Main challenges for and trends in health care reforms in the EU

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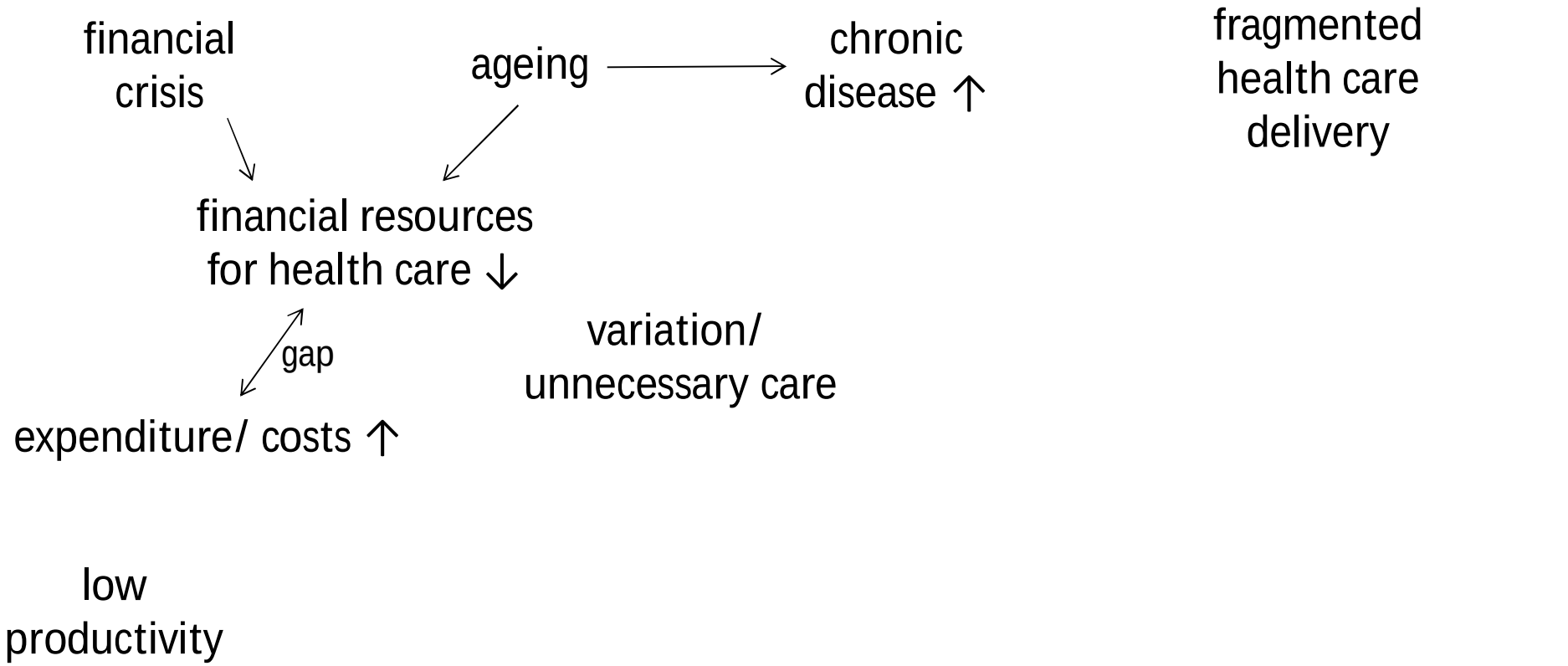
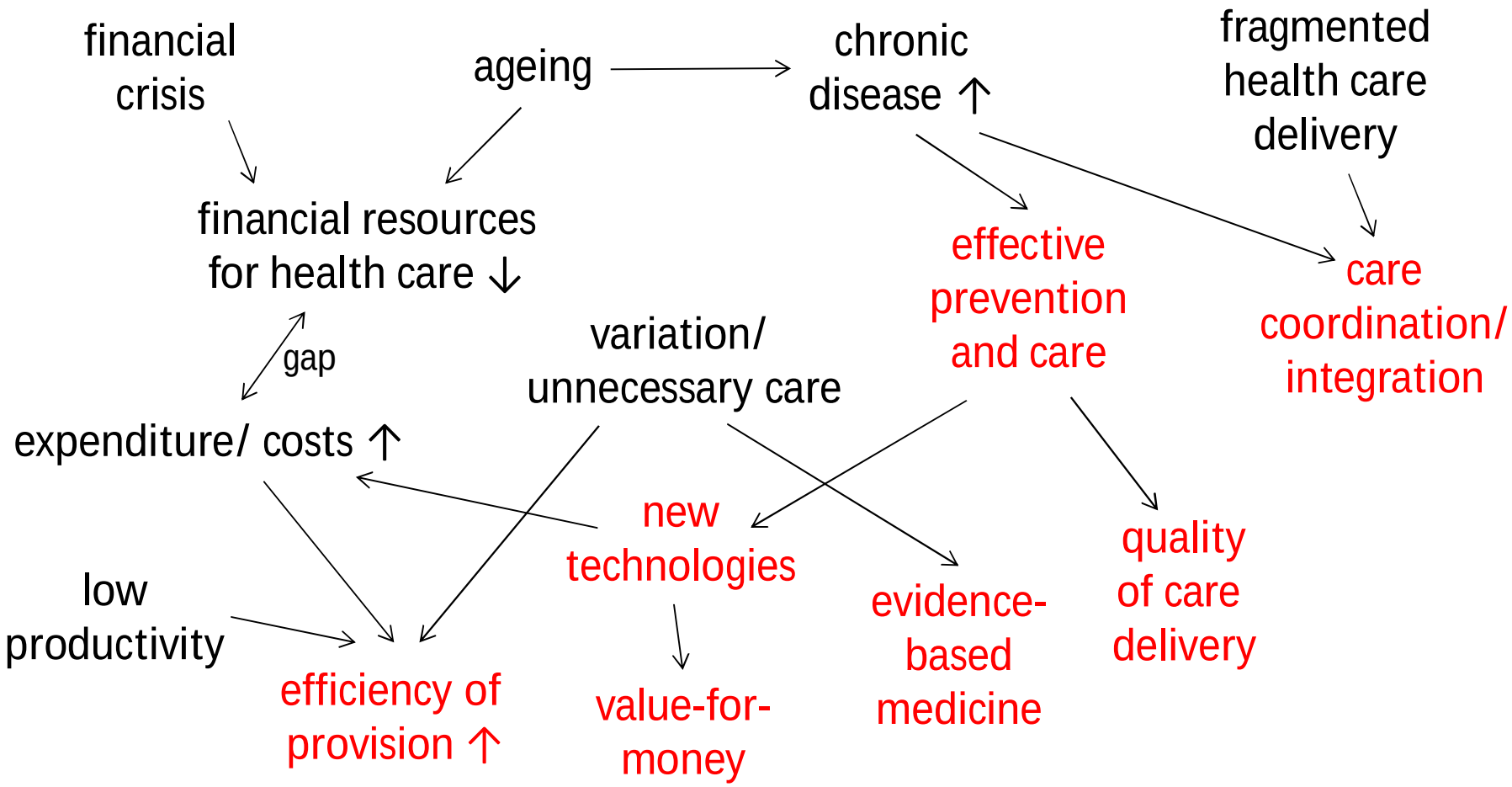
Challenges ...


