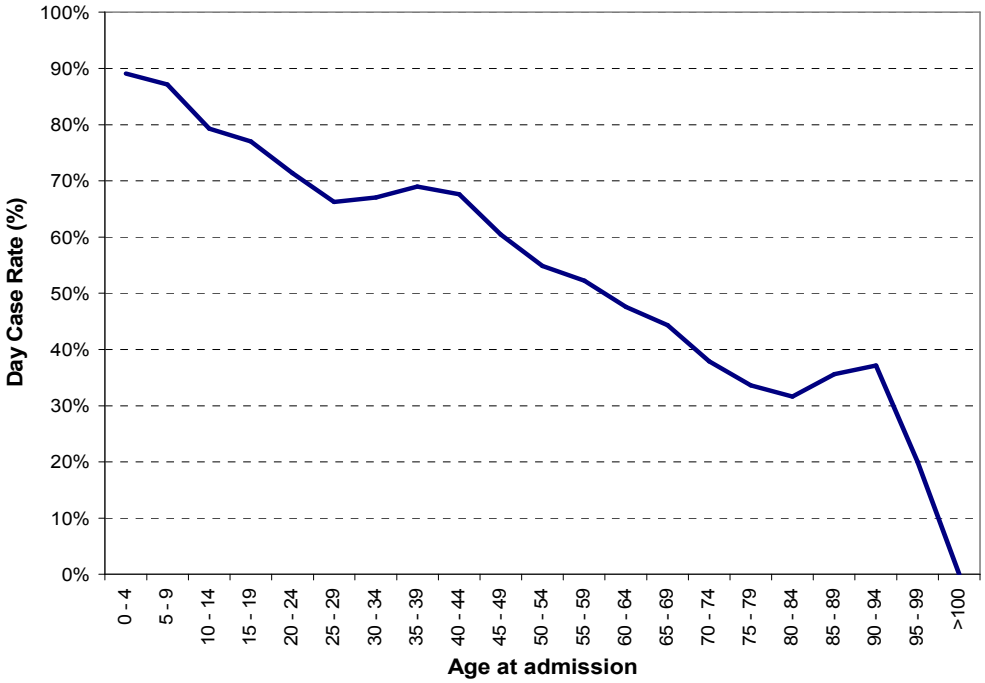

Figure 4: Economy of scale for elective overnight admissions in English hospitals. Data is from the 2006/07 reference cost collection.