Cost Objects: The ED Dilemma. How is your ED performing?

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Abstract

Background: The aim of this study is to propose a standardized methodology to identify a list of cost objects that can be used by any ED to compute costs considering that the resulting data must facilitate unit management by improving the information available for decision-making. Methods: This study considers two stages, first, we analyzed the case-mix of two hospitals collecting their data to define and diagram their processes, activities and to obtain their cost objects, second, we used four additional hospitals to validate our initial findings. Results: We recognized 59 cost objects. Hospitals may have all these cost objects or just a subset of them depending on the services they provide. Conclusions: Among the main benefits of our cost objects definition are: the possibility of tracing the processes generated by the services delivered by EDs, the economic sense in its grouping, the chance of using any costing methodology, the flexibility with other classification systems such as DRGs and ICDs, and the opportunity of costing for both diseases and treatments. Furthermore, cost comparison among hospitals using our final 59 cost objects list is more accurate and based on comparable units. In different EDs, each cost object will be the result of a similar combination of activities performed. We also present the results of applying this cost objects list to a particular ED. A total of 53 out of 59 cost objects were identified for that particular unit within a calendar year.

Background

Emergency care expenditures are a growing problem both in Chile and worldwide. The level of emergency care spending in the United States is between 5% and 6% of the total health expenditure, reaching 10% in some states (1). However, it is still unclear how much it costs to deliver emergency care worldwide. The reason is twofold. Firstly, cost calculation of clinical processes of Emergency Departments (EDs) does not allow
comparison between healthcare units or services. Secondly, no standardized
categorization for grouping costs has been defined, i.e. cost objects. A cost object is
anything for which a separate measurement of costs is desired (2). In health care, cost
objects could be patients, products, projects, service contracts, and any other work unit
(3).

**Cost Objects**

Different published studies use various types of cost objects for EDs. For example, cost
objects of an ED can be classified into three types based on the patient’s status: Urgency;
Emergency and Non-Emergency (4). This definition addresses the classification of patients
from a more macro perspective. Other key cost objects that have been used for allocation
are: Diagnostic Related Groups (DRGs) (5) and case-mix by using the international
classification of diseases (ICD) (6). These two classifications do not provide complete
information about ED services, since they were designed to facilitate billing considering
ED charges according to the acuity level of the patient and the intensity of supplies and
services provided, so most of the time EDs are seen as an intermediate service.

Other studies consider cost objects just for a subset of ED cases, such as: division costs
for services to specific patients, for example hospitalized patients (7) and pre-selected
diseases (8). Another methodology to compute the costs of the clinical processes in EDs,
uses homogeneous functional groups, which are defined based on similar consumption
activities followed by an imputation to clinical processes (9). However, the authors do not
present the cost objects and suggest that each hospital should code their own diseases
according to the ICD. Similarly, other authors define cost objects clustering as groups
whose services similar demands for ED functions (i.e. ambulatory patient groups,
physicians’ current procedural terminology groups) (10).

Other studies use cost centers related to patients (11). However, the study does not
distinguish the different services and processes carried out by the ED. It can be observed that there is still no consensus on how to classify cost objects for EDs. In fact, the choice of cost objects is difficult given the variety of services provided, yet very important. In this study we consider that a correct definition of cost objects should aim to measure the costs of either treatments or diseases if needed, and trace the processes and services provided by the ED considering the whole set of processes and activities the ED perform not just a subset.

Cost objects have enormous financial importance because they are the foundations of health insurance billing, and thus are tied to health systems financing. The lack of standardization and homogeneity in defining cost objects make comparing among units/services difficult and sometimes even impossible. Therefore a common definition of cost objects is required, in other words the same vocabulary for recording, reporting and monitoring emergency health problems. Thus, this paper aims to create a standardized methodology to identify a list of cost objects for EDs that can be used as a starting point to collect feasible data for decision-making purposes and to provide global data for analysis such as tracing processes, computing costs and allowing comparisons among other ED hospitals. Additionally, in order to test the viability of implementing this list of cost objects with a costing methodology, in this particular case we use the activity-based costing (ABC) method.

In the healthcare sector, there have been attempts to apply the ABC costing methodology since the 1990s due to the need to have more accurate and practical costing systems for a more effective cost control (12–14). There are some experiences in EDs arguing that this methodology allows for a better imputation of costs, eases processes monitoring, allows inter and intra-hospital comparisons, provides more realistic information and adapts better to the clinical decision process based on protocols (9, 15). Also, another study
computed the total cost of patient care in an ED using Time-Driven Activity-Based Costing (TDABC) (16).

The next section presents the methodology used to achieve these purposes.

Methods

In order to determine cost objects in EDs, this study considers two stages and a sample including a total of six hospitals. The first stage includes both on-site observations and interviews conducted in two different EDs. To ensure a more representative sample, the first hospital selected (hospital 1 in Table 1) is located in Santiago (the Chilean capital), while the second hospital selected is located in a smaller urban city (hospital 2 in Table 1). The observation and interviewing process lasted approximately three months in each ED, and as a result, diagrams using the Unified Modeling Language (UML) were constructed for each unit. The diagrams were then validated with personnel with at least five years of work experience at the unit. Subsequently, to elaborate a more comprehensive diagram that included the complexity of both cases observed so far, the diagrams were compared to each other considering the similarity and variability of the tasks required in each process and the resources needed to perform them. For example, Hospital 2 included an area in which the patient’s status was monitored while they remained under observation, whereas Hospital 1 did not include such a space because length of stay within the ED was less than 24 hours. Hence, the pathway followed by a patient that ends up being hospitalized differs from Hospital 1 to Hospital 2.

