Technische Universität Berlin

Ageing and the Challenge to Finance Health Care in Europe: An Overview and Innovations

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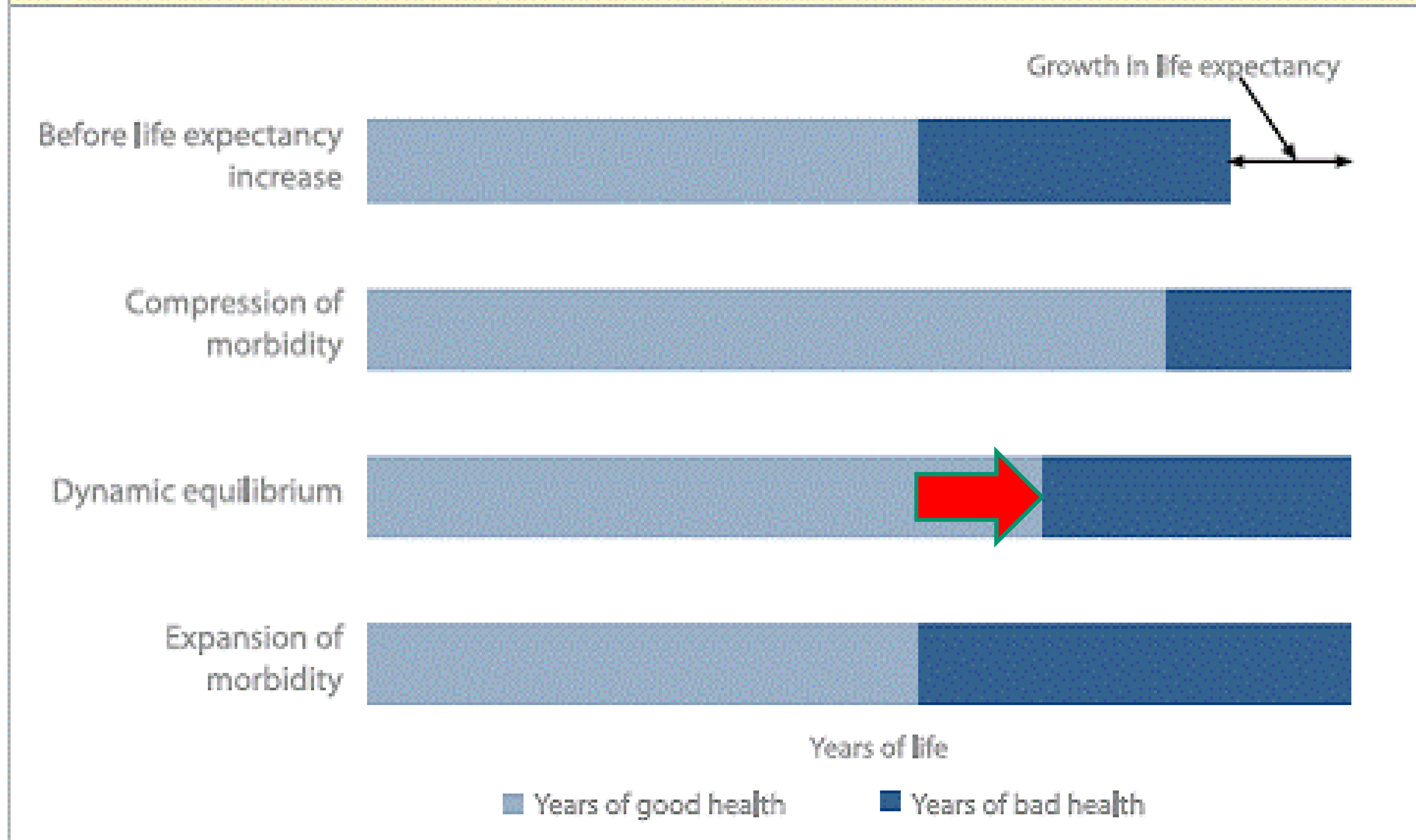
The ageing of the population: an example
The price of success?

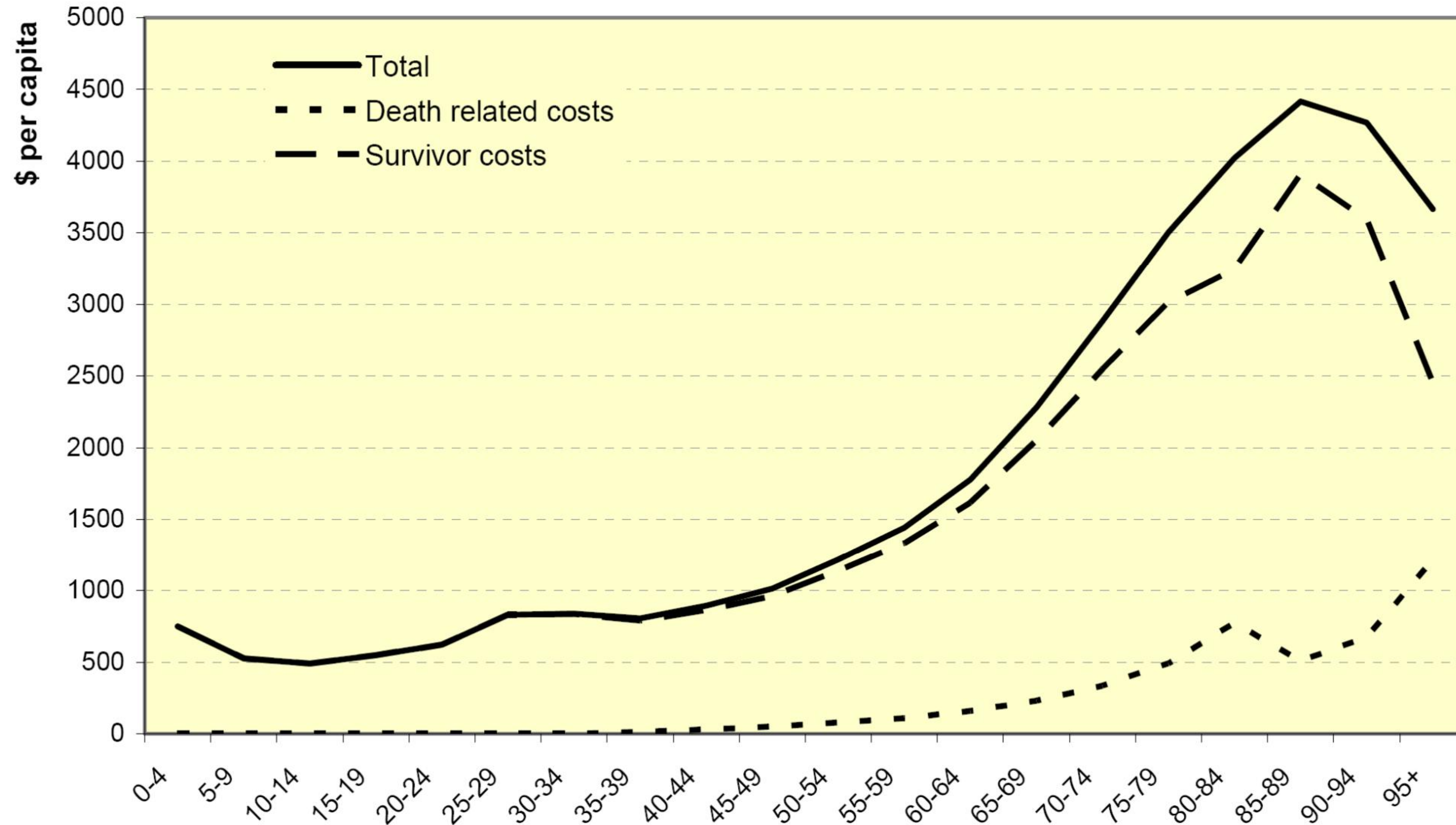
An ageing crisis?

