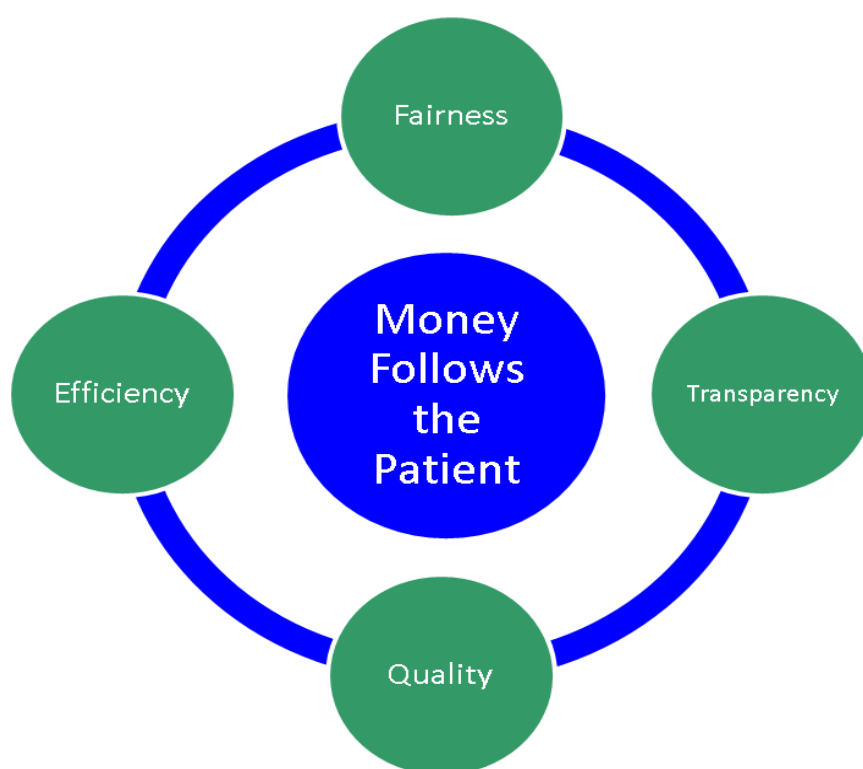


Money Follows the Patient

Policy Paper on Hospital Financing

Draft for Consultation



Tús Áite do
Shábháilteacht **1** Othar
Patient Safety **1** First

 **An Roinn Sláinte**
DEPARTMENT OF HEALTH

Money Follows the Patient

Policy Paper on Hospital Financing

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Executive Summary

Policy Context and Objectives

The Government is committed to the introduction of a new ‘Money Follows the Patient’ funding model which will:

- ✓ ensure a **fairer** system of resource allocation where hospitals are paid for the quality care they deliver,
- ✓ drive **efficiency** in the provision of high quality hospital services,
- ✓ increase **transparency** in the provision of hospital services, and
- ✓ ultimately, support the move to an **equitable**, single-tier universal health insurance system where every patient is insured and has their care financed on the same basis.

In order to help realise this commitment, draft policy proposals have been prepared on the introduction of a prospective case-based payment system (Diagnosis Related Group system) which will replace the current block grant allocation mechanism for public hospitals. These proposals represent an important first step in the process to transform the healthcare funding system so that it is truly patient-centred, value-focused and, thus, supportive of wider health sector objectives. The proposals focus on public treatment in public hospitals. However, they will be complemented by further policy development on a new charging regime for private patients in public hospitals. They will also be continually developed so that the funding system evolves to support integrated care across different settings, i.e. so that money can always *follow* the patient to the most appropriate care setting.

Defining the Service

The starting point of any new payment process is to define the services to be funded.

Having regard to the policy objectives outlined above, it is recommended that the ‘Money Follows the Patient’ system should be designed in accordance with the principles of equity and transparency (i.e. products should be defined such that one can compare ‘like with like’ and similar products will be funded similarly) and with the principles of efficiency and quality (i.e. the system should support the provision of quality care in the lowest complexity setting).

Therefore, the new payment system should ultimately apply to episodes of care provided in a **Medical Assessment Unit/ Acute Medical Assessment Unit/ Acute Medical Unit, Clinical Decision Unit, day ward or inpatient ward and all comparable episodes of care which are, or could be, delivered on a side-room or outpatient basis**¹. The counterpoint to this recommendation is that Emergency services (i.e. Emergency Department and Minor Injury

¹ It is acknowledged that certain coding and costing issues need to be addressed in order to fully deliver on this policy principle, and, in the first instance, the system will have to be limited to inpatient and daycase activity.

Units), outreach services and teaching and research costs should all be financed separately and outside of the ‘Money Follows the Patient’ system. In addition, outpatient services which are ancillary to a defined treatment or episode of care (e.g. initial consultation, assessment and follow up) should not be bundled into the main payment for reasons of complexity although this approach should be kept under review.

Furthermore, **services should be defined and priced by reference to complexity-adjusted episodes of care** and *not* by reference to setting. This is important if the system is to drive desired changes in the model of care delivery and means that, to the greatest extent possible, the same service should attract the same price whether it is delivered in a daycase ward or a side-room/ outpatient setting. Related to this, **prices should not differ depending on the category of hospital**. This approach is consistent with the immediate creation of Hospital Groups and is central to the longer-term policy intention of Hospital Trusts operating on a level playing field.

In terms of the classification system, episodes of care should be defined using the existing Hospital Inpatient Enquiry Scheme (HIPE) and the related AR-DRG grouper. The system should also be underpinned by quality guidelines in terms of defining *how* a service should be delivered (i.e. a ‘best practice’ approach).

Finally, in line with Government policy, it is proposed that mental health care should be treated in a similar manner to other acute episodes of care and funded on a ‘Money Follows the Patient’ basis. However, given the many challenges involved in transitioning towards case-based payments, it is suggested that ‘Money Follows the Patient’ begin with the existing AR-DRG system and transition towards the inclusion of acute mental health treatment.

Designing the Price

Having defined the services to be funded under ‘Money Follows the Patient’, it is then necessary to develop transparent policy principles to underpin the determination of prices.

In line with the ultimate goal of a value-based purchasing system, it is recommended that **prices should be based on best practice pathways**. When aligned with trading rules, this approach can provide a powerful tool for driving optimal quality of care. It is also fair, efficient and transparent in that prices are based on pre-agreed, published guidelines and hospitals are then appropriately reimbursed for providing services to that standard. As such, the approach is also consistent with the proposal to develop prices which are independent of setting and which support provision of care in the most appropriate setting. Moreover, the approach could also represent a logical starting point for the future development of integrated payment systems.

However, the major disadvantage associated with best practice pricing is the time required to achieve consensus on what constitutes ‘best practice’ and to develop robust guidelines. As

such, it is proposed that the **system should begin by setting prices by reference to average costs** but with a view to implementing best practice prices on an incremental basis.

Moving to the more technical question of a methodology for calculating prices, it is recommended that the **existing approach of indirect price-setting using relative weights should be maintained**. This is efficient and enables the relative resource consumption of different Diagnosis Related Groups (DRGs) to be compared. However, the approach will have to take account of the move towards best practice pricing.

The final issue to be addressed in designing prices is the treatment of different costs. Generally speaking, the price for an episode of care should encompass all costs appropriately associated with the delivery of that care. It is, therefore, recommended that the price should encompass:

- Pay Costs – Consultants, Non Consultant Hospital Doctors, Nursing, Paramedical, Administration, Support Services, Catering, Porters and Maintenance.
- Non Pay Costs – such as medicines, blood, medical & surgical supplies, radiology, laboratory equipment and supplies, heat, light & power etc.
- Costs of diagnostics, medical services, theatres, laboratories, wards and overhead allocations as appropriate.
- Costs of the clinical indemnity scheme as it relates to public hospitals (although a mechanism for including such costs may need to be developed over time).

In line with the recommendation that certain services should be funded separately to the ‘Money Follows the Patient’ system so as to support the objectives of fairness and transparency (‘comparing like with like’), **it is proposed that Emergency Department services, teaching costs and research costs should be excluded from DRG price calculations on the basis of a transparent, published methodology**. It is also recommended that certain other costs should be excluded from the calculation of the price in the initial years of the scheme, including **capital and depreciation, superannuation and bad debts**. However, it is suggested that these matters should be kept under review, particularly, in the context of moving to a single-tier UHI system involving both public and private providers.

Finally, in the interests of fairness and sustainability, it is recommended that the new system should encompass an **outlier payment mechanism** to take account of exceptional high cost cases. Outlier payments should be based on length of stay thresholds and should be linked to medical necessity, i.e. once a patient is deemed medically fit for discharge, no payment should apply for further time spent in an acute hospital setting.

Governance Structures

The ‘Money Follows the Patient’ system must operate within a clear and coherent regulatory framework. In advance of the introduction of universal health insurance, this requires an interim purchaser of care and a robust commissioning process as follows.

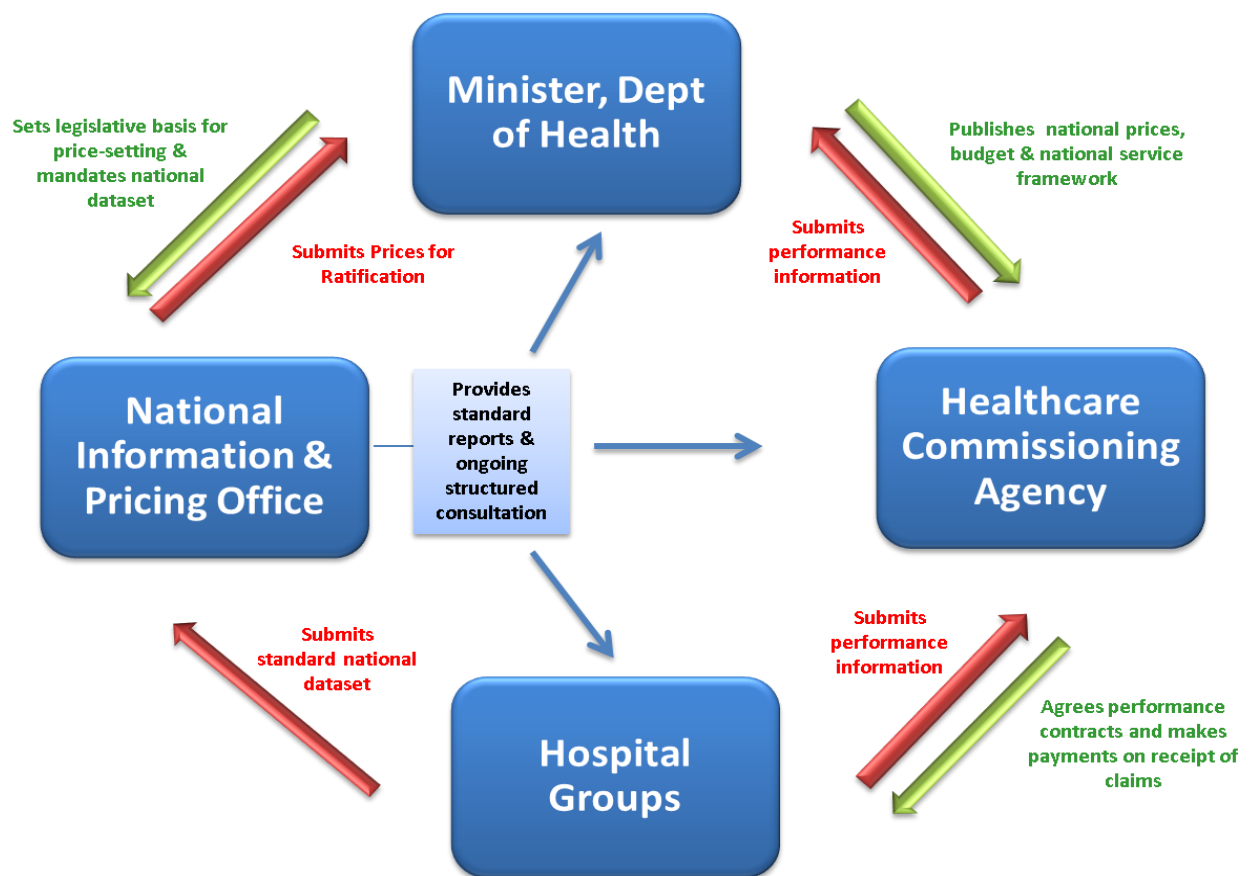
Firstly, in line with international evidence, it is recommended that **the price-setting function should be independent of the purchasing function**. It is, therefore, proposed that a new National Information and Pricing Office with multi-stakeholder oversight and strong clinical representation be established. This Office would set national DRG prices for the year ahead using activity and cost data.

