

CRITICAL ANALYSIS OF HOSPITAL FINANCING SYSTEMS

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Abstract

This paper presents a comprehensive analysis of the mechanisms, major issues and trends in the hospital financing approaches during the recent decade. It is well known that the hospitals are the most expensive component of healthcare costs as their maintenance and functioning exhaust the greatest part of healthcare resources of each country. While the hospitals consume a significant share of the healthcare resources, the healthcare managers search for novel payment strategies guaranteeing the efficient provision of healthcare. The most important instrument for hospital management and modeling of hospital performance is the financing mechanism. Thus, the appropriate, rational choice of financing model in the hospital sector has a strategic effect on the overall national healthcare system.

Key words: hospital payment mechanisms, healthcare financing model, health services, reforming payment strategies

INTRODUCTION

The hospitals are the most expensive component of as their maintenance and functioning exhaust the greatest part of the healthcare resources of each country and this is absolutely normal because of their major importance substantiated by the facts listed below:

- The hospital is not only a facility delivering some medical care or service; comprehensive programs associated with research, education and training of specialists are implemented there; it also fulfils social functions such as patients' rights protection and provision of information for the patients;
- The hospital is a basic source of health services as it ensures basic, as well as highly specialized health care for the population;
- The hospital is also an important actor in the national economy, generating added value and participating in the formation of the gross domestic product on one side, and being a large resources consumer, on the other.

The increased demand for hospital care and costs for its provision outline the necessity of adequate financing and, at the same time, effective allocation of the appointed hospital resources. Most countries face the issue: unrestricted health needs vs. limited funds of the hospital establishments to meet those health care demands. The global trend to population ageing additionally threatens the stability of the public healthcare funds and requires the implementation of measures to maximize the effectiveness of hospital expenditures.

The WHO Report (late 2010) states that one half to two thirds of all state health care costs are appointed for hospital care – globally some 300 billions annually are lost because of ineffectiveness. The hospitals must achieve 15% more than their current result without additional funds in order to be effective.

The developed healthcare systems continuously adapt the mechanisms for healthcare providers' payment to the quickly changing public-economic relationships. The reforming of payment mechanisms aims at elaboration of a set of financial incentives to improve the access to quality services encouraging at the same time cost restraining through more effective resource use. Thus the healthcare systems of the EU strive to introduce mechanisms to restrict undesired incentives, provoked by the mechanisms such as: offering unnecessary services; reducing the resources used for service provision, moral hazard, shifting diagnoses to more expensive ones.

DISCUSSION AND RESULTS

Based on review of publications discussing healthcare financing and available references on hospital financing, the hospital payment mechanisms can be classified in three main groups depending on the moment of financing identification:

1. *Retrospective* – the patient's appearance and activities performed for him determine the financing and finally the insurers reimburse all costs to the providers. The incomes of the hospitals depend directly on the amount of realized health activities;
2. *Perspective* – the activities scope is predefined (health care services, packages etc.) for a particular time period and the financing of the hospital establishments is based on pre-compiled costs;
3. *Combined* – it includes various combinations of elements of the retrospective and perspective methods.

The mechanisms can be classified in two main groups from the view point of relationships between financing and scope of realized services:

1. Unrestricted (open) systems where the financial incomes depend on and increase with the growth of the amount of rendered health services, that is "the more – the more";
2. Restricted (closed) systems where the increasing of the implemented activities do not generate increased incomes.

This theoretical description leads to the conclusion that the most market-oriented and meeting the demands for the providers of health care services design would be the retrospective and open one. On the other hand, though, in the current conditions of critically growing hospital service costs, limited resources and increased health care demands it should be assessed whether that particular mechanism is appropriate and really applicable in modern European healthcare systems. The choice of payment mechanism is to be outlined mainly by the following parameters: control on health costs, stimulation of the quality of delivered health activities; provision of social and geographic equity and accessibility to health care and satisfaction for both patients and medical specialists. The last decade evidences the active discussion on the issue of effectiveness of spent funds. What is the extent of meeting those requirements and which payment design is the best? The issue could be clarified by considering in-depth the listed funding methods in the following two aspects:

- financing unit describing the health care services included in the payment;
- the burden of financial risk between the customer/provider of services.

I. Retrospective financing systems – the incomes depend directly on the amount of performed health care activities. The insurers reimburse the hospitals for all costs incurred at health care services provision and at the same time there are no restrictions on the amount and cost of provided services. This financing method does not generate incentives for improved efficiency or reduced costs. The control within the system is hardly applicable and the financing burden is incurred by the financing body. This model was implemented in the USA by the 80s of the last century.

II. Perspective financing – the financing institution plans in advance the funds necessary for the next plan period (usually one year) of the hospital based on pre-defined unit:

Line-item budget – the hospital receives a total sum to cover the provision of all health care services over a particular period of time. The basis of the approved global budget is formed by the costs incurred during the past year (i.e. historical principle). In the end of the plan period the hospitals can keep all surplus and, respectively, to cover deficits.

Budget by paragraphs – this financing method was implemented in Bulgaria, the USSR and East European countries during the second half of the past century. The principle is as follows: a particular budget is fixed for each paragraph – staff, medications, food and other alimentation elements, thus the financing unit is the budget paragraph.

