



The average hospital [☆]

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Abstract

In 1998, the UK government introduced the National Reference Costing Exercise (NRCE) to benchmark hospital costs. Benchmarking is usually associated with “excellence”; the government emphasised the raising of standards in the 1997 White Paper “*The New NHS: Modern, Dependable*” that heralded the NRCE. This paper argues that the UK “New Labour” government’s introduction of, and increasing reliance on, hospital cost benchmarking is promoting “average-ness”. Average hospitals will be cheaper to run and easier to control than highly differentiated ones; they may also score more highly on certain measures of service improvement. The paper aims, through empirical investigation, both to demonstrate how the activities and processes of hospital life “become average” as they are transformed to comply with the cost accounting average and to indicate how the “average” is being promoted as the norm for hospitals to aspire to. To benchmark to average costs, comparisons are necessary. To compare hospital costs involves the creation of categories and classification systems for clinical activities. Empirical evidence shows that as doctors, patients and clinical practices are moulded into costed categories, they become more standardized, more commensurate and the average hospital is created. © 2004 Elsevier Ltd. All rights reserved.

Introduction

Health care is expensive; funding it puts a significant burden on national governments world-

wide. Acute care in hospitals is particularly costly and an explosion in medical technologies, associated with the rapidly growing science of genetics, looks likely to make it more so.¹ Hospitals are diverse and differentiated places, controlled by medical elites—and not readily transparent

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¹ The Wanless Report (2002) into the appropriate future funding of healthcare predicted a major expansion in medical technology worldwide, particularly in the area of genetics. During 2002, New Labour announced the establishment of six new genetic knowledge parks and two new genetic reference laboratories. The, then, Health Minister, Alan Milburn, said, “There is no other health care system in the world better placed to harness the potential of genetic advances than the NHS” (see: news.bbc.co.uk/1/hi/health/1763951.stm).

to organizational review. Yet spending on healthcare, investment in hospitals and demonstrations that illness is being “conquered” are persuasive symbols that any government “cares”. Given this situation, it is to be expected that governments would like more control over both hospital costs and the medical profession. The “average” hospital may offer a way of achieving the goals of less costly healthcare and less sovereign clinicians.

The average hospital has a cost index score of 100; this paper tracks the complex processes that create the hospital of average cost. Mapping costs on to the highly differentiated activities of health care to create averages is difficult and problematic. Yet, in the UK, there is a strong political will to use the average cost both as a specific measure to compare hospital performance and, generally, as a benchmark to control activities in health care. In this paper we aim, through empirical investigation, first, to demonstrate how the activities and processes of hospital life “become average” as they are transformed to comply with the construction of the cost accounting average and, second, to indicate how the “average” is being promoted as the norm for hospitals to aspire to.

Walgenbach and Hegele (2001) point out a central paradox of benchmarking: through benchmarking, organizational processes become increasingly similar (DiMaggio & Powell, 1991). This similarity erodes competitive advantage, hence, in the longer term, all an organization can expect from benchmarking is to become a “good average”. In the private sector, striving to be “average” is not an, obviously, advantageous strategy. However, for an expensive public sector activity like health care (which is financed from taxation and where competitive advantage between institutions for “customers” is not an issue) a benchmarking strategy that results in all hospitals becoming “more average” has political appeal. Average hospitals would be cheaper to run and easier to control than highly differentiated ones.

Before government intervention, evidence did not indicate that UK hospital costs tended to the average; rather there were some quite astonishing

Healthcare Resource Group (HRG)² comparisons. Below, two particular HRGs (one surgical, one medical) are illustrative of the range of reported cost variability. The British government proclaimed that these differences pointed to differing underlying levels of efficiency (see next section).

Surgical HRG (1997/98)	Medical HRG (1998/99)
Example: surgical HRG H02 (primary hip replacement—elective inpatient)	Example: medical HRG D15 (bronchopneumonia—non-elective)
Average HRG cost £3755	Average HRG cost £1211
Range of HRG costs £ 213–£19,960	Range of HRG costs £96–£13,443
Variation across range 9270%	variation across range 13,900%

Compiled from data in: DoH (1998b, 1999). Medical HRG data first became available in 1998/99.

Differential efficiency in cost performance can arise in three ways: first, from differences in the unit cost of resources used in hospitals (e.g. direct costs such as salaries and consumables); second, from differences in the running costs for hospital facilities (e.g. infrastructure costs and overheads); and, third, from variations in the clinical practices that drive cost (e.g. the skill mix employed in patient care, the use of diagnostic tests, the allocated theatre time and the designated length of stay in hospital post-procedure). Clearly, not all of these costs are controllable; in particular, infrastructure costs are fixed. Moreover, cost reduction may impact adversely on the quality of care delivered; despite this, hospitals are considered responsible for controlling their costs. But the extent of the HRG cost variations reported initially in hospitals raised questions about the meaningfulness of the

² HRGs are a variant on the Diagnostic Related Groups (DRGs) developed in the USA for pricing healthcare services. The UK National Casemix Office constituted HRGs to “...group together treatments that are clinically similar, consume similar quantities of resources and are likely to be similar in cost” (DoH, 1998a, p. 4).

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