The purpose of the second stage of this study was to validate the resources employed (direct and indirect costs), as well as the activities performed and services delivered (cost objects) for EDs. Using convenience sampling, four additional EDs were selected to further validate the diagram (hospitals 3 through 6 in Table 1). Table 1 shows some relevant descriptive information about the hospitals included in this study, as well as descriptive
information on the healthcare professionals that were involved in the validation process.

It is important to note that Chile is an upper-middle income country located in South America. The Chilean health care system is a mixed system, which is publicly and privately financed. There is a single public insurance (FONASA) and several private health insurance companies (ISAPREs). Most of Chilean citizens (70%) are covered by FONASA. Workers can choose to be covered either by FONASA or one of the ISAPREs operating in the country. There are no barriers in FONASA to access to emergency care and highly complex pathologies. FONASA is structured in 4 groups classified by income (A to D from lower to higher income). People in groups A and B receive free health care services, group C have to pay 10% cost-sharing, and group D pay 20% of health services. In case of an emergency public beneficiaries will face the same copayments. Except for Group A, the rest have the option of using private health care facilities subscribed by FONASA. On the other hand, ISAPREs can offer different premiums to their customers to improve their health plans; most of their beneficiaries use private facilities (17). There are copayments for people with private insurance when emergency services required exceed the plan´s ability to pay. In case of life-threatening situations, patients can receive medical attention from any ED.

In the following paragraphs we present a step by step description of the methodology executed to construct cost objects for EDs. Steps 1 through 5 correspond to stage 1 of this study, while step 6 and 7 correspond to stage 2.

**Stage 1: Identifying Cost Objects**

**Step 1: Collecting the data to define processes.** Through observation and interviews with all healthcare professionals working at the two EDs included in this study at this point (hospital 1 and 2), all the processes performed within the ED were identified, considering all the tasks needed to carry them out. Each one of the tasks is considered an
activity and a comprehensive list including all the activities identified (73) was elaborated. Observation occurred at different points in time (season, day of the week and time during the day) to account for seasonal effects.

**Step 2: Diagraming the processes.** Using a workflow chart (using UML), all the activities identified in the previous step were diagramed considering which ones needed to be performed in sequence and which ones could be conducted in parallel. A process involves a series of activities to achieve a particular end, we identified a total of 6 processes out of 73 activities.

**Step 3: Checking the databases available to complete the process information.** To make sure that all the processes needed to provide services that could be performed at the ED were considered, a list of all services accounted for each patient within the last two years was checked. When services provided very unfrequently were detected, the processes needed to provide them were included in the workflow charts, and therefore, the processes needed to perform them were identified.

**Step 4: Elaborating and validating processes and activities performed by the ED.** All the tasks (activities) for each process were defined. The comprehensive list of activities identified, now all included in a workflow chart, were validated using the expertise of at least one physician and one nurse from the ED, preferably those that had been working at the department the longest (see Table 1). Validation of both the description and the succession of the activities occurred.

**Step 5: Defining cost objects for the ED.** Once the list of identified activities was validated, groups of activities were created using three criteria. Firstly, activities were grouped according to their nature and sequence. The groups must be mutually exclusive in terms of activities, to avoid double counting when costing patients and represent 100% of the services provided by the ED. The latter translates into having combinations of
groups of activities that are consumed by patients without having an overlap of activities performed, unless those activities are in actuality executed multiple times. Each one of the groups elaborated will become a cost object of the ED. Secondly, these cost objects will allow us to trace back the processes and services the ED perform. Thirdly, these cost objects can be aggregated in order to compute the costs of treatments and diseases (using any coding system). The final list of cost objects (59) corresponds to the services provided by the ED unit.

**Stage 2: Validating the cost objects**

**Step 6: External validation of the activities.** The final list of activities from stage 1 was validated in four EDs by healthcare professionals with expertise at the unit (see hospital 3 to 6 in Table 1).

**Step 7: External validation of the cost objects.** The final list of cost objects from stage 1 was validated in the same four EDs by the same healthcare professionals as the previous step (see hospital 3 to 6 in Table 1).

After the validation process we tested the feasibility of applying these cost objects in order to calculate costs using the ABC method at a particular ED. We chose the ABC methodology because it has being posed as a promising model for measuring costs and for making effective cost improvement decisions for the ED. We followed Kaplan & Cooper approach (18) by:

1. Developing the activity dictionary.
2. Determining how much the ED is spending on each of its activities.
3. Identifying the ED´s products, services and patients, i.e. our cost objects list.
4. Selecting activity cost drivers that link activity costs to the ED´s products, services and patients.

The list of cost objects and activities derived from this study as well as the application of
the ABC method are presented in the results section.

Results

As shown in Table 2, we identified a total of 59 cost objects for EDs. A particular ED may provide all the services listed in Table 2 or a subset of them.

