

HGOV4100 – Fundamentals of Health Care Systems

Exam autumn 2021

Guidelines for assessment

1) *Reimbursement systems*

You and your colleagues are invited by the Minister of Health (MoH) of a middle-income country to help redesigning the country's hospital reimbursement system. The background for the initiative is strong expenditure growth following the reduction of hospital user charges. The MoH is also concerned with growing inequity in the allocation of hospital services across the countries 24 regions.

The reimbursement system of today has the following characteristics: 1) 'Per diem' based funding of actual costs. 2) The reimbursement goes directly from the central state to the hospitals. 3) The regional governments are responsible for investments in hospitals and are the owner of all public hospitals. The regional level plays no role in the financing of the hospitals' running costs.

At the first meeting with the MoH you are assumed to make a presentation of alternative reimbursement models. This presentation should make up the first part of your essay.

Alternative reimbursement models can be described by Jägers et al's 2x2-classification scheme: prospective vs retrospective models/activity based vs fixed payment models. To pass, a basic description of these dimensions and how they affect the risk allocation is necessary. A good grade was awarded if the candidate in addition discusses how different units of reimbursement (per diem, FFS, etc) works. Very good grades were awarded if the presentation also includes examples from around the globe.

In the second part of the essay, you should present two alternative reimbursement models and discuss how the two models are assumed to affect a) expenditure growth, b) allocation of services to different parts of the country, c) cost efficiency and d) waiting time to treatment. In the third part of the essay, you should indicate which of the two alternative models you will recommend for the MoH.

There is a wide specter of reimbursement models to choose from. Most students chose two of the following models for the discussion: A DRG-based models, a model based on a fixed budget (for example risk adjusted capitation) or a combination of these two. To pass, a precise description of the two models were necessary.

Good grades were awarded for answers including a systematic comparison between these two models and the current model in the country (the baseline). By systematic we mean that the effects of the different models on the evaluation criteria (expenditure growth, allocation of services to different parts of the country, cost efficiency and waiting time to treatment) were discussed one by one. Very good grades were awarded to those that also managed to discuss models that utilized the regional structure of the country.

A nice model suggested by a few of the candidates in part three of the answer, is to fund the regions by risk adjusted capitation, give the regions some tax description and then reimburse the hospitals by a combination of risk adjusted capitation and DRG-based financing.

2) Managed competition

The Netherlands implemented a radical reform in their social health insurance system in 2007. In the first part of the essay, describe the main changes of the system, including the risk allocation mechanisms that were applied to handle variation in risk of the insurance companies' enrollees.

Before 2006, the insurance part of the system consisted of a mixture of mandatory public insurance (app. 60% of the population) and voluntary private insurance. The main elements of the reform were the introduction of mandatory private insurance and annual consumer choice of both insurer and insurance contract, as well as the development of a comprehensive risk equalization mechanism to handle differences in the population between the insurance companies. To pass, a description of these elements were necessary.

Good and very good grades were awarded for further description of the details of the system, including for example the funding of children, details in the risk adjustment mechanism, the contracts between insurance companies and providers, a.s.o.

Following the reform, the Netherlands has experienced high expenditure growth and reduction in waiting times to elective treatment. How do you explain these effects?

There are many explanations: the aging of the population, more expensive drugs, a.s.o. A main mechanism do however seems to be the combination of competition among the insurance companies and a relative high income level among Dutch citizens. The effect has not been "a race to the bottom" as many feared but a gradual increase in health spending. A discussion of this mechanism and references to relevant literature has been awarded.

Let us assume that the Dutch politicians would like to curb future health expenditures. Can this be done without changing the main elements of today's system? If yes, how? If no, how would you change the system to achieve the objective of lower expenditure growth?

Most agreed that the problem could be solved within the current system. A systematic discussion of demand side (user charges, gate keeping, prevention, etc) and supply side (more competition in the insurance market, etc) strategies were awarded.