A separate purchasing entity, the Healthcare Commissioning Agency, should be grown from within the HSE before being established as a new statutory agency. The Agency would use the national DRG pricelist, in addition to the global hospital budget and service targets handed down by the Minister, to conclude annual performance contracts with each public Hospital Group. These annual performance contracts would set out activity targets by quarter to be funded at national DRG prices. They would also include quality targets underpinned by financial sanctions. The Healthcare Commissioning Agency would then pay Hospital Groups the national DRG price on receipt of confirmation that pre-agreed activity had been delivered. In this way, hospitals would receive a fair and transparent price for the care they deliver and would be encouraged to provide quality care in the most efficient manner.

Where, as part of the global hospital budget, the Minister provides funding for additional targeted activity, this should have to be pre-approved by the Healthcare Commissioning Agency and could be paid at rates other than the national DRG price. Only hospitals which meet their activity in the previous quarter should be eligible to bid for this additional funding. In other words, if a hospital has a waiting list, then people could be taken off it and treated elsewhere but the funding would have to follow the patient.

The information submitted by Hospital Groups for the purposes of payment would be subject to audit and would also be used (i) to set national prices for the coming year and (ii) to inform structured consultation with all stakeholders on any proposed changes to the DRG system. In this way, the pricing system would be subject to continual modification so that it remains fair and fit for purpose. This closed governance loop is represented diagrammatically below.

The Governance Loop



Finally, it is important to emphasise that the introduction of ‘Money Follows the Patient’ represents a complete transformation of the current performance management process. Under this transformation, the national service plans and policy priorities set out by the Minister would be explicitly executed via detailed performance contracts with each Hospital Group. Purchasing would be established on a bedrock of quality and, as such, a co-ordinated and streamlined approach to the monitoring and management of *all* targets- quality, activity and cost- via the performance contracts would be central to success.

Implementation

In order to realise the policy vision set out above, a number of major building blocks must be put in place as summarised in the diagram below:

Major Building Blocks to support Delivery of ‘Money Follows the Patient’



In reviewing each of these building blocks, it is notable that the Irish health system already demonstrates a strong capability to set prices and to classify and report activity in respect of inpatient and daycase services. However, timeliness of coding must improve dramatically in order to support the safe and successful introduction of ‘Money Follows the Patient’ and the classification system will have to evolve to fully articulate policy intentions. In addition, significant capacity and infrastructure must be developed in relation to financial and claims management both at central and hospital level, and this will require intensive work throughout 2013.

The successful introduction of the new policy is also crucially contingent upon a number of other policy initiatives, in particular the development of Hospital Groups.

In acknowledgment of the time required to create new Hospital Groups and to develop the building blocks outlined above, it is proposed that **‘Money Follows the Patient’ would start in shadow form in 2013**. This would involve hospitals continuing to receive their existing base budget under a vote cashing system. However, a process would be put in place to compare, on a systematic and periodic basis, (i) actual hospital activity against pre-agreed baseline activity targets and (ii) hospital expenditure against pre-agreed DRG prices. In this way funding variances and potential impacts would be highlighted although no changes would be made to a hospital’s budget on foot of the exercise.

In order to ensure that the structural and financial reform agendas for the hospital sector are fully aligned, shadow funding should be rolled out in 2013 to the Hub hospital of each Hospital Group. By focusing on the Hub hospital, this approach allows Hospital Groups time to develop while still facilitating shared learning across the entire Group. It also enables the health system to leverage maximum efficiencies and economies of scale when investing in necessary resources, thereby reinforcing the optimally efficient service delivery model envisaged in the creation of Hospital Groups.

The system should then move from shadow funding to **full phased implementation of ‘Money Follows the Patient’ from 1 January 2014**, subject to fully developed Hospital Groups and central financial management systems being in place.

Next Steps

The introduction of ‘Money Follows the Patient’ represents a sea-change for the Irish hospital system. The new funding model integrates governance, performance management and financing into a fully integrated process that is centred on the patient and driven by communication of patient level information. Communication is at the heart of the system and so, not surprisingly, the next step in developing this policy will involve engagement with stakeholders throughout the health service in order to support consultation on the draft policy and preparation of detailed implementation plans.

Successful introduction of ‘Money Follows the Patient’ will be the responsibility of many of us at all levels in our health system. While the task ahead is significant, the reward will be a fairer funding system which better supports the health service to do its job in caring for our citizens.

1. Establishing the Vision

1.1 Policy Context and Objectives

The Government has set out a far-reaching policy vision for the Irish health service. It is a vision of a single-tier health service which promotes health and wellbeing, provides equal access based on need rather than ability to pay and delivers true value for Irish citizens. The ultimate realisation of this vision will be achieved through universal health insurance.

There are a number of critical stepping stones on the path to universal health insurance. One of these is the introduction of a ‘Money Follows the Patient’ payment system whereby each patient will be funded on an individual basis. This initiative is central to supporting the delivery of a single-tier system and, as such, is central to supporting the fundamental objective of fairness which lies at the heart of the health reform programme.

However, as well as contributing to the goal of a single-tier system, ‘Money Follows the Patient’ is an important policy initiative which will bring benefits in its own right. First and foremost, ‘Money Follows the Patient’ is about creating a fairer system where hospitals are actually paid for the care they deliver rather than receiving a historically determined block grant. Services will be funded on a transparent basis with payments based on individual episodes of care provided in accordance with clear quality standards. This approach is not only more equitable but should also benefit citizens by driving greater efficiency and value for money in the delivery of services.

‘Money Follows the Patient’ is not about reducing budgets but, rather, about fairly rewarding the work that is delivered in our public hospitals and facilitating clinicians and management to use resources in the most effective way. Similarly, ‘Money Follows the Patient’ is not simply about driving activity but, rather, about purchasing *value* in terms of appropriate care which supports good health outcomes.

The policy reasons, therefore, for introducing ‘Money Follows the Patient’ can be summarised as follows:

- ✓ To support the move to an **equitable** single-tier system where every patient is insured and has their care financed on the same basis
- ✓ To have a **fairer** system of resource allocation whereby hospitals are paid for the quality care they deliver
- ✓ To drive **efficiency** in the provision of high quality hospital services
- ✓ To increase **transparency** in the provision of hospital services

1.2 Key Policy Commitments and Layout of Policy Paper

In order to achieve the above objectives, the Government will begin by introducing a ‘Money Follows the Patient’ financing mechanism for public patients and a corresponding charging regime for private patients in public hospital care. An interim purchaser of care for public patients will be created. With the introduction of universal health insurance, this purchasing function will be taken over by the insurance system and all patients will be insured and have their care funded on the same basis.

Although ‘Money Follows the Patient’ will start in hospitals, it is vital that money *follows* the patient to the most appropriate care setting. Therefore, while this paper maps out a policy framework to guide the initial introduction of a new model of funding within hospital settings, it does so in the full acknowledgement of wider reform plans for the strengthening of primary care, the creation of an integrated system of primary and hospital care, and the need for a funding model which continually evolves to support integrated, patient-centred care.

The layout of the remainder of this paper is as follows:

Chapter 2 provides a situation analysis of our current hospital system. Policy proposals in relation to the design of the ‘Money Follows the Patient’ system are then set out in chapters 3 to 5. Chapter 3 begins by considering the scope of the scheme and the basis for defining and classifying services. Chapter 4 then looks at the construction of prices under the system in terms of their calculation and composition. Chapter 5 proposes the overall governance structure and processes for the system. In other words, these chapters collectively seek to provide answers to the questions (a) what service do we want to purchase, (b) how do we set a fair price for that service and (c) what terms should govern the contract between the purchaser and the provider of the service. In each case, the chapters focus fundamentally on the introduction of case-based funding for public patients while acknowledging the need to also introduce a consistent regime of case-based charges for private patients and the implications of different policy proposals in that regard. Having considered the design of the future system, chapter 6 then looks at how we might bring that system into being and briefly reviews different implementation issues. To conclude, chapter 7 briefly scans the horizon by setting out next steps and identifying significant issues to be addressed as part of future development of the system, particularly in the context of a transformative reform agenda and a changing health landscape.

Finally, it is worth highlighting that the introduction of ‘Money Follows the Patient’ will represent a sea-change for the Irish hospital system. By its nature, it will change the basis of relationships at all levels of the system with governance, performance management and financing bound up in a fully integrated process that is founded on exchange, engagement and examination of timely patient level information. Each conversation within this system will centre on the patient and their treatment. Supporting the system through this sea-change will be critical and this is recognised in the commitment to continual engagement with stakeholders and in the ongoing work to develop detailed implementation plans.

2. Understanding the Starting Point

2.1 Eligibility and Public/ Private Patient Mix

Under the Health Act 1970, everyone who is ordinarily resident² in Ireland qualifies for public hospital care. Notwithstanding this, 46% of the Irish population have private health insurance and many people opt to be treated privately.

The Irish hospital system contains a mix of public and private hospitals, with public hospitals treating both public and private patients. On admittance to a public hospital, patients make a choice to be treated on a public or private basis by their medical consultant. Where available, private patients are accommodated in a private bed in either a private room or a semi-private room within the public hospital.

In order to control the level of private activity in public hospitals and to help ensure equitable access for public patients, a system of bed designation is in operation. This system, implemented under the Health Services (In-Patient) Regulations 1991, designates approximately 20% of the total beds in acute public hospitals as “private”. The remainder of the beds are designated as “public” or “non-designated”. Non-designated beds are open to both public and private patients and are comprised of intensive care and other specialist beds.

The Health Services (In-Patient) Regulations 1991 set out a principle that private patients should in general be accommodated in private or semi-private beds, while public patients should in general be accommodated in public beds. However, the regulations also permit a patient, who is admitted as an emergency admission and has elected to be treated privately by a consultant, to be accommodated in a public bed if no private or semi-private bed is available or until such a bed is available. The regulations stipulate that private patients being admitted on an elective basis shall *not* be accommodated in a designated public bed. The level of private activity in public hospitals is further controlled by a clause in the contracts of consultants with private practice rights. This clause specifies a maximum proportion of an individual consultant’s workload that can be private. Finally, patients admitted by a Type A consultant are deemed to be public patients for the duration of their stay irrespective of the source of referral or any subsequent request to be treated privately or any transfer to a consultant entitled to engage in private practice.

Notwithstanding the above controls on private patient numbers, a significant proportion of private patients who are provided with treatment in public hospitals are accommodated in designated public beds³.

² The term ‘ordinarily resident’ is a legal term used in section 45 of the Health Act 1970 to define eligibility for services.

³ In his Annual Report of 2008, the Comptroller and Auditor General stated that in the hospitals he reviewed, 50% of privately treated inpatients were not charged for their maintenance. See section 2.4 for further information on future policy intentions in relation to charging of private patients in public hospitals.

2.2 Public Hospital System

Number and Categorisation of Hospitals

There are 48 public⁴ hospitals in Ireland. For the purposes of private hospital charges, these are grouped into three categories based on hospital status⁵ and level of treatment complexity. Category 1 is comprised of Health Service Executive (HSE) regional hospitals, voluntary and joint board teaching hospitals, Category 2 includes HSE county hospitals and voluntary non-teaching hospitals, and Category 3 is made up of HSE district hospitals. A *Value for Money and Policy Review on the Economic Cost and Charges associated with Private and Semi-private Treatment in Public Hospitals*, which was undertaken in 2010, reported clear dissatisfaction with this hospital categorisation system and recommended that it be reviewed.

