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Limitations of the HRG Tariff: Day Case

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The introduction of payment by results (DH 2002) bought together government policy and DH implementation. The following quote from "Response to Reforming NHS Financial Flows" (DH 2003) provides clues to how the DH interpreted the policy direction.

"The payment by results proposals will actively encourage innovative service re-design and technological advances, where these are costs reducing…..As cost reducing technologies or clinical developments become more widely used, the average cost of treatment will fall, encouraging inefficient providers to adopt the service innovation…. The reason that we have decided to pay a single tariff for both day cases and inpatients is because we want to encourage patients to be treated in the most cost-effective manner."

There is a clear focus on cost reduction with the primary tool being a common price for elective overnight and day case activities. However, has this lofty aspiration created a loophole by which commercially savvy acute Trusts can make a quick buck? The modus operandi is simple. Re-badge outpatient activities, call them a 'day case' and get paid at the full tariff. The introduction of PbR has lead to a marked increase in the rate at which counting changes have been implemented with an apparent shift in counting from non-admitted to 'admitted' care in both the elective and non-elective arenas. The 2004/05 re-basing exercise inadvertently acted as a major impetus to acute Trusts to take the opportunity to change the way events were counted. PbR relies on the concept that activities within a HRG conform to the national norm for that activity, i.e. iso-resource or roughly costing the same amount.

For example, in the four years from 2002/03 to 2006/07 the number of 'day cases' in the surgical specialties (including Cardiology) rose by 276,990 (12%), however, the number of so-called 'day cases' in the non-surgical specialties rose by 382,470 (26%). The 2006/07 reference costs have some 627,000 so-called 'day case' admissions with a cost of less than £250 (equivalent to the cost of an outpatient attendance) while a further 604,000 have a cost between £250 and £350 (upper end of outpatient prices). Hence around 1,231,000 out of 4,502,000 'day case' admissions are questionable as outpatient activities.

The 2006/07 reference costs show that for 35% of elective HRG the so-called 'day case' version has greater than a £1,000 cost advantage as a by-product of the single elective

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tariff while in 61% of elective HRG the 'day case' version has more than a 35% cost advantage, i.e. the tariff is ripe for exploitation! Table 1 presents a few examples.

Adherence to the NHS Data Definitions has never been audited as part of a national framework. As such individual hospital sites can reach their own interpretations for various activities. Many 'regular day admissions' are incorrectly labelled as a day case along with a host of other minor tests and visits. Prior to payment by results (PbR) the Data Standards existed as an independent entity. All parties accepted that their interpretation was problematic and subjective but none were overly concerned since local differences in counting were reflected in local prices and as a result a degree of equilibrium was maintained. Table 2 gives an example of the huge range in apparent day case admission rates seen between different locations.

The Data Standards now exist within a PbR framework. They are no longer an independent entity but are an integral part of the operational platform for PbR and the tariff. As such their interpretation and application must be guided by the principles and context set by PbR. In the terms of the NHS Data Model we now have a parent–child relationship. Incorrect application is now a concern since it very clearly leads to financial consequences.

Clearly there are a group of genuine surgical procedures where a combined overnight and day case tariff is entirely appropriate, however, for most non-surgical HRG the designation of day case is a clear indicator of genuine lower resource consumption. These HRG should retain separate overnight and day case prices. A similar case can be made for the growing number of 'day case' equivalent emergency admissions (Jones 2007).

The DH needs to be far more 'street wise' if the tariff is to be used as a genuine tool for increasing efficiency and reducing the cost of healthcare.

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Table 1: Income advantage for 'day case' procedures

HRG	HRG Label	%DC	Combined EL Average Cost	DC Income Advantage	% DC Advantage
SA02D	Coagulation Defect with CC	69%	£1,923	£1,498	78%
PA13B	Cystic Fibrosis without CC	59%	£1,782	£1,147	64%
SA09E	Other Red Blood Cell Disorders with Intermediate CC	56%	£1,801	£1,391	77%
HC92Z	Spine non Trauma Diagnosis without Procedure	54%	£1,971	£1,569	80%
PA48A	Blood Cell Disorders with CC	48%	£1,533	£1,033	67%
HC11Z	Intradural Spine Minor 2	43%	£2,981	£2,173	73%
DZ13B	Cystic Fibrosis without CC	35%	£2,101	£1,617	77%
DZ10C	Lung Abscess-Empyema without CC	31%	£1,515	£1,077	71%
WA23V	Falls without specific cause with Major CC	27%	£2,646	£1,493	56%
PA53Z	Eating Disorders	13%	£5,057	£4,423	87%
EA36B	Catheter 18 years and under	7%	£2,165	£1,502	69%
AB05Z	Intermediate Pain Procedures	94%	£707	£124	18%
DZ23B	Bronchopneumonia with CC	8%	£2,429	£2,081	86%

The above are a small random sample. Some such as 'eating disorders' are clearly outpatient attendances while others such as 'bronchopneumonia with complications' appear to be something like a regular day attendance for long term conditions. Regular day attendances are a form of non-admitted care and have a separate tariff.

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Table 2: Variation between PCTs for day case admissions

HRG	Description	Admission Rate	Inter-PCT Variation Ratio
D40	Chronic Obstructive Pulmonary Disease or Bronchitis w/o cc	773	12.8
P18	Developmental Disorders	140	10.3
F35	Large Intestine - Endoscopic or Intermediate Procedures	64	8.9
F06	Diagnostic Procedures, Oesophagus and Stomach	55	8.6
L21	Bladder Minor Endoscopic Procedure w/o cc	82	8.6
F63	Gastrointestinal Bleed - Diagnostic Endoscopic or Intermediate Procedures	100	8.5
S24	Respite Care	60	7.9
L41	Vasectomy Procedures	72	7.8
A08	Percutaneous Image Controlled Pain Procedures	118	7.5
L20	Bladder Minor Endoscopic Procedure w cc	71	7.4
M01	Lower Genital Tract Minor Procedures	72	7.4
C58	Intermediate Mouth or Throat Procedures	88	7.3
J37	Minor Skin Procedures - Category 1 w/o cc	77	7.2
T12	Alcohol or Drugs Dependency	140	6.7
H26	Inflammatory Spine, Joint or Connective Tissue Disorders <70 w/o cc	142	6.6
E36	Chest Pain <70 w/o cc	230	6.5
B15	Other Lens Surgery Low Complexity	61	6.4
L30	Prostate or Bladder Neck Minor Endoscopic Procedure (Male and Female)	34	6.2
L48	Renal Replacement Therapy w/o cc	90	6.2
M18	Non-Surgical Treatment of Other Gynaecological Conditions	25	6.2
T09	Anxiety Syndromes	319	6.1
D16	Bronchiectasis	245	6.1
A07	Intermediate Pain Procedures	66	6.0
D22	Asthma w/o cc	497	6.0

Data covers nine PCT. The admission rate is the average over all nine PCT where 100 = national average. The inter-PCT variation ratio is a statistical measure of variation. A ratio of 1.0 is equivalent to simple random variation. Hence a ratio of 10 means that inter-PCT variation is 10-times higher than due to randomness alone. Version 3.5 HRG have been used as comparative data is not yet available in V4. Some 260 out of 580 HRG have an inter-PCT variation index of 1.5 or above.