foresight dialogues 2016

WHERE TO FROM HERE?

The development of an industry hospital alternative reimbursement model

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insight

Fee for service

Still the predominant form of hospital reimbursement in the private sector in South Africa.

Matches underlying cost and activity to revenue, but does not reward improvements in efficiency and innovative models of care delivery.

Fragmentation and inconsistency of tariff models and shapes makes it difficult to build broader reimbursement models incorporating other providers.

Makes for a poor patient experience

Proposition

We need to move toward more progressive reimbursement structures that embed the right incentives and align the interests of stakeholders as one means of improving sustainability of the healthcare system

In other countries

Typically, it's the government or a government agency that develops DRG based reimbursement models

Public sector

In South Africa, a public sector DRG development process has started, but has a long way to go

What should we do?

We can choose to wait, or we can choose move forward in the interim

(recent) History

Tariffs

2003/4
Single Exit Price and tariff adjustment process.

2007/2008
Net Acquisition Price and tariff adjustment process.

2006-2010 RPL process starts and falters. No industry standards.

Groupers

2000
3M DRG grouper developed.

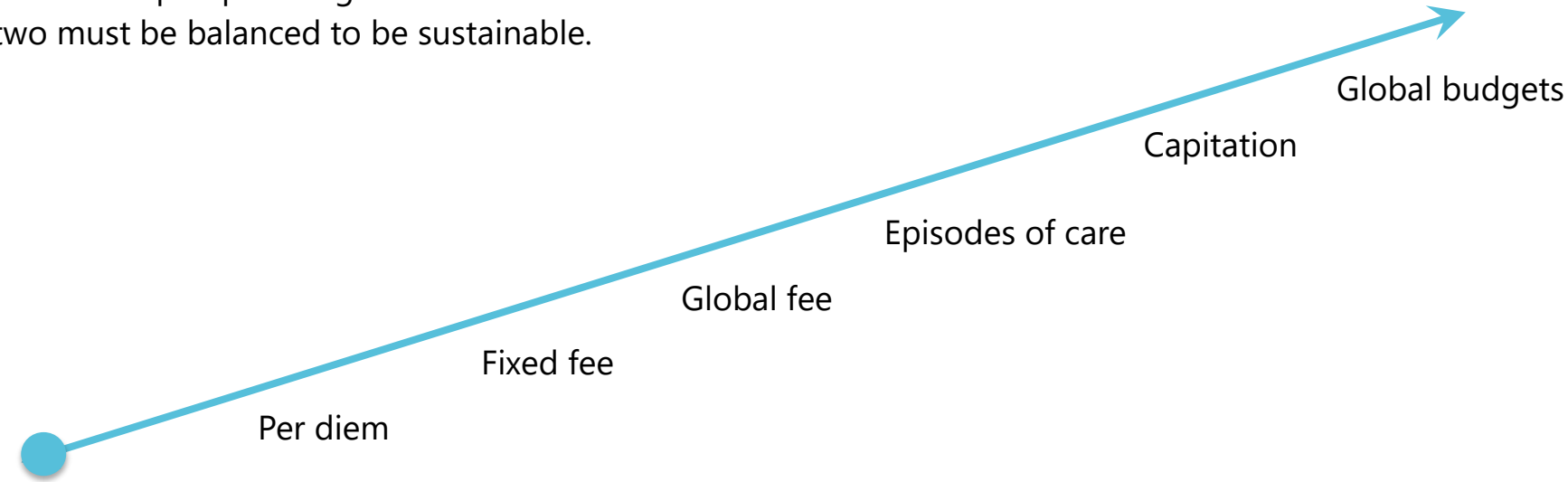
2003
3M stop supporting the IR- DRG. Maintained by some market participants.

2012
CareGauge (Insight) developed localized DRG; incrementally improved since.

Insight's DRG is now used by (+)55% of the funder market

Risks and Incentives

Risk and reward move together – more risk means the prospect of greater reward. The two must be balanced to be sustainable.



