The purchasing (and payment) market – European experience with hospitals and general practitioners

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What are we talking about?

Insurers

Risk pooling, risk adjustment

Health insurance market

Administering subsidies

Structured choice

Administering eligibility and mandate

Coverage dimensions

Active purchasing, negotiation

Health care purchasing market

Oversight, gover-nance

Financial and quality data on providers

Population

Free choice

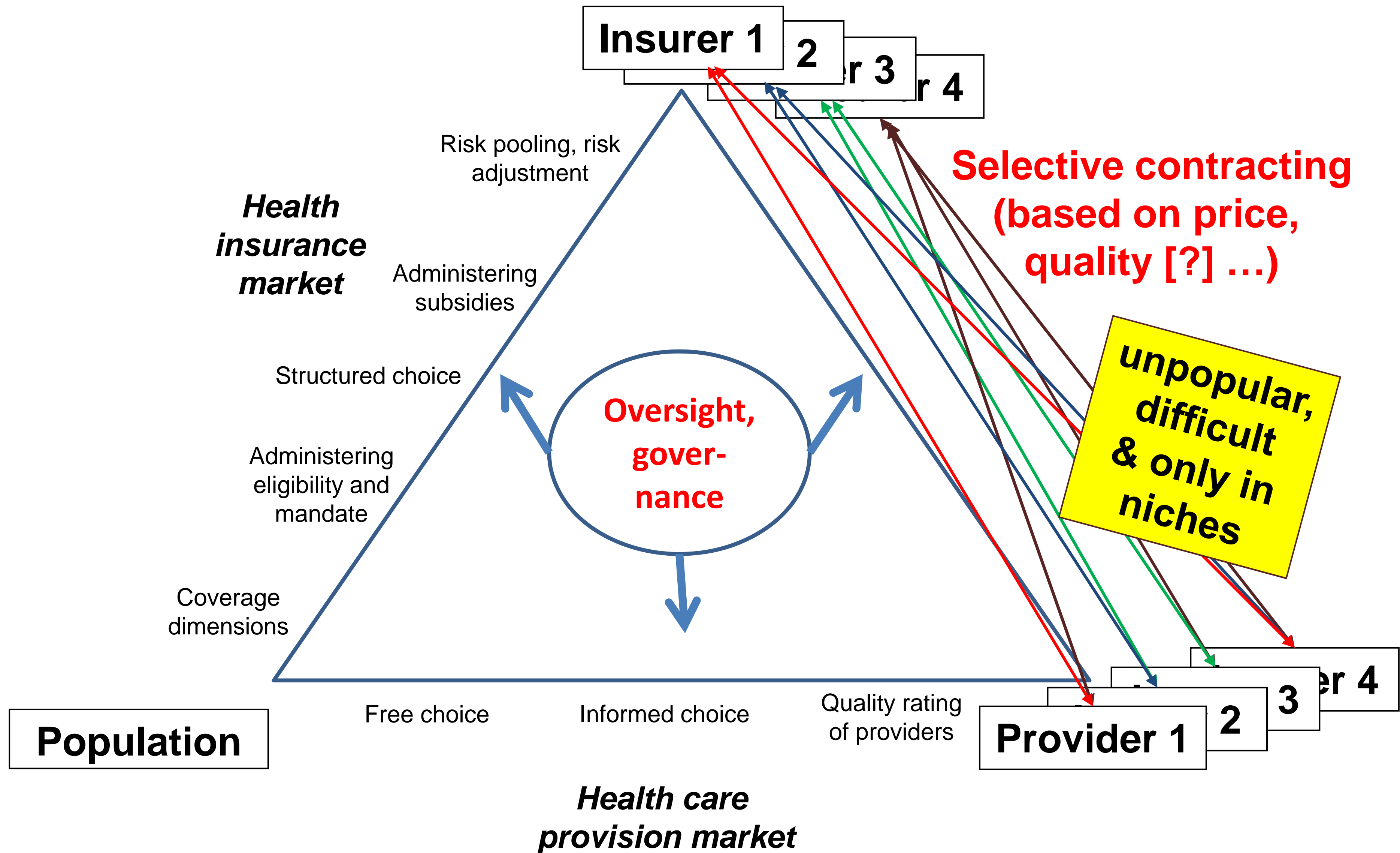
Informed choice

Quality rating of providers

Providers

Health care provision market

What are we talking about?



