

Measuring and costing delayed discharges: conceptual and methodological challenges

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Western societies are experiencing challenging economic times and in the UK the NHS is faced with budget reductions for the first time in decades. In the last few years, media reports of people staying in acute care for too long have proliferated. ‘Bed-blocking’ is the loaded term used to describe patients whose discharge from hospital is not timed with the speed desired by the institution. Synonymous expressions used in different countries and across time have similar meanings despite the contextual differences. ‘Delayed discharges’ is the recommended politically correct expression in the UK at the time of writing. In the 1990s, when the drive for efficiency embedded healthcare institutions, economists established that to maximise productivity in hospitals, patients had to flow through acute care at an average speed. Any deviance from this average is considered a decrease in efficiency and a misuse of public resources. Four interrelated issues challenge this economic theory and research studies such as the one carried out by Hendy *et al*¹ and published in this month’s issue of *Clinical Medicine* illustrates most of them.

- 1 Diagnosing and caring for acute patients is a complex process because of the unexpected and often difficult to control contingencies, stemming not only from the illness itself, but also from a host of organisational sources as well as from biographical and lifestyle sources pertaining to patients, their relatives and staff.² This complexity is at the centre of acute care and it clearly affects the clinical decisions to establish that patients are ‘medically fit’ to leave the hospital. ‘Medically fit’ does not mean that patients are no longer sick; rather that their medical condition does not require the technology, expertise, observation, costs etc provided in acute hospitals. Difficulties with the concept ‘medically fit’ and how this can affect research in delayed discharges are evidenced in the Hendy *et al* study when they wrote: ‘If a patient became unwell after being declared medically fit, periods of being medically fit were summed’. The authors did not interpret this as patients either being wrongly deemed ‘medically fit’ or accepting that ‘medically fit’ is a dynamic concept that fluctuates especially in acute emergencies and admissions. Instead, the authors recorded ‘fit days’ and ‘non-fit days’ without explaining the reasons for this fluctuation and still counting ‘non-fit days’ as delays.

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2 There are methodological difficulties in establishing objective definitions of delays and single causality agents. Research studies often rely on expert panels who determine when and why specific delays occur. The panel's composition affects outcomes (seniority, generalists or specialists, presence of therapists and social care representatives, etc) and so do panel consensus strategies and the frequency of multi-disciplinary meetings. In the UK, there is a legally binding definition of 'safe to transfer'³ that must also be followed for research purposes. Patients are 'safe to transfer' when the following stages are all simultaneously addressed:

- a clinical decision has been made that a patient is ready for transfer
- a multidisciplinary team decision has been made that a patient is ready for transfer
- the patient is safe to discharge/transfer.⁴

Disagreements about when patients are safe to transfer due to different institutional understandings are common and medical records cannot be the only documents used to examine reasons for delay (social services and therapy records should also be analysed). Research on the causes of delayed discharge frequently focuses on delays in social services and underestimates internal clinical and hospital organisational factors, which account for a significant proportion of delayed discharges.⁵

3 Economic theories of efficiency do not equate to clinical theories of efficient management of illness. Despite the official choice to use length of stay as a measure for efficiency, the clinical evidence linking shorter stays to quality of care is not straightforward. Traditionally, much of the literature explains that health outcomes are not affected by shorter stays and that extended stays are linked to increase morbidity. However, some authors⁶ expose the lack of causation between longer length of stay and poorer health outcomes. Delayed transfers of care are particularly associated with older patients with complex needs and geriatric medicine often purposely decelerates the process of discharge to achieve better long-term results.⁷ Gains made in the efficiency of treating acute care patients may even be made at the expense of pushing a larger fraction of patients into permanent care.

4 Short-term institutional savings do not equate to long-term decreased public expenditure. This is also the case for patients admitted in A&E or acute admissions units like the one researched by Hendy *et al.* To equate delays with 'cost per patient for the ward' does not take into consideration that patients flow through health and social care institutions at different time streams depending on their illness and social complexities.⁸ Calculations using single short-term measures are a guessing exercise that disregard increased expenditure for other public institu-

tions (or themselves!) because of premature discharge, eg increased number of readmissions, increased use of primary healthcare and social care services, and increased cost to families and carers. Furthermore, in the UK reducing hospital-based NHS care relocates free care services at the point of delivery to community services, which are means-tested and incur charges for the population.

Delayed discharge is a contested concept⁹ that can lead researchers through dangerous theoretical and methodological pathways. Patients are 'delayed' in hospital for multiple complex reasons (waiting for tests, second opinions, therapy, community care services, transfer to other social or health institutions, etc). Hospital productivity theories promote single public hospital institutions to treat more patients within the context of a large reduction in their physical infrastructure (ie the number of beds available is being constantly reduced). The conceptual subjectivity of who, when, why and for how much longer than expected people stay in hospital bedevils research, practice and legislation on delayed discharges. For the single institution, speeding up production beyond critical levels can also lead to poorer care and increased risks for patients. For countries that subsidise health and social care, the financial gains of reducing length of stay overlook the long-term outcomes for overall public expenditure, for patients and for those who care for them.

References

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