Below we present the costs for all the cost objects identified in the ED from Hospital 1, using the ABC method. As shown in Table 1, Hospital 1 is a high complexity and private teaching hospital with more than six hundred beds. As a teaching hospital, patients can be treated by EM specialists, medical interns and residents. The ER at this hospital has a medical and trauma unit, as well as a critical care unit, with 10 boxes in total. The layout of this ER also includes a triage area.

We calculated the cost of 53 out of the 59 cost objects that this ED provided within a calendar year. We identified and cost 6 processes and 73 activities. Figure 1 shows the indirect costs of the processes that took place in the selected ED.

As shown in Figure 1, the medical care process has the higher proportion (36.9%) of indirect costs whereas the administrative and logistic processes consume more than half (52.1%) of the indirect resources. The indirect resources included in this ABC application can be categorized as: salaries, depreciation of equipment and infrastructure, utilities and medical supplies, office supplies, and maintenance. In order to carry out ABC, we need to recognize the tasks that make up these processes, i.e. the activities. To assign indirect resources to the activities, we define resource drivers such as time, number of procedures, number of employees/ time, usage percentage, and square meters/time.

Once activity costs were calculated, then activities were assigned to the cost objects. To allocate the cost of the activities we use the following cost drivers: time, number of procedures, and consumption index. Table 3 presents the eight most expensive activities from this ED.
According to Table 3, the most expensive activities are medical evaluation ($146,054,786 chilean pesos, equivalent to US$225,000) and re-evaluation ($152,047,070 chilean pesos, equivalent to US$234,000). The main reasons for the elevated costs of these activities are the physicians’ salaries and equipment and infrastructure costs.

The next step of ABC is to allocate the cost of the activities to the cost objects. The cost objects are the 53 services provided by the ED. Table 4 shows the final allocation of direct and indirect costs to these services. The services with the highest total costs are medical consultation ($487,445,524 chilean pesos, equivalent to US$750,000), phleboclysis ($97,601,148 chilean pesos, equivalent to US$150,000) and preparation of patients for hospitalization ($93,013,711 chilean pesos, equivalent to US$143,000). Eighty percent of the medical consultation costs come from three activities: medical evaluation, re-evaluation and filling health records for patients. Similarly, 80% of the phleboclysis services’ cost relates to four activities: intravenous (IV) installation, withdraws of supplies for procedures, medication administration and sample taking activities, registering medical supply consumption, and storage control. For preparation of patients for hospitalization the highest costs (78%) are associated with three activities: filling nursing and medical records for hospitalization activities, and preparing patients for transporting.

However, if the unit cost is considered, the most expensive services correspond to referral ($134,507 chilean pesos, equivalent to US$207), resuscitation ($131,859 chilean pesos, equivalent to US$203), and diagnostic and therapeutic puncture ($43,526 chilean pesos, equivalent to US$67).

The proposed cost objects list can also be used to accumulate costs at different levels, such as patient or diagnoses. Table 5 shows an example of how the costs objects proposed can be aggregated at a diagnosis level, using the Pneumonia due to Streptococcus pneumoniae diagnosis (code J13 in the ICD-10 coding system).
As shown in Table 5, treating a patient diagnosed with Pneumonia due to Streptococcus pneumoniae costs $43,710 chilean pesos. This cost includes only the services provided by the ED. However, the revenue linked to those services could be imputed to the ED or to another unit at the hospital, given the classification of the services for billing purposes. In this particular case, the total revenue imputed to the ED corresponded to $19,050 chilean pesos. Hence, the ED had losses for an average of $24,660 chilean pesos per patient treated for that diagnosis in the time period included in the analysis.

The results are discussed in the next section.

Discussion

This study proposes a methodology to identify a cost objects list for EDs that facilitates their management by improving the information available for decision-making. The analyzed case-mix allowed us to recognize 59 cost objects. This list of cost objects is better than the proposals to date because it meets with the following three design criteria: 1) Cost Objects are related to diseases, their treatments and their associated activity groups; 2) they are mutually exclusive and represent 100% of the services; 3) It allows us to trace back the processes and services provided by the ED. Hospitals may have all these cost objects or just a subset of them depending on the services they provide. The method proposed in this study can be applied to any hospital; however the final list of cost objects may differ depending on the treated cases. Moreover, the final list may end up with new cost objects based on differences in practices across countries.

Both the method to define cost objects for EDs and the cost objects list proposed are independent of the costing methodology employed. For instance, either activity-based costing or volume-based costing may be used to calculate costs. Our methodology is flexible because it recognizes activities that are aggregated according to a defined criterion to identify the final cost object list of services provided by any ED. In terms of
information systems, using volume-based costing all that is required are the aggregated costs of the ED for the period under analysis, and then the selection of one driver to allocate the ED’s resources to compute the cost of the cost objects list. On the other hand, the ABC methodology used in this study allows us to aggregate the costs of activities or cost objects providing detailed information for the ED. For example, aggregating activities or cost objects at the condition level, the patient level, etc.

In comparison with previous studies, such as those using patient’s severity status as cost objects (Urgency; Emergency and Non-Emergency) (4), our proposed cost objects may both reach this level of aggregation as well as others, such as diagnoses, pre-selected diseases, case-mix and services. The same advantage can be seen when comparing to the cost objects proposal by several other authors (5,7,8). Among the main benefits of our cost objects definition are: the possibility of tracing the processes generated by the services delivered by EDs, the economic sense in its grouping, the chance of using any costing methodology, the flexibility with other classification systems such as DRGs and ICDs, and the opportunity of costing for both diseases and treatments. Furthermore, cost comparison among hospitals using our final 59 cost objects list is more accurate and based on comparable units. In different EDs, each cost object will be the result of a similar combination of activities performed.