Hospitals are grouped under a separate categorisation system for the purposes of the National Casemix Programme (see section 2.3). A list of the hospitals by category under each grouping system is set out in appendix A.

Services provided by Public Hospitals

Public hospitals provide a wide and diverse range of services as follows:

Table 1: Services Provided in Public Hospitals

Category	Services
Emergency	Emergency Department services Minor Injury Unit services
Inpatient (including Daycase)	Medical Assessment Unit/ AMAU/ AMU Clinical Decision Units Inpatient medical/ surgical Daycase medical/ surgical Daycase Dialysis Daycase Radiotherapy/ Chemotherapy ⁶ Rehabilitation Palliative care
Outpatient (non-emergency)	Consultation Diagnostics Dialysis Rapid Access Clinics Genetic testing
Long-term Residential Care	Long-term care
Outreach services	GP diagnostics and laboratory services Transportation services Neonatal screening services Other community focused services

⁴ 'Public' in this policy paper refers to HSE hospitals or voluntary hospitals which are publicly funded.

⁵ For example, whether the hospital is designated as a teaching hospital.

⁶ These services are captured as daycase services on the HIPE system.

In addition to these ‘direct’ services, public hospitals also engage in research and provide significant education and training for healthcare professionals. They also provide ‘commercial’ facilities such as shops, restaurants and car parks.

Finally, when considering the services provided by public hospitals, it is important to recognise the key role of ambulance services. The ambulance service is currently being reconfigured in line with best clinical practice. The number of control centres is being reduced to two nationwide (one in the East and one in Ballyshannon) on a phased basis. The new configuration will be supported by improved technology and will ensure a nationally co-ordinated system. The national service will also encompass the National Aeromedical Co-ordination Centre as recommended by HIQA.

Legal Basis for the Provision of Hospital Services

General Legal Framework

The HSE is mandated by the Irish Government under the Health Act 2004 to manage and deliver health and personal social services. In carrying out this function, the HSE must have regard to the policies and objectives of Government, to the resources available to it and to the need to secure the most beneficial, effective and efficient use of those resources⁷.

The HSE may also arrange for health and personal social services to be delivered on its behalf. The legal basis for any such arrangements is section 38 of the Health Act 2004. Where the HSE enters into an arrangement under section 38, it must firstly determine the maximum funding which will be made available and the services which must be delivered for that funding in respect of the HSE’s financial year. The relevant service provider must submit audited accounts to the HSE in addition to any other information which the HSE considers material to the provision of the service. Finally, it is worth noting that, where a service provider is acting on behalf of the HSE, the legal relationship in terms of the provision of services and the raising of charges is ultimately between the patient and the HSE.

Legal Framework Governing Hospital Services

Beyond the general duty to deliver health and personal social services, the HSE is also bound by specific legal requirements in relation to the provision of different types of hospital services. The legal framework as it relates to hospital services is set out below⁸.

Emergency Services: Emergency care services are provided by public hospitals under section 56 of the Health Act 1970. Current policy prohibits consultants from providing a private service in an Emergency Department of a public hospital and, therefore, all patients are

⁷ Section 7 of the Health Act 2004 refers.

⁸ Since 2009, “long-term residential care services” are defined separately to inpatient services and are provided under section 52(1A) of the Health Act 1970. Funding for long-term residential care services is provided via the Nursing Homes Support Scheme (individuals rather than facilities are funded under a ‘Money Follows the Patient’ type arrangement). Details of charges in relation to long-term residential care are set out at appendix B.

treated in an Emergency Department of a public hospital without any distinction between private or public patients.

Inpatient (including Daycase) Services: Inpatient and daycase services are provided by public hospitals to public patients under section 52 of the Health Act 1970. Everyone who is ordinarily resident in Ireland qualifies for services provided under section 52 unless they elect to be treated privately. Where this arises, public hospitals provide inpatient and daycase services for private patients under section 55 of the Health Act 1970.

Outpatient Services: Outpatient services are provided by public hospitals under section 56 of the Health Act 1970. Everyone who is ordinarily resident in Ireland qualifies for services provided under section 56. However, a person can elect to attend outpatient services as a private patient.

2.3 Funding and Charging of Public Patients

Funding of Services Provided to Public Patients

Public hospitals receive an annual block grant allocation from the HSE from which they fund the cost of treating public patients. These global budgets are determined on a historic basis with some adjustment for items such as inflation, public pay adjustments or new developments.

A large number of public hospitals⁹ participate in the National Casemix Programme. Under this programme, each hospital's budget for the following year is also adjusted using DRG-based activity and costs from the previous year¹⁰, i.e. the system is essentially retrospective. In 2011, this resulted in adjustments ranging between +/- 3% of participating hospitals' budgets. More detail on the National Casemix Programme is provided in subsequent chapters.

Finally, some public patient treatment is financed via the National Treatment Purchase Fund (NTPF). The NTPF is an independent statutory agency which was established by Government in 2004. Its central aim was to improve access for public patients by purchasing elective care for public patients on hospital waiting lists. In July 2011, the Minister for Health announced changes in the role of the NTPF to support the Special Delivery Unit (SDU). The NTPF continues to fund public patient treatment but is shifting its focus to target waiting lists more strategically and to incentivise hospitals to manage their lists proactively in the interests of patients.

⁹ In 2012, 38 hospitals participated in the National Casemix Programme.

¹⁰ Blend rates of 90% are currently used for inpatient and daycase.

Charges for Public Patients

Charges for public patient treatment are essentially defined by reference to care setting.

Emergency Services: A charge of €100 applies for attendance at an Emergency Department (ED) for an episode of care except where a person is referred by their GP, is subsequently admitted as an inpatient, is a medical card holder or qualifies under certain other exemption categories. The legal basis for the ED charge is set out in regulations made under section 56 of the Health Act 1970 (see appendix B for full details of the legal basis and a full list of exemptions from the ED charge).

Inpatient (including Daycase) Services: Public patients who are admitted as an inpatient or daycase patient are liable for a statutory charge of €75 per day capped at a maximum of €750 in any period of twelve consecutive months¹¹. Medical card holders, women in receipt of maternity services and certain other categories of patient are exempt from this statutory charge which is raised under section 53 of the Health Act 1970 (see appendix B for full details of the legal basis and a full list of exemptions from the charge).

Where public patients have their inpatient or daycase care in a public hospital purchased by the National Treatment Purchase Fund, they are not liable for the statutory inpatient charge.

Outpatient Services: There is no charge for outpatient services provided to public patients.

2.4 Funding and Charging of Private Patients

Charges for Private Patients

Inpatient (including Daycase) Services: Private inpatient and daycase treatment in publicly funded hospitals is financed via a system of ‘per diem’ (maintenance) charges. These charges are determined nationally by the Minister for Health and vary by hospital category and by private, semi-private and daycase status. The current ‘per diem’ charges are as follows:

Table 2: Charges for Private Inpatient Services in Public Hospitals

Hospital Category	Private	Semi Private	Day Care
HSE Regional Hospitals, Voluntary and Joint Board Teaching Hospitals	€1,046	€933	€753
HSE County Hospitals and Voluntary Non-teaching Hospitals	€819	€730	€586
HSE District Hospitals	€260	€222	€193

¹¹ These charges will rise, in line with Budget 2013 announcements, to €80 (max. of €800) during 2013.

In addition to the ‘per diem’ charges above, private inpatients are liable for a private daily charge (currently €75 per day up to a maximum of €750 in any consecutive 12 month period)¹². There are no exemptions from these charges.

Private patients are also liable for private fees charged by their consultant. These fees are a private contractual matter between the consultant and the patient.

The issue of private inpatient and daycase charges was examined in a 2010 *Value for Money and Policy Review of the Economic Cost and Charges Associated with Private and Semi-Private Treatment Services in Public Hospitals*. On foot of this review, private charges were significantly increased in 2011 and 2012. This increase was fully in keeping with the long-standing policy of moving towards recovering the full economic cost of providing treatment to private patients in public hospitals.

Outpatient Services: In the case of outpatient services, private patients are liable for the private consultant fee. Apart from the consultant’s fee, the only other charge payable by a private patient when attending the outpatient department of specific public hospitals is the charge for MRI scans.

Legal Basis for Private Charges

Inpatient (including Daycase) Services: Charges for the treatment of private patients in public hospitals are raised under section 55 of the Health Act 1970. A patient who chooses to receive services as a private patient forgoes his or her entitlement to be treated as a public patient and is, therefore, liable for charges under section 55.

‘Per diem’ (maintenance) charges are only raised where a private patient is in a designated private bed. As mentioned in section 2.1, bed designation regulations permit a patient admitted as an emergency admission to elect to be treated privately by a consultant and to be accommodated in a public bed if no private bed is available or until such a bed is available. No ‘per diem’ (maintenance) charge applies for such periods of accommodation in a public bed, or a non-designated bed, and so no private patient revenue accrues to the public hospital in these cases.

Outpatient Services: In the case of charges for MRI scans provided by certain public hospitals to private outpatients, this charge is payable under section 4 of the Health Services (Out-Patient) Regulations, 1993 (SI No. 178/1993) made under section 56(5) of the Health Act 1970.

Calculating Private ‘Per diem’ Charges

The level of the ‘per diem’ (maintenance) charge is set on an annual basis and is based on the cost of providing services.

¹² These charges will rise, in line with Budget 2013 announcements, to €80 (max. of €800) during 2013.

The cost is currently calculated using an average cost per bedday for each hospital category which is based on a weighted average cost for all hospitals in that category¹³. This information is sourced from the HSE Casemix system¹⁴. The cost per inpatient bedday contains all costs relating to the treatment of inpatients¹⁵ with the exclusion of the following:

- i. Consultants' pay cost per bedday;
- ii. Outpatient costs;
- iii. Superannuation;
- iv. Non Capital expenditure on Capital items;
- v. Bad Debts;
- vi. Retail outlets costs; and
- vii. Costs not related to a hospital's patients.

A number of adjustments are then made to the average cost with the aim of better reflecting the actual costs faced by hospitals. Firstly, costs relating to exceptional costs and unique issues which are excluded from traditional Casemix calculations are included in the average cost calculation. While it is logical to exclude these items to allow a 'like for like' comparison of hospitals' efficiency under Casemix, they are costs which must be met by the hospitals in delivering inpatient care and are, therefore, included for the purpose of identifying the average cost.

Due to the need to work from cost data derived from audited financial statements, the Casemix data underpinning the costing is two years in arrears, i.e. the calculation of the 2011 average cost utilised 2009 data. For this reason, costs must be inflated or deflated to reflect increases or decreases in costs over the period. The inflator/ deflator is broken down into pay and non-pay costs on a 70:30 basis. Pay inflation is derived from HSE hospital pay data (excluding superannuation and the consultant's contract payment). Non-pay inflation is measured using the sub-index of the Consumer Price Index Health Inflation measure which most closely relates to hospital costs.

Finally, while superannuation costs are initially stripped out, a superannuation charge of 13.1% of pensionable pay is subsequently added back into the costing. A capital depreciation charge and the costs associated with the Clinical Indemnity Scheme are also incorporated into the calculation.

¹³ The costs from each of the hospitals within a given category are weighted in accordance with the number of beddays in that hospital.

¹⁴ Costing data is not currently collected under Casemix for Category 3 hospitals.

¹⁵ This includes: (i) all pay costs such as medical (non-consultant hospital doctors), nursing, paramedical, administration, support services, catering and portering; (ii) all non-pay costs such as medicines, blood, medical & surgical supplies, radiology, laboratory supplies etc.; and (iii) costs of diagnostics, medical services, theatres, laboratories, wards and overhead allocations as appropriate. (*"Casemix Presentation to VFM Review National Steering Group"* cited in the Value for Money and Policy Review of the Economic Cost and Charges associated with Private and Semi-private Treatment in Public Hospitals)

The average cost per bedday for each category then informs the charges to apply for private and semi-private care. The charges are set at a level that ensures full recovery of the cost as calculated, while maintaining a 10% differential between private and semi-private charges.

