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THE SCOTTISH OFFICE

National Health Service in Scotland
Management Executive

NHS
MEL(1994)74

St. Andrew's House
Edinburgh EH1 3DG

Dear Colleague

A CURRENCY FOR COSTING AND CONTRACTING - AN INTERIM PAPER

26 July 1994

Summary

1. The Interim Paper provides guidance on the recording of clinical data for contracting, on the level at which providers should produce costs, on the feasibility of moving towards a common approach to contracting and on the level at which Inter-Trust comparative data should be produced. It also outlines work being undertaken at Project pilot sites which will add detail to these initial recommendations.

Action

2. NHS Trusts should begin work immediately in preparation for the 1995/96 Contracting round on the basis of the recommendations set out in Section 2 of the Interim Paper. This will make it easier for Trusts to implement the full guidance when it is issued in September.

3. NHS Trusts should give particular attention to the following:

a) **Planning of Work** - identifying the areas which will be considered to be high priority for the early introduction of detailed costing at local level. This is likely to revolve around analysis of workload. Consideration should be given to identifying staff who will take a lead in implementing the proposals.

b) **Training of Finance Staff** - to take this work forward, the Finance function will need appropriate technical and interpersonal skills. A sound knowledge of the strategic importance of the issues covered in the Interim Paper will also be vital.

c) **Clinical Commitment and Involvement** - to deliver the recommendations in full will require a high level of input from clinical staff. This emphasises the importance of the skills outlined in b) above and of working with, for example, Clinical Directors.

Addressees

For action:

Chief Executives, NHS Trusts
General Managers, Health Boards

For information:

General Manager, Common Services Agency

General Manager, State Hospital

To be copied to:

Directors of Finance

Medical Directors

Enquiries to:

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4. A paper on the Allocation and Classification of Costs is due to be issued by the Costing Project by the end of July. This contains recommendations on a minimum standard cost allocation method to support the costing of procedures and treatments. This standard should be followed for the 1995/96 Contracting round. Guidance on the selection of specialties to be costed in detail, as discussed in the Interim Paper, will also be sent out in July.

5. This letter should be copied to Directors of Finance and Medical Directors for information.

Background

6. This interim guidance results from work carried out as part of the National Costing Project over the last year. A major element of that work has been the development of a common approach to costing and contracting for acute hospital services. We recognise that guidance is now required to support the 1995/96 Contracting round. These interim recommendations precede detailed guidance to be issued in September 1994.

Yours sincerely

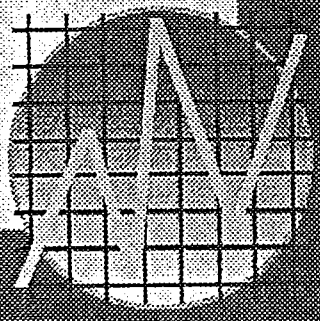
Geoff Scaife

GEOFF SCAIFE
Chief Executive

National Health Service in Scotland
National Costing Project for Acute Hospital Providers

A Currency For Costing and Contracting

June 1994



A CURRENCY FOR COSTING AND CONTRACTING

AN INTERIM PAPER

EXECUTIVE SUMMARY

1. PREFACE

1.1 The National Costing Project has two key objectives, the first being to provide guidance in selecting a currency for costing and contracting for acute hospital activity. The second aim is to develop a consistent supporting costing methodology.

1.2 The interim paper concentrates on the first objective, identifying the issues involved and recommending action to prepare for the 1995/96 Contracting round.

1.3 The paper will be of critical interest to Finance staff, Chief Executives, General Managers, Business Managers and Clinicians involved in the management of resources. It is vital that all those who have an interest in these issues are given the opportunity to contribute, particularly in view of the clinical focus of much of the project's work.

2. SUMMARY OF PROPOSALS FOR THE 1995/96 CONTRACTING ROUND

2.1 The need for a consistent and accurate source of clinical data is paramount as this forms the basis of clinical and management information. The present plans to move to the use of ICD10 and, later, Read coding conventions will need to be accounted for in currency development.

2.2 The currency for costing procedures and treatments is likely to be based upon 4th digit ICD9 and OPCS4 codes, the current clinical coding convention.

2.3 A common currency for contracting is unlikely to be feasible. Instead, the existing tariff arrangements for GP Fundholders should be retained and developed, with Boards and Trusts setting up local contract groups to a specific timetable linked in with other developments in the contracting process.