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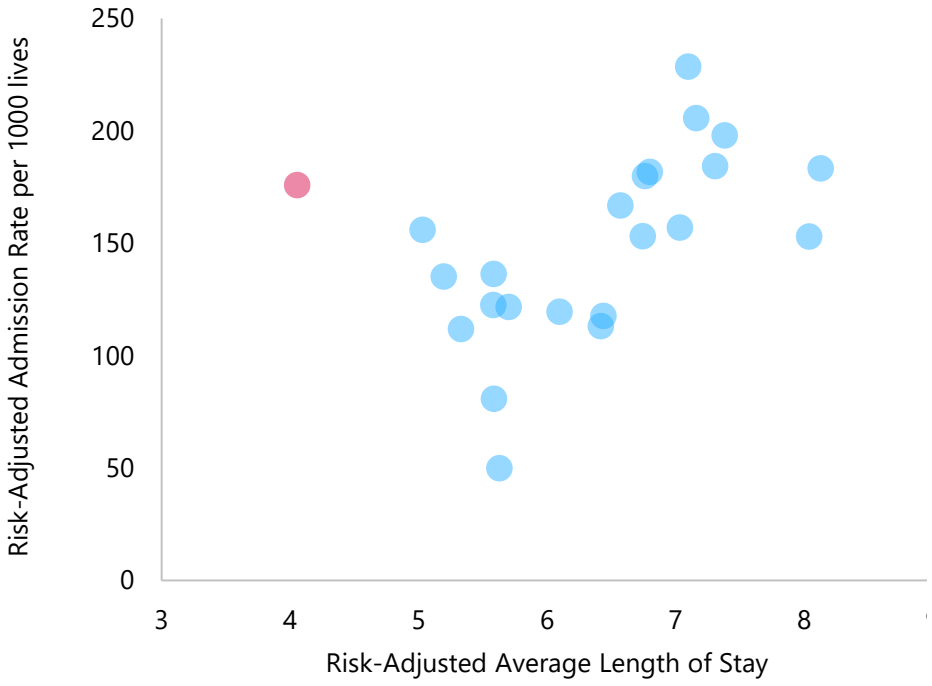
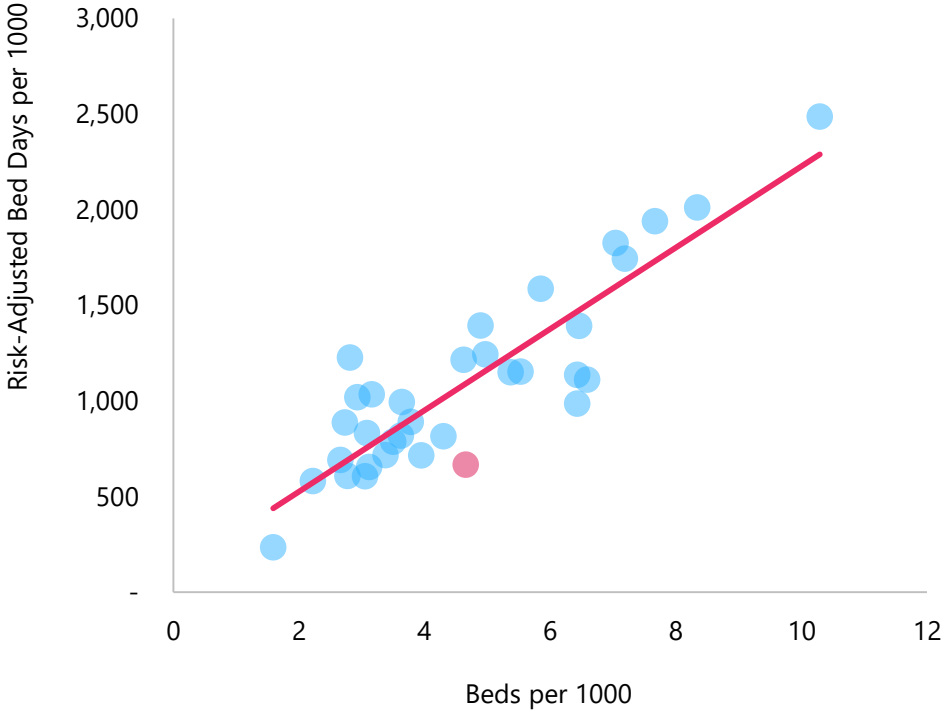
SA utilization statistics