The definition of cost objects is crucial, because hospital managers can expand their analysis by focusing on continuous improvement to increase the value of care. The complexity of EDs provide a valuable setting to apply ABC given the high activity variability and hard predictability of demand. Additionally, calculating costs through ABC would help focus improvement efforts even more, for example, it would help detect which activities do not add value, optimize processes of providing services and provide more realistic cost estimates to make better managerial or strategic decisions (19).
The use of the proposed methodology makes it possible to associate cost objects with service revenue. This enables assessing the margin by each group of services. In addition, it facilitates the creation of transfer prices between different units of a hospital. In the case of the emergency unit this is especially important because many of the patients are transferred to or attended by other units. In these cases the ED does not receive the proportional compensation corresponding to the services delivered, such as, management of imaging tests, preparation of patients for surgery and medical interconsultation. Therefore, this methodology could help assess the potential economic impact of an ED within the hospital.

This study has limitations due to (1) differences in practices across institutions and countries, as well as changes in practices over time due to the development of new knowledge; and (2) sample size used for validation purposes. Even though the proposed methodology for defining cost objects is applicable to any case, the list of cost objects generated as a result of this study may not include all the services that could be provided in an ED for three reasons. First, this study analyzed a sample of six EDs. Second, technological advances could change services currently provided and make others obsolete. Lastly, epidemiological changes may demand new services. The systematic application of this cost objects definition will enable managers to have better cost information for analysis and decision-making to avoid underfunding of EDs. Additionally, calculating these cost objects over time will allow internal comparability and benchmarking with other ED facilities. If we observed that two hospitals have a different unit cost for the same service, we may suspect that the hospital with the lower unit cost performs better than the other one. To validate the previous hypothesis, one would have to break down the difference in order to understand why those differences exist, evaluating at the same time the practices followed within each hospital. To clarify the
previous argument, we can use an example. Using data from Hospital 1 and 2, we observed that the unit cost computed for medical consultation corresponds to $11,534 for Hospital 1 and to $12,268 for Hospital 2 (See Table 6). When analyzing why these difference exists, we can see that there are three activities that account for at least four-fifths of the indirect cost of the ED for both hospitals. Out of these three activities, two of them (Medical evaluation and Medical re-evaluation) consume a larger proportion of indirect costs in Hospital 1 than Hospital 2, mainly due to a larger volume of medical consultations in Hospital 1 compared to Hospital 2. For the remaining activity (Record indications to the patient), the leading cause for the discrepancy between the two hospitals is the shorter amount of time that takes to perform this activity in Hospital 1. After comparing the practices between the two hospitals, we concluded that the use of information systems to carry out the activity accounts for the minutes saved.

Governments should encourage these types of methodologies in order to promote transparency, efficiency, and cost control through a better calculation of ED charges. Future research could use this cost objects list to assess whether the systematic comparison of income and costs within the emergency unit, as well as between different EDs, would allow us to detect opportunities for improvement indicating which processes should be intervened.

Conclusions

Cost objects have financial importance because they are the foundations of health insurance billing, and thus are tied to health systems financing. Different published studies use various types of cost objects for EDs. However, the lack of standardization and homogeneity in defining cost objects make comparing among units/services difficult and sometimes even impossible.

This study provides EDs with a standardized methodology to identify a list of cost objects
that facilitates their management and a methodology to adapt this list to their own context. This list is better than the proposals to date and can be applied to any hospital. Hospitals may have all these cost objects or just a subset of them depending on the services they provide. Moreover, the final list may end up with new cost objects based on differences in practices across countries. This list allows to trace processes, compute costs and comparability among other EDs, provides an economic sense in its grouping, and it is flexible with any costing methodology and classification system.

Abbreviations

EDs: Emergency Departments.
DRGs: Diagnostic Related Groups
ICD: International Classification of Diseases
ABC: Activity-Based Costing
TDABC: Time-Driven Activity-Based Costing
UML: Unified Modeling Language

Declarations

Ethics approval and consent to participate

This article does not require ethics approval. There is not human involvement in this study. Consent from the patient is not required, this study reports an assessment of the hospital situation not at the patient level. A consent form was written and signed to participate in the project.

Consent for publication

Not Applicable

Availability of data and material

The datasets used and/or analysed during the current study are available from the
corresponding author on reasonable request.

**Competing interests**

The authors declare no competing interests

**Authors' contributions**

The contribution of the author was as followed: VF developed the original research idea and questions, obtained the data for this study, conducted data analysis, interpreted the results, and wrote the manuscript. LN contributed to the original research idea and questions, interpreted the results, and contributed to the writing and revisions of the manuscript. AN conducted data analysis, interpreted the results, and wrote the manuscript. RM contributed to the writing and revisions of the manuscript. All authors read and approved the final manuscript.

