An edited version of this article has been published as: Jones R (2011) Is the short stay emergency tariff a valid currency? British Journal of Healthcare Management 17(10): 496-497. Please use this to cite.

Is the short stay emergency HRG tariff a valid currency?

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Recent articles in BJHCM have drawn attention to the muddle into which the Department of Health (DH) in England appears to have fallen in its attempts to set a valid and meaningful tariff for emergency assessment activities (Jones 2010a-b, 2011a-b). The issue has been obfuscated due to the A&E four hour target where the DH has been forced to turn a blind eye to the practice of 'admitting' patients, who in any other country of the world, would be considered to be emergency department assessments. In the USA such activities are regulated (under the Recovery Audit Contractor Program see http://www.aha.org/aha/issues/RAC/index.html) and hospitals caught initiating such 'nomenclature games' are forced to refund the money. However, by proposing a short stay tariff covering zero and one day stay emergency 'admissions' the DH has, in my opinion, fallen into the trap of setting a tariff covering two different classes of activity, i.e. ambulatory/emergency department and genuine inpatient (Jones 2006).

To assess the usefulness or otherwise of the short stay tariff involves comparing two sets of reference costs. In the 2006/07 reference costs submission the cost of 1,623,347 assessment unit 'admissions' were collected at HRG level but were never used to construct a tariff (Jones 2010a). An analysis of these costs are given in Figure 1 where it can be seen that the cost per HRG starts at around £50 and that 51% of HRGs relating to 69% of all assessments cost less than £250 and 89% of all assessments were for HRGs with an average cost of less than £300. I think you will agree that the vast majority of assessment unit costs are typically low and roughly comparable with the cost of an A&E or an outpatient attendance.

The second part of the comparison is with the 2009/10 reference costs where the average HRG cost of a short stay emergency 'admission' can be derived. Figure 2 gives the ratio of the short stay cost to the equivalent assessment unit cost. In Figure 2 the ratio of the two costs is an indication of the disparity in costs between a genuine inpatient admission and an emergency assessment. Hence a ratio of 10 indicates that the genuine inpatient cost is 10-times higher for the assessment cost where the diagnoses have been allocated to the same HRG.

So how do we explain the apparently higher ratio in costs for the smaller volume HRGs? For the very high volume HRG at the right hand side in Figure 2 this is explained by the fact that the majority of all 'admissions' do not progress any further than the assessment unit so nearly all of the costs are the equivalent to an emergency department visit (zero day stay) and there are very few genuine 1 day stay (a single overnight stay) admissions in these HRG. Indeed, the high volume HRG are emergency department visits by another name, such as: non-interventional cardiac conditions, head injury, syncope & collapse, poisoning without complications, etc. A ratio of 1.0 for the two costs would indicate that 100% of all 'admissions' were assessment unit attendances. At the low volume end the opposite is true and the HRG is characterised mainly by genuine admissions. In these

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instances (especially where there are less than 100 for the national count) the HRG assigned to the assessment unit attendances may well be due to poor or incorrect coding.

Given such a huge disparity in real costs the danger (and questionable validity) of the short stay tariff is that it encourages acute Trusts to 'admit' higher and higher volumes of otherwise emergency department attendances into assessment units where low cost events are remunerated at inflated prices and also 'achieving' the four hour target as a pleasant by-product. It remains my opinion that this is not the basis for a valid tariff and leaves the DH open to accusations of not understanding the issues at stake relating to costs and human behaviour. Indeed PCTs and CCGs should be insisting on a contract with an agreed local tariff covering such activities.

