Hospital Care Recommendations On Financing Models

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• Since the introduction of the DRG-based Prospective Payment Systems (PPSs), concerns have been raised that they might not contain enough incentives to improve quality of hospital care

• Indeed, these concerns might be somehow reasonable as PPSs are usually associated to some negative unintended effects, especially for quality of care

• Existing empirical evidence does not seem to have established very clear-cut results

• The InterQuality Project aims at studying in depth the typical incentives provided by DRG-based PPS
Research on Hospital Care

• Here, we present the results of the “InterQuality Project” on hospital care

• The whole content of our research on hospital care can be found in the following two reports:
  ▪ Report D4.1 “Financing hospital care”
  ▪ Report D4.2 “Recommended financing models”

• The main research results are summarized in the “WP4 Policy Brief”
Brief Overview of “Report D4.1”

- Descriptive analysis of PPSs in the hospital care sector in Italy, Denmark and the UK

- Theoretical analysis of the effects of PPSs as related to some crucial features of healthcare systems

- Empirical analyses of the effects of the adoption of PPSs in the hospital care sector, using the highly decentralized Italian NHS as a ‘natural laboratory’
Brief Overview of “Report D4.2”

• General lessons on enhancing quality of hospital under PPS

• Policy implications grounded on both theoretical and empirical analyses

• Concrete prescriptions for improving the provision of hospital care
Policy Recommendations

- We provide 10 policy recommendations related to four dimensions of hospital care: efficiency, quality, medical technology and inappropriateness of care.

- They consist of a set of financial and regulatory tools that should help policy makers to improve the overall performance of the European DRG-based PPSs.

- Given the complexity of the issue, we limited our recommendations to those that are rigorously grounded, based on a strong conceptual and evidence-based assessment.
The financial responsibility of each hospital is crucial for the overall efficiency of the system. Therefore, in those systems where the extent of the PPS is rather limited, it should be extended to expect the realization of its typical effect on cost-efficiency. Furthermore, stringent penalties for hospital management in case of bankruptcy should be introduced, to counteract the negative effect of the lenient budget constraint in the hospital sector.
HOSPITAL EFFICIENCY
Policy Recommendation 2
Optimal scale of production

Those countries with a considerable presence of private or, more generally, small hospitals should not expect by PPS the ability to induce a considerable high cost-efficiency in the system. Instead, along with the implementation of PPS, the structure of supply should be organized with a contained number of providers characterized by a more appropriate dimension, around the known optimal scale of production in the hospital sector.
HOSPITAL EFFICIENCY
Policy Recommendation 3
Excess of capacity

Healthcare policies aiming at reducing hospitalization, while avoiding inefficient waste of resources, should ensure that the induced reduction in outputs would not generate an excess of capacity, but would come together with a corresponding reduction in inputs.
Especially in those countries characterised by a low competition and a pervasively debauched working environment, the implementation of a DRG-based PPS should always go along with specific Pay for Performance (P4P) programmes introducing incentives for quality. However, for the incentives to have an impact the P4P programme should be designed according to the design features concerning: size of incentive, type of incentive, target unit of incentive, communication strategy, involvement of stakeholders.
A plausible tool to encourage high quality and cost-effective hospital care could be to introduce, still in the context of a PPS, the so-called Best Practice Tariffs (BPTs). Presumably, in those areas of hospital care where specific criteria are satisfied, the BPT design should provide hospitals with an effective financial incentive to move toward better medical practices and, in turn, to improve the overall quality of care.
It would seem appropriate to combine a DRG-based PPS with a specific design for readmissions. Indeed, a reasonable readmission policy should be to provide a somehow reduced DRG tariff for patients readmitted within 30 days of a discharge.
DIFFUSION OF MEDICAL TECHNOLOGY

Policy Recommendation 7

Transitory add-on payments and periodic DRG tariff revision

The process of adoption of new medical technology equipment should go along with a specific procedure, partially untied from the typical mechanism of PPS. In particular, this specific procedure should be based on two main cornerstones: a transitory add-on payment on the basis of periodic hospital applications and a periodic revision of DRG tariffs to include the additional costs of new technologies.
APPROPRIATENESS IN HOSPITAL CARE
Policy Recommendation 8
Tariff discrimination among treatments

Whenever providers have an effective possibility of choice among competing medical treatments, active policies should design incentives to minimise the risk of providers strategically inducing the most expensive ones. In this regard, a concrete option for attenuating the risk of strategic behaviour could be *slightly under-reimbursing* the most expensive medical treatment and, correspondingly, *slightly over-reimbursing* the cheapest one.
Attention should be even greater for those financial incentives addressed to private providers, as they tend more than other providers to respond strategically in terms of profit maximization. To this extent, for those countries having a considerable share of healthcare services provided by private hospitals, the possibility to discriminate tariffs across providers could contribute to mitigate the problem.
A system characterised by a considerable number of small hospitals providing the full range of healthcare services might imply a higher level of clinical inappropriateness. Instead, the structure of supply should be organised with a contained number of providers characterised by a sufficient degree of specialisation in the healthcare services provided.
General Conclusions

• Despite the effects of PPS are not all desirable, is not the time yet to abandon PPS for financing hospital care

• The right direction is to consider more carefully the role of specific DRG design features as well as the country context

• These features should be viewed as a tool in the hand of policy makers to counteract undesirable effects of PPS

• To this extent, the results of our research are expected to help policy makers in moving a step forward toward an optimal design of DRG-based PPS
WP4 Works

Published papers:

Papers under review

European Commission Reports
• InterQuality Report “D.4.1 - Report on financing hospital care”
• InterQuality Report “D.4.2 - Report on recommended financing model”
Thank you for your attention!

InterQuality website:
http://www.interqualityproject.eu/