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Tables

Table 1: Hospitals ED included in the sample.
| Institution | Used in | Characteristic                                      | Medical Providers                                | Number of beds | Interviewee's position | Years of Experience |
|-------------|---------|----------------------------------------------------|--------------------------------------------------|----------------|------------------------|---------------------|
| Hospital 1  | Stage 1 | High Complexity and Private Teaching Hospital.    | EM Specialists, Medical interns, Residents       | 607            | Physician              | 6                   |
|             |         |                                                    |                                                  |                | Physician              | 8                   |
|             |         |                                                    |                                                  |                | Nurse                  | 1                   |
| Hospital 2  | Stage 1 | High Complexity and Public Teaching Hospital.     | EM Specialists, Medical interns, Residents       | 466            | Nurse                  | 1                   |
|             |         |                                                    |                                                  |                | Nurse                  | 8                   |
| Hospital 3  | Stage 2 | High Complexity Public Hospital.                  | EM Specialists, Residents                        | 340            | Physician              | 7                   |
|             |         |                                                    |                                                  |                | Physician              | 5                   |
|             |         |                                                    |                                                  |                | Nurse                  | 1                   |
| Hospital 4  | Stage 2 | Specialty High Complexity Public Hospital.        | EM Specialists, Residents                        | 176            | Physician              | 1                   |
|             |         |                                                    |                                                  |                | Nurse                  | 2                   |
|             |         |                                                    |                                                  |                | Technician             | 6                   |
| Hospital 5  | Stage 2 | High Complexity Public Hospital.                  | EM Specialists                                   | 211            | Physician              | 8                   |
| Hospital 6  | Stage 2 | High Complexity Public Hospital.                  | EM Specialists, Residents                        | 545            | Physician              | 8                   |

Table 2: List of Cost Objects for EDs.
| N° | Services                                                        | Description                                                                                                                                 |
|----|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| 1  | Administration of drugs by subcutaneous or intravenous injection | Administration of injectable medications of medications can be administered to the patient without an additional approval process or paperwork because they are controlled drugs. |
| 2  | Administration of non-injectable drugs                          | Administration either oral, buccal or other enteral route non-injectable medications of medications that can be administered to the patient without an additional approval process or paperwork because they are not controlled drugs. |
| 3  | Administration of non-injectable prescribed drugs               | Administration either oral, buccal or other enteral route prescribed non-injectable medication of medications cannot be administered to the patient without an additional approval process or paperwork because they are controlled drugs. |
| 4  | Administration of prescribed drugs by subcutaneous or intravenous injection | Administration of injectable medications of medications cannot be administered to the patient without an additional approval process or paperwork because they are controlled drugs. |
| 5  | Alcohol screening test                                          | Application of validated screening tools for alcohol misuse and alcohol use disorder.                                                                 |
| 6  | Application of a larger orthopedic medical cast                 | Procedure in which a large orthopedic cast is used to treat a trauma condition.                                                             |
| 7  | Application of a shorter orthopedic medical cast                | Procedure in which a short orthopedic cast is used to treat a trauma condition.                                                             |
| 8  | Arterial blood gas sample                                       | Arterial blood gas (ABG) sampling to obtain information patient’s respiratory status (blood oxygen and carbon dioxide levels), as well as the patient’s acid-base balance. |
| 9  | Black braided silk suture                                       | Procedure for approximation and/or litigation of soft tissue which a black braided silk suture is used. This type of suture is a non-absorbable multifilament composed of an organic protein. |

Table 2: List of Cost Objects for EDs (continue).
| No. | Services                        | Description                                                                                                                                 |
|-----|--------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| 10  | Bladder instillation           | Bladder instillation is a combination drug therapy to painful bladder or cystitis type symptoms including frequency, burning pain or stinging sensations when passing urine. It works by reducing inflammation and discomfort within the bladder. |
| 11  | Blood culture sample           | Blood culture collection to test for foreign invaders such as bacteria, yeast, and other microorganisms in the blood.                          |
| 12  | Blood glucose test             | Procedure to test the amount of glucose in blood.                                                                                           |
| 13  | Blood sampling                 | Blood specimen collection to obtain blood for laboratory testing.                                                                             |
| 14  | Burn wound dressing            | Procedure to dress a dermal burn to absorb fluid, avoid maceration and seal the wound from the outside environment to reduce pain and infection.|
| 15  | Catgut suture                  | Surgical suture procedure in which a catgut suture is used. This type of suture is naturally degraded by the body's proteolytic enzymes. It is used for surgical procedures such as general closure, ophthalmic and orthopedics. |
| 16  | Complex foreign body extraction| Complex localization, incision and removal of foreign body because of the location of the foreign body inside the patient's body and the material or shape of the foreign body. |
| 17  | Complex wound dressing         | Procedure to dress a complex wound that requires specialist wound care intervention. Complex wound dressing often results from the treatment of any number of other conditions, including cardiac, pulmonary, neuromuscular and renal diseases. |
| 18  | Diagnostic and therapeutic puncture | Medical diagnostic and therapeutic puncture for sample and treatment purposes.                                                             |
| 19  | Diagnostic puncture            | Medical diagnostic puncture for sample purposes.                                                                                           |
| 20  | Discharge of deceased patients | It involves all the administrative processes the ED needs to follow to discharge deceased patients.                                            |
| 21  | Electrocardiogram              | Test provided at the ED to evaluate whether the patient's heart is beating at a normal rate and strength.                                       |