The distribution of the financial burden in the budgets is shared between the insurer and provider of financing if, at budget compilation, the specific demands of the serviced population, type of provided medical care and other criteria have been considered.

The shortcomings of the budgets are associated with lack of possibilities for flexibility and independence of the hospital management, of incentives for achievement of particular results and maximal effectiveness, strive to quality improvement, spending all allocated funds for the period without real necessity for this.

Payment per procedure – the pricelist is the basis of this method. The service (procedure) rendered is the financing unit in this case. The number of procedures/services, provided under the contracts between the financing institutions and the providers determines the level of resources to be paid to the hospital. The main strive created by this mechanism is focused on maximal income for the provider by rendering a maximal number of expensive medical services. With this hospital financing system the whole financial burden is transferred onto the financing institution. The negative features are: it stimulates the realization of more and/or unnecessary activities that could cause the diminution of their quality, rendering health services that are unnecessary for the patient as well as poor macro control on the system. On the other hand, the administration is simple, there are incentives to improve the effectiveness, though only when the value of the implemented health service is greater than the reimbursement stake. A particularly valuable feature of “payment per procedure” is that it creates a barrier for unnecessary transfer of patients to the expensive “higher stages” of the healthcare system.

Payment per day – with this model the insurers pay to the hospitals a fee for an bed-day. If this fee is equal for everyone, the hospitals suffer the financial burden of the variation of the costs of one bed-day. On the other hand the financial burden transfers onto the financing institution because of the option provided by the system for substantial increase of the hospital beds occupancy. The advantages of this method are its simple administration and, together with that, there are no incentives for extensive offering of more than the necessary health services.

The disadvantages are that the providers have incentives to reduce new admissions and to prolong the stay of already admitted patients in order to compensate for the more expensive bed-days in the beginning of the treatment with the lower costs for the convalescence period – this leads to negative effects on quality, at the same time impeding and even restricting the access.

Payment per case – this method has two versions: per discharged patient or per diagnosis. The first version grounds the hospital financing on a preset charge per discharged patient, not depending on the case type. The second version suggests a model with case-mix adjusted discharge model, the financing is based on a certain payment per one discharge, standardized for the differences in the case-mix. The most popular and widely implemented international approach is the diagnosis related groups (DRG).

The clinical pathway is a type of payment per case when the provider is paid for an administered treatment with a predefined set of healthcare activities over a given period with a particular diagnosis. The method combines the hospital financing for a given diagnosis with the necessary algorithm for the quality of the administered treatment. This approach has been implemented in Bulgaria for more than a decade for hospital care financing. The financial burden is laid on the hospital because of the possibility for the cost of the clinical pathway to be lower than the real treatment cost. Besides that the method recognizes only the particular diagnosis but not the presence of patient’s concomitant health conditions. The idea of the “clinical pathway” is reasonable but its practical implementation has a number of disadvantages: the risk for the financing body is associated with the patient’s admission for a clinical pathway with a greater cost. The specialists’ opinion is that this circumstance affects the national statistics for hospitalized morbidity rate. The financial burden belongs to the hospital because of the possible lower cost of the clinical pathway than the real treatment cost. Besides that the method recognizes only the particular diagnosis but not the presence of patients’ concomitant health conditions.

With the model “payment per case” the insurer experiences the risks associated with the variations in admissions. The providers, themselves, assume the risk from the accumulation of greater costs from the preset reimbursement amount. The main benefit from the implementation of the “payment per

case” in the hospital payment systems is the incentive for the providers of medical services to realize more effective care because that type of payment systems reimburse the hospital on the bases of approximate investments necessary for a particular treatment. Thus it is not beneficial for the hospitals to realize unnecessary services (e.g. additional and necessary tests) or to encourage longer stay at the hospital. The hospitals are financially motivated to apply the most adequate means for patient’s treatment and to eliminate dissipation.

III. Combined financing – the practices rarely use some of the above described hospital financing methods in their authentic version. The combined financing is a mix of methods that were considered nationally reasonable by the healthcare policy makers. A combination of two methods is usually implemented where one of the methods is the leading, and the other – the auxiliary one. For example – the payment per procedure is often combined with daily fees for financing of main services such as food and other overheads. Besides that, most systems have options for additional payments as incentives for the providers to achieve particular goals.

All presented methods encourage various approaches to hospital care provision. For example, fixed payments for admission stimulate the hospitals to increase their admissions while the fixed payments per in-patient stay are an incentive for longer patients’ stay at the hospital. The budgets challenge the providers of medical services to restrict health services but they can also encourage them to more effective health services in order to avoid unnecessary spending of the assigned resources and respectively increasing the gained benefits.

CONCLUSION

The comparative analysis of the financing methods showed that it is not reasonable to give them a definite or final evaluation because of the fact that the specificity of each presented system can be an advantage or disadvantage depending on the preset goals.

The strive of health experts and policy makers should be focused on designing a combined payment system, adapted to the national priorities, where there is a balance between the quality of the provided service and the socially reasonable fee paid for it.

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