

HGOV4100 – autumn 2018 – Guidelines for sensors

General:

Grades are based 40% on question A and 60% based on question B.

For every sub-question under question A, up to one point was given for correct definition and up to 1 point was given for a relevant example.

For question B, up to 5 points were given for definitions, up to 5 points were given for description of relevant tasks/institutions and up to 5 points were given for the discussions/normative considerations.

Max numbers of points given were 10 for question A and 15 for question B, altogether 25 points.

The cut offs (points vs grades) were set like this:

$23.0 \leq A \leq 25.0$

$21.0 \leq B < 23.0$

$19.0 \leq C < 21.0$

$15.0 \leq D < 19.0$

$12.0 \leq E < 15.0$

$F < 12.0$

The median grade was B.

Specific comments:

Part A Short answers

Define the following concepts. Illustrate each definition with an example.

1) Asymmetric information

- Definition: One party has more information than the other
- Examples: Relationship between GP and patient, insurance company and insured, among others. Different examples were used.
- Comment: All students got 2 points

2) Skimping

- Definition: Reduce quality for patients that demand high resources while provide low contribution
- Examples: Reduce use of procedures.
- Comment: Also an easy question. 95% got it right.

3) Imperfect information

- Definition: The easiest is to define perfect information and then take the negation

of this. Perfect information is defined as: the actors know where they are (in time and space), they observe actions of others, there are no simultaneous moves

- Example: Many examples were used, for example related to the GP-patient relationship, insurance companies vs. insured.
- Comment: 80-85% got 2 points. A few mixed up with incomplete information

4) Creaming

- Definition: Attracting patients that demand little resources while providing high contributions.
- Example: Young, low risk inhabitants.
- Comment: Also quite easy. I think 95% had 2 points.

5) Capitation

- Definition: Payment arrangement for health care service providers where payment is “per head”.
- Examples: Number of inhabitants in a hospital catchment area or on a GP’s list.
- Comment: 80-90% managed the definition. Fewer had relevant examples.

6) Risk adjustment

- Definition: A process that takes into account the underlying health status of a patient or inhabitant when setting the payment.
- Examples: Risk adjusted capitation for GPs, risk adjustment of grants to hospitals.
- Comments: 80% got it right.

Part B Essay

- 1) Describe the main elements of the DRG-system and discuss potential problems related to use of the system as a method for reimbursing hospitals,

The answer should start out by defining DRG as a case-mix measure and describe how DRGs are made: Patients are classified into app 500-800 DRGs and a cost weight is calculated for each DRG. Cost weights can be calculated by bottom up or top down methods. DRGs’ can be used for monitoring activity and productivity in the acute hospitals and for reimbursements. Exemplifications will strengthen the answer.

The essay can proceed by classifying DRGs as a reimbursement system along dimensions as retrospective vs. prospective and fixed vs. activity based. A DRG based reimbursement system will be prospective and usually activity based. In some cases, DRG- based reimbursement systems are used in cost-volume contracts (fixed payment systems).

Problems related to the use of the DRG-system include upcoding, creaming and skimping, high transaction costs. A high grade is given to essays that not only describe these (and other) problems but also explain why they occur and how the problems can be reduced.

- 2) Patient selection might be a problem in insurance system with increasing competition between the sickness funds. Explain why the problem occurs and which remedies that can be implemented to reduce the problem.

Patient selection are of two types – adverse and advantageous selection. The problem of adverse selection: Action by consumers and sickness funds to exploit unpriced risk heterogeneity. For a sickness fund, there are incentives for selection if:

$C \neq SI$, where C = costs and SI = social insurance contribution

Reasons why the problems occur will mainly be related to increased competition as indicated in the text. A careful description with examples from countries in both Europe and elsewhere will strengthen the essay.

There are (at least) three types of measures to handle adverse selection: Risk sharing (retrospective), risk adjustment (prospective) and others (open enrollment, ...). A precise understanding of the differences between these mechanisms is necessary to get a high grade. Figures that illustrate the flow of funds under the different arrangements will often work well.

Types of risk sharing arrangement include proportional risk sharing (the solidarity fund reimburses a fixed share of “acceptable” costs), outlier risk sharing (the solidarity fund reimburses costs above an annual threshold) and compensation for high risks (the solidarity fund reimburses costs for i.e the 5% most costly insured).

Risk adjustment measures are usually more sophisticated and includes reimbursements per cases. Examples from the Netherlands can be illustrative in this case and strengthen the essay.