Table 2: List of Cost Objects for EDs (continue).
| Nº  | Services                                    | Description                                                                                                                                 |
|-----|---------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| 22  | Endotracheal intubation                     | Endotracheal intubation is a medical procedure in which a tube is placed into the trachea, usually through the mouth to assist breathing. |
| 23  | Enema                                       | Procedure used to stimulate stool evacuation.                                                                                               |
| 24  | Feeding tube insertion                      | Technique in which a nasogastric tube is inserted into the patient’s nose, reaching first the back of the throat and pushed down the esophagus until it reaches the stomach. |
| 25  | Histoacryl                                  | Procedure in which histoacryl is applied for closing wounds.                                                                                   |
| 26  | Intramuscular drugs administration          | Technique used to deliver medications deep into the muscle through an injection of medications that can be administered to the patient without an additional approval process because they are not controlled drugs. |
| 27  | Intramuscular prescribed drugs administration | Technique used to deliver medications deep into the muscle through an injection of medications that cannot be administered to the patient without an additional approval process or paperwork because they are controlled drugs. |
| 28  | Installation of a removable cast walker boot | Procedure in which a removable cast walker boot is placed to treat trauma conditions such as severe sprains, fractures, tendon or ligament tears in the ankle or foot. |
| 29  | IV fluid change                             | Procedure in which the IV fluid bag is changed for another based on the needs of the patient.                                                |
| 30  | Life risk care management                   | It involves all the administrative processes the ED needs to follow to admit a patient with a life-threatening condition regardless of their ability to pay. |
| 31  | Management of imaging tests                 | It involves all the administrative processes the ED needs to follow to ensure that an ED patient is scheduled for imaging tests prescribed and transported from the ED to the Imaging Unit and back to the ED. |
| 32  | Medical attention of patients arrived by ambulance | It involves all the administrative processes the ED needs to follow to admit a patient arriving by ambulance.                                 |
| 33  | Medical consultation                        | It includes the administrative process required to admit the patient into the ED, as well as the physician’s evaluation.                     |

Table 2: List of Cost Objects for EDs (continue).
| Nº | Services                                | Description                                                                                                                                                                                                 |
|----|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 34 | Medical interconsultation              | It includes the administrative process required to a specialist to further evaluate the patient, in order to correctly diagnose the patient, as well as the specialist’s evaluation.                       |
| 35 | Medium-complex foreign body extraction | Medium-complex localization, incision and removal of foreign bodies because of the location of the foreign body inside the patient’s body or the material or shape of the foreign body.                        |
| 36 | Monofilament nylon suture              | Procedure for approximation and/or litigation of tissue which a monofilament nylon suture is used. This type of suture is non-absorbable by the body.                                                              |
| 37 | Nebulization                           | Procedure in which a nebulizer is used to treat a person with asthma or another respiratory condition to administer medication directly and quickly to the lungs.                                           |
| 38 | Observation day                        | It involves all the procedures required to monitor the patient's status while the patient remains under observation.                                                                                       |
| 39 | Orthopedic trauma medical attention    | It includes the administrative process required to admit patient into the ED, as well as the evaluation of the patient’s condition by an orthopedic trauma specialist.                                      |
| 40 | Oxygen therapy                         | Procedure in which oxygen is provided if oxygen saturation of a patient is below the threshold defined as desirable for the patient’s condition in order to reach the targeted oxygen saturation level.          |
| 41 | Phleboclysis                           | It corresponds to the administration of fluids intravenously drop by drop, by the drip method, through a peripheral catheter.                                                                                |
| 42 | Polypropylene suture                   | Procedure for approximation and/or litigation of tissue which a polypropylene suture is used. This type of suture is non-absorbable by the body.                                                              |
| 43 | Preparation of patients for hospitalization | It includes the administrative process, preparation and transference of patients to be hospitalized.                                                                                                   |
| 44 | Preparation of patients for surgery    | It includes the administrative process, preparation and transference of patients for surgery.                                                                                                           |
| 45 | Reduction                              | Procedure to repair a fracture or dislocation to the correct alignment without surgery.                                                                                                                    |

Table 2: List of Cost Objects for EDs (continue).
| Nº  | Services                          | Description                                                                                                                                 |
|-----|----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|
| 46  | Referral                         | It includes all the administrative processes required to transfer a patient to another hospital, primarily because the hospital currently treating the patient has not all resources required to successfully treat the patient's condition. |
| 47  | Resuscitation                    | A life-saving procedure performed when someone stopped breathing or the heart has stopped beating, i.e., cardiopulmonary resuscitation (CPR). |
| 48  | Secretion clearance              | Technique aiming to remove sputum (the combination of mucus and saliva) from the patient's lungs.                                          |
| 49  | Simple foreign body extraction   | Simple localization, incision and removal of foreign body because the foreign body is located in a place of the easy to reach and the material or shape of the foreign are not likely to cause harm while the extraction process conducted. |
| 50  | Simple wound dressing            | Procedure to dress a simple wound. This type of wound defined as a dry dressing, apply to viable skin which does not require specialist wound care intervention. |
| 51  | Skin suture                      | Procedure for approximation and/or litigation of tissue using cutaneous suture.                                                           |
| 52  | Splinting                        | Procedure to apply a rigid or flexible device that maintains position a displaced or movable part; also used to keep and protect an injured part. |
| 53  | Stomach pumping                  | Procedure of cleaning out the contents of the stomach through a gastric lavage.                                                           |
| 54  | Stool sample                     | Stool specimen collection to obtain stool (feces) for laboratory testing.                                                                 |
| 55  | Teaching activities              | It includes all the teaching and research activities carried out within the ED.                                                            |
| 56  | Urethral sounding                | Procedure that involves inserting a sound into the urethra for dilatation of strictures or for obtaining access to the bladder.             |
| 57  | Urine specimen collection        | Urine specimen collection to obtain urine for laboratory testing.                                                                           |
| 58  | Verify injuries                  | Procedures requested by a judicial order or the police to verify type and severity of injuries.                                             |
| 59  | Vicryl suture                    | Procedure for approximation and/or litigation of tissue using vicryl suture. This type of suture is absorbable, synthetic, and normally braided. |