- Compression of morbidity
  - *Longer and healthier life expectancy*
  - *"Living longer and dying faster"*
- Reduced cost of dying at older ages
- Lower life time health costs by the healthier
- Drawing less from health services
- Contributing for longer: late retirement

The good news: We get older, because we are healthier (even though some still have doubts)



Separating the (high) costs of dying from overall health-care costs shows a more modest picture

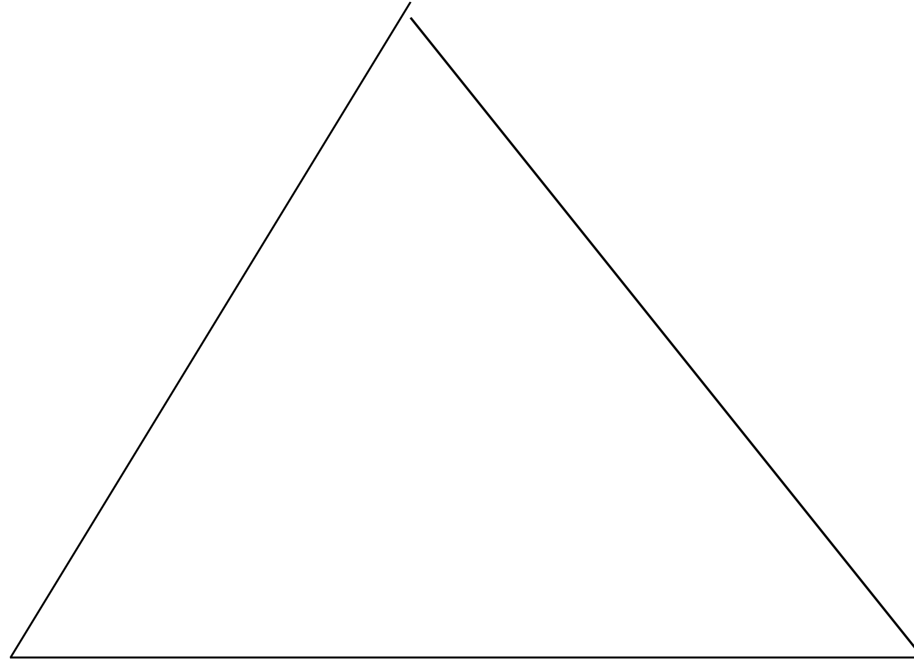


Public health spending: exp. growth rates/ year 1971-2002 [* from 1981]	Age effect	Income effect	Other factors	Total spending
Australia (to 2001 only)	0.5	1.7	1.7 *(1.4)**	4.0 *(3.6)**
Austria	0.2	2.5	1.5 *(0.0)**	4.2 *(2.2)**
Belgium (from 1995 only)	0.4	2.2	0.6	2.9
Canada	0.6	2.1	0.4 *(0.6)**	3.1 *(2.6)**
Denmark	0.2	1.6	0.1 *(-0.5)**	1.9 *(1.3)**
Finland	0.6	2.4	0.5 *(0.2)**	3.4 *(2.6)**
France	0.3	1.9	1.6 *(1.0)**	3.9 *(2.8)**
Germany	0.3	1.6	1.9 *(1.0)**	3.7 *(2.2)**
Greece (from 1987 only)	0.4	2.1	0.8	3.4
Ireland	0.0	4.4	0.9 *(-1.0)**	5.3 *(3.9)**
Italy (from 1988 only)	**0.7**	**2.2**	**-0.1**	**2.1**
Japan (to 2001 only)	0.6	2.6	1.8 *(1.1)**	4.9 *(3.8)**
Luxembourg (from1975 only)	0.0	3.3	0.7 *(-0.1)**	4.2 *(3.8)**
Netherlands (from 1972 only)	0.4	2.0	0.9 *(0.3)**	3.3 *(2.6)**
New Zealand	0.2	1.2	1.4 *(1.0)**	2.9 *(2.7)**
Norway	0.1	3.0	2.2 *(1.5)**	5.4 *(4.0)**
Portugal	0.5	2.9	4.4 *(2.8)**	8.0 *(5.9)**
Spain	0.4	2.4	2.5 *(0.8)**	5.4 *(3.4)**
Sweden	0.3	[illegible]	…7 *(-0.4)**	2.5 *(1.5)**
Switzerland (from 1985 only)	0.2	[illegible]	2.9	3.8
United Kingdom	0.1	[illegible]	…5 *(1.0)**	3.8 *(3.4)**
United States	0.3	[illegible]	…7 *(2.6)**	5.1 *(4.7)**
Average	**0.4** *(0.3)**	**2.5** *(2.3)**	**1.5** *(1.0)**	**4.3** *(3.6)**

Only 1/10th

1/3rd and modifiable

Third-party Payer



Population

Providers:
hospitals,
primary care etc.

Collector of resources

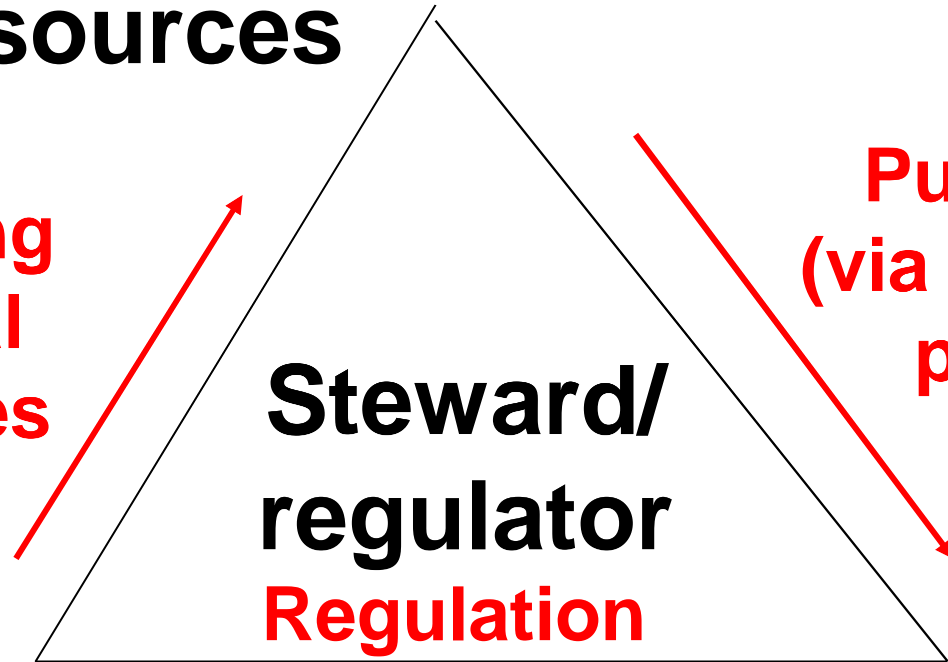
Third-party payer:
Local Health Authorities; Health insurance funds