financial crisis
ageing
chronic disease ↑
fragmented health care delivery
financial resources for health care ↓
gap
variation/ unnecessary care
expenditure/ costs ↑
low productivity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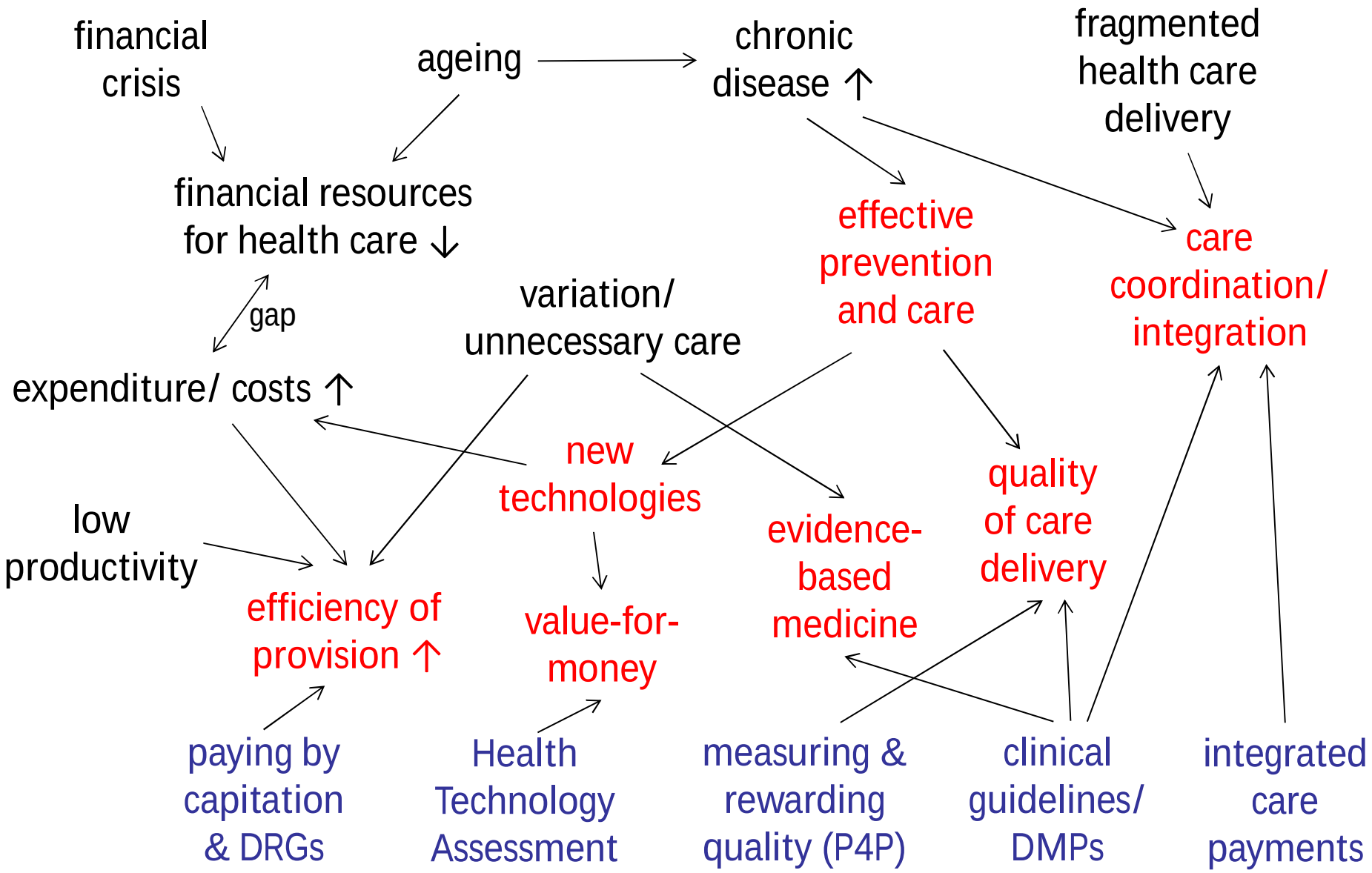
new technologies
quality of care delivery
low productivity
evidence-based medicine