What are we talking about?

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Insurer 1
2
3
4

Health insurance market

Risk pooling, risk adjustment

Administering subsidies

Structured choice

Administering eligibility and mandate

Coverage dimensions

Oversight, gover-nance

Regulated contracts

Population

Free choice

Informed choice

Quality rating of providers

Provider 1
2
3
4

Health care provision market

Technische Universität Berlin

Regulation of contracts includes …

- Uniform definition of **benefits** (not gold, silver, bronze)
- Uniform definition of **reimbursable units** (be they FFS, DRGs …)
- **Rules for contracting** (parties involved, contracting periods, whether selective contracts are allowed …)

- Uniform requirements for **access** (usually uniform, possibly exceptions for elective treatments)
- Uniform minimum requirements for **financial and quality reporting**
- Rules for **payment** and its adjustment (for volume, quality …)

Incentives of different forms of hospital payment

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Payment mecha-nism	Patient needs (risk selection)	Activity		Expendi-ture control	Technical efficiency	Trans-parency	Quality	Admini-strative simplicity
		Number of services/ case	Number of cases					
Fee-for-service	+	+	+	—	0	0	0	—
Global budget	—	—	—	+	0	—	0	+

Incentives of different forms of hospital payment

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		Number of services/ case	Number of cases					
Fee-for-service	+	+	+	—	0	0	0	—
DRG based case payment	0	—	+	0	+	+	0	—
Global budget	—	—	—	+	0	—	0	+

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Incentives of different forms of hospital payment

→ “dumping” (avoidance), “creaming” (selection) and “skimping” (undertreatment)
→ up/wrong-coding, gaming

Payment mecha-nism	Patient needs (risk selectior	Ac y		Expendi-ture control	Technical efficiency	Trans-parency	Quality	Admini-strative simplicity
		Number c services/ case	Numbe of cases					
Fee-for-service	+	+	+	–				–
DRG based case payment	0	–	+	0	+	+	0	–
Global budget	–	–	–	+				+

USA 1980s

European countries 1990s/2000s

Incentives of different forms of hospital payment

Payment mecha-nism	Patient needs (risk selection)	Activity		Expendi-ture control	Technical efficiency	Trans-parency	Quality	Admini-strative simplicity
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Fee-for-service	+	+	+	—	0	0	0	—
DRG based case payment	0	—	+	0	+	+	0	—
Global budget	—	—						

USA 1980s

What do European countries do to turn these incentives into positive ones?

DRG payment in Europe – basics

Excluded costs
(e.g. for infrastructure; *in U.S. also physician services*)

Payments for non-patient care activities
(e.g. teaching, research, emergency availability)

Payments for patients not classified into DRG system
(e.g. outpatients, day cases, psychiatry, rehabilitation)

Additional payments for specific activities for DRG-classified patients (e.g. expensive drugs, innovations), possibly listed in DRG catalogues

Other types of payments for DRG-classified patients
(e.g. global budgets, fee-for-service)

DRG-based case payments,
DRG-based budget allocation
(possibly adjusted for outliers, quality etc.)

All relevant cost categories are taken into account

Priority activities not related to a particular patient are separate from DRG payments

Certain high-cost activities are paid separately

DRGs are combined with budget or are volume-limited

- More clinically meaningful groups are defined,
- based on actual costs (on average or "best practice"),
- quality is measured and
- payment adjusted

