BETTER POLICIES FOR BETTER LIVES

# Advances in payment systems:

## What's Next?
## Quality and across levels of care

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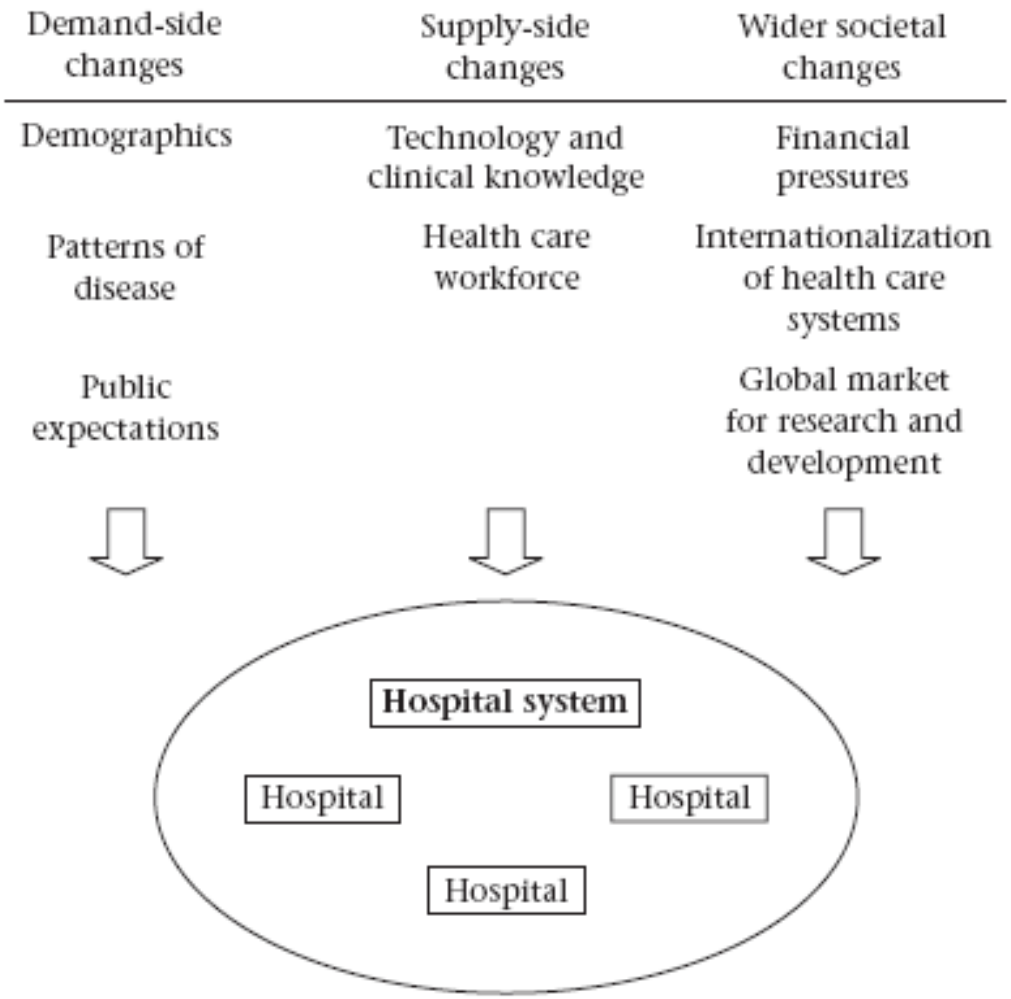
# Pressures for changes in the hospital sector

Three common elements:

(i) Financial constraints on public spending – and on the health sector at large

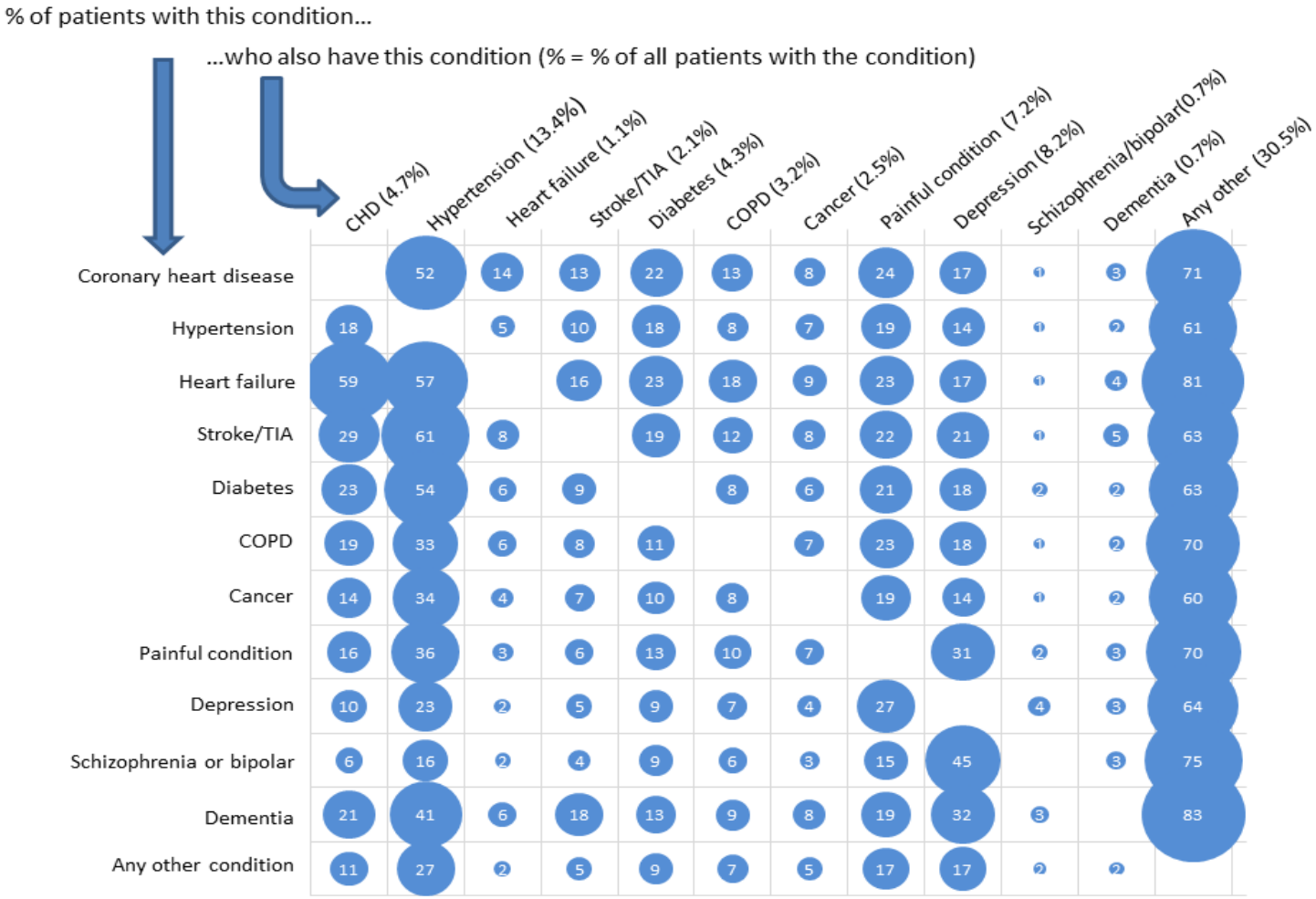
(ii) Ageing population, and the rise of chronic conditions and multi-morbidity

(iii) Changes in medical practice




Source: European Observatory, 2002

# Rising chronic conditions… and the challenges of multi-morbidity




Source: OECD (2011)

# EVOLUTION OF Purchasing arrangements

**Passive**

Output and prices defined by provider

**Active**

Output and prices defined by purchaser

**Strategic**

Output fully specified: which services and how and by whom they will be provided

Prices: financial incentives aligned with service delivery objectives

Cooperative relationship between purchaser and providers.