Day-case charges are adjusted in line with inpatient charges, i.e. they are increased by the same percentage as inpatient charges.

Policy on Private Hospital Charges

As mentioned in section 2.1, a significant proportion of private patients who are provided with treatment by a public hospital are not currently charged for these services because of bed designation regulations. In contrast, the public hospitals' consultants receive private fees even where the hospital cannot collect its charge. This represents a loss of income to the public hospital system and a significant subsidy to private insurance companies. As part of Budget 2013, it was announced that legislation would be brought forward to enable the charging of all private patients in public hospitals. This new measure will require primary legislation which is scheduled to be in operation by Summer 2013. This approach is entirely consistent with the move towards 'Money Follows the Patient'.

2.5 Other Hospital Charges

Charges in respect of Road Traffic Accidents

Section 2(1) of the Health (Amendment) Act 1986 allows the HSE to recover the full economic cost of hospital services from a person who received or is entitled to receive damages or compensation arising from a road traffic accident. The Act does not withdraw eligibility for public hospital services from road traffic accident victims, but allows the HSE to recover the costs of hospital services provided at the full economic cost. This relieves the Exchequer and taxpayer of costs that are legitimately proper to the insurance sector.

The economic cost is calculated on the basis of an Annual Daily Charge (ADC) which is arrived at by dividing a hospital's total expenditure by the number of bed days for a calendar year. ADC was the subject of legal proceedings (the 'Crilly case') over a number of years, culminating in the Supreme Court ruling in July 2001 which found that ADC is reasonable, proper and intra vires the Health (Amendment) Act, 1986.

Other Charges

Details of charges relating to delayed discharge and long-term care are set out in appendix B.

2.6 Private Hospital System in Ireland

As mentioned in section 2.1, the Irish hospital system contains a mix of public and private hospitals. There are currently 21 private hospitals affiliated with the Independent Hospital

Association of Ireland and involved in the provision of acute care. They collectively provide over 1 in 6 acute beds to the Irish healthcare system and employ circa. 8,000 people in a range of positions¹⁶. As well as providing diagnostic services, private hospitals treated over 200,000 day and inpatient discharges, typically on an elective basis, in 2009; this amounted to nearly 13% of total discharges from public and private hospitals combined¹⁷.

2.7 Policy on Hospital Structures

Creation of Hospital Groups

The Programme for Government commits to the transformation of public hospitals into independent, not-for-profit trusts. As a first stage in this process, the Minister for Health intends to put in place Hospital Groups on an administrative basis in early 2013. This will involve organising every public acute hospital in Ireland into a set of Hospital Groups under a single consolidated management structure. Each group will have a clearly defined budget and employment ceiling, along with arrangements for the deployment of staff across the group.

The creation of Hospital Groups will take account of the key principles and criteria set out in the forthcoming Framework for Smaller Hospitals.

Finally, while Hospital Groups will be a precursor to Hospital Trusts, the groupings and their governance arrangements will be reviewed prior to the establishment of Hospital Trusts to ensure an appropriate environment for the introduction of universal health insurance.

Academic Medical Centres

An issue for consideration in the context of creating Hospital Groups is the emergence of several academic medical centres in Ireland.

An Academic Medical Centre (AMC) is a partnership between one or more medical schools or universities and one or more hospitals, with a triple focus on clinical services, research and education. The British Medical Association describes the benefits that it can bring as:-

- questioning and critical appraisal of established knowledge;
- new ideas, evidence and products, which bring about improved patient care and reductions in the cost of healthcare;
- direct benefits to patients treated; and
- an active contribution to a culture of high quality clinical services.

Within Ireland, a number of ventures, at different stages of development, are currently underway, as follows:

¹⁶IHAI website (accessed 9th November, 2012)

¹⁷*Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector (Volume 1)* (ESRI, 2010).

Dublin Academic Medical Centre: The Dublin Academic Medical Centre (DAMC), which incorporates the Mater Misericordiae University Hospital, St. Vincent's Healthcare Group, and the UCD School of Medicine & Medical Science, was established in July 2007 with a tripartite memorandum. Its immediate goal was to integrate research and education activities across the three institutions and create joint clinical departments.

Beaumont/Connolly/ RCSI AMC: This partnership incorporates Beaumont Hospital, Connolly Hospital and the Royal College of Surgeons of Ireland (RCSI).

Trinity Health (Ireland) AMC: Trinity Health (Ireland) includes Trinity College Dublin, St James's Hospital and the Adelaide and Meath Hospital Dublin Incorporating the National Children's Hospital at Tallaght.

Cork/Kerry AMC: Discussions are currently taking place regarding collaboration between the public hospitals in Cork and Kerry and University College Cork.

2.8 Moving towards a DRG-based System

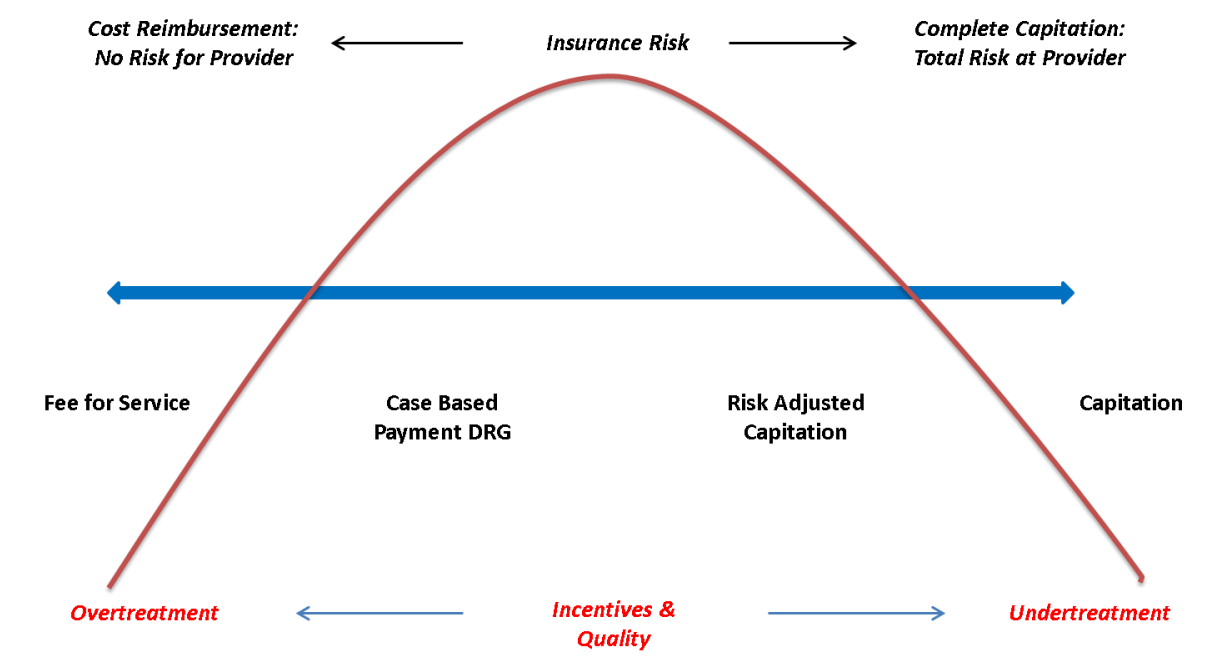
Programme for Government

The Programme for Government commits to the introduction of a 'Money Follows the Patient' payment system for hospital care. There are a number of options for fulfilling this commitment, ranging from a daily patient rate ('per diem' charging) to procedure-based pricing ('fee for service') to prospective case-based payment ('DRG-based' funding system). In considering these options, international evidence shows a strong convergence towards DRG-based hospital payment systems. The rationale for such a trend relates to the relative advantages of such systems. DRG-based systems provide a greater incentive for efficiency: they overcome the longer lengths of stay associated with both global budgets and daily rates, while simultaneously mitigating the tendency for supplier-induced demand associated with 'fee for service'. This is not to suggest that DRG-based systems are a panacea but, rather, that they are increasingly seen as the best possible financing solution for the purposes of achieving the following multiple objectives:

- ✓ To have a **fairer** system of resource allocation whereby hospitals are paid for the care they deliver ('equal pay for equal work')
- ✓ To drive **efficiency** in the provision of hospital services
- ✓ To increase **transparency** in the provision of hospital services

Moreover, if designed correctly, DRG-based systems can address potential quality issues associated with under provision or over provision of care¹⁸ (see figure 1 below).

Figure 1: Impacts of different Reimbursement Methods



Source: Adapted from Presentation, *Implementation and development of G-DRG in Germany* by Dr. Frank Heimig, CEO InEK GmbH, in Dublin, 27th / 28th of January, 2010

Finally, from the perspective of the Irish health system, a DRG-based model is also consistent with the objective to move to an **equitable** single-tier system where every patient is insured and has their care financed on the same basis.

Previous Analysis of Hospital Financing Systems

In recent years, the issue of hospital financing has been the subject of two major Departmental reports.

The Expert Group on Resource Allocation and Financing reported in 2010 and recommended that prospective based funding be introduced in all relevant areas of the public health and social care system on a phased basis, beginning in the acute hospital sector. In the case of public acute hospital care, a prospective, casemix-adjusted activity based system was recommended.

The Value for Money and Policy Review of the Economic Cost and Charges associated with Private and Semi-Private Treatment in Public Hospitals was also published in 2010. It

¹⁸As noted in *Diagnosis-Related Groups in Europe. Moving towards transparency, efficiency and quality in hospitals* (WHO, 2011), 'fee for service' can lead to the provision of unnecessary services or to oversupply of inappropriate services which negatively affects both patient outcomes and efficient service delivery.

similarly recommended that the existing ‘per diem’ charging regime for private activity in public hospitals be replaced by a case-based charge using DRGs.

Taking account of international evidence and of the detailed analysis already undertaken in the context of both of the above reports, the Implementation Group on Universal Health Insurance advised that the Programme for Government commitment on ‘Money Follows the Patient’ should be realised through the introduction of a prospective DRG case-based payment system. Accordingly, the Hospital Financing Group, which was established to drive work on ‘Money Follows the Patient’, was asked to prepare policy proposals on this basis.

Finally, the Implementation Group has also recommended that the initial focus should be on designing a ‘Money Follows the Patient’ system for hospital care. Thereafter, the Hospital Financing Group should quickly move to consider further development of the payment system to better support integrated care across settings (e.g. bundled payments). The remaining chapters of this policy paper proceed on the basis of the Implementation Group’s recommendations and focus on public treatment in public hospitals.

3. Defining the Service

3.1 Introduction

The first step in developing policy proposals for a DRG-based payment system is to define the services or products which should be funded under that system. Having regard to the advice of the UHI Implementation Group, this will, in the first instance, be limited to hospital services.

In purchasing hospital services, the State wishes to support the **best health outcomes in the most efficient manner**. It is also concerned with accountability; public funds must be allocated in a fair and transparent manner and must deliver value for money. These concepts of efficiency, equity and transparency are reflected in the policy objectives outlined in chapter 1. The policy objectives also underscore the ultimate goal of a single-tier health system where all patients are funded on the same basis.

This chapter proposes high level policy principles in relation to defining the services to be funded under a 'Money Follows the Patient' system, with particular regard to the principles of **equity, transparency and efficiency**. It also considers the classification and grouping system which will form the common language for defining services.

