Comparative analysis of hospital care payments in five countries

C. Van de Voorde, S. Gerkens, K. Van den Heede, N. Swartenbroekx
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

<table>
<thead>
<tr>
<th>Objective</th>
<th>England</th>
<th>France</th>
<th>Germany</th>
<th>the Netherlands</th>
<th>U.S. Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase efficiency</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Increase productivity</td>
<td>x</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Increase activity</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
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<tr>
<td>Fairness between hospitals</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transparency in financing</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Enhance innovation</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve quality</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Reduce excess capacity</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Increase competition between hospitals</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Accessibility</td>
<td></td>
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<td>x</td>
<td></td>
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<tr>
<td>Cost containment</td>
<td></td>
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</table>
## Scope of DRG-based payments

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

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