# Evolution of provider payment models

**Paying for inputs**

- Line item budgets
- Fee-for-service with no fee schedule

**Paying for outputs**

- Fee-for-service

**Paying for performance**

P4P: Performance targets and incentive payments

More bundled outputs

- DRG
- Capitation

**Paying for outcomes/ results**

- Full capitation with performance incentives
- Episode-based payment with performance incentives

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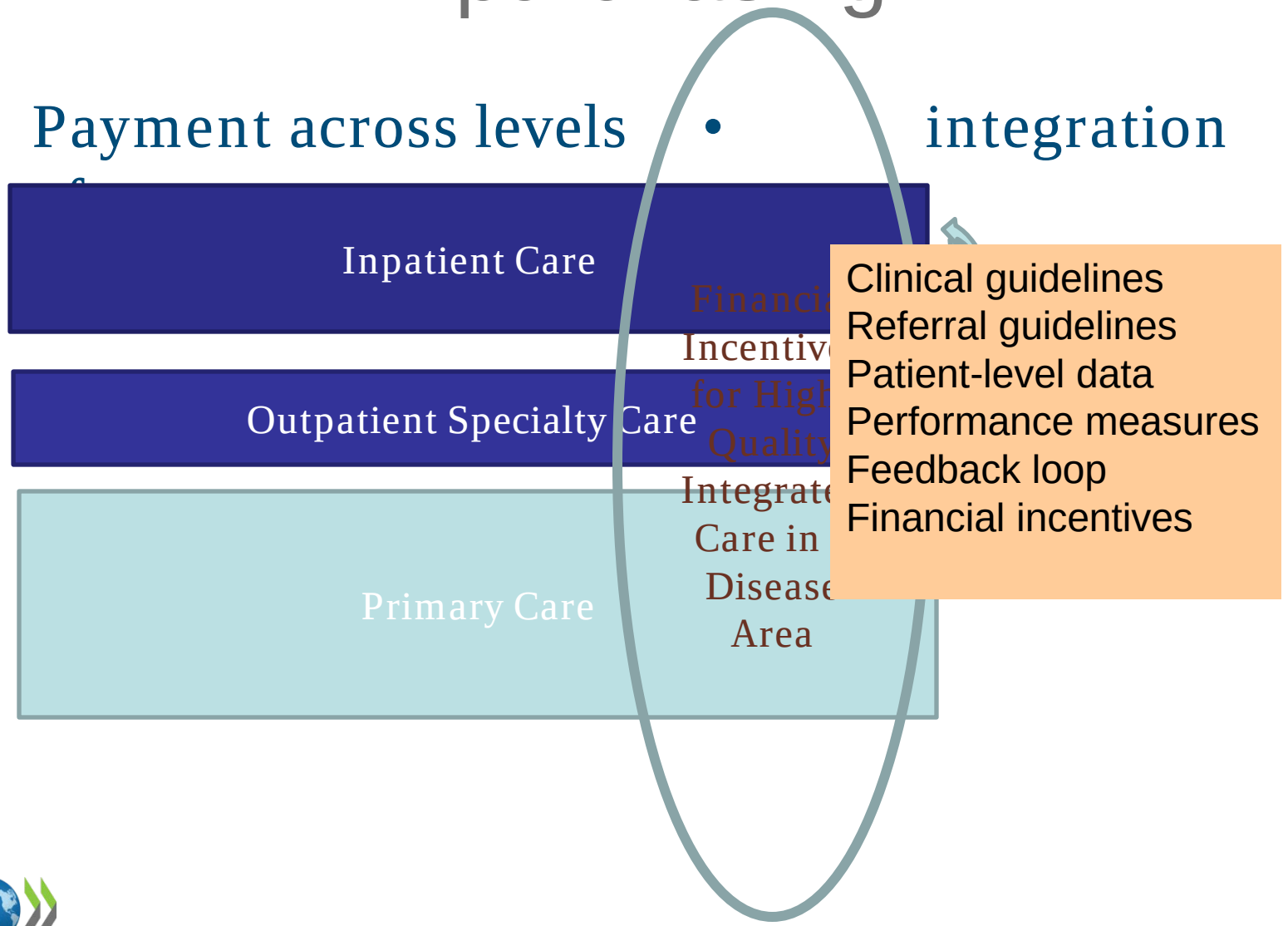
# The next step in strategic purchasing