Ste[illegible]d/
re[illegible]lator

YOU

Population

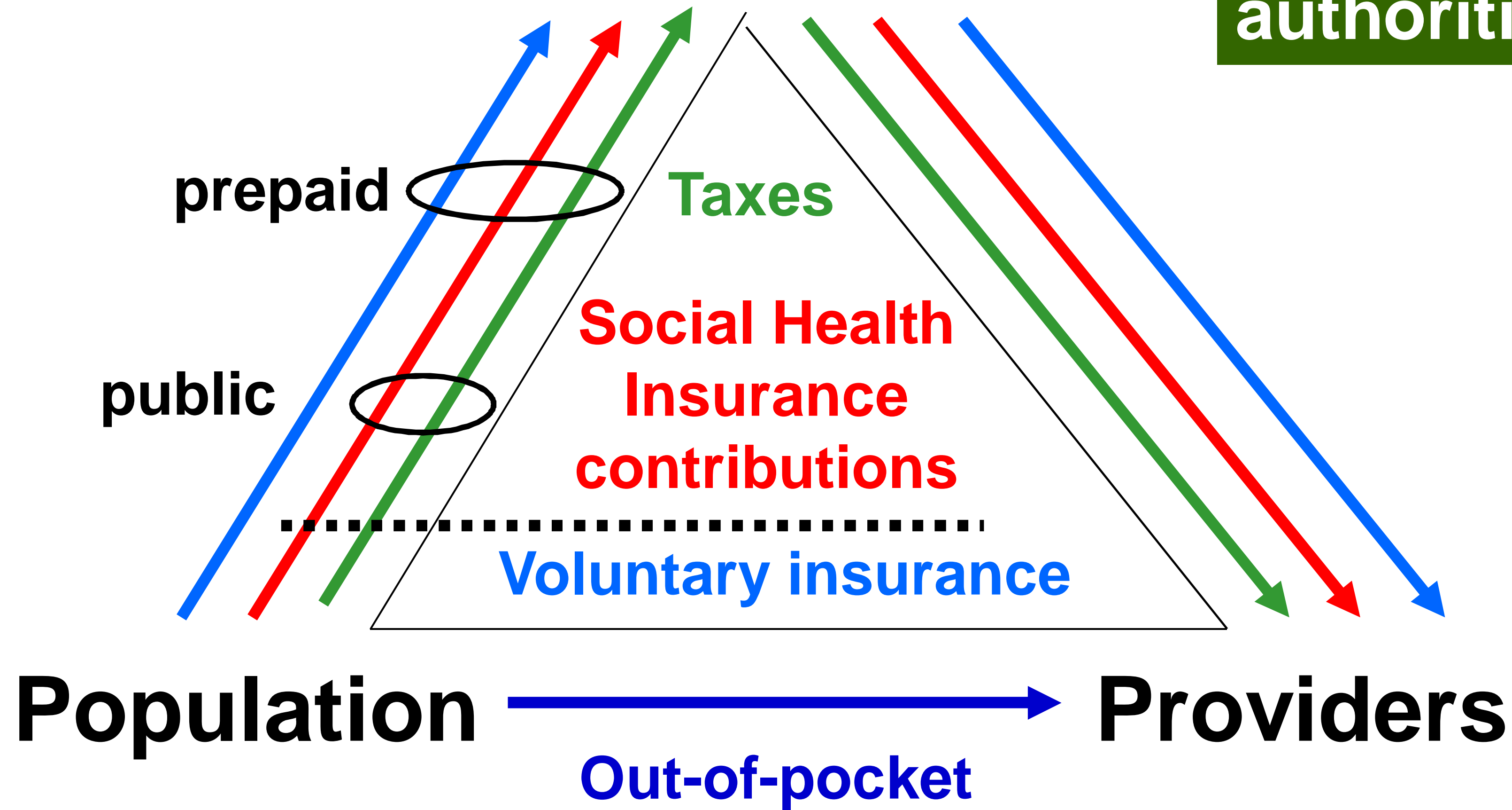
Providers:
hospitals, primary care etc.


Resource pooling & allocation
Collector of resources
Third-party payer
Mobilizing financial resources
Purchasing (via contracts)/ payment
Steward/ regulator
Regulation
Population
Coverage: Who? What? How much?
Access to and provision of services
Providers
Creating human & technical resources
Functions

