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Casemix Costing in Ireland- Uses beyond ABF

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Introduction

In Ireland the National Collection of Casemix Costs is the responsibility of the Healthcare Pricing Office (HPO) which form one of the pillars of the National Finance and Procurement Division of the Health Service Executive. The collection of costs is done using two methodologies, excel based Specialty Costing for 44 acute hospitals and Patient Level Costing for a limited number of key price setters. Although the foremost reasons for collecting the costs are Activity Based Funding and DRG price setting, in recent years, the HPO has increasingly been called on to provide costs and data for service planning, cost analysis and support the budget setting process. To a large extent this is a result of 'traditional' finance divisions concentrating mainly on financial accounting, management accounting such as monthly reporting, budget v actual and cost containment without a focus on what patients and services are consuming resources as a granular level as happens with casemix costing. The traditional systems in use do not routinely allocate overheads back the service that consumes them whereas specialty costing preforms this function. It also endeavours to allocate the costs of all ancillary services consumed as part of a patient encounter back to the patients who consume them.

Methods

The specialty costs collected to determine the ABF value and overall split by patient type were extensively reengineered to focus costs by patient type at general ledger expenditure category level. It focused on identifying marginal costs, on analysing trends in cost per case and on calculating the funding required for additional activity.

Results

The cost of additional activity was used to enhance the traditional budget setting process as Ireland currently uses ABF as a retrospective benchmarking and adjustment process rather than setting budgets solely using ABF. It showed how casemix costing can support finance divisions when bidding for additional funding for new service initiatives and increased activity. It also shed a light on how a national patient level cost collection would hold valuable information that could support not just ABF and price setting but financial planning and analysis. It has highlighted the usefulness of cost data patient and patient type level for evaluation the cost effectiveness of treatment and pathways of care. It also allowed for focus to be placed on the inherent productivity in a reducing cost per case during a time of price increases and inflationary pressures.

Discussion/Conclusions

Discussion on how reframing the conversion from budget versus actual in traditional finance to what patient care costs and how does this moves over time can support funding and planning decisions for service providers and bring traditional finance and casemix closer together and show how rather than competing for resources the areas should be working together. Casemix and costing methodologies should be seen as important tools in bringing disparate sections of finance together to ensure that healthcare funding distributed based on the complexity of care required and the cost of that care rather than based on historical budgets.

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