# Financing methods of hospital sector
# Integration of health service providers
# Integrated payment systems

Healthcare policy, Management and Economics,
Public Health, Lecture 12

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## Reimbursing Hospitals

- There are three alternative reimbursement systems for hospitals
- None of these systems emerges as the ideal solution, which explains why we observe blended systems in practice

# A typology for hospital payment systems

| | ***Retrospective*** | ***Prospective*** |
|---|---|---|
| *Fixed* | Not applicable | Annual global budgets |
| *Variable* | Fee for service | Per patient/case |

# Retrospective variable: cost reimbursement

- Retrospective per diem pricing used to be a common reimbursement system in many countries
- In publicly funded national health services one would divide the hospital's total costs in the previous year by the number of patient days
- This per diem price would then be adjusted for inflation and multiplied by the number of patients treated in the following year — which would then determine the scale of the hospital's reimbursement

## Retrospective variable: cost reimbursement

- In private health insurance systems the retrospective reimbursement system was even simpler: register all costs incurred in the treatment of each individual patient and send the bill to the insurance company, which would then reimburse the hospital
- Such retrospective reimbursement systems have inbuilt incentives to increase length of stay, to provide more diagnostic tests, and to increase quality—all of which escalate cost

## Prospective fixed budgets

- One simple solution to lack of budget discipline is for the third-party payer to allocate fixed annual budgets to providers
- Prospective fixed budgets mean that the third-party payer avoids all financial risk; it is the provider who faces the risk

## Prospective variable

- This alternative emerges as the solution to different problems in different institutional settings
- Typically, the prospective variable system is based on a classification of all hospital admissions according to the homogeneity of the resource use and clinical characteristics (principal and secondary diagnoses, procedure, age)
- The most commonly used classification system is called *diagnosis-related group* (DRG)

## Macro vs micro level

- In countries with tax-financed health care, it appears that the major concern among policy makers about the effects of the variable prospective reimbursement model is the lack of cost control at the macro level
- A suggested solution is to combine a fixed-budget model at the macro level with an activity-based model at the micro level.

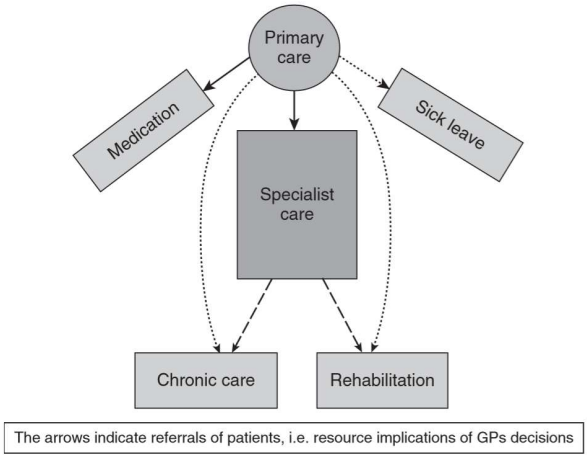
## Integrating the health care provider system

- A characteristic feature of the health sector is that most of its 'customers' flow through at least two provider levels

## Combinations of payment systems in primary and secondary care

- When budgets become fixed independent of activity, hospitals no longer have the incentive to increase admissions
- The most immediate consequence is hospital waiting lists, something that carries a heavy political burden
- As a result of a 'blame game' between politicians and hospital managers, what are intended as 'hard' budgets turn to 'soft' budgets in exchange for a promise to reduce waiting lists

# The 'body' of the health care provider system




The arrows indicate referrals of patients, i.e. resource implications of GPs decisions

# Thank you

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