Table 3: Eight most expensive activities (Chilean Pesos = CLP).
| Ranking | Activity name                                         | Process name               | Annual Cost (CLP) |
|---------|------------------------------------------------------|----------------------------|-------------------|
| 1       | Medical re-evaluation                                | Medical care               | $152,047,070      |
| 2       | Medical evaluation                                   | Medical care               | $146,054,761      |
| 3       | Record indications to the patient                    | Administrative process     | $88,170,350       |
| 4       | Patient management for imaging examination          | Logistic process           | $54,408,061       |
| 5       | Management of the unit                               | Administrative process     | $37,020,211       |
| 6       | Clinical admission                                   | Administrative process     | $36,199,886       |
| 7       | Withdraw supplies for procedures, meds administration and sample taking | Logistic process | $34,493,631       |
| 8       | Take vital signs                                     | Diagnosis support procedures | $29,179,405       |

Table 4: Total Costs for ED Cost Objects (Chilean Pesos = CLP) including direct and indirect costs
| Ranking | Services                                      | Indirect Costs | Direct Costs | Total Costs | Unit Costs |
|---------|----------------------------------------------|----------------|--------------|-------------|------------|
| 1       | Medical consultation                         | $487,445,524   |              | $487,445,524 | $1         |
| 2       | Phleboclysis                                 | $67,044,073    | $30,557,075  | $97,601,148 | $1         |
| 3       | Preparation of patients for hospitalization  | $91,101,584    | $1,912,126   | $93,013,711 | $1         |
| 4       | Management of imaging tests                  | $71,325,226    |              | $71,325,226 | $1         |
| 5       | Resuscitation                                | $37,052,388    |              | $37,052,388 | $13        |
| 6       | Blood sampling                               | $30,124,604    | $392,805     | $30,517,409 | $1         |
| 7       | Urine specimen collection                    | $18,900,132    | $56,725      | $18,956,857 | $1         |
| 8       | Electrocardiogram                            | $10,555,702    | $150,097     | $10,705,798 | $1         |
| 9       | Preparation of patients for surgery          | $8,932,030     | $438,436     | $9,370,466  | $1         |
| 10      | Life risk care management                    | $9,080,651     |              | $9,080,651  | $1         |
| 11      | Referral                                     | $7,801,401     |              | $7,801,401  | $13        |
| 12      | Administration of prescribed drugs by subcutaneous or intravenous injection | $7,655,239 | $80,933 | $7,736,172 | $1         |
| 13      | Administration of noninjectable prescribed drugs | $7,451,112 |              | $7,451,112  | $1         |
| 14      | Monofilament nylon suture                    | $6,892,450     | $290,026     | $7,182,476  | $2         |
| 15      | Simple wound dressing                        | $6,744,059     | $333,805     | $7,077,865  | $1         |
| 16      | Complex wound dressing                       | $6,889,495     | $122,572     | $7,012,068  | $2         |
| 17      | Administration of drugs by subcutaneous or intravenous injection | $6,201,138 | $112,933 | $6,314,072 | $1         |
| 18      | Teaching activities                           | $6,225,455     |              | $6,225,455  | $1         |
| 19      | Administration of noninjectable drugs        | $5,515,973     |              | $5,515,973  | $1         |
| 20      | Nebulization                                 | $4,330,711     | $1,005,900   | $5,336,612  | $1         |
| 21      | Arterial blood gas sample                    | $5,286,625     |              | $5,286,625  | $1         |
| 22      | Splinting                                    | $2,187,641     | $2,262,020   | $4,449,661  | $1         |
| 23      | Blood glucose test                           | $2,945,942     | $147,546     | $3,093,488  | $1         |
| 24      | Application of a shorter orthopedic medical cast | $1,904,884 | $955,495 | $2,860,379 | $1         |
| 25      | Installation of a removable cast walker boot | $289,805       | $2,509,500   | $2,799,305  | $2         |
| 26      | Orthopedic trauma medical attention          | $2,348,362     |              | $2,348,362  | $1         |
| 27      | Black braded silk suture                     | $2,212,104     | $80,069      | $2,292,173  | $2         |
Table 4: Total Costs for ED Cost Objects (Chilean Pesos = CLP) including direct and indirect costs (continue)
| Ranking | Services                                         | Indirect Costs | Direct Costs | Total Costs | Unit Cost |
|---------|-------------------------------------------------|----------------|--------------|-------------|-----------|
| 28      | Intramuscular prescribed drugs administration   | $1,848,525     | $20,737      | $1,869,262  | $1.63     |
| 29      | Medical interconsultation                        | $1,724,532     |              | $1,724,532  | $1.03     |
| 30      | Intramuscular drugs administration               | $1,476,210     | $28,942      | $1,505,152  | $1.02     |
| 31      | Application of a larger orthopedic medical cast  | $622,032       | $855,619     | $1,477,650  | $2.77     |
| 32      | Stool sample                                     | $1,461,081     | $4,253       | $1,465,334  | $1.01     |
| 33      | Skin suture                                      | $1,280,692     | $29,963      | $1,310,655  | $2.26     |
| 34      | Stomach pumping                                  | $983,161       | $92,603      | $1,075,764  | $1.01     |
| 35      | Vicryl suture                                    | $745,130       | $35,083      | $780,212    | $2.08     |
| 36      | Histoacryl                                       | $528,726       | $10,882      | $539,608    | $1.01     |
| 37      | Endotracheal intubation                          | $478,748       | $23,326      | $502,074    | $1.01     |
| 38      | Diagnostic puncture                              | $453,459       | $21,398      | $474,857    | $2.05     |
| 39      | Diagnostic and therapeutic puncture              | $390,482       | $44,779      | $435,261    | $4.20     |
| 40      | Alcohol screening test                           | $375,863       |              | $375,863    | $1.01     |
| 41      | Medical attention of patients arrived by ambulance| $254,133       |              | $254,133    | $1.01     |
| 42      | Catgut suture                                    | $209,568       | $9,610       | $219,178    | $2.05     |
| 43      | Blood culture sample                             | $207,715       | $8,157       | $215,873    | $1.01     |
| 44      | Polypropylene suture                             | $186,282       | $19,626      | $205,909    | $2.06     |
| 45      | Discharge of deceased patients                   | $146,451       |              | $146,451    | $1.00     |
| 46      | Urethral sounding                                | $118,086       | $12,822      | $130,908    | $3.04     |
| 47      | Complex foreign body extraction                  | $117,215       | $590         | $117,806    | $1.01     |
| 48      | IV fluid change                                  | $95,742        | $5,622       | $101,364    | $1.00     |
| 49      | Reduction                                        | $95,091        |              | $95,091     | $1.00     |
| 50      | Oxygen therapy                                   | $36,802        | $23,757      | $60,558     | $1.01     |
| 51      | Verify injuries                                  | $51,283        |              | $51,283     | $1.00     |
| 52      | Medium-complex foreign body extraction           | $16,662        |              | $16,662     | $1.01     |
| 53      | Simple foreign body extraction                   | $16,579        |              | $16,579     | $1.01     |
Table 5: Example of costing at a diagnosis level (Chilean Pesos = CLP).