efficiency of provision ↑
value-for-money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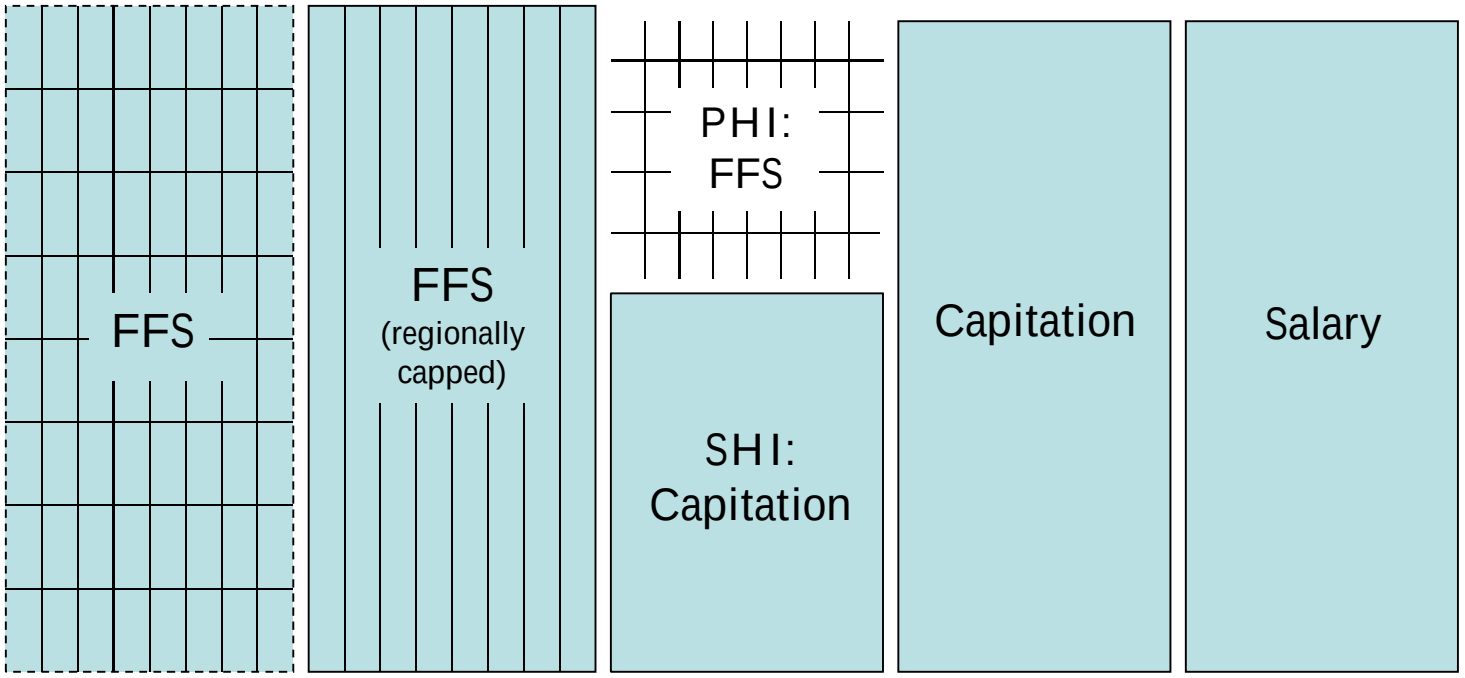
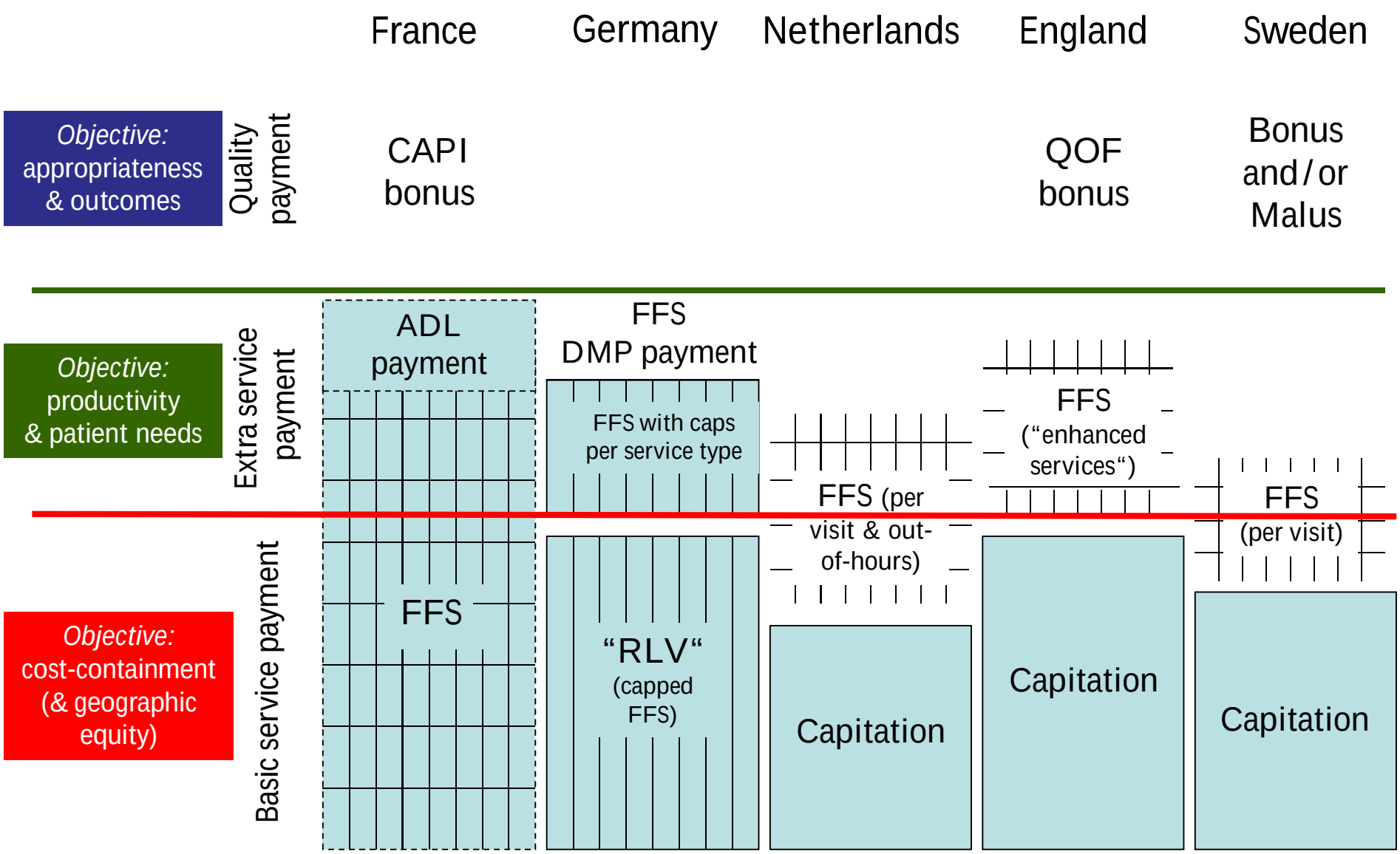
value-for-money
paying by capitation & DRGs
Health Technology Assessment
measuring & rewarding quality (P4P)
clinical guidelines/ DMPs
integrated care payments