Euro DRG

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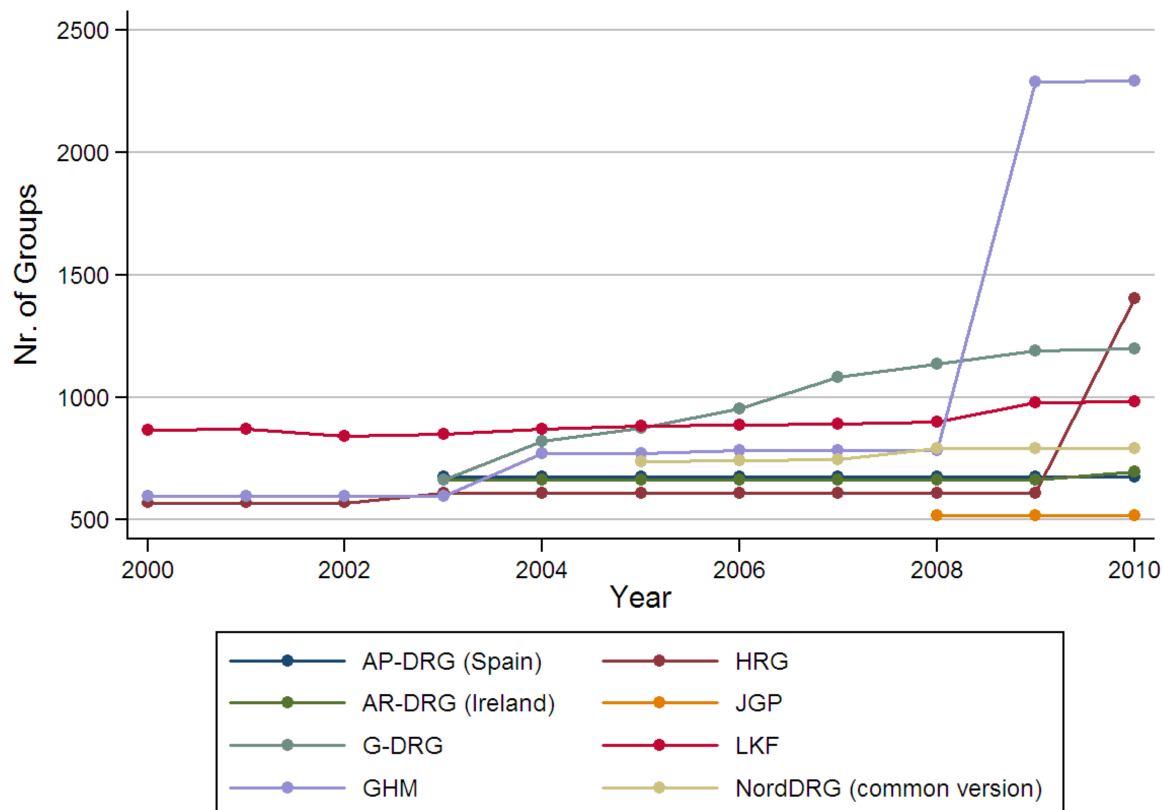
TU

Patient classification systems in Europe are more refined than in US



	AP-DRG	AR-DRG	G-DRG	GHM	NordDRG	HRG	JGP	LKF	DBC
DRGs / DRG-like groups	679	665	1,200	2,297	794	1,389	518	979	≈30,000
MDCs / Chapters	25	24	26	28	28	23	16	-	-
Partitions	2	3	3	4	2	2*	2*	2*	-

Fee-for-service-type additional payments for high-cost and innovative technologies

	England	France	Germany	Nether-lands
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 • High-cost drugs/ devices	Since 2012: • ICU • Care in cooperation with practice-based physicians
Innovation-related add'l payments	Yes	Yes	Yes	Yes (for drugs)

Adjustment of DRG payments for quality

EuroDRG · MiG 2002-2012 Health Care Management · TU

Type of adjust-ment	Mechanism	Examples
Hospital based	• Payment for entire hospital activity is adjusted upwards or downwards by a certain percentage • Hospital receives an additional payment unrelated to activity	• **Predefined quality results are met/not met *(e.g., in England up to -2.5%)*** • Hospitals install new quality improvement measures *(e.g. in France)*
DRG/ disease based	• Payment for all patients with a certain DRG (or a disease entity) is adjusted upwards or downwards by a certain percentage • DRG payment is not based on average costs but is awarded to those hospitals delivering 'good quality'	• Insurers negotiate with hospitals that DRG payment is higher/lower if certain quality standards are met/not met *(e.g., in Germany and the Netherlands)* • DRG payment for all hospitals is based on 'best practice'; that is, costs incurred by efficient, high-quality hospitals *(e.g., in England)*
Patient based	• No payment is made for a case	• **Certain readmissions within 30 days are not paid separately but as part of the original admission *(e.g., in England and Germany)***