3.2 Equity and Transparency- Comparing 'like with like'

Range of Services

Beginning with the concept of equity, it is important to consider the range of services currently provided within acute hospital settings and to ensure that our product definitions enable the comparison of 'like with like'. In chapter 2, we broadly identified hospital services as comprising:

- **Emergency** (Emergency Department and Minor Injury Unit);
- **Inpatient and Daycase** (MAU/ AMAU/ AMU, Clinical Decision Units, Inpatient medical/surgical, Daycase medical/ surgical, Daycase Dialysis, Daycase Radiotherapy/ Chemotherapy, Rehabilitation, Palliative care);
- **Outpatient** (Consultation, Diagnostics, Dialysis, Rapid Access Clinics, Genetic testing);
- **Long-term Residential Care**;
- **Outreach** (GP diagnostics and laboratory services, Transportation services, Neonatal screening services, Other); and
- **Teaching and research**

Emergency Services: In reviewing the above list, it is apparent that emergency services are a distinct set of products involving a rapid response to sudden illness or trauma (i.e. the focus is on rapid evaluation and initial treatment of sudden illness). As such, these products differ fundamentally from inpatient and daycase services. This is recognised in the Programme for Government which acknowledges the need for hospitals to “compete on an equal footing” and for hospitals with Emergency Departments to be compensated for the associated cost of that service. This suggests that Emergency Department costs should certainly be funded separately or ‘unbundled’ from inpatient and daycase services.

Furthermore, emergency services are, by their nature, something which must be maintained at a certain level regardless of actual demand, i.e. we need them to be there but hope we don’t need them. Recognising this ‘public good’ characteristic, it is questionable whether Emergency Department costs should be funded under a ‘Money Follows the Patient’ system, although this is something which could be usefully kept under review¹⁹.

Inpatient and Daycase Services: By contrast, many inpatient and daycase services are, to a significant extent, interchangeable products. This is evident, not only from the fact that inpatient and daycase services share the same legal basis, but also from the ongoing performance management focus on increasing the proportion of certain specified procedures which are provided on a daycase basis. Furthermore, looking beyond the existing public hospital sector, it is notable that, as clinical practice develops, certain procedures are migrating from daycase to sideroom settings²⁰. This underscores the importance of considering these products collectively when designing a ‘Money Follows the Patient’ system. However, it simultaneously highlights one of the most problematic aspects of defining hospital products, namely how to distinguish between daycase or sideroom services on the one hand and outpatient services on the other hand (see below).

This issue is potentially further complicated when one considers the emergence of new service models such as Medical Assessment Units and Clinical Decision Units. These units have been confirmed as providing inpatient services which are separate and distinct from Emergency Department services²¹ and have been approved for coding as such. However, patients may be referred to such units from Emergency Departments, Outpatient Departments or directly from their GP with the result that some of the services provided in MAUs could be interchangeable with outpatient or daycase services in terms of the treatment delivered (this is notwithstanding the fact that only elective work is classified as daycase while same day services in MAUs are non-elective). Thus, while there are currently some coding and costing²² issues associated with MAUs, it would appear that MAU services should be

¹⁹ It is acknowledged that this would represent a departure from current speciality costing under Casemix whereby a proportion of ED costs are included within the budget model for inpatient services.

²⁰ Side room settings are generally understood as treatment rooms within an outpatient setting.

²¹ While the units are classified as inpatient services where inpatient treatment is provided, they may be under the care of Emergency specialists.

²² It would appear that costing issues should be addressed by the move to patient level costing.

considered collectively with other inpatient and daycase services when designing a ‘Money Follows the Patient’ system.

Outpatient Services: Moving from inpatient care to outpatient care, two fundamental issues stand to be considered, namely (1) how to define outpatient services or products and (2) whether these should be captured separately to inpatient care. Currently, a broad range of services is captured under the loose term ‘outpatient services’. These break down into two fundamental types of services:-

- services which comprise a consultation or diagnostic test or some other form of *assessment* to establish whether an intervention or other response is required/ has been successful and,
- services which represent a *response* to a particular diagnosis or assessment.

If we accept that the latter services could be interchangeable with some current services either provided in MAUs or provided on a daycase or sideroom basis, then we should again consider these collectively with inpatient etc. services.

By contrast, where the services comprise an assessment to establish whether some form of treatment is required, then the services could be either defined and financed separately or bundled in with the main episode of care. To this end, international experience suggests that a bundled approach would add significant complexity and could cause the system to become administratively unmanageable if it resulted in a vast proliferation of DRGs. Immediate practical considerations are also relevant: HIPE currently captures the episode of care from the point of admission to the point of discharge and, in the absence of a unique identifier; linking related episodes of care could be problematic. Also, the outpatient Treatment Related Group (TRG) model is not as advanced as the inpatient DRG model. It is, therefore, proposed that outpatient ‘assessment’ services should be financed separately from the main episode of care, although again this is a matter which could be kept under review. Indeed, the funding of outpatient services is something which will have to be given careful consideration as ‘Money Follows the Patient’ policy evolves.

Long-term Care: As previously mentioned, since 2009, “long-term residential care services” are defined separately to inpatient services and are provided under section 52(1A) of the Health Act 1970. Funding for long-term residential care services is provided via the Nursing Homes Support Scheme (individuals rather than facilities are funded under a ‘Money Follows the Patient’ type arrangement). As such, these services would certainly fall outside the scope of any proposed ‘Money Follows the Patient’ system for hospital care.

Outreach Services: These services are essentially community-focused. It is, therefore, suggested that they should fall outside the scope of the initial ‘Money Follows the Patient’ funding system in line with the direction that the policy should focus firstly on hospital care.

Teaching Services: These services are distinct from the actual provision of episodic care to a patient. This is again recognised in the Programme for Government when it states that

hospitals must compete on an equal footing and that teaching hospitals should be compensated for training healthcare professionals. This suggests that teaching/ training costs should be funded separately and outside of the core ‘Money Follows the Patient’ payment.

Research costs: As a general principle, it is suggested that research activity is separate to the provision of direct patient care and should be funded separately. However, this is an issue which stands to be explored in-depth when considering how to capture and support innovation and new technology within any new financing model, and this is discussed further in chapter 5.

In conclusion, if we wish to treat similar products in a similar way, then **the ‘Money Follows the Patient’ payment system must encompass inpatient, daycase and certain comparable outpatient services.** These products all concern the provision of episodic care to an individual patient and are highly interchangeable in nature, particularly as clinical practice continually evolves. By contrast, emergency services constitute a distinct product which provides an unplanned rapid response service for the general population. As such, it is proposed that Emergency Department services are excluded from the ‘Money Follows the Patient’ system in the first instance although this is something which should be kept under review²³. Long-term residential care and outreach services are also distinct services which are generally community-focused and, in the case of long-term residential care, underpinned by a separate legal and financial structure. It is, therefore, proposed that long-term residential care and outreach services are excluded from the ‘Money Follows the Patient’ payment system. Finally, it is noted that teaching and research costs are separate to the direct provision of patient care and should, therefore, also be funded outside of the ‘Money Follows the Patient’ system.

Range of Hospitals

When calculating public casemix budgets and private patient charges, hospitals are grouped into distinct categories in order to better compare ‘like with like’.

As already noted in chapter 2, there is considerable dissatisfaction with the current hospital categorisation system for private patient charges.

Under the National Casemix Programme, hospitals are arranged into four groups- ‘Teaching’ (8), ‘Non Teaching’ (26), ‘Maternity’ (3) and ‘Paediatrics’ (2). This system was introduced to enable comparison of similar hospitals and, in particular, to ensure that hospitals which had significant teaching costs were not disadvantaged by being compared to non-teaching hospitals²⁴. However, if unique costs (e.g. Emergency Department) and indirect costs (e.g. teaching) are being financed separately to the core ‘Money Follows the Patient’ payment system and services are being costed on a strict ‘patient level costing’ basis, then the justification for categorisation of hospitals appears to fall away.

²³In making this recommendation, it is also noted that current coding systems do not yet capture emergency department treatment.

²⁴ National Casemix User Manual, 2011

The argument against categorisation is further reinforced when one considers the plans to move towards Hospital Groups with a single consolidated management team and a single clearly defined budget and employment ceiling. This fundamental reorganisation of the hospital system suggests that the same, standard DRG-based price and product list could and should be used to negotiate contracts with each Hospital Group, with the onus then falling on the Group to deploy resources so as to deliver those services in the most efficient manner. In this way, the ‘Money Follows the Patient’ system can complement and support the important work of the national clinical programmes and the creation of Hospital Groups, thereby reinforcing the drive towards performance improvement and quality care.

In conclusion, given the short-term intention to create Hospital Groups and the longer-term policy of a single-tier system, **it is proposed that we move away from the current hospital categorisation systems.** National pricelists should define services by DRG alone and not by reference to hospital category. That said, where robust evidence indicates significant structural differences, it seems reasonable that the cost implications of these differences can be captured through transparent cost weights or top-up payments. For example, across Hospital Groups, the provision of paediatric services may perhaps warrant the application of higher cost weights. Similarly, a Group with a significant remote or disadvantaged population may justifiably require a top-up payment to take account of this.

3.3 Efficiency and Quality- Encouraging Care in the Right Setting

As demonstrated in section 3.2, equity considerations demand that we collectively consider inpatient, daycase, sideroom and certain comparable outpatient (‘treatment-focused’) services when designing a ‘Money Follows the Patient’ payment system. This is also extremely important from an efficiency perspective.

Firstly, a failure to comprehend these services collectively and treat ‘like with like’ could give rise to significant gaming and cost shifting. If similar services are funded on a ‘per patient’ basis in one setting (e.g. daycase ward or MAU) and by a block grant in another setting (e.g. rapid access clinic in an outpatient department), then incentives will naturally be skewed away from the block grant funded setting. This would run counter to all policy intentions and undermine the critical work of the clinical programmes and the SDU.

Moreover, if we are to establish a model that truly aspires to fulfil the policy criteria, one that supports continuous innovation and encourages quality care in the lowest complexity setting, then our system design must also involve defining services, to the greatest extent possible, by reference to episodes of care and not by reference to setting. Thinking must not remain anchored in funding facilities or settings but must shift to a concept of funding patient *needs* (i.e. complexity-adjusted episodes of care). In other words, in defining products to be funded

under ‘Money Follows the Patient’ any differentiation by reference to setting should be justified from a genuine cost perspective and should be subject to ongoing review.

Finally, in the case of private patients, a shift away from a ‘setting-defined’ service and price could dissipate some of the disputes which currently cause insurers to pend claims (e.g. disputes over what constitutes a daycase or whether a person should have been treated as an inpatient for a particular illness), in addition to encouraging efficiency in care provision.

It is accepted that the development of a DRG-based pricing system which is independent of setting may not be fully achievable in the initial phase of ‘Money Follows the Patient’. In particular, it is noted that the outpatient TRG model has only recently been rolled out to all hospitals and that blend rates stand at 10% for these services. However, daycase A-DRGs are essentially derived from the AR-DRG with the patient firstly assigned to an AR-DRG and the first three digits then being used to determine the A-DRG. As such, there may be scope to consider the relationships between these two models in terms of early movement towards a single price system independent of setting.

In conclusion, **it is proposed that services should be defined by reference to the episode of care provided and not by reference to care setting to the greatest extent possible.** This approach is central to overcoming gaming and creating an inbuilt drive towards efficiency within the system. In practical terms, this might involve beginning with the existing DRG system for inpatient and daycase care but reviewing this to establish where potential exists for establishing a single efficient price for particular episodes of care regardless of whether they are coded as being delivered on an inpatient or daycase basis. Simultaneously, work could be undertaken to establish a list of ‘same day’ episodes of care which should be coded regardless of whether they are delivered on an outpatient or inpatient basis (i.e. in an outpatient, MAU or daycase setting). Patient level costing should then enable an efficient, best practice price to be established for these episodes with a view to ultimately incorporating these episodes within the ‘Money Follows the Patient’ payment system regardless of care setting. Thereafter, the continual refinement of the system by reference to the principle of costing based on best practice should ensure that inefficiencies deriving from an inappropriate care setting are systematically washed out²⁵.

Clinical Guidelines and Healthcare Standards

In addition to encouraging care at the lowest appropriate level of complexity, any ‘Money Follows the Patient’ system should be embedded within a quality framework. Ultimately, this should require purchasing functions to be legally circumscribed by indemnity requirements and by quality standards (i.e. a purchaser may not contract with a healthcare

²⁵ For example, if overheads are being apportioned to an episode of care in a daycase setting purely *because* a treatment is being provided in that setting and not because the overheads are appropriate and necessary to the type of treatment being provided, then this apparent cost differential will always remain in the system if prices are set by simple reference to care setting and average costs. Therefore, an examination of the model of best practice care and the costs which accrue to that model is central to ensuring a fairer and more efficient price-setting process.

provider if they are not indemnified, licensed and compliant with any necessary standards or conditions associated with that licence).