Traditional forms of paying GPs (until early 2000s)



Payment components in GP care today



- England: sex and 7 age bands = 14 categories (1.0 = males 5-14 → 8.9 females 85+) *plus* adjustments for long-term illness and standardised mortality ratio *plus* adjustment for cost (GP, staff, land, buildings)
- Germany: based on actual utilisation in previous year
- Netherlands:
  3 age bands plus deprivation in area = 6 categories
- Sweden: several age bands and/or morbidity factors (plus socio-economic factors)

Percentage of total payment per component (estimates)

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	France	Germany	Netherlands	England	Sweden
Objective: appropriateness & outcomes	5%			25-30%	max. + / - 3%
Objective: productivity & patient needs	1% 95%	<5% 30%	40-45%	<10%	10-20% (Stockholm 60%)
Objective: cost-containment (& geographic equity)		60-70%	55-60%	65%	80-90% (Stockholm 40%)

The McGraw-Hill Companies

New from Open University Press

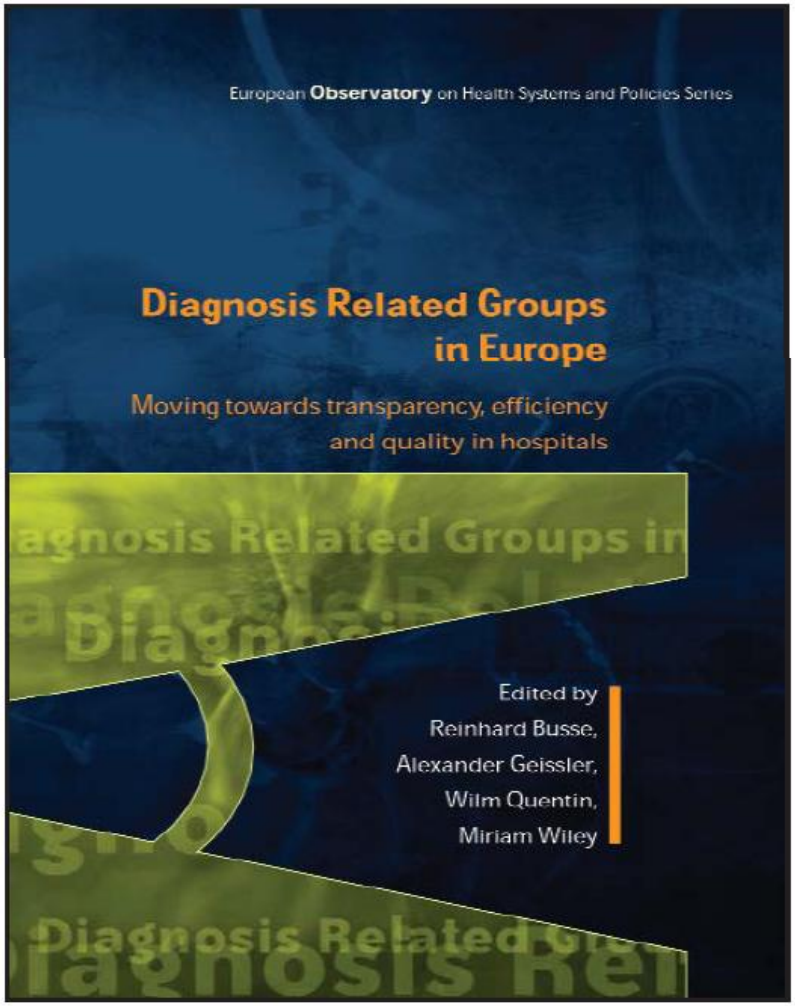
Diagnosis-Related Groups in Europe

Moving towards transparency, efficiency and quality in hospitals

Reinhard Busse, Alexander Geissler, Wilm Quentin and Miriam M. Wiley (Eds)

Berlin University of Technology, Germany; Berlin University of Technology, Germany; Berlin University of Technology, Germany; Economic and Social Research Institute, Dublin, Ireland

Diagnosis Related Group (DRG) systems were introduced in Europe to increase the transparency of services provided by hospitals and to incentivise greater efficiency in the use of resources invested in acute hospitals. In many countries, these systems were also designed to contribute to improving - or at least protecting - the quality of care. After more than a decade of experience with using DRGs in Europe, this book considers whether the extensive use of DRGs has contributed towards achieving these objectives.