The McGraw-Hill Companies

New from Open University Press

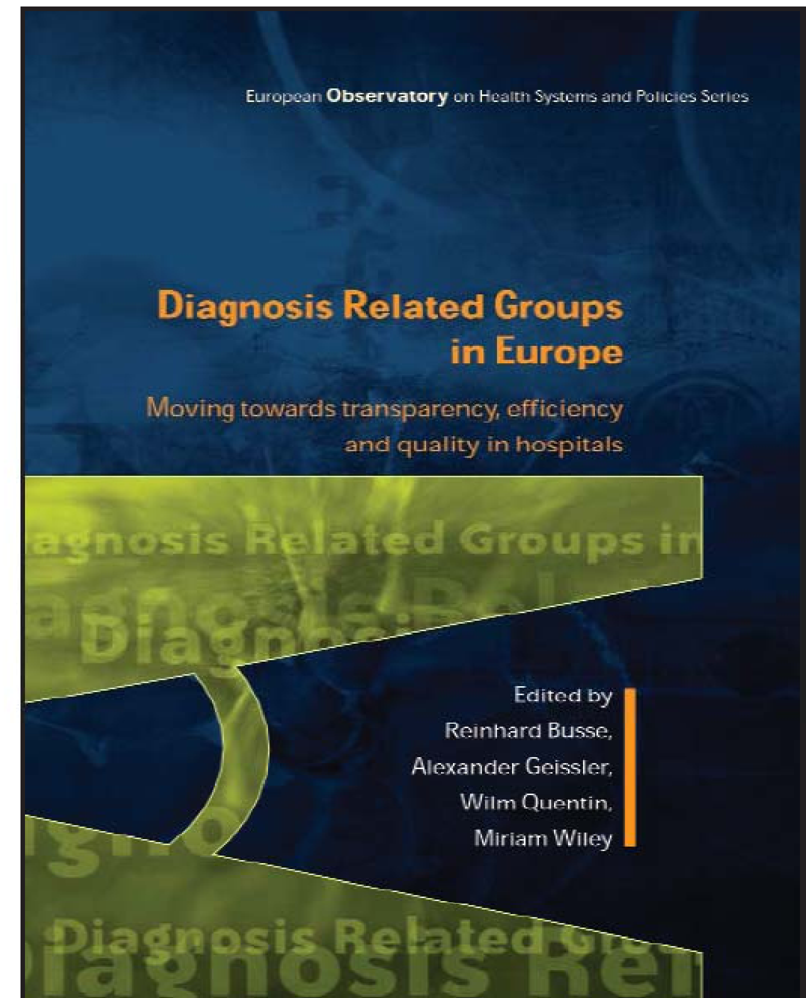
Diagnosis-Related Groups in Europe

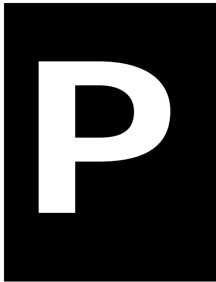
Moving towards transparency, efficiency and quality in hospitals

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.





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Theory and Practice in the Design of Physician Payment Incentives

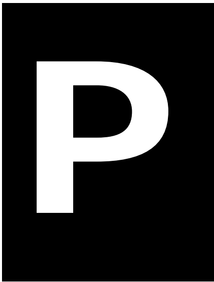
JAMES C. ROBINSON

University of California, Berkeley

There are many mechanisms for paying physicians; some are good and some are bad. The three worst are fee-for-service, capitation, and salary. Fee-for-service rewards the provision of inappropriate services, the fraudulent upcoding of visits and procedures, and the churning of "ping-pong" referrals among specialists. Capitation rewards the denial of appropriate services, the dumping of the chronically ill, and a narrow scope of practice that refers out every time-consuming patient. Salary undermines productivity, condones on-the-job leisure, and fosters a bureaucratic mentality in which every procedure is someone else's problem. But American medicine exhibits numerous interesting compensation systems that blend elements of retrospective and prospective payment, of fee-for-service, salary, and capitation. These innovations seek a middle ground between high- and low-intensity incentives, between piece rates and straight salary. Payment

Advantages and disadvantages of different forms of GP payment

Payment mecha-nism	Patient needs (risk selection)	Activity		Expendi-ture control	Technical efficiency	Trans-parency	Quality	Admini-strative simplicity
		Number of services/ case	Number of cases					
Fee-for-service	+	+	+	–	0	0	0	–
Capi-tation	– (if not risk-adjusted)	–	+	+	+	–	0	0
Salary	0	–	–	+	0	–	0	+