- Payment across levels
- integration

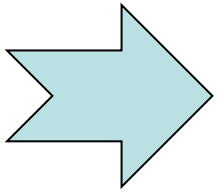
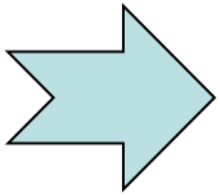


- **Germany**—Disease management programs place primary care physicians as care coordinators for patients with chronic conditions, using financial incentives to reward better care quality
- **Netherlands**— new "care groups" receive bundled payments to manage chronic conditions
- **U.S.**—new "Value-Based Purchasing" initiatives accompanied by Accountable Care Organizations and Medical Home models
- **New Zealand**—group practices formed into Primary Health Organizations to better address population health needs; accompanied by P4P for chronic disease management

## Toward Strategic Purchasing

**Greater accountability for results requires more integrated service delivery**

# Diagnostic Related Groups for Hospitals

- From Fee for Service 
- From Hospital budgets 
- Different objectives:
  - Bundle activity
  - Increase activity—decrease waiting lists
  - Drive down length of stay

# Implementation of DRGS in OECD

**Characteristics of select OECD countries which use DRG based financing**

| Country | PUBLIC | | PRIVATE NOT FOR PROFIT | | PRIVATE FOR PROFIT |
|---|---|---|---|---|---|
| | Budget | Capital* | Budget | Capital* | Payment |
| Australia | Yes, prospective | No | No | Yes | Procedure based |
| France | Yes, prospective | Yes | Yes, prospective | Yes | DRG |
| Germany | No | No | No | No | DRG |
| Netherlands | Yes, prospective | Yes | Yes, prospective | Yes | |
| United Kingdom | Yes, prospective | Yes | Yes, retrospective | Yes | Retrospective costs |
| United States (Medicare) | No | Yes | No | Yes | |
| Greece | Some subsidies | No | Some subsidies | No | Procedure based |
| Switzerland | Cantons may regulate activity | Yes | Cantons may regulate activity | Yes | DRG |