The National Clinical Effectiveness Committee (NCEC) is the body which provides a framework for national endorsement of clinical guidelines and audit to optimise patient care. It plans to develop a national suite of clinical guidelines which will provide explicit and transparent guidance for the delivery of safe, high quality and cost-effective care. These guidelines will supersede all previous guidelines on a topic and will be utilised across the public and private healthcare system.

The national suite of clinical guidelines will provide a means of identifying the most effective interventions and/or services for a given condition. As such, **it is proposed that these guidelines should underpin the DRG payment system in terms of defining *how* a particular service should be delivered (i.e. a ‘best practice’ approach) and the corresponding costs associated with that best practice approach.**

3.4 Classification and Grouping System

So far we have considered how to define hospital services within the ‘Money Follows the Patient’ payment system in terms of the broad principles of equity, transparency, efficiency and quality. However, beyond this, it is necessary to have a robust classification and grouping system which can meaningfully and consistently describe episodes of care. The public acute hospital system already collects, codes and reports demographic, clinical and administrative data on discharges and deaths through the HIPE National Database. The classification or coding system used is ICD-10-AM / ACHI / ACS.

Classification System

ICD-10-AM is the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification. The ICD-10-AM disease component is based on the World Health Organisation (WHO) ICD-10. ICD-10-AM is used in conjunction with the Australian Classification of Health Interventions (ACHI), and the Australian Coding Standards (ACS) to reflect an accurate health episode of care. This classification has been in use since 1st January 2005 and was selected by the ESRI at the time as the best integrated coding scheme for diagnoses and procedures available internationally.

ICD-10 is currently the most advanced international classification system and the ICD-10-AM system is updated every two years so that it keeps pace with advances in clinical practice²⁶. Therefore, it is appropriate that **the HIPE system would be maintained as the standard classification and coding system on which future universal prospective**

²⁶ While the ICD-10-AM is updated every two years in Australia, Ireland only adopts every second edition (i.e. it chooses to update every four years).

payment systems would be built²⁷. However, it should be noted that this will represent a departure for private health insurers and, ultimately, private hospitals²⁸.

Grouping System

Ireland currently uses the Australian AR-DRG grouper which groups each hospital's inpatient and daycase workload into 698 DRGs.

A EuroDRG project, involving analysis of DRG systems in 11 countries including Ireland, was published in 2011 and concluded that there is no 'one size fits all' or optimal DRG system. These findings, coupled with the intention that 'Money Follows the Patient' should be introduced as quickly as possible, suggests that the existing AR-DRG grouper should form the starting point for the Irish 'Money Follows the Patient' system. However, it should be immediately reviewed from the perspective of the policy outlined at section 3.3 above, namely that services should be defined without reference to setting to the greatest extent possible. Thereafter, it should be subject to ongoing review through a structured consultation process with clinicians and others. This process would involve providing stakeholders with a platform to suggest periodic changes to the DRG system. Any such changes would have to be justified from not only a clinical but also from a cost perspective (i.e. if suggesting the separation of an existing DRG into multiple DRGs, there would have to be a significant cost differential between the proposed new DRGs). This approach should allow a 'living' evolving DRG system which meets the requirements of the Irish health system and which is continually stress-tested against the fundamental principle of fairness.

3.5 Boundary Issues

For reasons already outlined, it is proposed that the episode of care under 'Money Follows the Patient' should begin at the point of admission and end when the patient is deemed medically fit for discharge. However, boundary issues may be expected to be contentious and to require very careful consideration. In particular, the boundary between acute care and step-down or long-term care is already something which can give rise to delayed discharges from acute hospital settings. It will be important, therefore, to ensure that 'Money Follows the Patient' is continually developed as part of a coherent overall funding system where incentives are aligned so as to support rather than impede the transition of the patient to the most appropriate care setting.

²⁷ This statement does not imply that we could never move away from ICD-10-AM and adopt a different modification if considered necessary. However, it does imply that we would continue to use a dataset based on the most up to date classification system and encompassing the comprehensive range of data currently collected under HIPE. Indeed, ICD-11 is currently under development by the WHO.

²⁸ Private health insurers have their own legacy coding system and also use ICD-9.

3.6 Mental Health

The Programme for Government lays a strong emphasis on mental health. In particular, it talks about (i) being able to access mental health services in primary care settings, (ii) including a range of mental health services in the standard insurance package under Universal Health Insurance and (iii) reducing the stigma of mental health.

In line with this policy, it is proposed that mental health care should be treated in a similar way to other acute episodes of care and funded on a ‘Money Follows the Patient’ basis. However, international evidence indicates that this is not easy to achieve. In other countries, various difficulties associated with data and classification limitations have meant that the mental health sector has lagged behind the rest of the health sector in relation to the introducing case-based payments with many systems still relying on historical block grant funding. Given the many challenges involved in transitioning towards case-based payments, **it is suggested that ‘Money Follows the Patient’ begin with the existing AR-DRG system and transition towards the inclusion of acute mental health treatment.**

3.7 Conclusion

In summary, it is proposed that the following core policy principles should underpin the scope and definition of services under the ‘Money Follows the Patient’ payment system:

- The ‘Money Follows the Patient’ system should be designed in accordance with the principles of equity and transparency (i.e. defining products such that one can compare ‘like with like’ and similar products will be funded similarly) and with the principles of efficiency and quality (i.e. the system should support the provision of quality care in the lowest complexity setting).
- The ‘Money Follows the Patient’ system should ultimately apply to episodes of care provided in a MAU/ AMAU/ AMU, Clinical Decision Unit, day ward or inpatient ward and all comparable episodes of care which are, or could be, delivered on a side-room or outpatient basis. It is acknowledged that certain coding and costing issues need to be addressed in order to fully deliver on this policy principle.
- To the greatest extent possible, services should be defined and priced by reference to complexity-adjusted episodes of care and not by reference to setting.
- Consistent with the above point, services should not be defined and priced by reference to hospital categorisation.
- The episode of care under ‘Money Follows the Patient’ should begin at the point of admission and end when the patient is deemed medically fit for discharge²⁹.

²⁹ In the case of services provided on a side-room or outpatient basis, the concept of ‘point of admission’ will need to be agreed. The episode should commence with the decision to provide the person with the necessary treatment and the corresponding registration of that treatment.

- Services which should be financed separately and outside of the ‘Money Follows the Patient’ system include Emergency services (i.e. Emergency Department and Minor Injury Units), outreach services and teaching and research³⁰ costs. Long-term residential care will also be funded separately under the Nursing Homes Support Scheme.
- Outpatient services which are ancillary to a defined treatment or episode of care (e.g. initial consultation, assessment and follow up) should not be bundled into the main payment for reasons of complexity although this approach might usefully be kept under review.
- Related to the above point, the overall system must remain administratively feasible.
- Overall health funding policy should take account of boundary issues, in particular the interface between acute and step-down care, and should support timely transition from acute to step-down settings.
- Given the many challenges involved in transitioning towards case-based payments, it is suggested that ‘Money Follows the Patient’ begin with the existing AR-DRG system and transition towards the inclusion of acute mental health treatment.

³⁰ As a general rule, research costs should be met from outside the ‘Money Follows the Patient’ system in order to support transparency and comparability of service and prices. However, as noted in section 3.2, this issue will be explored more fully in later chapters.

4. Designing the Price

4.1 Introduction

The previous chapter set out the core policy principles for defining the services to be funded under a 'Money Follows the Patient' system. It proposed that the new funding system should ultimately apply to episodes of care provided in a MAU/AMAU/AMU, Clinical Decision Unit, Day ward, Inpatient ward and all comparable episodes of care which are, or could be, delivered on a side room or outpatient basis. It stressed the importance of moving away from payments based on setting both from an equity *and* an efficiency perspective. As such, it recommended that, any differentiation by reference to care setting should be justified from a cost perspective and should be subject to ongoing review. This principle forms an important starting point in terms of designing price.

This chapter considers the design principles which should underpin the determination of prices. It offers recommendations on the basis for setting price, the overarching methodology for calculating price and the treatment of various costs when calculating price.

4.2 Setting the Price - On What Basis?

Three broad policy options exist for setting price. These are:

- A) Prices based on Average Costs
- B) Normative or 'Best Practice' Prices
- C) Below Average Cost Prices

International evidence illustrates that the general approach to setting prices is by reference to the average cost of treatment. This approach has benefits in that it is relatively straightforward and encourages those hospitals with above average costs to reduce their cost base and be more efficient. However, whilst it incentivises hospitals to drive down costs to the average it may not incentivise them to go beyond that. At the same time, in an open ended system, it may incentivise supplier-induced demand as long as marginal cost is less than or equal to the average cost. Average cost pricing is also vulnerable to shifts in performance of the most expensive hospitals such that the use of a median cost rather than the mean might be preferable in terms of stability and efficiency.

The development of normative prices, whereby prices are based on best practice pathways for specific conditions and can be set either above or below the average cost, appears to offer significant advantages. Applying best practice prices encourages better quality of service and patient experience whilst also incentivising care to be provided in the appropriate setting. The payment would be fair and efficient, in that hospitals are appropriately reimbursed for providing the best quality and most efficient care, and it would be transparent, as the price

would be based on agreed principles for best practice. As such, the creation of best practice prices seems consistent with the policy recommendations in chapter 3 to develop prices which are independent of setting and based on best practice guidelines set by the National Clinical Effectiveness Committee. The approach could also represent a logical starting point for the future development of integrated or bundled payments.

However, the potential disadvantage associated with this approach is the time required to achieve consensus on what constitutes ‘best practice’. In this regard, the experience of England is noteworthy, in that it was eight years before Best Practice Tariffs were introduced³¹. That said, Ireland is in a strong position given the significant work of the Clinical Care Programmes and the National Clinical Effectiveness Committee in identifying best practice care.

Finally, prices can be set below average cost at any given point on the observed distribution of costs. This approach has the benefit of driving major improvements in efficiency and could, therefore, be a very desirable option given the current economic situation and the need to reduce costs in the hospital sector. Nevertheless, this approach must be set against the need to ensure the financial sustainability of hospitals while introducing the new funding model. Adopting this method may also confuse stakeholder and public perception regarding the objectives of ‘Money Follows the Patient’. This is particularly pertinent to Ireland at time when implementing a new funding model could be seen as crude way of cutting funding for frontline services.

In conclusion, **it is proposed that the introduction of best practice prices using patient level costs best supports the policy goal of delivering quality care in the most appropriate setting** (as reflected in the objectives of equity, transparency, efficiency and quality). Ultimately, best practice pricing should be introduced to the greatest extent possible. However, given the difficulties in implementing such an approach quickly, it would seem feasible to begin with setting prices by reference to average costs but with a view to implementing best practice prices on an incremental basis.