| Cost Objects                          | ICD-10 Code                        | J13: Pneumonia due to Streptococcus pneumoniae |
|--------------------------------------|------------------------------------|-----------------------------------------------|
| Medical consultation                 |                                    | $11,710                                       |
| Arterial blood gas sample            |                                    | $3,876                                        |
| Blood sampling                       |                                    | $5,795                                        |
| Management of imaging tests          |                                    | $5,689                                        |
| Intramuscular prescribed drugs admin |                                    | $6,724                                        |
| Administration of non-injectable     |                                    | $5,714                                        |
| Nebulization                         |                                    | $4,202                                        |
| Total Cost                           |                                    | $43,710                                       |

Table 6. Cost Comparison between Hospital 1 and 2 for the Medical Consultation Cost Object (Chilean Pesos = CLP).
| Activity                                      | Cost Driver       | Annual Cost (CLP) | %     | Annual Cost (CLP) |
|----------------------------------------------|-------------------|-------------------|-------|------------------|
| Request of medical advice from physician     | Time              | $8,457,972        | 2,0%  | $7,249,918       |
| Medical evaluation                           | Time              | $146,054,786      | 34,4% | $111,668,897     |
| Medical re-evaluation                        | Time              | $152,047,070      | 35,8% | $116,224,158     |
| Take vital signs                             | Time              | $29,179,405       | 6,9%  | $25,041,997      |
| Call patient into the examining area         | Number of patients | $28,583,417      | 6,7%  | $24,356,080      |
| Record indications to the patient            | Number of patients | $88,170,350      | 20,8% | $109,191,496     |
| Monitoring of clean laundry stock            | Number of patients | $3,646,956       | 0,9%  | $3,574,159       |
| Coordinate personnel                         | Time              | $7,402,449        | 1,7%  | $6,309,599       |
| Cleaning of the ED                           | Number of patients | $3,114,947       | 0,7%  | $2,989,540       |
| Security surveillance                        | Number of patients | $5,698,803       | 1,3%  | $5,044,004       |
| Management of the unit                       | Number of patients | $15,089,370      | 3,6%  | $13,171,222      |
| **Total Cost**                               |                   | **$487,445,524** |       | **$424,821**     |
| **Number of medical consultations**          |                   | 42,262           | 34,6% |                  |
| **Unit cost**                                |                   | **$11,534**       |       | **$12,2**        |

**Figures**
Figure 1

Indirect Costs of the processes from the selected ED.