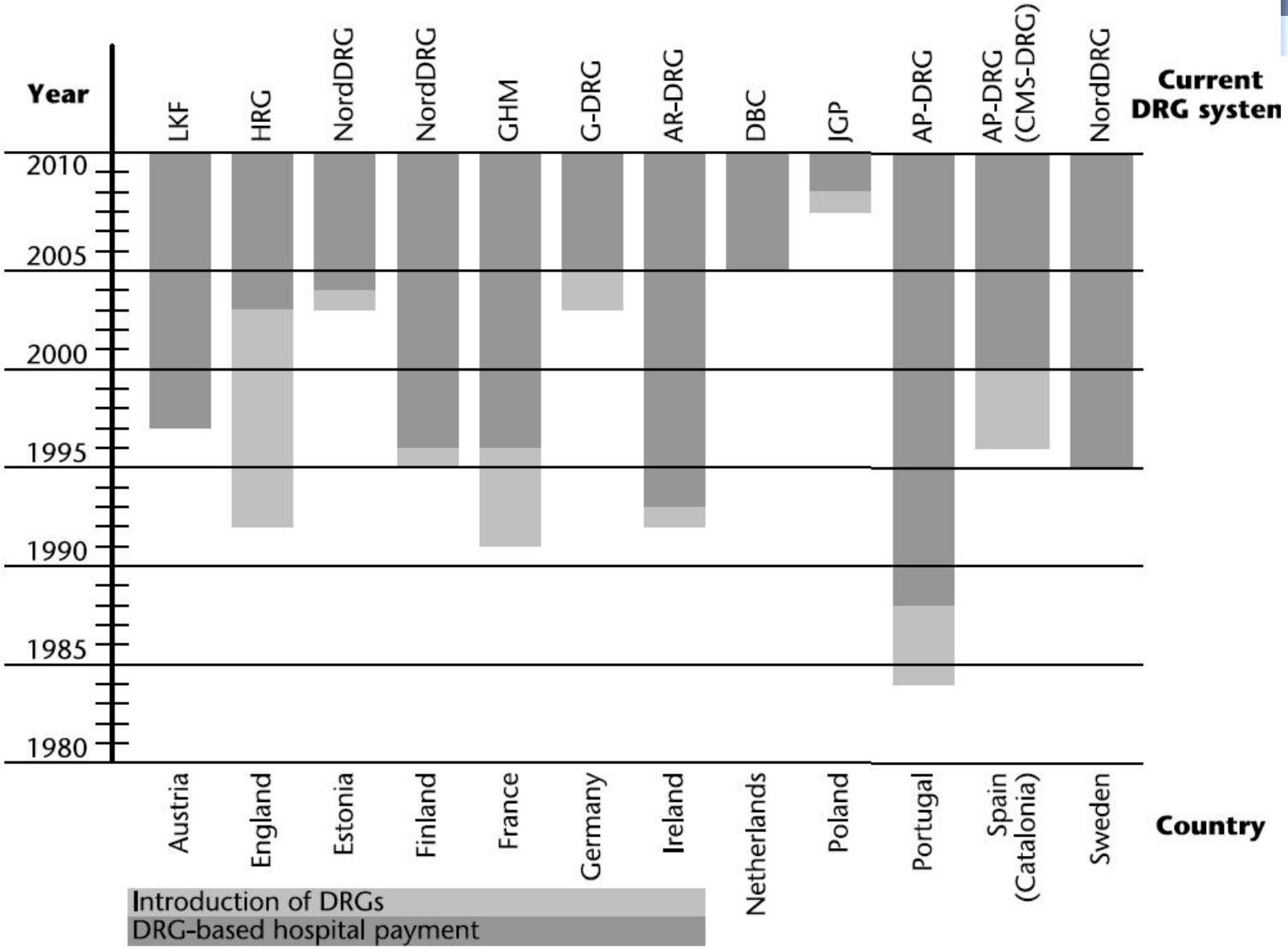


Figure 2.1 From DRG introduction to DRG-based budget allocation and payment

DRG-based hospital payment within revenue mix

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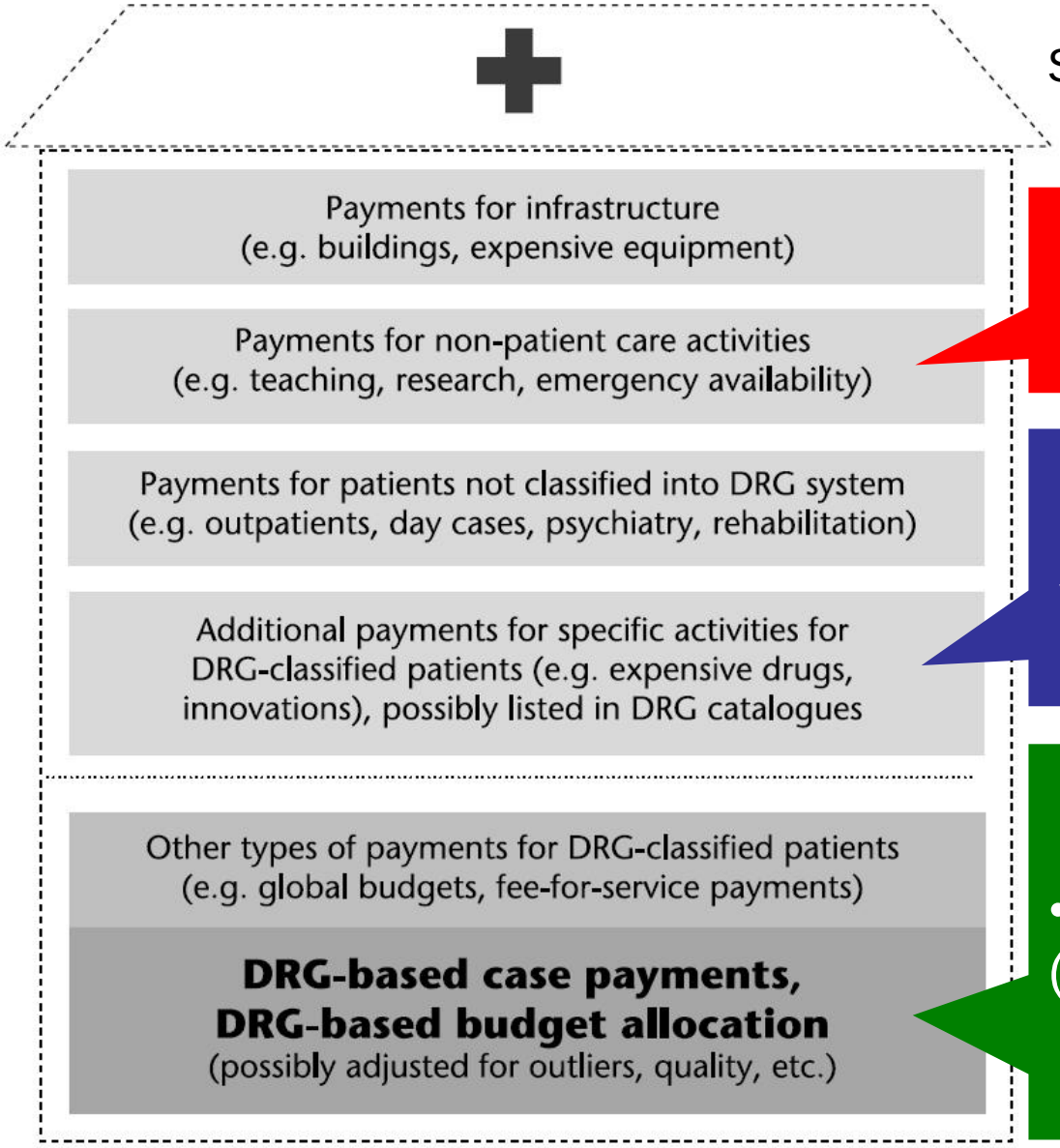