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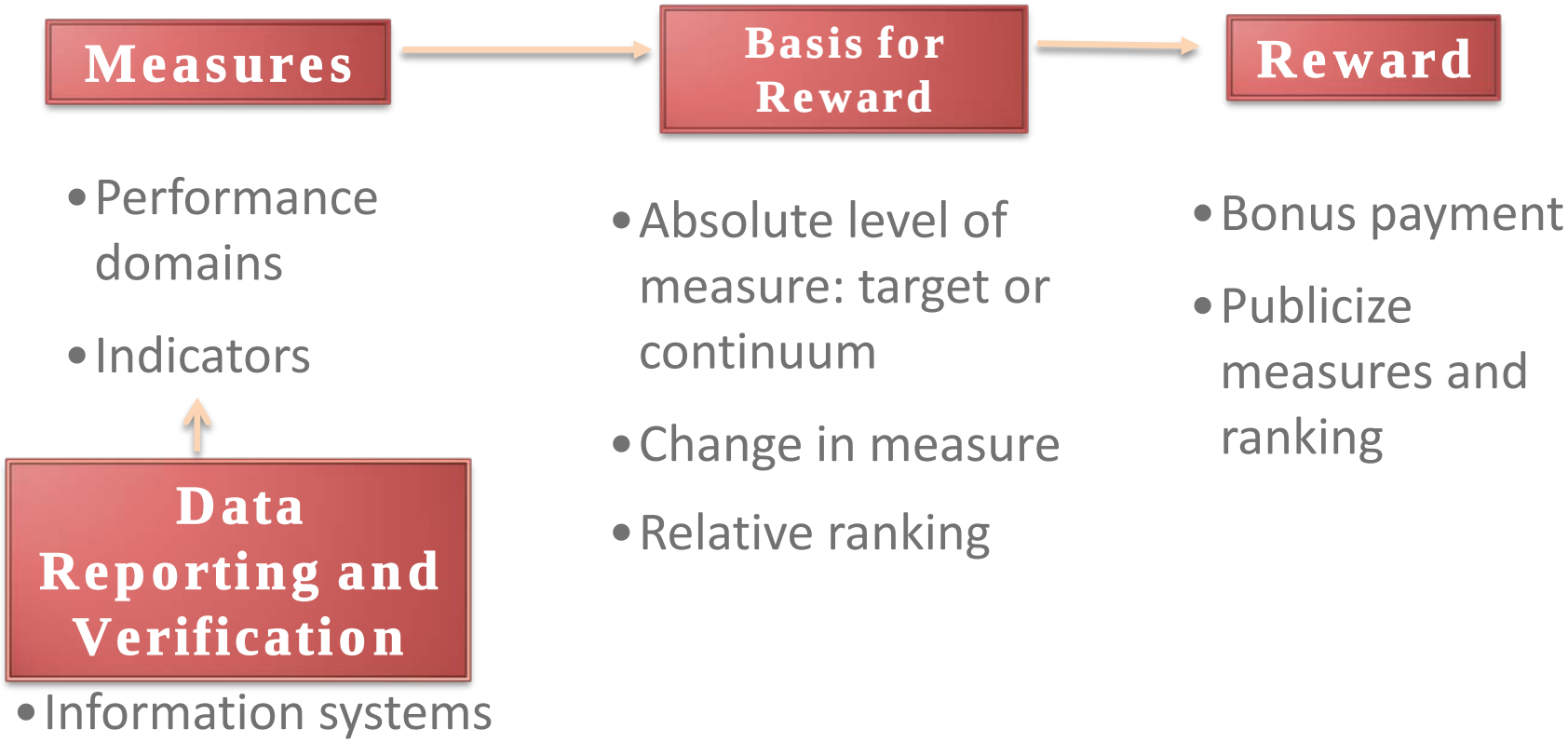
# Most countries have moved to DRGs: but what is next?

- DRGs are activity-based financing that don't reward quality
- Can quality be added to hospital payment?
- Most P4P schemes are for primary care, where health care processes are simplier/ clinical guidelines more straightforward

# What is Quality: OECD Health Care Quality Indicators (HCQI)

- Clinical quality
  - Outcomes: 30 day mortality after acute myocardial infarction (AMI)
  - Process measure---clinical guidelines
- Patient Safety
  - Hospital acquired infections (reporting?)
- Patient satisfaction—critical, but hard to measure (waiting times)

# An anatomy of a P4P program




Source: Adapted from Scheffler RM: *Is There a Doctor in the House? Market Signals and Tomorrow's Supply of Doctors*, Stanford University Press, 2008.