sickness funds private insurers

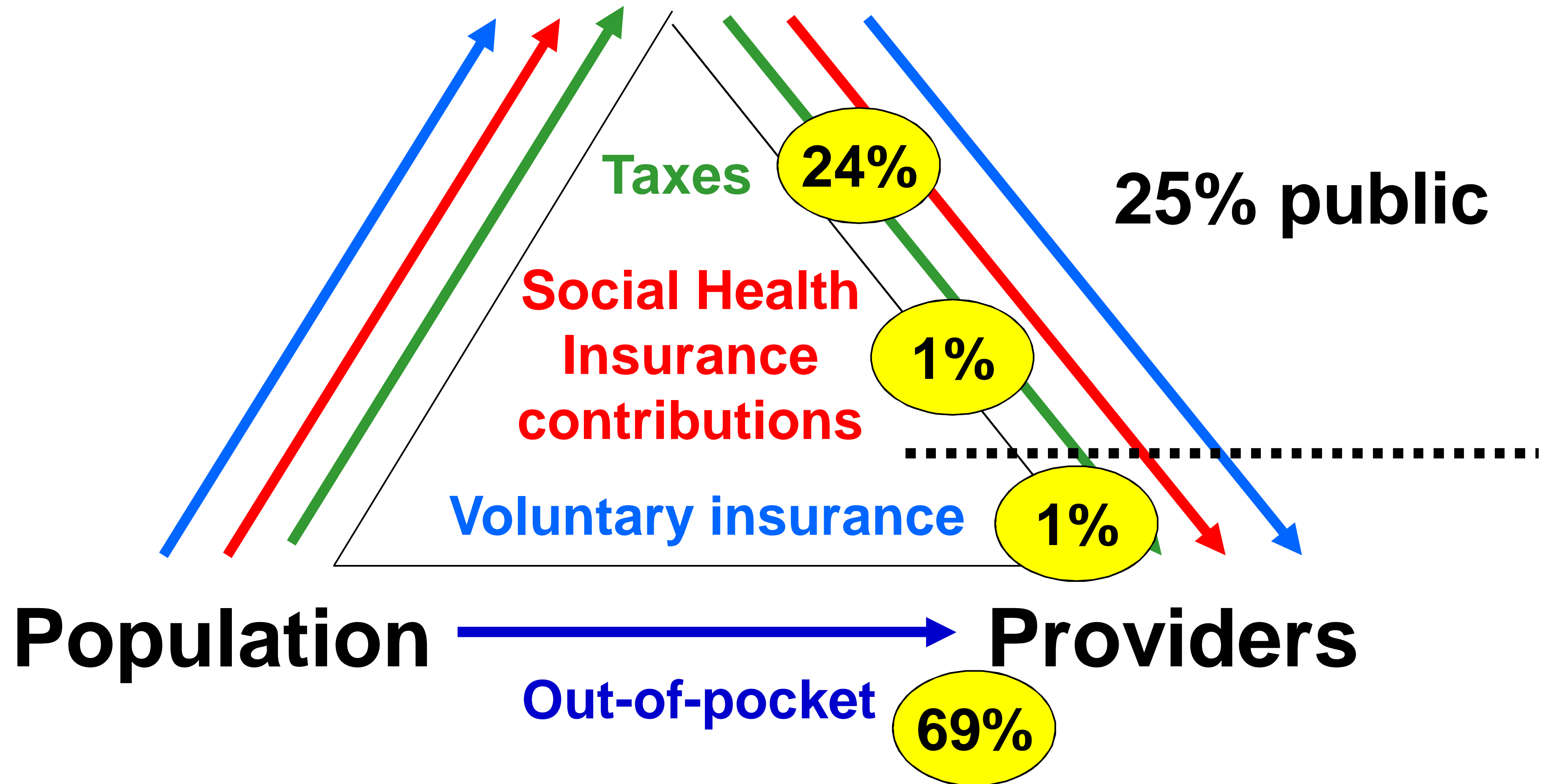
Third-party Payer

health authorities



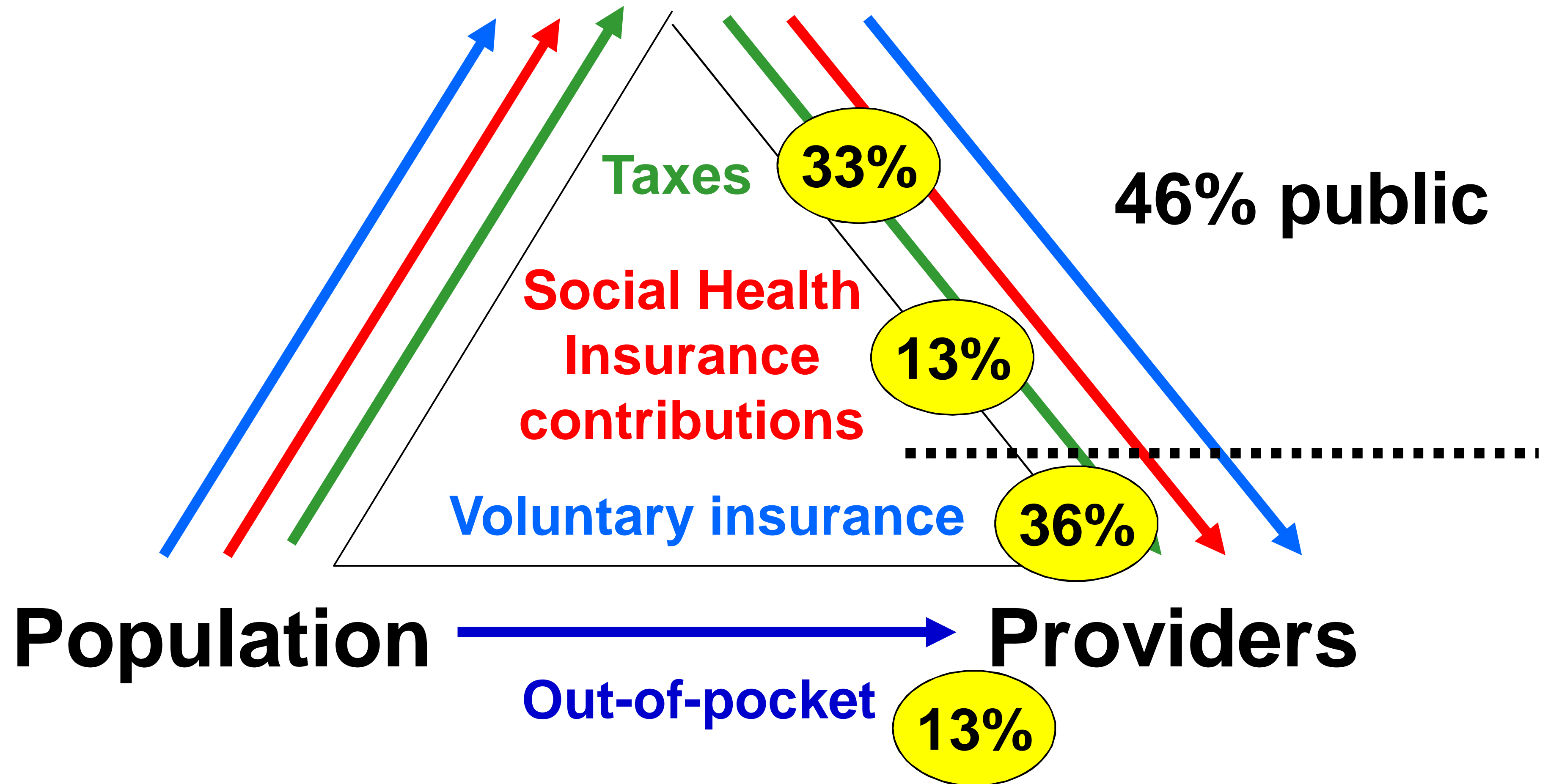
Issue 1: Finding the “right“ funding mix …