2.4 Inter-Trust comparisons will be through publication of ICD/OPCS and, later, HRG costings.

2.5 Detailed recommendations will be released in September 1994, but in the meantime, the following assumptions should be made:

(a) A minimum standard cost allocation method will be applied to derive the full cost of each specialty, analysed by patient type.

(b) For each specialty, inpatient and day case workload should be analysed by OPCS4 and ICD9 (4th digit) code by indentifying:

- those procedures/treatments which account for 80% of activity,
- those which, although low in number, are high in cost,
- and by appropriate grouping of the remaining codes.

(c) The costs of procedures and treatments identified in (b) above will be derived through costed profiles of resource use. A minimum standard approach and those specialties to be dealt with in detail will be specified in September.

3. BACKGROUND

3.1 Clinical information, sometimes costed, will be used at a number of levels within the NHS and for a variety of purposes. It may be used:

- by clinicians as part of the process of audit or research,
- within Trusts to support local management decisions,
- to facilitate the contracting process,
- nationally, to inform policy and planning and for comparative purposes.

3.2 A framework for a common currency must therefore allow for effective use of clinical data for management information,allowing for aggregation where necessary, covering:

- Costing
- Contracting
- Comparison

4. RECORDING OF CLINICAL DATA

4.1 A currency must be able to describe patients at the right level of detail to retain clinical meaning and some indication of case-mix, while being able to assign significant costs.

4.2 The building block should therefore be the standard clinical coding classifications in use in Scotland, ICD9 and OPCS4, but moving to ICD10 and Read in future. The standard used must be accurate and consistent, providing a solid foundation for contracting. The current conventions, while not ideal, are considered adequate for this purpose.

5. COSTING

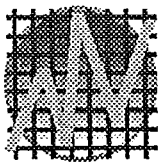
5.1 A cost valuation will need to be placed on all types of diagnosis and treatment. However, by concentrating on high volume codes, the bulk of overall activity can be accurately costed. Only half of the available 8000 ICD codes are used in Scotland, of which only 400 account for 80% of activity. The proportions for OPCS codes are similar. A different percentage parameter may be more appropriate for larger specialties where more codes are in use.

5.2 Certain codes will be low volume but high in cost. These will need to be identified separately. The remaining codes can be costed in appropriate groups.

5.3 Other factors, such as the treatment of outpatient costs, elective as opposed to emergency admissions, patient age and comorbidity will be considered in later stages of the project.

5.4 The costs of individual specialties or sub-specialties will be derived through a process of cost allocation.

5.5 Costs of procedures and treatments will be based upon costed profiles of resource use which reconcile to specialty costs.



6 CONTRACTING

6.1 The key issue with regard to contracting is the question of whether a common currency for contracting should be applied across Scotland or whether currencies should be defined locally. Options include:

- OPCS/ICD9
- Diagnosis Related Groups (DRGs)
- Healthcare Resource Groups (HRGs)
- the development of Scottish Resource Groups
- locally defined contract groupings
- A mixture of the above.

6.2 The use of ICD/OPCS in contracts may be cumbersome because of the numbers of codes involved. An aggregation into some form of grouping would be necessary. DRGs have been largely discredited and to develop Scottish Groupings would be an expensive option. HRGs are as yet untested in a Scottish environment. This has led to the interim conclusion that there is unlikely to be any single common currency for contracting at this stage.

7. INTER-TRUST COMPARISON

7.1 It is essential that there is at least one level at which consistent information is available to allow comparisons to be made between Trusts.

7.2 The recommended approach outlined in paragraph 2.4 can be expanded to conclude that:

(a) Initially, Trusts should provide information on all locally costed ICD/OPCS activity to allow comparisons to be made for 1995/96.

(b) Subsequently, costed HRG information should be produced once the grouping has gained a firmer foundation in Scotland. This will also allow cross-border comparison with English Trusts.

8. FUTURE STUDY

8.1 Up until the end of August 1994, the hypotheses behind the recommendations will be tested at the two pilot sites so that firm guidance can be issued in September.

8.2 Work on the use of HRGs will be carried out towards the end of the year.

8.3 The implications of a change to Read coding and to ICD10 will be identified.

8.4 Guidance on the underlying costing methodologies to support these recommendations will be issued between now and September.

