Recommendations on Pricing Regulation of Healthcare Services

Analysis and recommendations based on International Best Practice and Experiences in Switzerland and Germany

Expert group of healthcare financing and policy, symedric Inc., Berne (Switzerland), 2018

Expertise

Our track record includes international healthcare policy consulting in Switzerland, Germany, China, Kazakhstan, Vietnam and other European countries through the European Casemix Expert Group. We have a vast expertise in developing customized healthcare policies for hospital financing and planning and to support implementation.
What relevant aspects have to be met by future healthcare policies in order to encourage financially sustainable, widely accessible and high quality care?
We evaluate and support the necessary steps towards the realisation of defined health care financing and policy goals.

Current situation

There is no international consensus on best practice when financing healthcare services, healthcare providers or infrastructure. But most of the wealthy and developed countries try to establish systems to best control costs while stimulating efficiency and to focus on outcome quality without restricting medical care. Such systems give responsibility to the health care providers without restricting individual care and access to services.

In the past decades the hospital planning has been primarily based on resources and infrastructure planning, e.g. by numbers of beds or health care providers per population (input oriented). Keeping these goals in mind it is necessary to link the mentioned resources with actual services per population or regions (output oriented approach).
There are several options to evolve from a fee for service tariff towards a state of the art tariff system for health care provider payment using the international experience of best practice solutions. In order to facilitate the implementation of any adequate financing and reimbursement system we recommend the following steps:

1. Improve documentation, coding and costing
2. Standardized terminology (coding and billing guidelines)
3. Calculate and evaluate distinct services (DRGs for inpatient care, mixed FFS and capitation for outpatient care) with own (national) cost data
4. Develop a Healthcare Cost Index / price benchmark
5. Develop quality measures

We recommend to define a step-by-step approach over approximately five years. In the short run we recommend to prioritize the inpatient hospital sector because it is more rigid to change but the goal has to be to include all healthcare sectors.

In order to achieve the expectations and strategic objectives of the reforms, it is important to be clear about the different incentives associated with the different options. Since financial sustainability is one of the objectives of the reform, an overall annual budget per hospital could be considered favourable, as the budgeting process is easy and payment organisations have the full control over expenditure. The downside would be a lack of transparency and less motivation for hospitals and doctors to treat patients. On the other hand, a fee for service that can be used today, might be favoured by healthcare providers, as additional activities are always reimbursed and there is a high financial motivation to perform medical activity.
A DRG-tariff-system combines the anticipated positive effects and properties of the two systems and mitigates the unwanted effects. The following figure illustrates the desired and undesired incentives of different tariff systems in addition to the advantages and disadvantages of different options that are described in the report.

Incentives of different hospital financing systems

	Activity		Expenditure Control	Technical Efficiency	Quality	Administrative simplicity	Trans-parancy
	Number of services per case	Number of cases					
Fee-for-service	+	+	-	0	0	-	0
DRG-based payment	-	+	0	+	0	-	+
Fee-per-day	-	0	-	-	0	+	-
Global budget	-	-	+	0	-	+	-

Source: based on Diagnosis-Related Groups in Europe, Open University Press, 2011 and WHO, 2000.

Focus on inpatient care: Financing and reimbursement of hospitals

DRG systems are used for hospital financing in one way or another, in most high income countries over the world. Refined DRG systems, using various criteria (such as primary diagnosis, secondary diagnosis, medical procedures, Age, Sex, Weight, Intensive Care treatment, etc.) to describe the severity and complexity of a patient's health problem, are

considered as the state of the art mechanism to pay for hospital services. This is especially the case for somatic inpatient treatments, though the development and implementation of related tariff systems to pay for psychiatric treatments, rehabilitation and outpatient services is happening in numerous countries as well.

Trends in coverage of services in DRG-like Patient Classification Systems (PCS) in Europe

Country	*Inpatient*	*Day cases*	*Psychiatry*	*Rehabilitation*
Austria	X	X[a]	–	–
England	X	X	in the process of extension	
Estonia	X	X[e]	–	–
Finland	X	X	X[b]	X[b]
France	X	X	in the process of extension	
Germany	X	X[a]	planned for 2013	–
The Netherlands	X	X	X	X
Ireland	X	X	–	–
Poland	X	X[a]	in the process of extension	
Portugal	X	X[a]	–[c]	–[c]
Spain	X	–[d]	–	–
Sweden	X	X	X	X

Source: Diagnosis-Related Groups in Europe, Open University Press, 2011

Different reasons for DRG systems

Over the past 25 years, several countries have introduced diagnosis related costing of procedures or similar classification systems for different reasons. It is wrong to think that such systems were introduced with the main aim of setting tariffs or as a direct payment tool only for hospital services. Indeed, there were a number of different objectives.It is essential that the introduction and use of any such system is clearly linked to the specific goal(s) as set by its prospective users.

Diagnosis related costing of procedures can be used for the following goals:

1. Establishing transparency regarding services provided and costs of the services
2. Documentation of services and statistical data collection
3. Optimisation of the internal hospital processes
4. Internal hospital management (budgeting, strategic controlling)
5. Planning of hospitals according to morbidities
6. Budgeting of hospitals and planning of financing of hospitals
7. Benchmarking and comparison between hospitals for similar services (competition)
8. Setting tariffs and direct payments of services of hospitals (retrospective and prospective).

According to the needs and goals of the different countries either a specific DRG system was...

- … chosen and implemented without any changes
- … chosen and then adapted to the local needs
- … completely independently developed.

Countries with preferences for goals 1, 3 and 7 (as mentioned above) would choose a diagnosis related system. Countries with preferences for goals 1-3, 5 and 8 would opt more for a system oriented to processes and less to diagnosis.