Selected issues in regard to quality

Separate priority activities not related to a particular patient from DRG payments

Pay separate for patient-related activities which you want to incentivize (upon prior authorization, 2nd opinion?)

- Define clinically meaningful groups (constant updating),
- which are cost-homogeneous (on average or „best practice“),
- measure quality and
- adjust payment

Conclusions from EuroDRG project

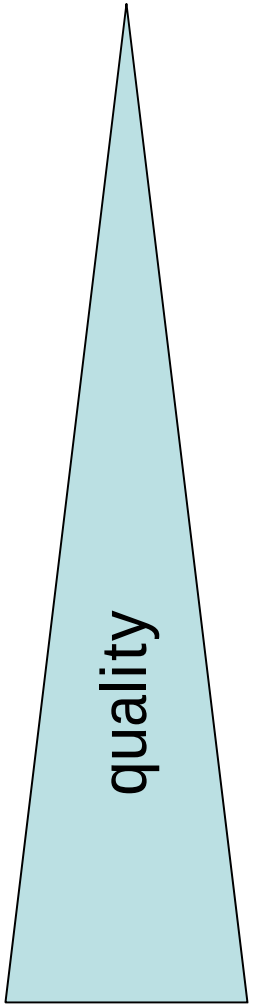
- DRG-based hospital payment is the main method of provider payment in Europe, but systems vary across countries
  - Different patient classification systems
  - DRG-based budget allocation vs. case-payment
  - Regional/local adjustment of cost weights/conversion rates
- To address potential unintended consequences, countries
  - implemented DRG systems in a step-wise manner
  - operate DRG-based payment together with other payment mechanisms
  - refine patient classification systems continously (increase number of groups)
  - place a comparatively high weight on procedures
  - base payment rates on actual average (or best-practice) costs
  - reimburse outliers and and high cost services separately
  - update both patient classification and payment rates regularly
- If done right (which is complex), DRGs can contribute to increased transparency and efficiency – and possibly quality

Strategy: Paying for quality of care

for Structure, e.g. access time, provider's function as a gatekeeper or for including patients in registers

for Processes, i.e. for treating chronically ill according to established practice, e.g. adherence to guidelines

for Outcome of care, i.e. short- or long-term clinical outcomes or patient satisfaction

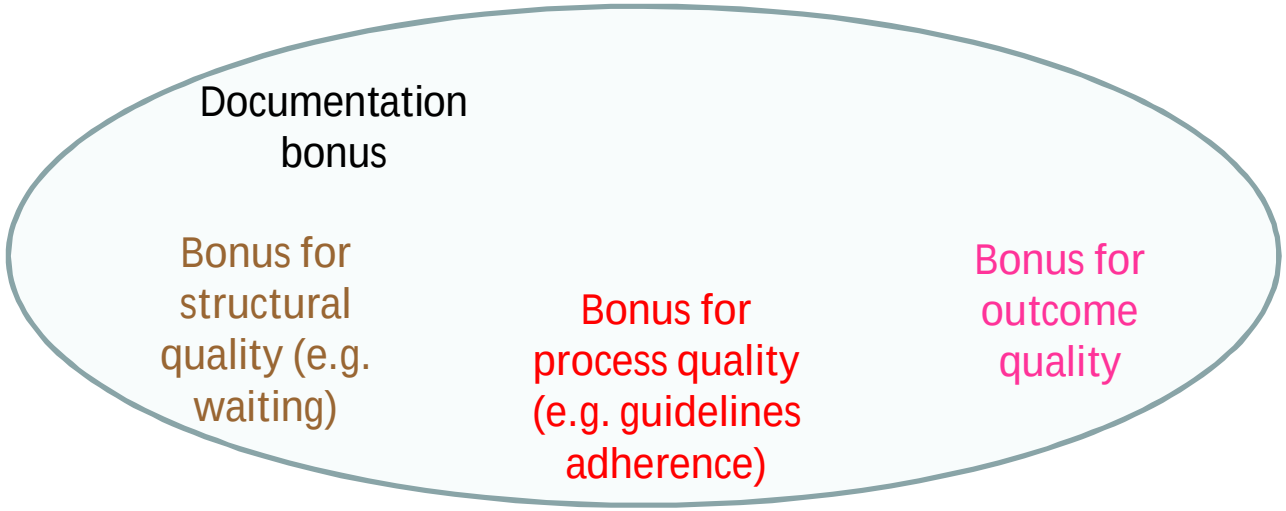


Capitation

or

Case-based

and



Paying for quality

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Financial incentives to (primarily) improve quality of care