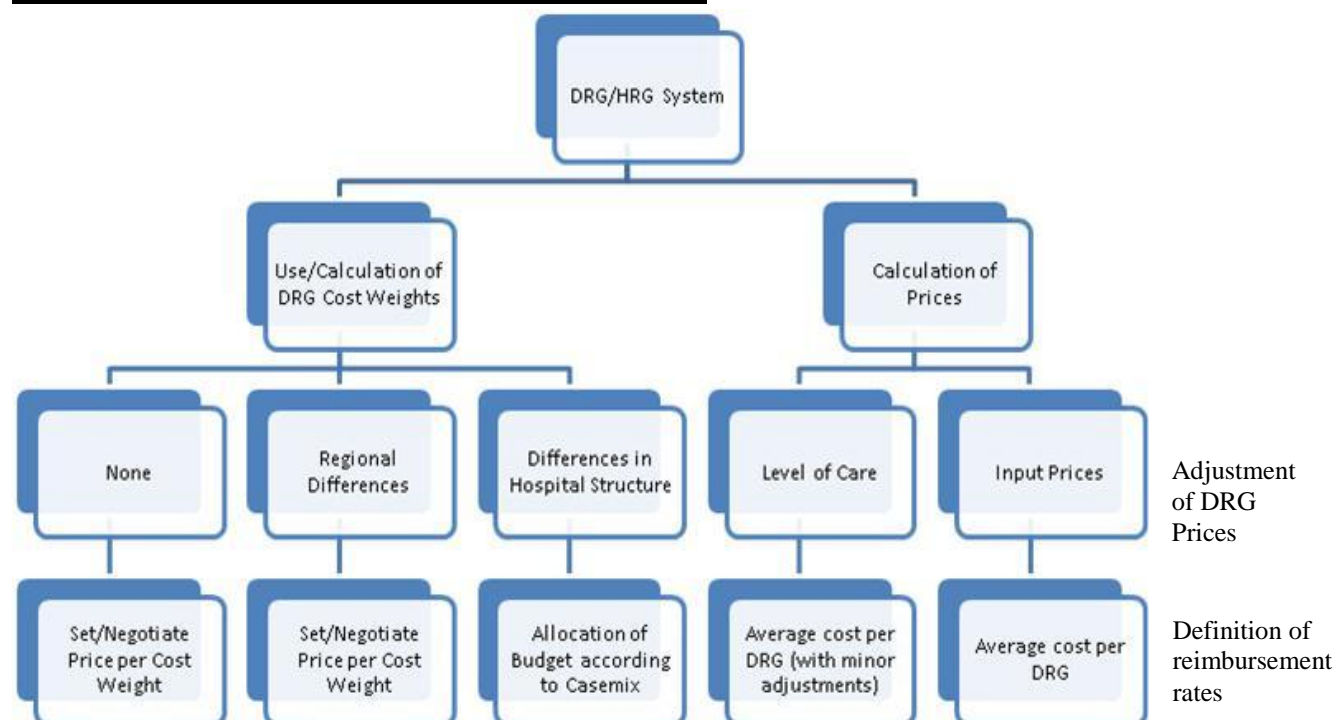
In setting a price by reference to average or best practice costs, it will be important to take account of time lag between the period used to calculate the costs and the period for which the prices are being set. A transparent, verifiable and reasonable process will be required to take account of inflation/ deflation and any known efficiencies between the cost and price periods.

³¹ For more information on the experience of England in introducing Best Practice Tariffs, see appendix C.

4.3 Calculating the Price – Overall Methodology

While alternative methodologies are used internationally in designing DRG case-based funding models (see figure 2 below), there are two broad approaches to calculating case-based prices, namely direct price setting and indirect price setting.

Figure 2: Designing the Payment System for DRGs



Source: Adapted from Schreyogg et al (2006)

Direct Price Setting – Tariffs

The direct approach involves calculating a ‘raw tariff’ as the basis of the payment. The raw tariff is calculated by reference to the average cost of DRGs, and the same raw tariff applies to all providers of services. Once the raw tariff has been calculated a further adjustment can then be made to reach the final monetary conversion. This adjustment is often made to reflect and account for structural differences perhaps between providers or regions.

A primary example of the application of raw tariffs is the UK with its Payment by Results funding system. This system calculates a weighted average cost for each HRG³² which forms the basis of the tariff. The tariff is set based on the average cost calculated by all hospitals for each HRG. In the case of England, a Market Forces Factor is then applied to take account of differences with regard to the cost of land, labour and buildings. This tariff is calculated for inpatients, daycases, outpatients and emergency department services. The stated principle of HRGs is that “they should reflect the care of the patient and not the setting in which the care

³²HRG in the UK is similar to DRG.

is delivered” and in England this was supported by setting tariffs with a single price for both daycases and inpatients.³³

The advantage of a tariff is that it is a more direct and more straightforward approach to calculating the payment. However, it does require that all prices have to be set; it is not possible to set a single price and use that as the basis for determining all other prices.

Indirect Price Setting – Relative Weights

The application of relative weights is the more common approach used internationally. The reason for this is that it defines the relationship between different resource groups according to the intensity of the resources used. This allows for comparison of DRGs in terms of whether or not they are above or below average cost of treatment across all DRGs. In simple terms, DRG relative weights are calculated by dividing the average costs of cases falling within a DRG by the average treatment costs of all cases in a country. In applying relative weights countries will also tend to calculate the casemix indices of hospitals which enables them to compare differences in patient populations across hospitals.

The advantage of the relative weights approach is that it requires only one single price to be set for a cost weight equal to 1 (‘the base rate’) and then all other prices can be calculated automatically. It also provides an insight into the resource usage of a DRG relative to the overall average cost of treatment. Additionally, relative weights (referred to in Ireland as relative values) are calculated in the current casemix model thus the concept is already familiar.

Given the current familiarity with cost weights and their use as a comparative tool, **it is proposed that this price setting approach should be maintained under ‘Money Follows the Patient’.** However, this approach will have to take account of the move towards best practice pricing. Furthermore, as noted in chapter 3, hospitals are currently arranged into four categories with a different base rate applying to each category. With the creation of Hospital Groups and the longer term move towards a single-tier system, it is proposed that categorisation of hospitals should be removed and a price should be set purely by reference to service unless particular structural differences between groups can be robustly proven³⁴. As such, **it is proposed that cost weights would be used to set a single national base price.**

4.4 Treatment of Costs

The National Casemix model derives costs from the Annual Financial Statements to develop a DRG cost per case for patients in public hospitals. The costs used in that process can be broadly categorised as follows:

³³ *Payment by Results Guidance for 2009-2010*. Initially the same tariff was applied to both inpatients and daycases.

³⁴ As already noted in chapter 3, a key exception here may be paediatric hospitals which may merit different relative weights or some system of additional payments.

- Pay Costs – Consultants, NCHDs, Nursing, Paramedical, Administration, Support Services, Catering, Porters and Maintenance.
- Non Pay Costs – such as medicines, blood, medical & surgical supplies, radiology, laboratory equipment and supplies, heat, light & power etc.
- Costs of diagnostics, medical services, theatres, laboratories, wards and overhead allocations as appropriate.

The above costs are also included in the calculation of ‘per diem’ charges for private patients in public hospitals with the obvious exception of consultant pay.

A number of costs are excluded from the Casemix model in order to reflect the actual cost of care provided to the patient. The costs excluded from the Casemix model are outlined in the table below. The table also contrasts the position with the treatment of these costs when calculating private ‘per diem’ charges.

Table 3: Treatment of Costs under Casemix Methodology & Per Diem Costing Methodology

	Treatment of Costs in Casemix Model	Treatment of Costs in Private Per Diem Charges
Pay Costs		
Consultant Pay	Included	Excluded
Superannuation	Excluded	Charge Included (@ 13.1%)
Non-Pay Costs		
Capital & Depreciation	Excluded	Capital Depreciation Charge included
Bad Debts	Excluded	Excluded
Retail Outlets Costs	Excluded	Excluded
Exceptional Costs	Excluded	Included
Costs not related to a hospital patient	Excluded	Excluded
Unique Items agreed under Casemix Model	Excluded	Included
Bad Debts	Excluded	Excluded
Clinical Indemnity Scheme Charge	Excluded	Included
Research Costs	Excluded	Excluded

It is proposed that the ‘Money Follows the Patient’ system would be consistent with the current casemix and ‘per diem’ costing approaches in terms of including:

- Pay Costs – Consultants, NCHDs, Nursing, Paramedical, Administration, Support Services, Catering, Porters and Maintenance.

- Non Pay Costs – such as medicines, blood, medical & surgical supplies, radiology, laboratory equipment and supplies, heat, light & power etc.
- Costs of diagnostics, medical services, theatres, laboratories, wards and overhead allocations as appropriate.

In addition, it is recommended that the ‘Money Follows the Patient’ system should include costs associated with the clinical indemnity scheme as it relates to public hospitals. This is consistent with the current requirement on the HSE to reimburse the State Claims Agency for clinical indemnity costs and also mirrors the approach in relation to private ‘per diem’ charges as recommended by the *Value for Money and Policy Review on the Economic Cost and Charges Associated with Private and Semi-Private Treatment Services in Public Hospitals*. It is also consistent with international practice in relation to treatment of costs within DRG models.

Notwithstanding this recommendation, it is acknowledged that clinical indemnity costs are currently managed centrally within the HSE and incorporating them into the ‘Money Follows the Patient’ payment system would require a new financial process which will take time to develop and put in place. One approach in this regard would be for the ‘central clinical indemnity fund/ cost centre’ to bill each Hospital Group in respect of the service provided and Hospital Groups would, in turn, recoup this cost via the DRG payment system. This approach could also be applied in respect of other shared services where economies of scale dictate that a consolidated national shared service is the most efficient delivery model but where this must be balanced with the need for a fair, single-tier healthcare system in which prices reflect true economic cost. It would also ensure that the financial cost of clinical negligence is visible to hospital management and Boards, thereby reinforcing the incentive to improve risk management practices. This issue will be considered further in conjunction with the State Claims Agency and the HSE, especially in the context of establishing Hospital Groups.

Chapter 3 already recommended that the cost of certain services should be met from outside the ‘Money Follows the Patient’ system in order to better support the key objectives of fairness and transparency (‘comparing like with like’). Accordingly, **it is proposed that Emergency Department services and teaching and research costs should be excluded from DRG price calculations.** This will require a transparent methodology for identifying and excluding these costs³⁵.

³⁵ Teaching hospitals have been identified as being more expensive than non-teaching hospitals (i) because they generally treat patients of a greater severity than non-teaching hospitals and (ii) because medical education and teaching can be associated with delays in the treatment process. Two previous studies have considered the costs associated with teaching in hospitals. The 2005 Indecon Report estimated the unit cost per student associated with undergraduate medical education/training in the hospital setting. Using estimates of time spent between staff and undergraduate students and interns, the unit cost per student was estimated to be a range of €8,555 - €9,010 p.a. They also estimated internship training to be in the region of €32,272 - €48,732 per intern p.a. An earlier study by Lynch in 1993 also sought to identify the cost of teaching, education and research on hospitals. The study found that the differences in costs between teaching and non-teaching hospitals was concentrated on the cost of treating patients rather than caring for them and the costs were concentrated in diagnostic facilities, drugs and supplies rather than in medical pay.

In considering the composition of the price under ‘Money Follows the Patient’, it is proposed that a number of other cost items would also be excluded from the calculation of the price in the initial years of the scheme. However, it is suggested that these matters should be kept under review, particularly, in the context of moving to a single-tier UHI system involving both public and private providers.

Capital and Depreciation: Some countries exclude capital costs from their DRG costing process. As highlighted in the table above, capital costs are currently excluded from the calculation of DRG prices within the casemix model but a capital depreciation charge is incorporated³⁶ within the charges applying to private patients in public hospitals.

While the inclusion of some measure of depreciation within the calculation of DRG prices for ‘Money Follows the Patient’ would be desirable from an accountancy perspective, the public sector system does treat capital and revenue costs separately. The global budgets currently provided to hospitals are intended to cover revenue rather than capital costs. Thus, the inclusion of capital costs within the DRG price would cause a mismatch between budget allocations and prices, and would also result in a loss of transparency in terms of prices reflecting the actual current costs of care. Furthermore, policy in relation to ownership of land and management of capital ventures by Hospital Trusts has yet to be worked out. For all of these reasons, **it is proposed to exclude capital costs in the initial calculation of DRG prices under ‘Money Follows the Patient’.**

Superannuation: In the current casemix budget model superannuation is excluded when determining the cost per case by DRG. A charge of 13.1% is, however, incorporated into the costing methodology for setting prices for the treatment of private patients in public hospitals. Superannuation costs would also be factored into the price setting process for private patients being treated in private hospitals.

