Costing the patient not the classification (UK, Australia, Middle East)

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Introduction

Challenging financial times mean that limited health finances are already stretched to breaking point.

Understanding the true costs of clinical variation helps drive hospital efficiencies. It underpins accountability of clinical decisions and resources consumed by patients.

Unfortunately many clinical costing systems are still being implemented that use combinations of external relative value units (RVU), statistical processes, and simple time based measures instead of explicit linkage of provider and service utilisation to patient consumption. These approaches restrict the ability to link Service provision and management to patient cost explicitly.

Patient based costing and analysis of patient-level service provision and consumption of resources allows all elements including service quality to be factored into the delivery of healthcare to patients. If costing is based on patient consumption variation in resource use should be reflected in the costs and can be measured. It highlights missing and poor data quality needed to carry out bottom up costing (theatre sessions as opposed to actual minutes).

This presentation examines recent cost studies conducted in Australia, the UK and the Middle East; describing the level of actual consumption and service level data used in the study and how these impacts on the opportunities to use the cost study results in providing useful management information to the hospitals involved and can limit Casmix development.

It also provides an examination of the benefits to be achieved and demonstrates that costing method must be explicitly described as part of the information presented along with costing results

Methods

Using example templates and best practice to identify best practices in bottom up costing, this includes the following:

Theatre sessional costing
Out of hrs costs for testing (Rad/Path)
Nursing times re-profiled for acuity/hrs on the ward
Actual Ward costs.

Highlighting the need for greater accountability of how the GL is constructed and maintained by management accounts, as this is a cornerstone for the costing process. Key lessons learnt and what to avoid for the best costing outcomes.

Results

Looking at the cost distribution for top down against bottom up costing submissions.

Showing how bottom up costing results are linked to accountability and forge a deep relationship between finance and clinical staff.

Linking the outcomes to the bottom up costing process and how this helps to give the patients the best service and quality available.

Results will be shown in a live reporting environment in QlikView.
Conclusions
Using top down costing process to build an activity based funding mechanism will lead to instability in health economies.

Bottom up costing increases accountability, links information, finance and clinical staff together to form a united front to tackle the financial hardships that are being felt worldwide.

Clinical staff are now using true bottom up costing to create real business cases for investment into services.

They are also driving the agenda for what is available for costing studies and are now also looking at the quality of data into the process, which is not possible to validate by the finance/Information staff.

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