A CURRENCY FOR COSTING AND CONTRACTING

AN INTERIM PAPER

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A CURRENCY FOR COSTING AND CONTRACTING

1. PREFACE

1.1 One of the two principal objectives of the National Costing Project is to provide guidance in selecting a currency for costing and contracting for acute hospital activity. This currency would be a common language or languages which describes what is being costed or being purchased and provided under a contract. The other key aim is the development of a consistent costing methodology. An interim paper, 'Allocation and Classification of Costs' will be released in July 1994. This paper will provide initial guidance on working towards a consistent methodology in support of the currency framework, with a final paper to be issued in September.

1.2 This interim paper identifies the key issues that are being considered in working towards a currency system that meets the needs of all users and proposes action for providers to take in preparation for the 1995/96 Contracting round. In support of this the paper details work carried out so far and describes future studies outlining the hypotheses being be tested within the project. Work at this time deals primarily with inpatient and day case workload. It is recognised that further development will be required to cater for outpatients.

1.3 This paper will be of critical interest to Finance staff, Chief Executives, General Managers Business Managers and Clinicians involved in the management of resources. It is vital that the views of all those who have an interest in these issues have an input. This applies particularly to the clinical aspects of the project's work as it is clinicians who are best placed to define the terms in which the Health Service's workload is expressed.

2. SUMMARY OF PROPOSALS FOR THE 1995/96 CONTRACTING ROUND

2.1 The requirement for a consistent and accurate source of clinical data is paramount, as this forms the basis for any subsequent clinical or management information. The present plans regarding standard clinical classifications are as outlined in 4.9.3.

2.2 The currency for costing procedures and treatments is likely to be based upon 4th digit ICD9 and OPCS4 codes, subject to results of current work in the pilot sites. This will, therefore, lead to a high level of consistency across Scotland.

2.3 It seems unlikely that a common currency for all contracts is feasible and the existing tariff arrangements for GP Fundholders should be retained and developed. In the light of other proposals, a consistent and comparable level of detail in the costing of activity will form a solid foundation on which Trusts and Purchasers can move ahead in developing contracting currencies locally. This process will link in with overall developments in the purchaser-provider relationship.

2.4 Inter-Trust comparisons will be possible via publication of ICD/OPCS and HRG costings.

2.5 A paper containing recommendations on the two issues described in paragraph 1.1 will be released in September 1994 to support the 1995/96 Contracting round and beyond. However, to enable Trusts to make progress now, it should be assumed that the key elements of the recommendations will be as outlined below.

(a) A minimum standard cost allocation method will be applied to derive the full cost of each specialty, analysing costs by inpatients, day cases, outpatients, day care and, if appropriate, community.

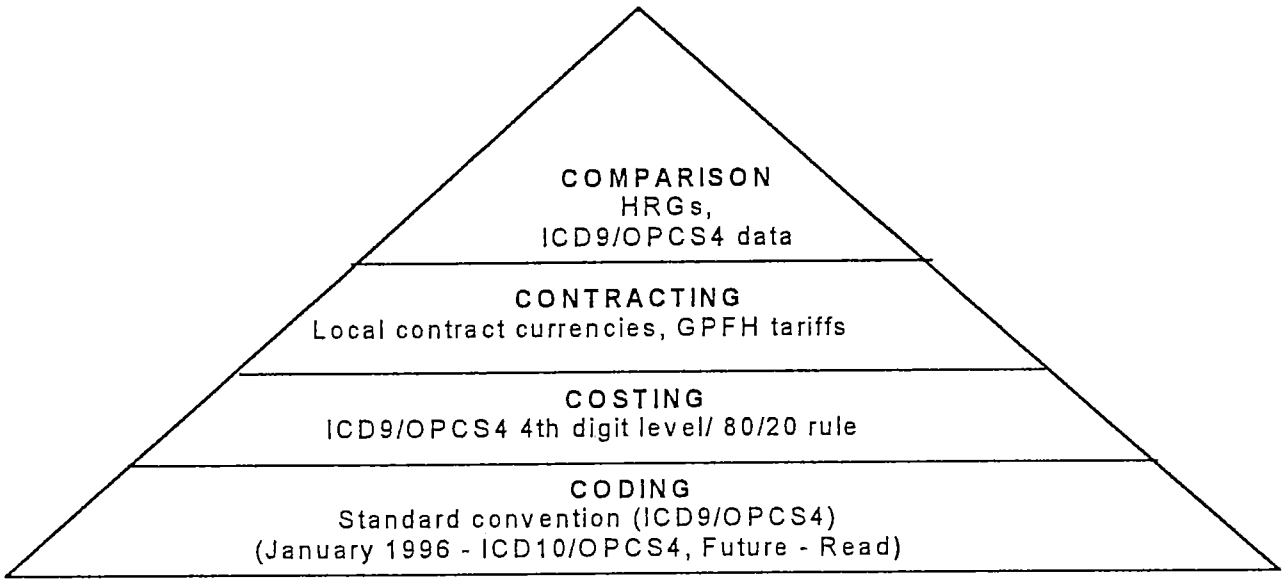
(b) For each specialty, inpatient and day case workload should be analysed by OPCS4 and ICD9 (4th digit) code as follows:

- Identification of those specific and clinically meaningful procedures and treatments which account for 80% of activity,
- of those procedures/treatments which, although low in number, are high in cost,
- and appropriate grouping of the remaining codes.

(c) The costs of procedures and treatments identified in (b) above will be derived through costed profiles of resource use. A minimum standard approach to costing will be specified in September. It is unlikely that, for 1995/96, Trusts will be in a position to cost all specialties at this level of detail. Guidance will be issued in advance of the final September report indicating a number of selected specialties on which detailed costing work should be concentrated.

2.6 The overall approach can be summarised diagrammatically in Figure 1 below:

FIGURE 1



3. BACKGROUND

3.1 Clinical information, sometimes costed, will be used at a number of levels within the NHS and for a variety of purposes. It may be used:

- by clinicians as part of the process of audit or research,
- within Trusts to support local management decisions,
- to facilitate the contracting process,
- nationally, to inform policy and planning and for comparative purposes.

3.2 The source of this information will be accurate clinical data, which should be collected efficiently, without duplication and in a way that allows the data to be aggregated to various levels in a standard way across Scotland. For this to happen, there must be agreement about a minimum standard for use throughout the country. This issue will be dealt with in Section 4 below.

3.3 There are then three key management activities to consider when exploring a framework for a common currency that will enable this clinical data to be used effectively as management information:

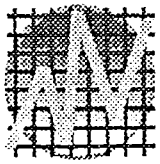
- Costing
- Contracting
- Comparison

3.4 Each of these activities is self-contained, but they are all interdependent and any framework developed must acknowledge this fact. Issues related to selecting a common currency for each of the three are dealt with in Sections 5 to 7 below.

4. RECORDING OF CLINICAL DATA

4.1 The principal objective in developing a currency is to describe patients and their treatment in enough detail to be able to assign significant costs of care. This must be done without demanding information that is so expensive to collect that the cost outweighs its value to management. To achieve this objective, it is necessary to go beyond broad categorisation of clinical care, such as simply indicating the specialty of treatment. To give a truly useful indication of cost, the conditions that require treatment must be described, as must some aspects of the care provided, such as operations and procedures. These summarised descriptions of patient populations are referred to as clinical case-mix.

4.2 Medical conditions and their management are described by clinicians in terminology that is complex, which can vary in detail and is far from universally standard. The recently developed 'Read Version 3' thesaurus of clinical terms is an attempt to standardise nomenclature and code it for entry into clinical information systems. Thus, Read 3 allows very detailed clinical material to be entered of which only part will be relevant to costing. A sample of the Read structure is given overleaf.



LEVEL	TERM	READ
1	Infectious parasitic diseases	A
2	Viral disease with exanthem	A5
3	Rubella	A56
4	Rubella neurological complication	A560
5	Rubella + encephalomelitis	A5601

Within the Read structure there are more than 250,000 codes with further expansion capability to respond to changing medical classification needs. Due to its comprehensiveness it can be cross referenced to the other classifications, e.g. ICD9 and OPCS.

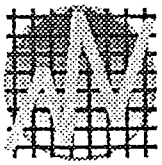
4.3 If information about clinical disorders and care is to be presented in a way that allows its range to be understood and clinical case-mix compared across different providers, it must be summarised and standardised. The standard approach in Scotland is for trained coders to allocate diagnoses and procedures to categories in a standard classification based on raw clinical data. At present, the standard for diagnoses is the 9th edition of the International Classification of Diseases (ICD9) and for operations, the 4th revision of the Office of Population Censuses and Surveys Classification of Surgical Procedures (OPCS4).