Risk-adjusted admission rate per 1000 lives vs. risk-adjusted average LOS



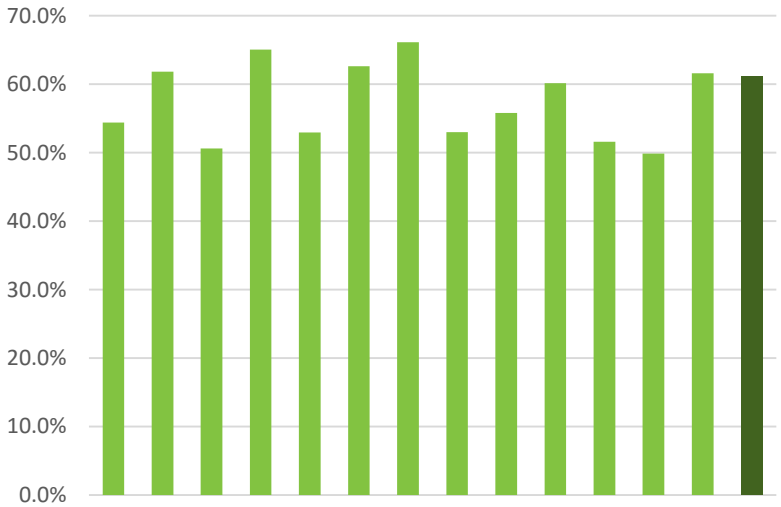
Risk-adjusted bed days per 1000 vs. beds per 1000



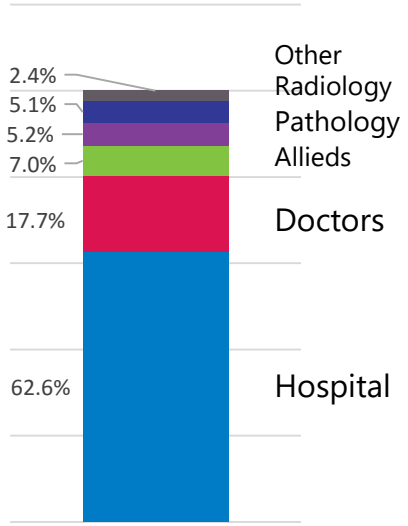
Source: International benchmarking of hospital utilization, Insight study for HASA

In Hospital expenditure splits

Percentage of medical schemes costs incurred in hospital



In hospital spend by category



Desirable characteristics of a reimbursement model

Simple: the structure should not be overly complicated, should be relatively easy to implement and administer, and monitor

Inclusive: the model should cover as much of the financial flows as is feasible to include, taking into account multiple stakeholder roles

Accurate: the model should accurately represent the cost of delivering services to avoid cross subsidies and unintended incentives

A first peek,

Fixed Fees for certain Surgical DRGs (that behave well statistically)

+ a hybrid fixed fee (for theatre time, stock equipment and procedure fees) & per diem model for other Surgical DRGs

+ Per diems for Medical DRGs

with very limited trimming (1% of the admissions at the upper end)
cleaned for error admissions, removing neonates and pre-MDC admissions

This includes 84% of admissions
And 70% of spend

Yields an 81% R^2

We propose the following:

An Insight hosted round table discussion with funders and hospitals interested to further the issue, participating in their individual capacities to avoid any competition risks

We will table a “straw man” proposed structure to be debated and critiqued by this forum to allow a broad range of input on an inclusive basis

Similarly a governance model for the model will be tabled for discussion an critique, to keep stakeholder input balanced

This approach seems the best option we have of getting close to an “industry standard” hospital alternative reimbursement model palatable to the affected stakeholders.

Critical to achieve a tipping point of participation.

Added benefits

Build a foundation for wider, more inclusive reimbursement models for hospital and related providers, to align incentives of all parties. **Teamwork!**

Quality

Industry standards on case mix are necessary to build industry standardized measures of quality. And make progress towards being able to contract on **Value**.

So where to from here?

We can choose to wait, or we can choose move forward in the interim and lay the foundation for an improved health system

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