Traditional forms of paying GPs (until early 2000s)

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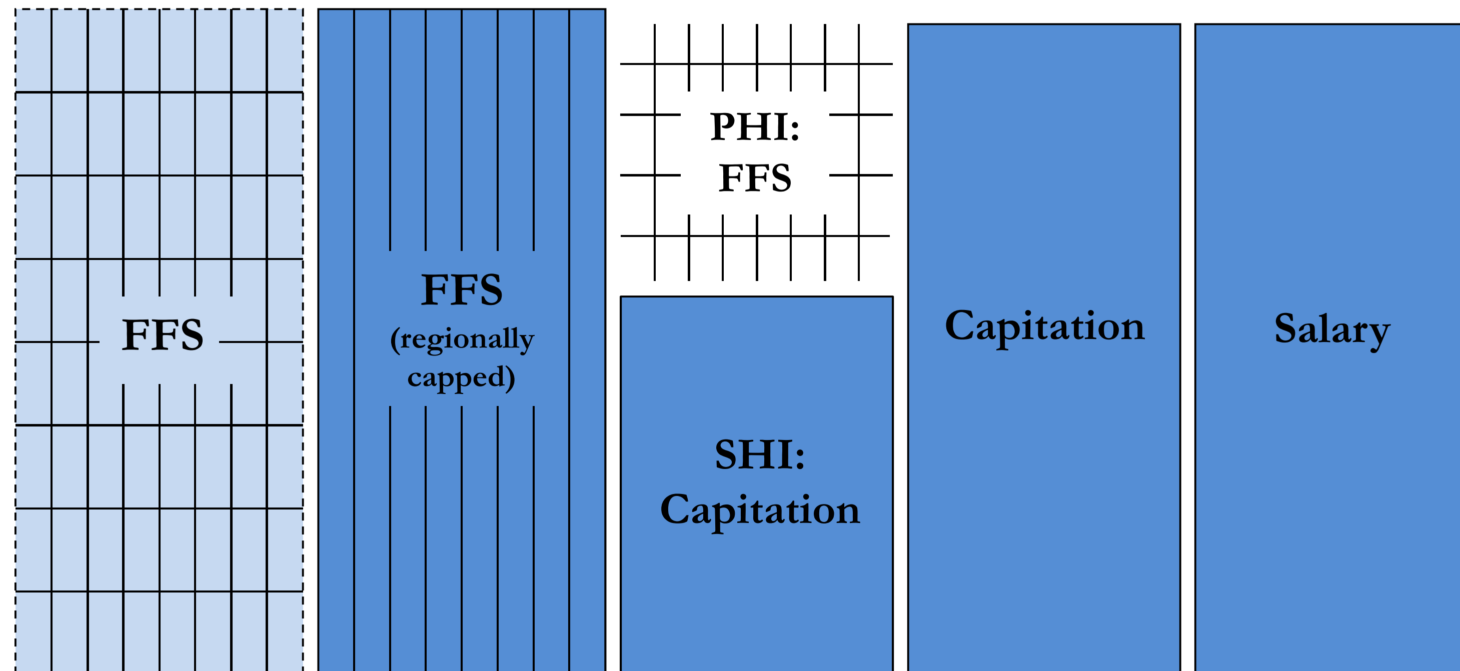

Blended payment components in GP care today

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Objective	Payment	France	Germany	Netherlands	England	Sweden
Objective: appropriateness & outcomes	Quality payment	CAPI bonus			QOF bonus	Bonus and/or Malus
Objective: activity & patient needs	Extra service payment	ADL payment	FFS DMP payment FFS with caps per service type	FFS (per visit & out-of-hours)	FFS (“enhanced services“)	FFS (per visit)
Objective: cost-containment (& geographic equity)	Basic service payment	FFS	“RLV“ (capped FFS)	Capitation	Capitation	Capitation

Tentative lessons for US

- Total costs and quality of health care are mainly the result of provision (not insurance policies) → purchasing/ payment market crucial to achieve health care reform objectives
- Access, cost control (i.e. control of expenditure = prices x utilization) and quality transparency need careful regulation (and probably contracts involving all insurers and all providers)
- Blended payment mechanisms are especially powerful if applied to all providers by all insurers

Presentation available at:

www.mig.tu-berlin.de

www.healthobservatory.eu