4.4 Both classifications were developed to allow recording of information for epidemiological and statistical returns and neither is ideal for the purposes of costing. For instance, ICD9 has to accommodate every possible disease and clinical problem and this means that there is inevitably a need to group diseases together and provide catch-all categories such as 'other diseases of the pancreas'. Some of these groups may contain conditions that are very different clinically and in terms of costs. However, for the most part, ICD9 and OPCS4 are adequate to record activity for costing purposes. Indeed, the detail may often be greater than required.

4.5 ICD9 will be superseded by a more detailed revision in Scotland by April 1996 (ICD10). At the same time, it is hoped that Read 3 will be in widespread use and may, in time, become the standard classification for recording clinical data at a basic and detailed level.

4.6 In total, there are some 8000 diagnostic codes available for classification purposes but only 4000 of these are used in diagnosing Scottish patients. The five most commonly used codes in Scotland in 1992 represented 10.8% of total activity, as shown below:

410.9	Acute Myocardial Infarction	2.9%
789.0	Abdominal Pain	2.8%
786.5	Chest Pain	2.0%
413.9	Angina Pectoris	1.6%
366.9	Cataract, Unspecified	1.5%



4.7 In terms of operative procedures, around 4500 OPCS codes are used each year in identification of Scottish activity. The five most commonly used OPCS4 codes in Scotland in 1992 accounted for 11.3% of activity recorded, illustrated below:

C75.1	Insertion of Prosthetic Replacement for lens	3.3%
G45.9	Unspec Diagnostic Fibre-optic Endo Exam of Upper GI Trac	2.4%
Q10.3	Dilation of Cervix Uteri and Curettage of Uterus, NEC	2.0%
X55.8	Other Specified Operations on Unspecified Organ	1.9% *
M45.9	Unspecified Diagnostic Endoscopic Examination of Bladder	1.7%

* X55.8 is used to cover a variety of procedures that are not specifically identified in OPCS4. Its use is currently under review.

4.8 High quality data is of vital importance to the accurate description of activity and to the production of effective management information. It is vital that attention continues to be given to seeking improvements in data collection so that the information that derives from it can be used as effectively as possible.

4.9 SUMMARY

4.9.1 It is vital that whichever clinical coding system is used for primary identification of patient diagnosis and treatment, it must be one that:

(a) utilises an appropriate, comprehensive and precise coding convention which reflects clinical practice,

(b) can be applied accurately by providers in describing individual cases, enabling linkage of resources used to care provided,

(c) can be widely and consistently understood by clinicians and managers and that

(d) provides a solid foundation on which to cost and contract, and supports the development of more sophisticated forms of contract.

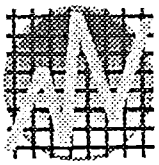
4.9.2 The development of clinical coding conventions must be managed carefully so that coding can be used as efficiently and effectively as possible to support the business of the NHS. This should include consideration of a migration path for data gathered in the past under different conventions, so as to allow historical comparison.

4.9.3 At this stage, the development of currencies for management information activities is proceeding on the assumption that:

(a) ICD9 and OPCS4 will continue as the basic coding conventions for 1994/95 and 1995/96.

(b) ICD10 will replace ICD9 as the convention for diagnosis coding in January 1996.

(c) The use of Read will become widespread but will not be in use widely enough for it to be adopted as the convention until after 1996.



5. COSTING

5.1 While recognising the need to place a cost valuation on all types of diagnosis and treatment and on occasion, individual episodes, it is essential that attention should, in the first instance, be concentrated on the high volume codes. Accurate costing of these will contribute towards full recompense for expenditure and effort by the provider. However, there are low volume, high value items of workload that will also need to be identified and costed to provide more meaningful description of the true nature of resource use.

5.2 Considerable investigation work has been carried out on the Pareto or 80/20 principle, which states that only a few high volume items account for the vast majority of overall activity. For example, it may be that the top twenty items explain 80% of workload.

5.3 An analysis of the 1992 statistics for Scotland shows that only 822 ICD9 and OPCS4 codes (only 5% of the total available codes) account for over 80% of all inpatient cases, the remaining 20% being covered by some 7000 codes in regular use. The proportions are similar when expressed in terms of inpatient stay. It is likely that, for individual providers, even fewer than 800 codes would account for similar proportions of local activity. This assumption is currently being tested at the pilot sites. The table below illustrates these findings.

