

Chapter 18

From the Margins to the Mainstream: Clinical Costing for Clinical Improvement

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ABSTRACT

Healthcare system performance needs information on cost and revenue of care because of the rising healthcare costs. Empowering clinicians with clinical costing information is central to the success of containing costs. This information holds clinical data linkage unifying clinical, financial and administrative datasets, and seems to facilitate the spending of scarce health care resources in a way that produces the biggest difference in clinical outcomes. This chapter looks at the methodology and processes of clinical costing and its potential applications to facilitate the delivery of value-based healthcare, which confers quality care at lowest unit cost. Policy implications would be purchasing value-based healthcare, based mostly on quality of care after removing avoidable costs for inefficiency and poor quality. Clinician participation in the clinical costing is the key to success, because clinicians will be informed of the options available to choose the most value-based healthcare, which will, in turn, take care of the tight healthcare budget. Yet, this method of clinical costing is still at the margins.

INTRODUCTION

A Melbourne physician has asked a sensible question in a recent newspaper article: “How can we save on healthcare costs if doctors are kept in the dark?”, because she finds it hard to answer a very simple question from one of her patients on discharge: “Doc, how much did my care cost?” She concludes that educating those who are on the frontline of healthcare about the true cost of the care they offer could make for a more informed profession (Srivastava, 2014). She advocates for the empowering of the doctors on communicating the deeply sensitive issue of cost to patients at all stages of illness, and about the meaning and cost of interventions at the end of life. Fortunately, the clinical costing information

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system can answer not only this type of question fairly easily and accurately on her behalf, but also a more complex question such as “Is the healthcare system lean and mean?”

There is much empirical research into the costing of clinical practice, but to a great extent this focuses on the specific disease or a practice in a specific clinical setting and overlooks the clinical costing in general. Researchers seem to be reticent to do thorough research on the clinical costing sector, and only a few papers have been written for clinical communities to understand what clinical costing is.

THE OBJECTIVES OF THE PAPER

This paper is aiming to fill the gap of research on the clinical costing sector, its history, methodology and processes, and its potential application for studying the association between value-based care to the individual patient and to society as a whole with real world examples. This research does not just stop at an inquiry about the issues but also moves a step further, and explores possible actions, particularly in favour of a clinically-driven approach based on public health concepts to distribute limited healthcare resources.

BACKGROUND

The rising cost of health care is attracting a great deal of attention with the upsurge of interest in clinical costing on the release of a recent report indicating that healthcare spending alone will exceed all revenue collected by the Australian states and local governments in 2045 (The Australian Government, 2011). Health care costs will continue to rise in every country. Possible reasons for rising health care costs are aging populations and costly new treatments. Insurance companies and governments reimburse for health care performed (for example, activity-based funding) rather than clinical outcomes achieved (outcome-based funding) (Duckett, Bredon, Weidmann, & Nicola, 2014; Kaplan & Porter, 2011). This type of healthcare funding gives rise to a situation where only a few patients take direct responsibility for the cost of their healthcare (Kaplan & Porter, 2011), because only a few people acknowledge a more fundamental source of cost information: clinical costing systems by which healthcare costs are measured.

The biggest problem of rising healthcare costs seems to be that costs are measured in the wrong way and clinical costing information is interpreted wrongly (Kaplan & Porter, 2011). Some poor clinical costing systems allocate costs to services based on reimbursements using inaccurate allocation rules rather than actual resource utilisations. Since costs are wrongly measured clinical improvements and sustainable cost reduction are impossible. Healthcare services usually turn to simplistic actions such as across-the-board budget cuts in expensive but necessary services, and head counts. As Kaplan and Porter (2011) point out, the results of these arbitrary budget cuts on discrete components of care are higher system costs and poorer clinical outcomes later. All health care professionals could try to understand the cost of their services and how these costs compare with clinical outcomes.

Clinical costing seems to be under-researched and under-published. For example, only 36 papers were found in the PubMed database with the criteria of “clinical costing”, “last 5 years” and “English”; and almost all of them were related to the application side of clinical costing. Therefore, this paper will discuss what clinical costing is, who generates the costing data and how this information could be used, based on three bodies of literature: health economics, public health research and accounting.

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