# P4P mechanisms aim at addressing these problems and create behavorial change through six factors (1)

1. Health-increasing substitution (+)

2. Health-decreasing substitution (-)

3. Increased provider effort (+)

4. Risk premium costs (-)

5. Monitoring costs (-)

6. Net externalities (+ or -)

# Paying Hospitals for Performance in Medicare
## Ambiguous evidence

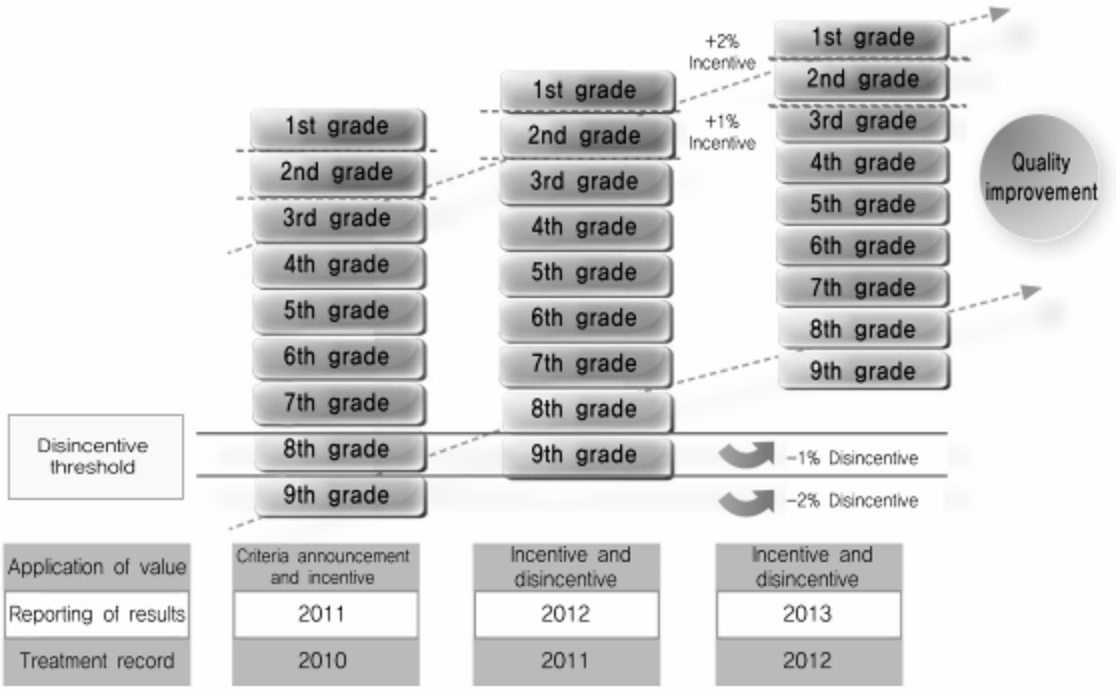
- United States Medicare *Hospital Quality Incentive Demonstration* (HQID), implemented by Premier Inc.
  - 5 clinical domains covered:
    - Acute Myocardial infarction;
    - Coronary Artery By-Pass;
    - Heart Failure:
    - Pneumonia;
    - Hip and Knee replacement

- Evaluation of the program by Premier Inc. very positive;

- External evaluation concluded that HQID had no/negative impacts on quality of care (Glickman et al., 2007)...

# Korean: using performance measurement to reward high performing hospitals

- Performance is defined in four areas of care: AMI, C-section rates, stroke and use of prophylactic antibiotics.
- Hospitals are ranked in 9 grades




Bonuses are distributed on the basis of quality improvement with regards to initial baseline performance measurement upon participation in the scheme (+1% or +2% of total costs) – similarly, penalties are applied to hospitals not improving.

# Key Lessons from OECD review

1. Rise of Chronic Disease requires greater integration of care—both into and out of the hospital
   - Very difficult to control volume without integration (including aftercare)
   - Emergency admissions

2. DRGs are usually the first step
   -mixed with budgets offer greater control

3. P4P is much easier for primary care/more complex for hospital care
   -complex data requirements
   -possible negative substitution
   -quality gains may be offset by cost of implementation

4. Easier to tackle specific quality issues identified—focus on something that is wrong and fix it (e.g. paying for readmissions)