Designing cost systems in healthcare
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Context

NHS faces challenge of major cost savings
New funding and governance regime of trusts
Introduction of new costing tools PLICS and SLR in Acute Hospital Trusts
Recent CIMA survey: over 70 % of trusts responding had implemented PLICS and/or SLR

How can these new tools enable more effective management?
New costing tool in the NHS: PLICS

- PLICS: Patient-level-costing and information system
- Recommended by the DH
- In Germany, mandatory for hospitals informing the tariff
- From trust level to service line level
- From top-down costing to bottom up costing methods

- Hospital: improving financial transparency and efficiency
- National level: improving accuracy of tariff, economic calculations
Recent research

- Upcoming report from Nuffield Trust
  - New Frontiers in NHS Efficiency. Will patient level costing yield efficiency savings?

- HaCIRIC report
“...and that’s the situation that a few of us are now finding, with PLICS we’ve got the information and we can then start to reflect upon that and decide well, how can we do it better, but if you don’t have that information to start with you can’t make it better”
Clinician A

“No because I think length of stay indirectly tells you what you want to know. PLICS exists as a financial package but the way the cost base has been built up, it’s not sufficiently accurate to give data that I would say is wholly reliable at the moment. [PLICS] is superficial, generalized, lacking real sensitivity and we could do so much better.”
Clinician D
Risk

Assumption: If information is “better” - more granular (service or patient level) and more regular (monthly, quarterly) - then management is automatically improved.

Risk: Consuming many resources to produce more refined and regular information without effectively supporting decision making to improve performance.
Findings

Technical characteristics of PLICS: often no improvement in quality of cost information

Why?

PLICS philosophy not sufficiently clear in DH guidelines
Supplier-driven implementations
Clinician engagement in cost system design not sustained
Overheads excluded (allocations)
Old habits and new tool (reporting costs not managing; allocations, …)
Next steps

Set out more clearly the underlying philosophy of cost analysis and management in official DH documents.

Develop training for NHS staff in the roles and potentials of appropriately constructed cost information.

Develop the evidence base on the potential and effectiveness of PLICS (UK, EU and abroad).
The current paper

- In-depth case study in a UK trust
- Extant literature emphasizes costing system errors
- Understanding cost system design in healthcare
- “Tested” through a purposefully executed case study
- Drawing on Adler and Borys framework of enabling and constraining tool
Research Design

Single Case – UK Acute Trust
  • Significant recent improvements in financial performance
  • >15 Service Lines
  • Good clinical performance

Field work (Dec 2010 – June 2011)
  • Interviews with 5 Clinicians and 9 Managers
  • Observation of 4 Financial Management Meetings (Jan & Mar)
  • Analysis of 11 internal reports and presentations
... for IMD [one type of procedure] we have had 89 patients. For pacing [a related clinical procedure] we had 169 patients, okay. And I tried to match between Omnicell and your register, okay, and I did that exercise. What I found was, these patients were not found in Omnicell, they were found in the register, they were not found in Omnicell. The total is about 8 patients of IMD and 8 patients of pacing.

T1: I think what happened there is, we’ve got two pacing theatres and the Omnicell cabinets are kept one in the pacing theatres so if you work in Theatre B, the doctor could say to you, I don’t know whether I want to put an adaptor in or a protector in or... So the technician goes, takes things out under general and takes them to the theatre and I think they’re not being put back in under the patient. I think they take out multiple devices just to cover every eventuality so they’re not really...

C: So we assign double device costs on some patients, is that what you’re saying?

M1: Yeah. Device costs was wrong... So that is what I’m coming to...

C: Okay. So we’ve just got to make sure they go back on this… [...]

M1: Right, okay, he’s the Technical Director of... Omnicell is the stock management system, you know, [...]What he says is, he has written a sort of software, which checks the anomalies within the system, [...]and he’s going to send weekly that list to key people and then they can go and collect the data.  […]

C: So that is what is going to happen, that should reduce this kind... [of problems]

T1: But what I’ve ordered as well, to make it easier, I’ve ordered a scanner so they can scan...

M1: But until... Until... Until... Can I request you one thing? Until that is being done, can you ask somebody to check within the register on this?

T1: No, it’s too time consuming for the technicians at the moment. I can’t do that. I haven’t got the time to sit and do that sort of check, what’s been taken out of the cupboards, because have you seen the Omnicell lists? They’re just ridiculous...

C: What we’ll do is speak to everyone and say, you must put them back. [...]

C2: Can you up to date, one of the comments I made previously when I saw an iteration of this work on the Consultant Allocated Costs, there was a real gap in that if a Consultant did one case in a day and went on till three in the afternoon, and a second case wasn’t done, then they showed the costs for the one case and not the opportunity lost costs because they didn’t do two cases in a day, and that is an unfair reflection on the productivity of a consultant if you don’t include the lost opportunity in that, and that was something we’ve asked.

M1: It’ll be, this has been approached in a different way, slightly different, it may not satisfy your question in full but I’ll tell you what I am doing, I have divided the theatre costs, total cost of the content of the theatre as in the case of a Surgeon to reflect with their job plan, like we have so many theatres and so many Surgeons to operate, to utilise the theatre, the sessions are allocated to each in turn, they have got to find patients if not the patient that the authority found has to share the costs, so if you consider in the whole year or in a period of time, Consultants having equal theatre sessions allocated to them through their job plan and the theatre schedule, the total costs allocated for these patients will be distinctive [...]