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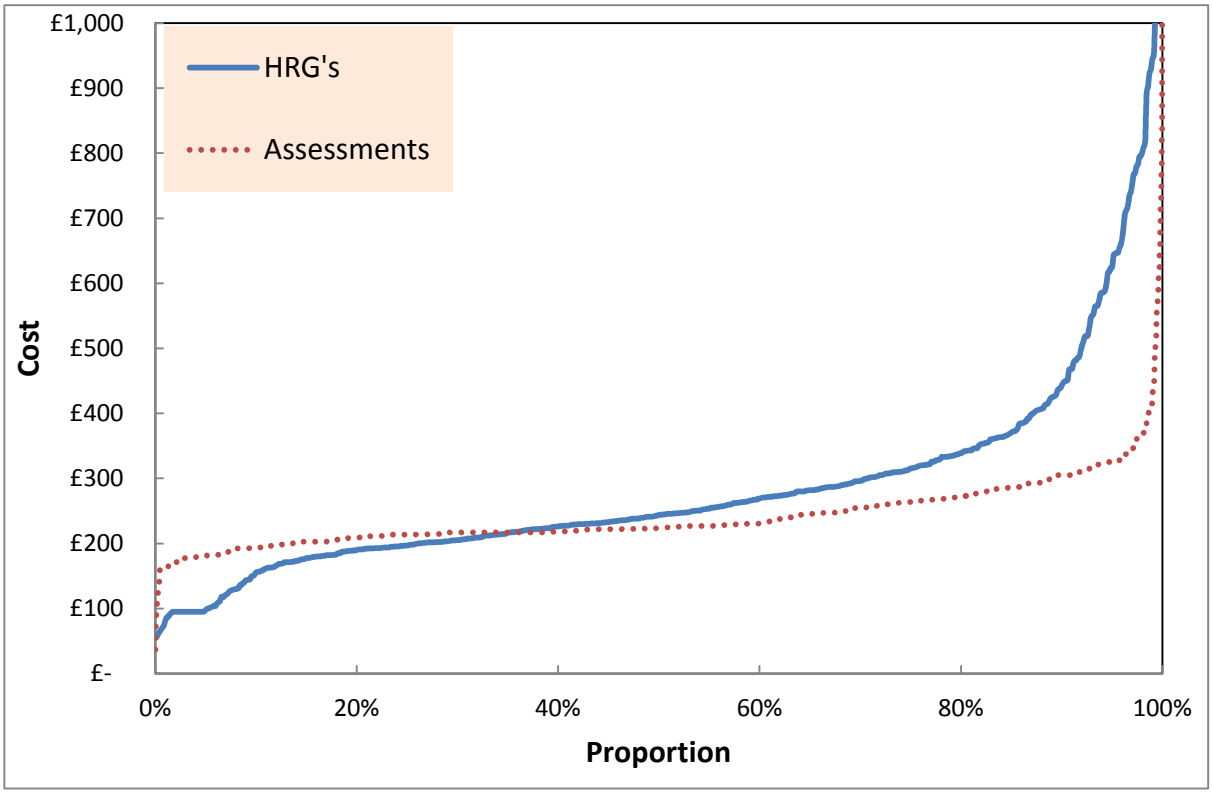
Figure 1: Cost of assessments conducted in emergency assessment units



Footnote: Data is from the 2006/07 reference cost collection.

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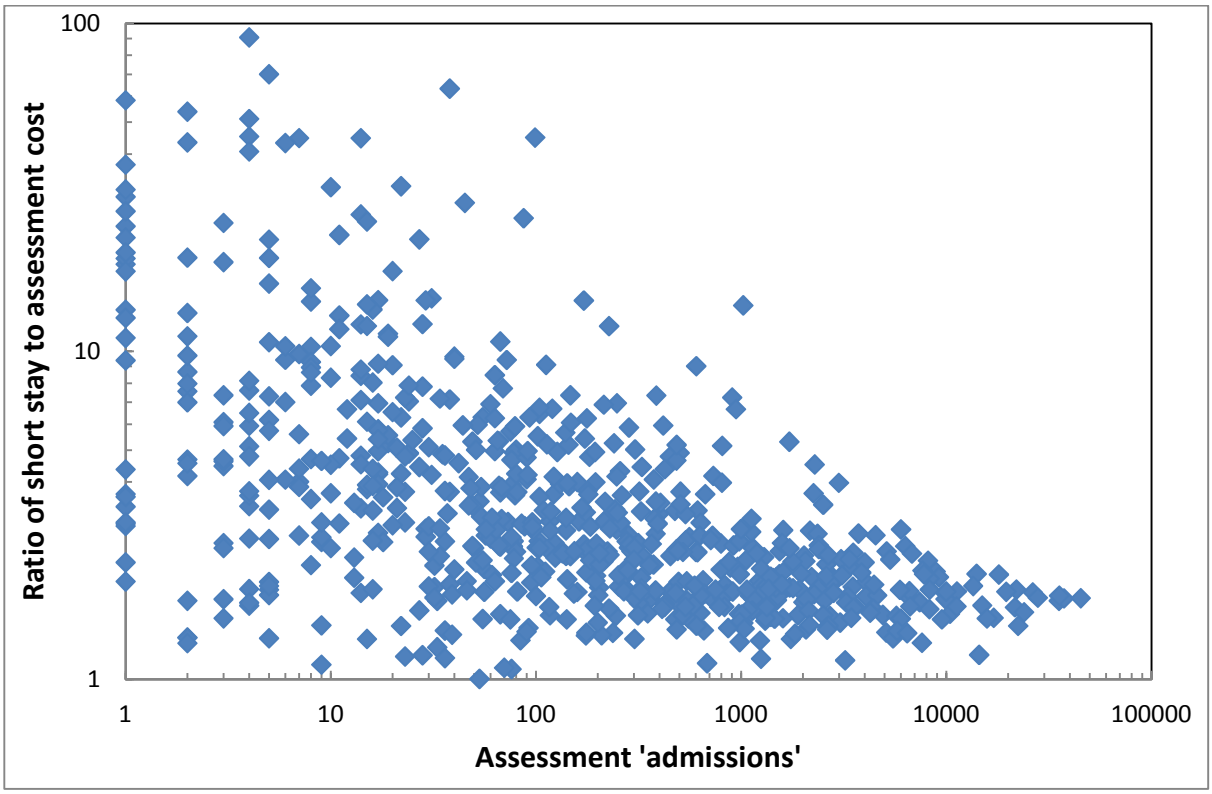
Figure 2: Ratio of HRG cost for short stay tariff and assessment unit equivalent.



Footnote: Assessment unit costs at HRG level are from the 2006/07 reference cost collection while the equivalent short stay costs are from the 2009/10 reference cost collection.