… targeting structures of care	… targeting processes of care	… targeting outcomes of care
Per patient bonus for physicians for acting as gatekeepers for chronic patients and for setting care protocols or providing patient education (FR)	Points for reaching process targets (UK: QOF; FR: CAPI; AUS: PIP)	Points for reaching outcome targets (UK: QOF)
Bonus for DMP / PIP recruitment and documentation (GER; AUS)	P4P (mainly hospitals, US)	P4P (mainly hospitals, US)
Points for reaching structural targets (UK: QOF; FR: CAPI)		

Strategy: Paying for care coordination

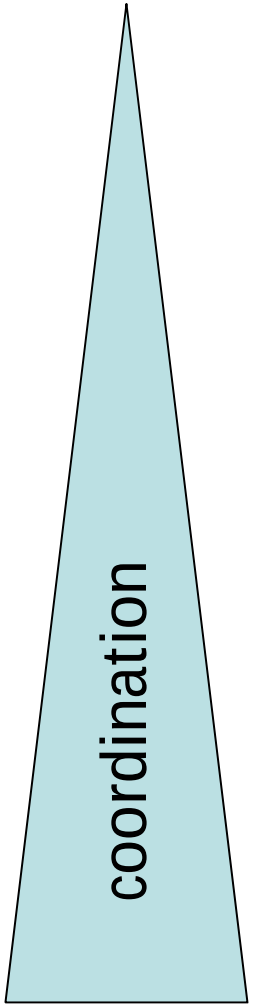
1st level: separate payment for coordination or extra effort

2nd level: bundled payment across services (for one provider but incl. referrals/ prescriptions)

3rd level: bundled payment across providers (but restricted to a set of activities, e.g. only those related to one disease)

4th level: bundled payment across services and providers

Main incentive: be efficient and keep savings!



Paying for care coordination

Separate provision

Full Integration

Capitation

or

Case-based

and/ or

Coordination/ extra effort payment

Bundled payment for one provider across services (incl. referrals/ prescriptions)

Bundled payment for group of providers for specific services

Bundled payment across providers and services

Documentation bonus

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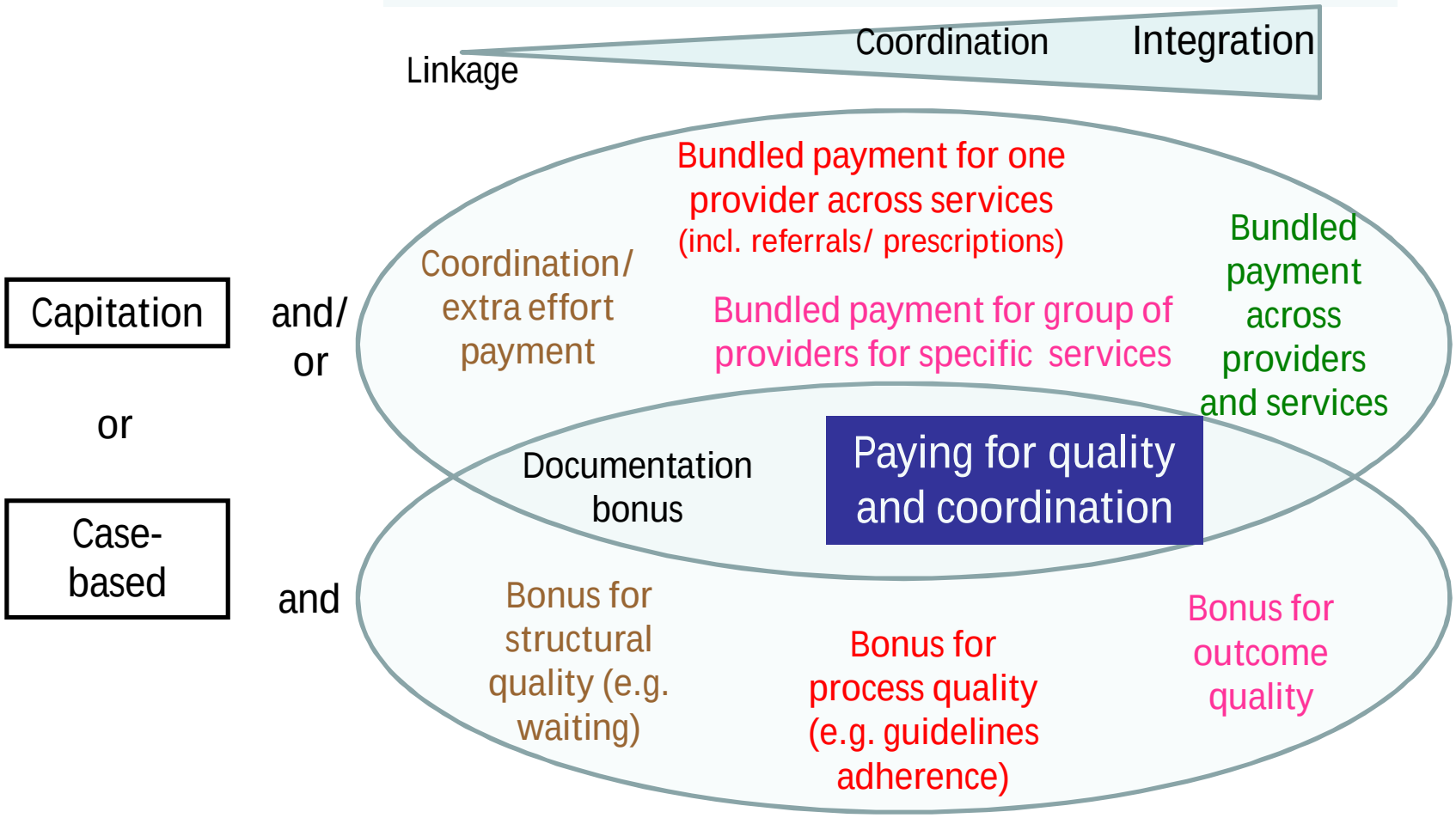
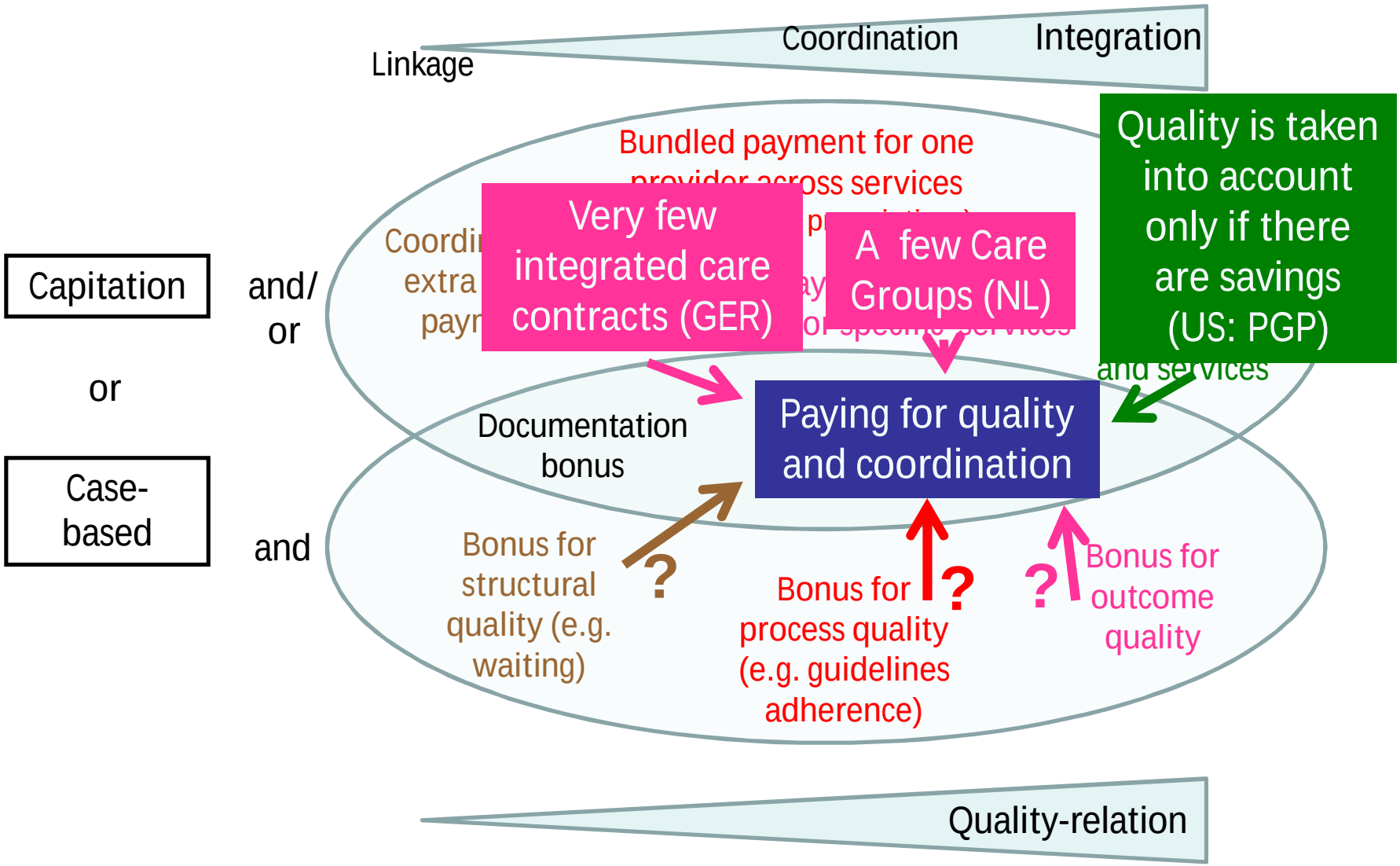
Financial incentives used to (primarily) improve care coordination