Third-party Payer



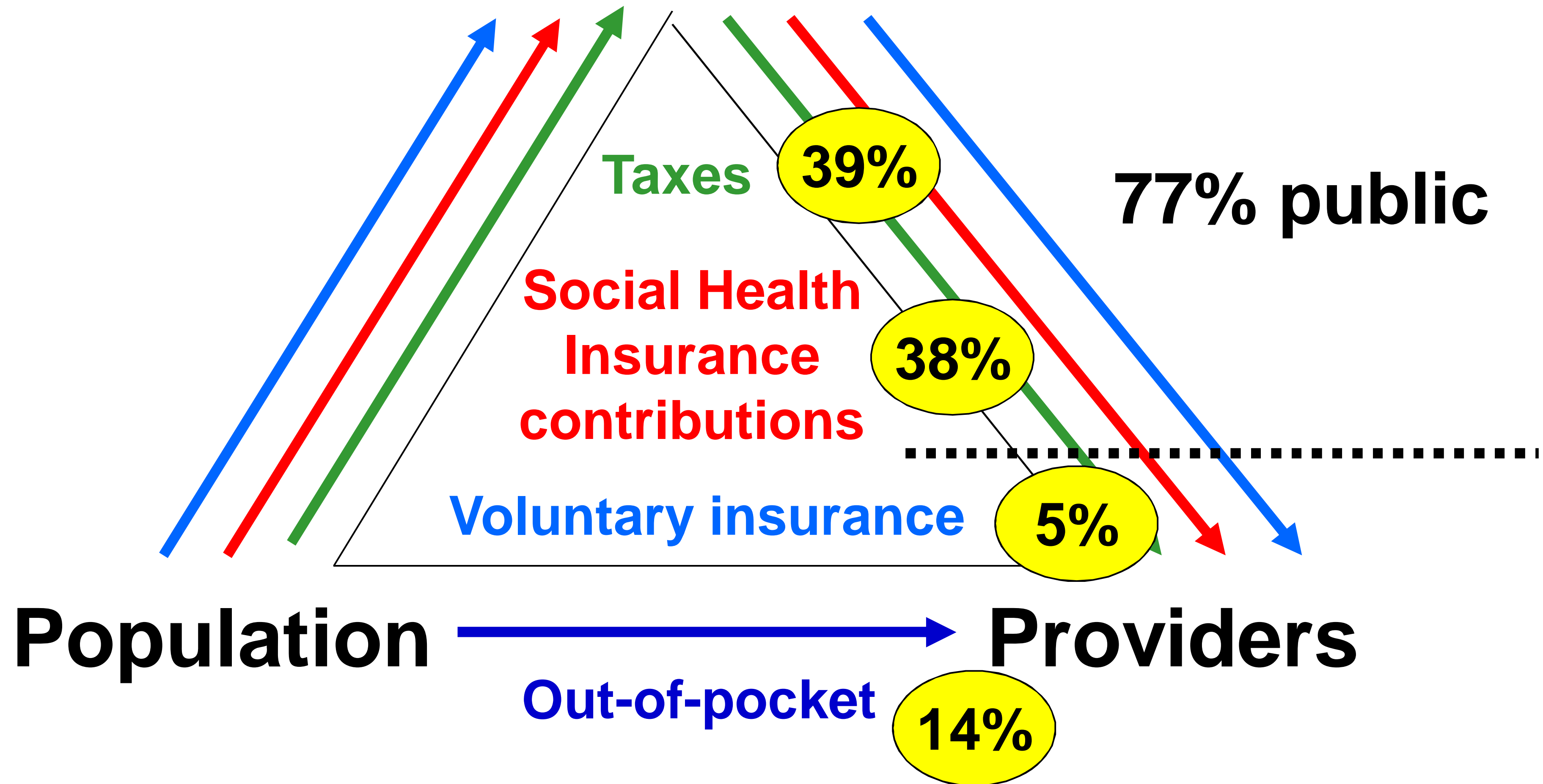
India 2006

Third-party Payer



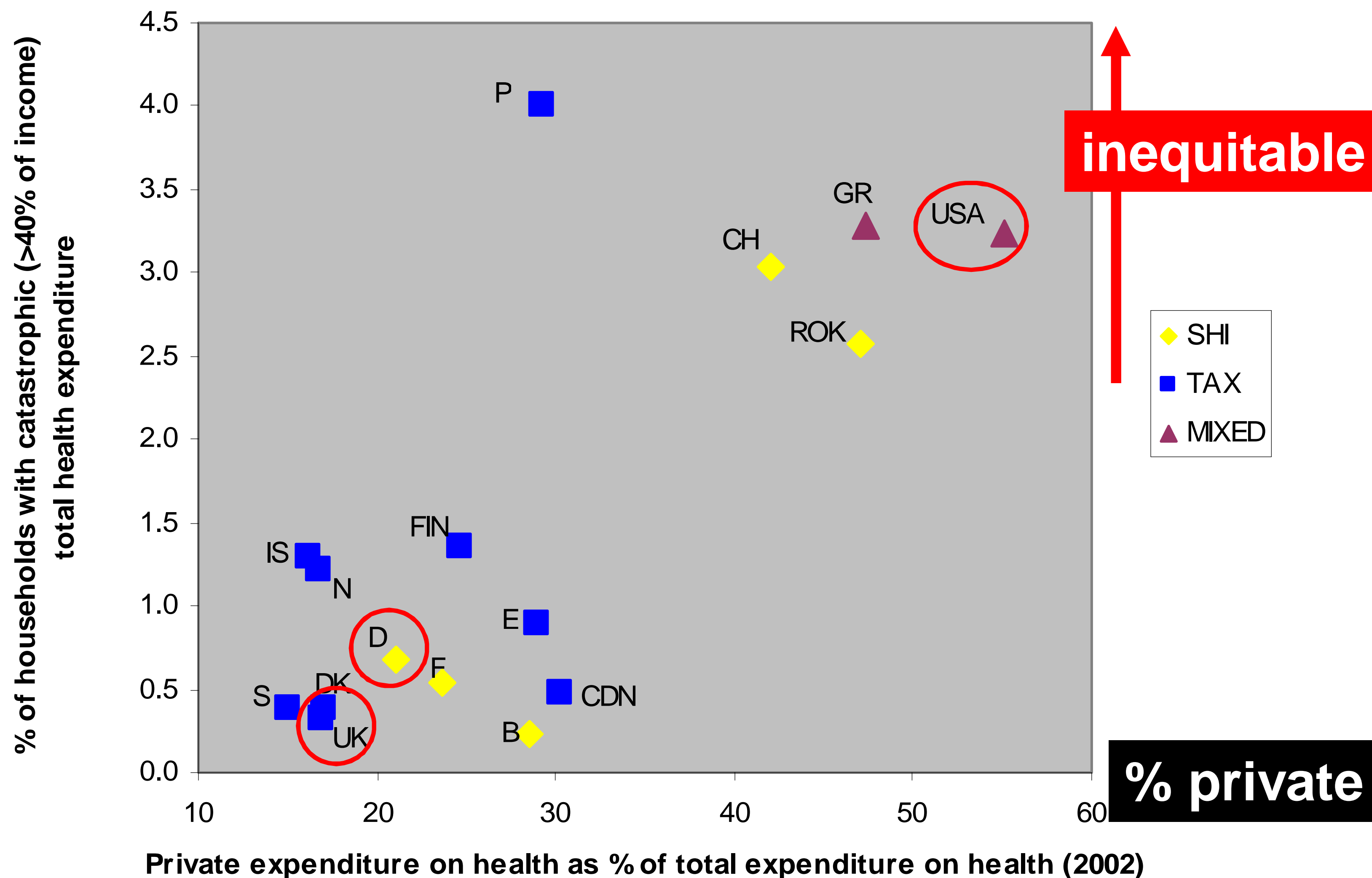
USA 2006

Third-party Payer



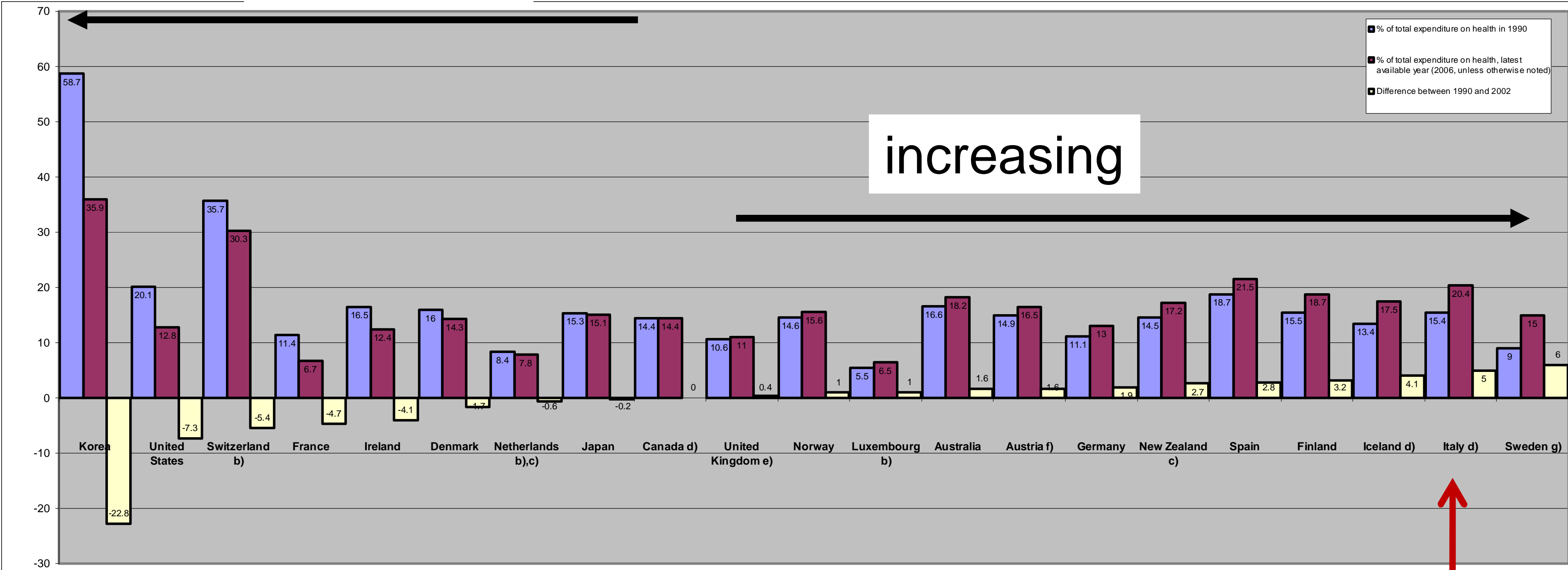
High income (excl. US) 2006

The more public (less private) – the better? Yes, for equity

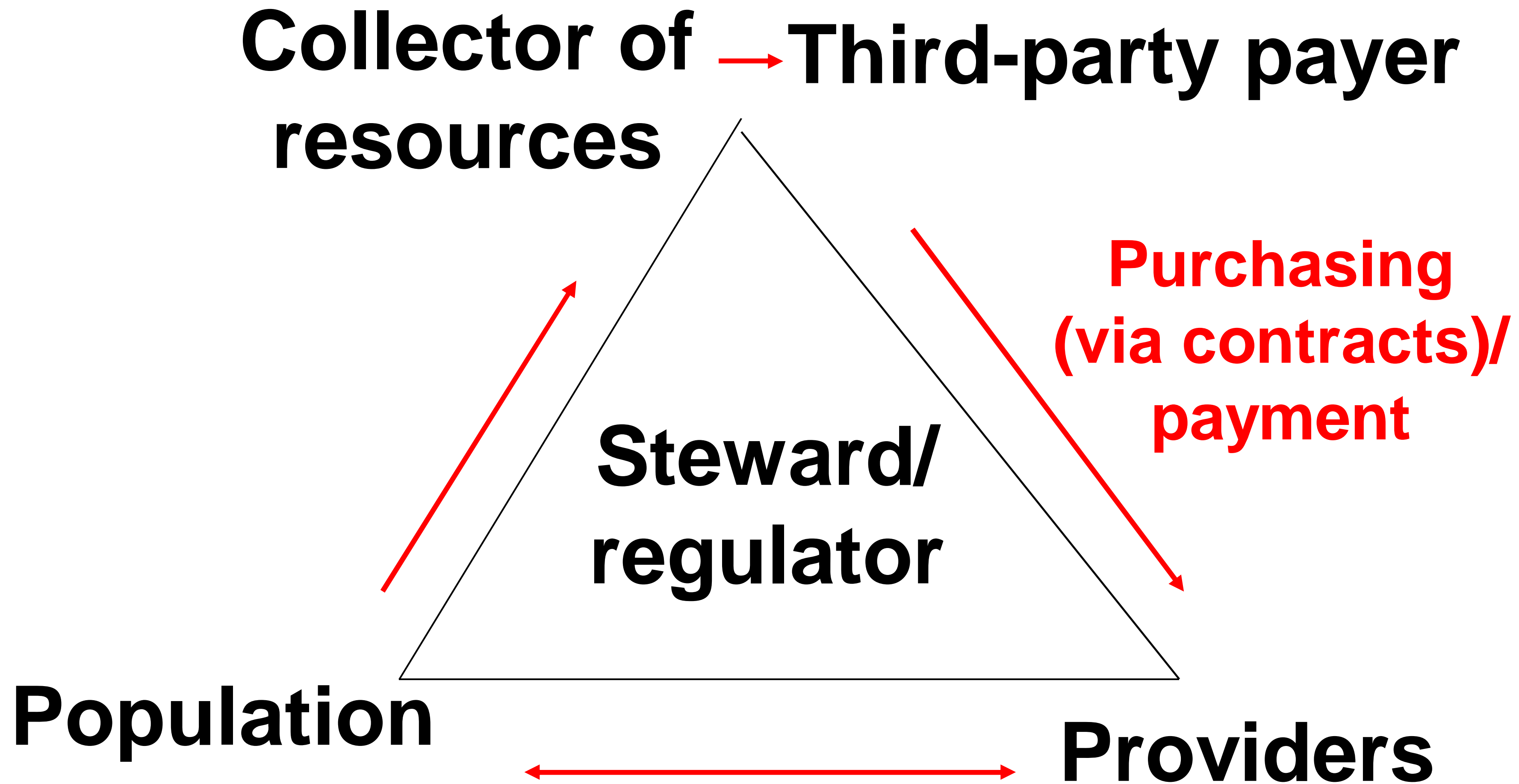


Out-of-pocket 1990-2006: a mixed picture

decreasing



Italy



Issue 2: Making payers and providers accountable for need, costs, quality …

Reform trends → purchasers

- NHS: development of purchasers through purchaser/provider split
  → purchasers = regions, health authorities, primary care trusts …
  providers = autonomous institutions (responsible for their own staff)
- SHI: transformation of sickness funds from payers to active purchasers

Reform trends → changing the way hospitals (and other providers) are paid

Fee-for-service	DRGs (per case)	Budget
* Ill patients usually attractive * *Over-provision* of Services * Under-referral * No incentive for high quality	* Very ill patients (within DRG) not attractive * Tendency to average provision * Contradictory weak incentives	* (ill) Patients not attractive * *Under-provision* of services * Over-referral * Quality: bad results -> more work

USA → ← **Europe**

Reform trends → changing the way hospitals (and other providers) are paid

Fee-for-service	DRGs (per case)	Budget
* Ill patients usually attractive	* Very ill patients (within DRG) not attractive	* (ill) Patients not attractive
* *Over-provision* of Services	* Tendency to average provision	* *Under-provision* of services
* Under-referral		* Over-referral
* **No incentive for high quality**	* **Contradictory weak incentives**	* **Quality: bad re-sults -> more work**

