

Unit Costing

The National Treatment Agency is in the process of calculating the unit costs of drug treatments. Within the next few months, it will produce something not that far off a price list for a whole range of interventions. This briefing looks at the background to unit costing and what it will mean for the drug sector.

What is happening?

The NTA, with the help of the Audit Commission, has developed a system to calculate the unit costs of drug treatments. All statutory drug services and bigger voluntary providers have been asked to provide detailed information, breaking down the cost of different interventions, on a series of specially designed spreadsheets. Number crunchers at the Audit Commission are in the process of analysing the figures provided, from which they will devise a set of unit costs for a whole range of treatments. In December, drug action teams and providers will be told what these costs are, and where their service figures in a cost range. Providers will not, however, be shown other services vital statistics. A final report on the exercise will be published next March.

Why is this taking place?

The NTA says this one-off exercise will be used to inform service commissioning from next year, and the Comprehensive Spending Review, the process which will determine the amount of money allocated drug treatment post 2008. The speed with which the exercise has been carried out was caused by the need to get the Treasury headline figures by the end of October. The wider backdrop, though, is the prevailing cost-driven climate in the NHS, which has seen unit costing introduced in many other areas. Driven by a desire for more transparency, cost effectiveness and efficiency, the Government believes it is no longer acceptable to dish out funding for services, with little understanding of how the money is spent and to what benefit. Commissioning on the basis of unit costs on the other hand, should be equitable and clear. The drug sector is now getting a taste of this medicine.

Likely impact of unit costing?

Unit costing is likely to have a significant impact on the sector. For a start, the figures given to the Treasury will influence the amount of funding allocated to drug treatment from 2008, something that will have huge repercussions for the sector. The set of "reference costs" produced are also likely to make a big impression on commissioners and the commissioning process. The NTA says the figures are intended as a guide and not a fixed price list, but it would be odd if joint commissioning managers did not use the unit costs to assess whether services are currently providing value for money, and determine what future contracts should cost. During the recent consultation on the allocation of new



BRIEFING
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capital money for residential services, commissioning managers complained that the process was taking place before unit cost figures were available, leaving open the possibility of them having to disinvest in services earmarked for refurbishment, that are identified as providing poor value for money. The likelihood is that over time, services will be commissioned on the basis of unit costs, a significant departure from current practice.

What do providers think?

Providers have no problem with the principle of unit costing and agree that it makes sense to understand how money is spent. In fact, some voluntary agencies not asked to take part in the exercise, including the Westminster Drug Project, have decided to do it for their own benefit, and in anticipation of the fact that it is likely to lead to a new commissioning model. There are concerns, however, about the ability of unit costing, to come

up with a fair price for interventions, when clearly the cost of delivery and level of service provided, will vary from one agency to another. Providers of tier 2 services, in particular, say it is not possible to come up with an accurate unit cost for a lot of tier 2 interventions, because of the unstructured nature of the work and varied roles staff delivering it have. They contend they can only provide a rough guesstimate, in the absence of a long-winded and impractical time sheet exercise, and that as a result, the unit costs produced will not be robust. Providers are also concerned, that despite assurances to the contrary, commissioning will become driven by set unit costs, especially as funding gets tighter. In addition, some voluntary sector providers have complained that the system being used is geared too much towards the statutory sector. Others say it is about time their statutory peers were subjected to closer scrutiny.

What's the NTA's position?

The NTA has been keen from the outset to stress that this is not an attempt to drive down costs or produce league tables. But it is unapologetic about the fact that it wants to bring about more cost-driven drug treatment. Hugo Luck, the NTA's project lead, points out that the "direction of travel" in the NHS, is clearly focused on delivering value for money, while the drug sector has to be able to account for the huge increase in funding it has benefited from. However, he continues that the exercise will produce a range of unit costs for interventions rather than a single cost, and that it wants commissioning to be driven by the cost of *effective* treatment, not the cheapest treatment. "He adds that the system adopted held up well during piloting in the south east and has gone smoothly so far, with two thirds of the information requested submitted.