	ICD9	OPCS	NET ICD9
Cases	768,377	342,557	425,820
Days Stay	5,422,032	1,951,163	3,470,869
Codes Used - 4 Digit	4,143	4,581	3,710
Cases 80% Level - Codes	404	410	280
Stay 80% Level - Codes	410	542	269
Mean Stay	7.1	5.7	8.2

5.4 Further analysis was carried out to identify how many codes accounted for various percentage volume levels. This information is presented in Appendix One. Only 62 OPCS codes account for nearly 50% of procedures undertaken and only 82 ICD codes for nearly 60% of cases where no OPCS code was entered.

5.5 A method of costing the 20% low volume codes is being tested as part of the pilot site work. The approach is to examine the cost structure of the key high volume codes and to derive costings from this for low volume codes that are of a similar nature. Certain low volume codes may have particularly high associated costs and will need to be treated separately, as mentioned in 5.1.

5.6 Some initial work has also been conducted on the variations in the number of codes that would need to be costed for different specialties. Ophthalmology and Ear, Nose and Throat have only a small number of codes making up 80% of activity compared with General Medicine.

5.7 It is possible that different parameter levels, e.g. 65%, may have to be adopted for some individual specialties. Those with a large number of codes and few patients for each may find that the 80/20 principle does not totally apply.

5.8 The ability to relate codes to specialties is also a necessity recognising the need for directorate and management reporting and responsibilities. Cost structures in different clinical areas will also vary considerably, for example, drugs may be a high cost component in some specialties while therapy services may be more significant in other areas. The establishment of common methodologies for costing these component parts of overall cost will be a key issue.

5.9 The implications of differences in cost between, for example, elective and emergency cases, patients in different broad age categories, together with complicating factors such as comorbidities have not been quantified as yet. Later stages of the project's work will deal with these important issues.

5.10 SUMMARY

5.10.1 In determining the codes to be used in costing, it is important that:

(a) the number of codes to be costed should be at a manageable level taking the 80/20 rule into consideration,

(b) the level at which workload is costed can be reconciled to the level at which contracting takes place and to that at which basic level data is collected to maintain a cohesive structure,

(c) costed codes can be specialty related and, hence, be an integral part of management and directorate reporting and that

(d) costed codes are clearly identifiable to a specific procedure or diagnostic activity (this is generally not possible at a summary coding level).

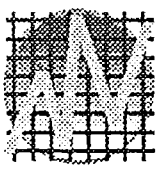
5.10.2 The hypotheses being tested in the pilot sites are as follows:

(a) The costs of individual specialties or sub-specialties will be derived through a process of cost allocation.

(b) The costs of procedures/treatments within specialties will be derived for ICD9 and OPCS4 codes at the 4th, detailed, digit level rather than the summary 3rd digit level.

(c) Application of the 80/20 rule will ensure that the number of items to be costed will be manageable and affordable. The high volume/low volume-high cost treatments and procedures will be costed individually, with the remainder placed in appropriate groups for costing purposes.

(d) Costs of procedures and treatments will be based upon costed profiles of resource use, which reconcile to specialty costs, using suitable costing techniques such as 'relative cost estimation'(see 'A Framework for Costing' June 1993, pp 14-20).



6 CONTRACTING

6.1 The key issue with regard to contracting is the question of whether a standard currency for contracting should be applied across Scotland or whether purchasers and providers should define currencies locally for use in individual contracts. These may change through time as the contract process evolves.

6.2 CURRENCY OPTIONS

The starting point for answering this question is a review of the options available. these are:

6.2.1 OPCS/ICD9

If activity is costed at the most detailed level within the ICD/OPCS structure (e.g. at the 4th digit) it may be considered simpler to contract at the same level. A variation would be to contract at the 3rd digit or summary level while recognising that there can be considerable variations within certain groups.

6.2.2 Diagnosis Related Groups

DRGs were developed in the USA and evaluated in England in the 1980s but were deemed to be inappropriate as clinical practices were seen to be significantly different from the USA. However they have been used with some effect within Scotland.

6.2.3 Healthcare Resource Groups

HRGs have been developed through project teams of consultants drawn from hospitals in England, with individual participation from some consultants in Scotland. Later versions of HRGs will be prepared with the full involvement of Scottish clinicians. The HRG structure is outlined in Appendix Two.

6.2.4 Scottish Resource Groups

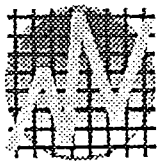
Should the established groupings prove inappropriate for use in Scotland, one option would be to develop a National grouping specific to the Scottish environment. This could take the form of a variant on HRGs or DRGs, or be developed 'from scratch'.