No incentives for appropriate continuity of care across providers

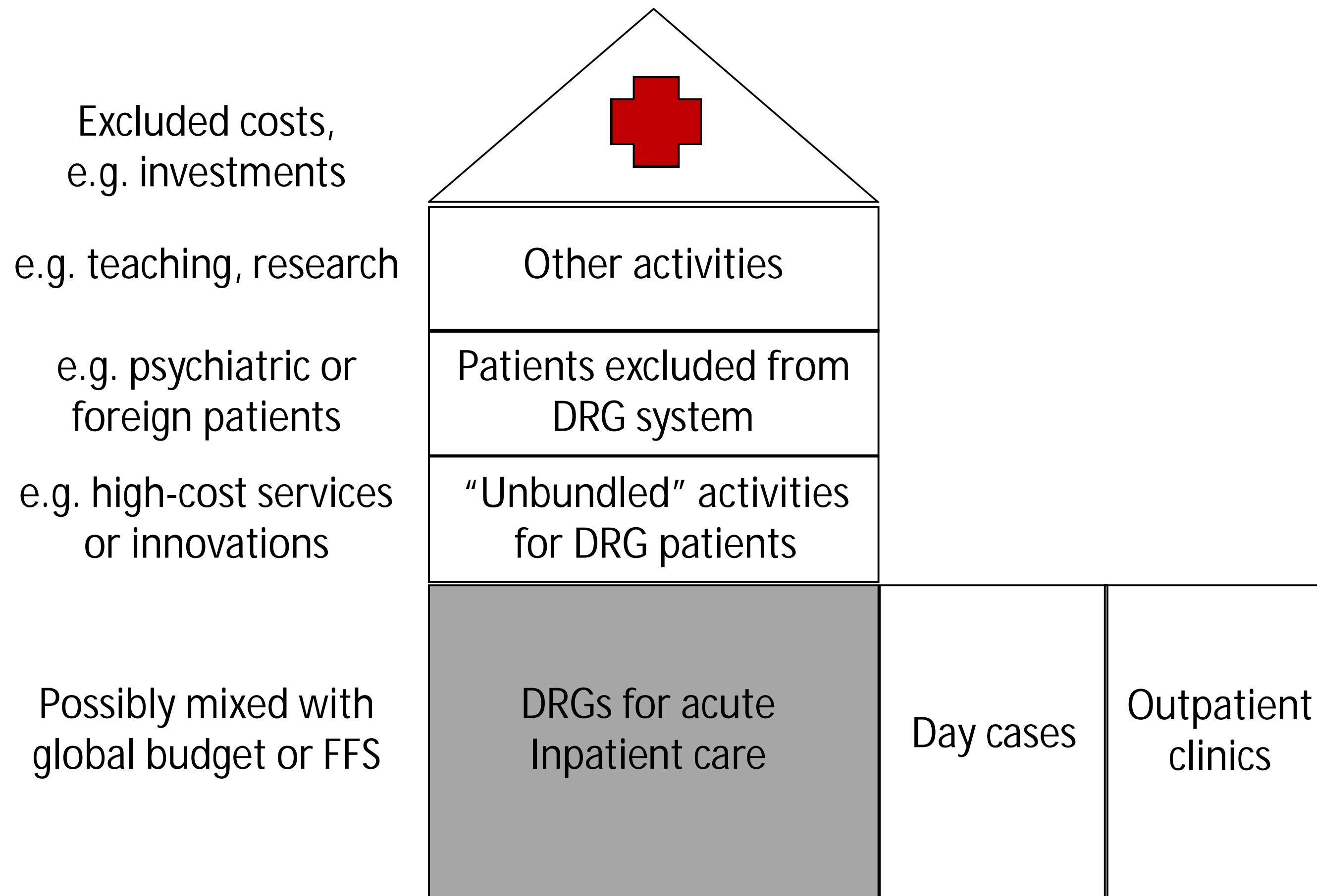
→ Quality indicators, transparency & pay-for-performance
→ Managed care

So then, why DRGs?

To get a common "currency" of hospital activity for

- transparency → performance measurement → efficiency benchmarking,
- budget allocation (or division among purchasers),
- planning of capacities,
- payment (→ **efficiency**)

For what types of activities? Scope of DRGs – the "DRG house"



Being aware of strategic behaviour of hospitals in times of DRGs

Options to avoid deficits under DRGs

Revenues
Costs/

Increase revenues (right-/ up-coding; negotiate extra payments)

Total costs

DRG-type payment

Reduce costs (personnel, cheaper technologies)

Reduce LOS

LOS

How DRG systems try to counter-act such behaviour:
1. long- and short-stay adjustments

Revenues

Short-stay outliers

Inliers

Long-stay outliers

Deductions (per day)

Surcharges (per day)

LOS

Lower LOS threshold

Upper LOS threshold

How DRG systems try to counter-act such behaviour:
2. Fee-for-service-type additional payments

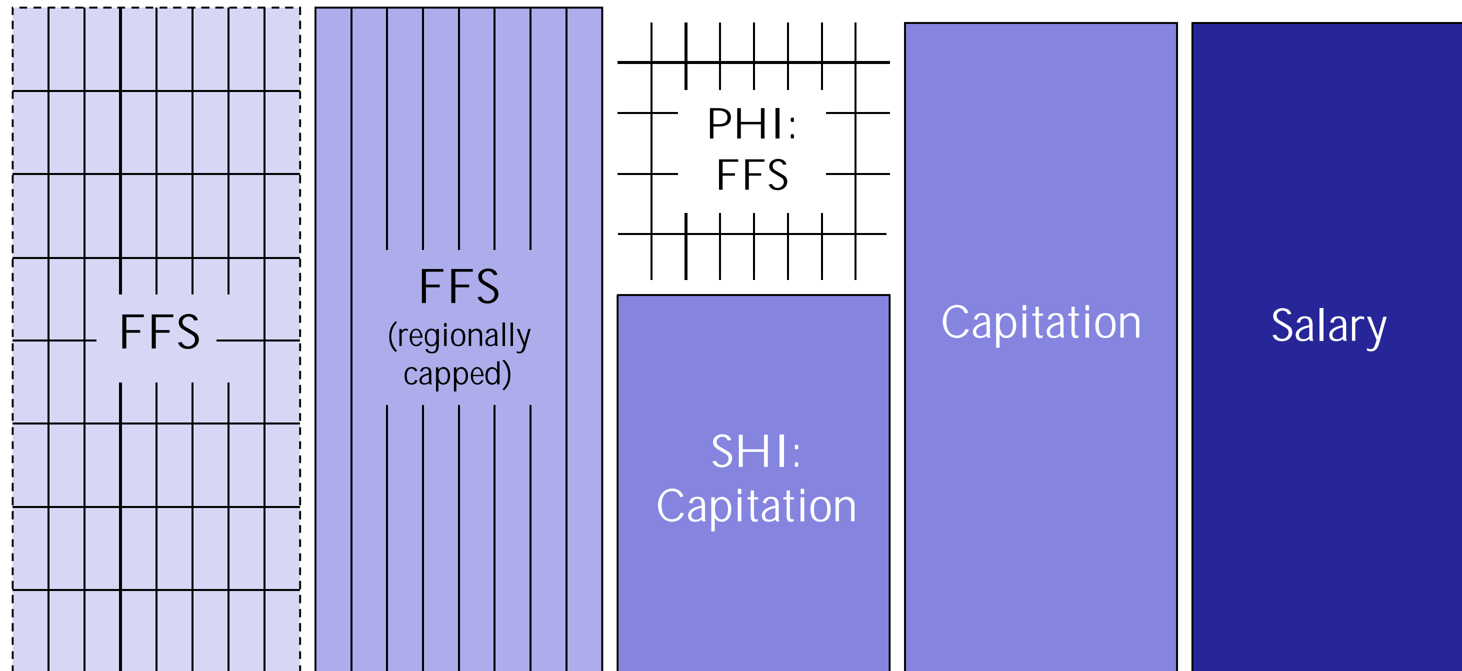
	England	France	Germany	Nether-lands
Payments per hospital stay	One	One	One	Several possible
Payments for specific high-cost services	Unbundled HRGs for e.g.: • Chemotherapy •Radiotherapy •Renal dialysis •Diagnostic imaging •High-cost drugs	Séances GHM for e.g.: • Chemotherapy •Radiotherapy •Renal dialysis Additional payments: • ICU • Emergency care • High-cost drugs	Supplementary payments for e.g.: • Chemotherapy •Radiotherapy •Renal dialysis •Diagnostic imaging •High-cost drugs	No
Innovation-related add'l payments	Yes	Yes	Yes	Yes (for drugs)