… for coordination/ extra effort	… for bundling across services	… for bundling across providers	… for bundling across services and providers
"Year of care" payment for the complete package of chronic disease management (UK) or service incentives (AUS)	GP "fundholding" (UK)	1% of overall health budget available for integrated care → majority of integrated care (GER)	1% overall health budget available for integrated care → population-based integrated care (Kinzigtal; GER)
Per patient bonus for physicians acting as gatekeepers for chronic patients/ for setting care protocols/ providing patient education (FR)		Payment for professional cooperation and diagnostic-related bundled payment (FR)	Shared savings for Accountable Care Groups ; tested in Physician Group Practice demonstration (US)
Bonus for DMP recruitment and documentation (GER) or initial payments (AUS)		Integrated Care Groups (NL)	
Service outcome payments (AUS)		Bundled payment for acute-care episodes (US)	


Linkage
Coordination
Integration
Capitation
or
Case-based
and/ or
and
Coordination/ extra effort payment
Bundled payment for one provider across services (incl. referrals/ prescriptions)
Bundled payment for group of providers for specific services
Bundled payment across providers and services
Documentation bonus
Paying for quality and coordination
Bonus for structural quality (e.g. waiting)
Bonus for process quality (e.g. guidelines adherence)
Bonus for outcome quality
Quality-relation
Structure
Process
Outcome
Paying for quality


Linkage
Coordination
Integration
Capitation
and/
or
or
Case-
based
and
Bundled payment for one
provider across services
Very few
integrated care
contracts (GER)
A few Care
Groups (NL)
Quality is taken
into account
only if there
are savings
(US: PGP)
Documentation
bonus
Paying for quality
and coordination
Bonus for
structural
quality (e.g.
waiting)
Bonus for
process quality
(e.g. guidelines
adherence)
Bonus for
outcome
quality
Quality-relation

Conclusions

- Current challenges demand an array of instruments to fulfill the answers
- Improving efficiency and value-for-money is on the agenda of all countries (answers exist but demand political will to implement)
- To improve quality of care, new – and more incentivised – answers are necessary
- Paying for care and improving/ ensuring quality – traditionally seen as different pillars – thus have to be combined
- Ultimate challenge is to manage and reward quality and coordination/ integration (rather than just efficiency)