6.2.5. Locally Defined Contract Groupings

These are groupings devised purely for use at local level. This gives the advantage of reflecting local need for clinical and management use. However, the unique nature of such groupings would cause problems in terms of comparability if there was no clear way of mapping the groupings across to other levels in any agreed currency structure.

6.2.6 A 'Mixed Economy'

A combination of some or all of the above could be employed.



6.3 OPTION EVALUATION

6.3.1 Costing is likely to take place based on ICD9/OPCS4 codes, so it is natural to consider the possibility of activity in contracting being specified at the same level of detail. It seems unlikely, because of the potential number of codes and differences in case-mix between Trusts, that contracts could be managed effectively at this level of detail. Therefore, some form of aggregation will be necessary.

6.3.2 In an attempt to simplify the process, sets of ICD9 and OPCS4 codes have been used to produce HRGs and DRGs. Although there are many fewer HRGs and DRGs, they are still numerous (there are over 500 HRGs). It may be necessary to aggregate many of them into larger groups for contracting. A further concern is that DRGs have been rejected in England after extensive analysis and that HRGs are relatively new in concept. A particular issue is that the latest version of HRGs does not yet have a fully operational computer grouping programme available to allocate ICD/OPCS codes. This will be released towards the end of 1994. Therefore, it is unlikely that the use of up-to-date HRGs could commence until the 1996/97 Contracting round.

6.3.3 The option of producing a set of Scottish Resource Groups would be expensive and should only be considered as a last resort.

6.3.4 Allowing purchasers and providers to define their own Local Contract Groups has several advantages, especially if considered against the background of a consistent coding and costing currency framework. It avoids the need for a nationally defined schedule of contracting groups that would be unlikely to satisfy everybody and it allows for local circumstances to be taken into account in contract negotiations. Additionally, it gives scope for currencies to evolve and become more detailed as each year goes by. The main disadvantage is that it would involve 'reinvention of the wheel'.

6.3.5 A 'mixed economy' of currencies can either be the optimum solution that balances flexibility and prescription, or it can be a recipe for confusion. One solution would be:

(a) to retain and develop a common currency for GP Fundholders,

(b) to allow Health Boards and Trusts to develop their own local contract groups to reflect local circumstances and priorities and

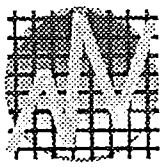
(c) to introduce potential common currencies for specialties based on best practice.

6.4 SUMMARY

6.4.1 In determining a contracting currency, the candidates for this role must be assessed on:

(a) their effectiveness in describing recognisable and stable clinical entities which are useful to clinicians and managers in their analyses and management of activities,

(b) their resource-cost homogeneity,



(c) the practicability of calculating the costs involved, so as to hold administrative workload to an acceptable level,

(d) the existence of a review and maintenance mechanism to ensure that the structure and ongoing cost implications of a selected currency can be kept up to date with clinical and service developments,

(e) their alignment with the reporting structures of purchaser and provider and

(f) their use as a medium to communicate information for planning and monitoring purposes between purchaser and provider.

6.4.2 The proposed approach at this stage is as follows:

(a) the GP Fundholder tariff schedule is retained and developed to maintain consistency and comparability,

(b) Health Boards and Trusts are allowed to develop local contract group currencies,

(c) these currencies will reconcile to the level at which costing has taken place. The process will link in with the overall development of the purchaser-provider relationship.

6.4.3 This approach retains the possibility of introducing national commonality as the contracting currencies develop.

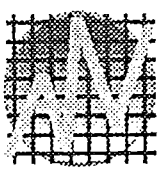
7. INTER-TRUST COMPARISON

7.1 It is essential that there is at least one level at which consistent information is available to allow comparisons to be made between Trusts that also takes some account of variations in case-mix.

7.2 The likely approach is that:

(a) initially, Trusts should provide information on the costs of all procedures and treatments at the 4th digit level of ICD/OPCS that they have costed locally. The detail will vary from Trust to Trust but the information will be a valuable basis for sound comparisons to be made for 1995/96;

(b) subsequently, Trusts should produce cost information for each HRG once a grouping mechanism becomes available and once HRGs have been tested for their robustness in the Scottish environment. This will also allow comparison with English Trusts, who are required to produce information on this basis.