How DRG systems try to counter-act such behaviour: 3. adjustments for quality

- England & Germany: no extra payment if patient readmitted within 30 days
- Germany: deduction for not submitting quality data
- England: up 1.5% reduction if quality standards are not met
- France: extra payments for quality improvement (e.g. regarding MRSA)

Paying family doctors … the old way

France Germany Netherlands England Sweden



Paying family doctors … the new way

France | Germany | Netherlands | England | Sweden

Objective: appropriateness & outcomes

Quality payment

CAPI bonus

QOF bonus

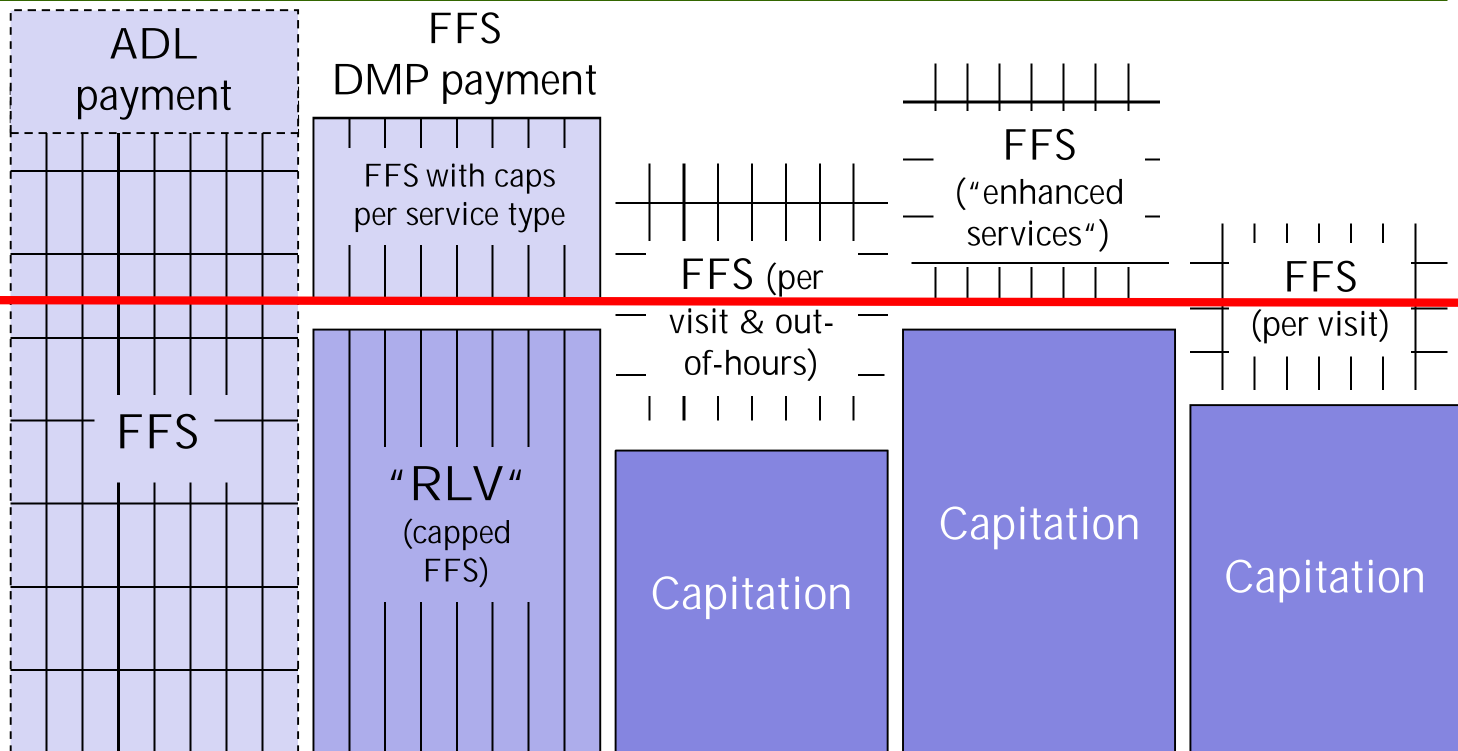
Bonus and/or Malus

Objective: productivity & patient needs

Extra service payment

Objective: admin. simplicity & cost-containment (& geogr. equity)

Basic service payment



For GP payment, countries are moving toward a "European model" consisting of:

(1) Capitation (inscription)/ capped FFS (visit-triggered) to pay for providing basic services;

60%

(2) special lump sums for specific patient groups (if capitation is not sufficiently risk-adjusted) + FFS for (potentially) underprovided services and/or requiring special expertise or technology;

20-30%

(3) quality-related bonus (or malus) for (not) reaching certain targets.

10-20%

Examples of new payment measures

- ‘year of care’ payment for the complete service package required by individuals with chronic conditions (DK)
- Per patient bonus for physicians for acting as gatekeepers for chronic patients and for setting care protocols (F)
- bonus for DMP recruitment and documentation (D)
- 1% of overall health budget available for integrated care (D)
- bonuses for reaching structural, process and outcome targets (UK)
- ‘pay-for-performance‘ bonuses (US)

Population ageing
Strengthen the health systems response

- Improved management of chronic conditions
- Coordination / integration of care
- Focus on primary prevention (tobacco, alcohol,..)
- Support healthy ageing, e.g. fall prevention programmes

Presentation available at:

www.mig.tu-berlin.de