Federaal Kenniscentrum voor de Gezondheidszorg
Centre Fédéral d'Expertise des Soins de Santé
Belgian Health Care Knowledge Centre

Comparative analysis of hospital care payments in five countries

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Background

International

- International trend of prospective case-based hospital payment systems since 1990s
- Two more recent trends: financial incentives to improve quality and implement integrated care systems

Belgium

- 'Roadmap' of Minister Onkelinx for a prospective hospital payment system, based on pathologies (Council of Ministers, October 2013)

Goal of the study

Identify lessons learned from hospital payment systems and remuneration of medical specialists in a selection of countries with case-based prospective payment systems

- Selected countries with ‘case’ defined on basis of Diagnosis Related Groups (DRG)-variant: England, France, Germany, the Netherlands, U.S. Medicare

Research objectives

Examine hospital payment system and remuneration of medical specialists

Explore intended/unintended effects

Examine financial incentives to improve quality and implement integrated care systems

Objectives of DRG-based hospital payments as stated by official bodies

Objective	England	France	Germany	the Netherlands	U.S.Medicare
Increase efficiency	x	x	x	x	x
Increase productivity					x
Increase activity	x	x			
Fairness between hospitals	x	x	x		
Transparency in financing	x		x	x	
Enhance innovation	x				
Improve quality	x		x	x	
Reduce excess capacity			x		x
Increase competition between hospitals			x	x	
Accessibility				x	
Cost containment					x

Scope of DRG-based payments

	England	France	Germany	the Netherlands	U.S. Medicare
Medical specialist remuneration	Yes, salaried	Yes in public/private non-profit hospitals, salaried No in private for-profit hospitals, fee-for-service	Yes, salaried	Yes, salaried and self-employed (number of DBCs)	No, fee-for-service
Capital costs	Yes	Yes (but not all)	No	Yes	Yes
Mental health care	No, but some initiatives	No, but some initiatives	Separate system is planned	Separate system	Separate system
Rehabilitation care	Only some types	No, but some initiatives	Yes	Separate system	Separate system
Outpatient ambulatory care	Yes	No	No (except pre- and post-care)	Yes	No (except pre-care)

Lessons learned are based on

1. Design characteristics of DRG-based hospital payments
2. Hospital response strategies and guiding policy measures
3. Evaluation of impact
4. Financial incentives for quality and integrated care

Lessons learned?

- Clearly define objectives of hospital payment system: go beyond ‘efficiency’ or ‘quality’ as objective
- Impact
  - Increased transparency of hospital product and price
  - Fair allocation of resources between hospitals improved
  - Total hospital costs: mix of payment tools is needed for volume/cost containment

Lessons learned?

- Quality:
  - no evidence of adverse effects but additional measures are needed to guarantee or improve quality
  - P4P and DRG-related quality measures: potentially effective for quality, but convincing evidence is still lacking
- Waiting lists: do not follow from DRGs but from (hard) budget constraints
- Independent treatment centres increase risk of patient selection

Lessons learned?

- Design characteristics make an important contribution to whether priorities are reached
  - Transition period
  - Recent and high-quality cost data
  - DRG-institute to manage and control DRG-system
  - Scope of DRG-based payments
- Align incentives of hospital management and medical specialists
- Make SWOT-analysis of system in place

THANK YOU!

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Colophon

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