8. FUTURE STUDY

8.1 Work will be carried out at the pilot sites in Kirkcaldy and Aberdeen up until the end of August 1994 to develop and test the best solution as follows:

(a) for each pilot site, the activity data will be analysed in similar manner for 1993 Scottish Statistics in order to identify the high volume ICD9 and OPCS codes making up the 80% of local activity;

(b) the SMR data will then be analysed by specialty, each being examined to identify the codes which comprise 80% of the activity;

(c) each of these high volume codes will have cost profiles produced for them in order to calculate individual procedure costs;

(d) costs will be extrapolated for the low volume codes which have a similar resource utilisation pattern to the costed high volume codes;

(e) low volume codes with a potentially high cost will be identified and costed;

(f) a bottom up costing exercise based on forecasted 1994/95 volumes and costs will be conducted for selected specialties covered within the pilot sites to test the findings. This will inform the selection on specialties to be costed nationally for 1995/96.

8.2 Once the latest HRG grouping software becomes available in the Autumn of 1994, a grouping of ICD9 and OPCS codes with related costs will be performed. This will be carried out in the following stages:

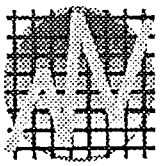
(a) the top 20% of codes will be mapped to HRGs, thus identifying the high volume HRG codes as well as the main OPCS/ICD9 codes that will influence the price of each HRG group;

(b) total activity will be mapped to HRGs. This will identify any HRG codes not in the top 20% which may be low volume but high in cost individually;

(c) each HRG group will be examined to test that the codes within them are at a similar cost level. Inappropriate code groupings will be highlighted and referred to the National Casemix Office of the English NHS Executive, who are leading the development of HRGs, for further study;

8.3 The implications of a change to Read coding will be identified.

8.4 Further products from the costing project will assist in the move towards consistency in the costing methodology underlying clinical activity. These products will include the interim paper, 'Allocation and Classification of Costs'. This paper gives guidance on the treatment of costs in clinical and non-clinical support services and on the classification of costs into fixed, semi-fixed and variable. Other papers will deal with costing in clinical support areas contributing to care.



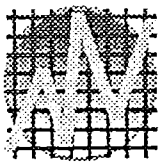
APPENDIX ONE - FREQUENCY OF CODED CASES

OPCS ANALYSIS 1992

CASES	CODES	CUM CODES	CUM CASES %	CUM STAY %
>1000	1	1	3.3	2.2
5000 - 9999	7	8	16.3	14.6
1000 - 4999	54	62	47.1	39.3
500 - 999	63	125	59.8	50.8
250 - 499	111	236	70.9	65.1
100 - 249	265	501	83.1	78.7
50 - 99	329	830	89.7	86.5
10 - 49	1236	2066	97.5	96.4
5 - 9	724	2790	98.9	98.4
<5	1791	4581	100	100

ICD9 ANALYSIS 1992

CASES	CODES	CUM CODES	CUM CASES %	CUM STAY %
>20000	1	1	4.9	3.7
15000 - 19999	1	2	8.9	5.2
10000 - 14999	3	5	17.1	8.4
5000 - 9999	5	10	25.1	21.7
1000 - 4999	72	82	58.7	59.4
500 - 999	71	153	70.1	70.1
250 - 499	114	267	79.3	80.0
100 - 249	254	521	88.3	88.5
50 - 99	287	808	93.1	93.4
10 - 49	993	1801	98.5	98.7
5 - 9	547	2348	99.3	99.4
<5	1362	3710	100	100



APPENDIX TWO

	HEALTHCARE RESOURCE GROUPS (HRGs) VERSION 2	NUMBER OF CODES
A	Nervous System	30
B	Eyes and Periorbita	46
C	Head, Neck and Mouth	73
D	Respiratory System	37
E	Cardiovascular System	42
F	Digestive System	52
G	Hepto-Biliary & Pancreatic System	21
H	Musculoskeletal System	52
J	Skin (including Burns)	22
K	Endocrine and Metabolic	19
L	Urinary Track and Male Reproductive System	54
M	Female Reproductive System	21
N	Obstetrics and Neonatal Care	9
P	Diseases of Childhood	27
S	Poisoning, Infectious Diseases and Non Specific Groupings	22
T	Psychiatry	15
	TOTAL	542

Note: The number of codes in the final version for 'C - Head, Neck and Mouth' will be reduced as there is duplication of groups in the first approach.