It is noted that superannuation costs are outside of the control of individual public hospitals and are something that can vary significantly across hospitals, particularly in the context of recent voluntary redundancy and retirement schemes. The treatment of superannuation costs in the public health system is also noteworthy. Superannuation deductions of current employees are treated as income in the Annual Financial Statement, and hospitals are funded for the difference between the income and expenditure. For these reasons, **it is proposed to exclude superannuation costs in the initial calculation of DRG prices under ‘Money Follows the Patient’.**

Bad debts: Following the introduction of ‘Money Follows the Patient’, the potential for bad debts will have three possible sources, namely the interim public purchaser, the patient or another purchaser (i.e. generally a health insurer). Firstly, it seems reasonable to assume that

³⁶This was recommended in the *Value for Money & Policy Review of the Economic Cost and Charges Associated with Private and Semi-Private Treatment Services in Public Hospitals*.

the public purchaser will honour contracts and pay hospitals based on agreed activity. Secondly, Government policy is to move towards charging all private patients in respect of their care as part of a wider move to a single-tier system where everyone's care is financed on the same basis. Thus, if the DRG price were to incorporate the cost of bad debts, this would arguably represent a subsidy to the private insurance system and could remove the incentive to pursue bad debts at hospital level. Alternatively, it could result in double payment or overpayment in cases where the hospital with a strong income collection rate is still receiving a significant compensation in respect of bad debts within the DRG payment (in this regard, it is noteworthy that costs will be based on historical data and, therefore, historical trends regarding income collection and debt. For these reasons, **it is proposed to exclude bad debts from the calculation of DRG prices under 'Money Follows the Patient'**).

High Cost Drugs: Certain high cost drugs may need to be excluded from the calculation of DRGs and funded separately, e.g. certain chemotherapy drugs. Detailed operational policy will be required on this point to ensure that expenditure on high cost drugs is subject to appropriate management and cost control.

4.5 Outlier Policy

DRG based payment systems seek to appropriately reimburse for the average patient in a DRG. However, some patients will be significantly above or below average costs i.e. outliers. A robust outlier policy is, therefore, an essential element of any credible prospective case-based funding system.

Many countries make additional payments for outlier cases that fall under the DRG based system. The primary method used by countries for defining outlier cases is on the basis of length-of-stay threshold (as is the current practice in Ireland)³⁷, although some countries define outliers on the basis of costs. The payment method for compensating hospitals in respect of outliers also differs across countries with 'per diem' (current practice in Ireland) and 'fee for service' methods being applied. Furthermore, to prevent excessively low lengths of stay which are not clinically acceptable, some countries also determine lower length of stay outlier thresholds and calculate a reduced payment rate for these patients.

It is proposed that the 'Money Follows the Patient' system should include an outlier policy based on average length of stay. However, additional payments under this policy should be explicitly linked to medical necessity and not to inappropriate delays in leaving hospital settings. Ultimately, once a patient is deemed medically fit for discharge, no payment should apply for any further days spent in the hospital setting.

³⁷ Current boundaries are set at 1.96 standard deviations above and below the mean (after trimming the data at 2.96 standard deviations). We also have a 17 day rule which means the maximum length of stay between the average length of stay and the boundary points is 17 days above and below.

5. Governance Structures

5.1 Introduction

This chapter presents proposals on governance structures and processes. It is divided into two parts. Part A considers the interim governance structures which need to be put in place to deliver ‘Money Follows the Patient’ along the path to universal health insurance. Part B considers the governance process for ‘Money Follows the Patient’. It seeks to delineate:

- the **roles** of different stakeholders,
- the **relationships** between stakeholders, and
- the **rules** that govern those relationships.

As such, it involves setting out the regulatory framework within which the ‘Money Follows the Patient’ system will operate.

Part A- Governing Structures

5.2 Long-term Policy Vision

When considering interim governance structures, it is necessary to begin by reflecting on the long-term policy vision set out by Government. That vision involves a multi-payer insurance model where contracting for hospital services resides with health insurers. This implies that any purchasing structure established to finance individual hospital treatment for public patients will be interim in nature and will evolve to have many of its core functions absorbed by health insurers. However, there will still be an important role for a central funding authority. Under universal health insurance, the role of health insurers will be both complemented and constrained by a statutory Insurance Fund. Among its functions, the Fund will directly finance certain costs, such as Emergency Department and Ambulance costs.

Finally, an issue which stands to be considered is how prices should be set under universal health insurance. It may be desirable for insurers to continue to individually negotiate price, as is presently the case. Alternatively, it may be considered that an independently determined national pricelist should be a feature of the future landscape or that, for specific services, it simply makes economic sense to set and pay a single, national price³⁸. Regardless of the preferred design of the final universal health insurance model, a key issue will be to ensure that the State retains access to comprehensive national demographic, clinical and cost datasets so as to inform policy and planning within the Irish health system.

³⁸ A possibility might be that we would have a hybrid system similar to the Dutch model, under which national prices are set for certain services while others are the subject of competitive contracting. Alternatively, the State could set and publish a full suite of maximum national prices but insurers could freely negotiate these as part of selective price and volume contracts with hospitals. This approach would also allow insurers the flexibility to introduce bundled payments for particular services.

5.3 Interim Functions to be Delivered

The Programme for Government acknowledges the need for an interim purchaser of care in the transition to universal health insurance. The overall purpose of this body will be to purchase care for public patients in accordance with the legislative and policy rule-set laid down by the Minister for Health. However, in order for this purpose to be achieved, there are a number of functions to be delivered. These are set out in table 4 below alongside details of current structures for delivering on these functions where applicable.

Table 4: Functions to be delivered under ‘Money Follows the Patient’

Function	Current Responsibility in Public System	Current Position in Private System
Functions related to Price-setting		
Central Management of the HIPE dataset	ESRI	N/A
Setting Coding Standards	ESRI	Insurers use their own coding system
Central development of patient level costs	HSE Casemix Office ³⁹	N/A
Central Management of the DRG system	HSE Casemix Office	N/A
Price-setting	HSE Casemix Office, National Treatment Purchase Fund (NTPF)	Insurers negotiate with private hospitals while the Minister for Health sets private fee rates in public hospitals
Functions related to Purchasing		
Agreeing Claims dataset	N/A	Insurers set the claims dataset
Agreeing price and volume contracts with hospitals	N/A (The national service planning function is managed by HSE’s Corporate Planning and Corporate Performance Directorate and the Department of Health)	Insurers have contracts with private hospitals
Claims Management	N/A (HSE Vote and Treasury make cash payments to hospitals; NTPF purchases some care on foot of claims)	Insurers
Functions central to both Price-setting and Purchasing		
Auditing Hospital Coding	ESRI	Insurers undertake audit in relation to claims

As can be seen from the table, dual systems currently exist for financing of public hospital care with mainstream funding provided by the HSE and some additional targeted funding provided by the NTPF. At present, NTPF funding is supporting the performance improvement work of the Special Delivery Unit (SDU). However, it will be important that the two funding streams are rationalised and managed by a single, interim purchaser over

³⁹ The National Casemix Office is currently responsible for managing the national speciality costing process which will be complimentary to patient level costing. A patient level costing study is currently underway.

time. A final noteworthy issue when considering transitional structures is the Minister's intention to return the HSE Vote to the Department of Health and to dissolve the HSE.

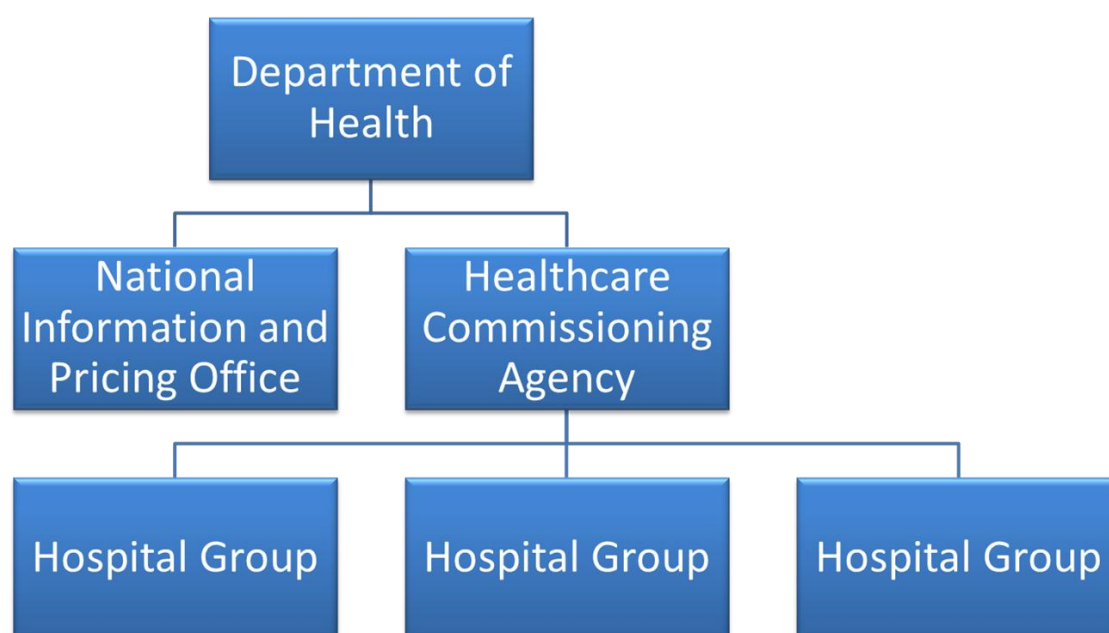
5.4 Structures for Delivering Interim Functions

International evidence demonstrates that many countries separate the price-setting function from the purchasing function either through the creation of an independent agency or by retaining the price-setting function within the Department of Health. The backdrop to this approach generally involves either multiple independent purchasers of services or different levels of Government acting as co-funders of services.

Following on from a review of international evidence, four different policy options in terms of structures were identified and explored by the Hospital Financing Group. On foot of this analysis, **it is proposed that the price-setting function should be independent of the purchasing function even within the interim system.** This is considered important in terms of the integrity of the process and ensuring support and buy-in from the hospital system.

It is, therefore, suggested that the price-setting function would be absorbed into a National Information and Pricing Office with multi-stakeholder oversight and strong clinical representation, while the purchasing function would be built up from within the HSE prior to creating an independent statutory commissioner (see figure 3 below).

Figure 3: Proposed Interim Governance Structure



This proposed approach should offer a number of advantages as follows:

- ✓ The National Information and Pricing Office provides a robust governance structure for price-setting with a strong degree of independence which should support the development of prices based on policy and best practice.
- ✓ By situating the information and pricing functions within one organisation, it acknowledges the critical linkages between the two functions, particularly in the context of using best practice pricing to drive changes to the model of care delivery.
- ✓ Importantly, the approach also explicitly recognises the wider uses of the HIPE and DRG systems beyond price-setting by situating them within an overall National Information and Pricing Office (this could be lost if the price-setting function and related datasets were situated within the purchasing entity).
- ✓ The multi-stakeholder oversight of the National Information and Pricing Office should ensure strong collaboration, coherence and collective ownership across our health system in relation to the development of health information, health informatics and fair pricing mechanisms.
- ✓ In the longer term, the National Information and Pricing Office could address the important consideration outlined in section 5.2, namely to ensure that, with the ultimate transition to a multi-payer universal health insurance system, the State retains access to comprehensive national demographic, clinical and cost datasets so as to inform policy and planning within the Irish health system.
- ✓ The development of new purchasing structures from within the HSE, crucially ensures that the HSE's existing legal basis for contracting with/ funding providers can be used to support 'Money Follows the Patient' purchasing in advance of the creation of a new statutory Healthcare Commissioning Agency.
- ✓ The approach is also likely to entail the least system disruption and the smoothest and quickest transition to 'Money Follows the Patient' as some of the key personnel and systems required for the new Healthcare Commissioning Agency are already within the HSE. As such, the administrative reshaping of these areas to create an 'agency within an agency' appears to represent the most straightforward means of delivering on 'Money Follows the Patient'.
- ✓ The approach allows linkages to be forged with the PCRS, thereby enabling the development of shared IT platforms and administrative processes which should, in turn, support an integrated purchasing function across primary care and hospital care. As such, it is consistent with overall Government policy on health reform.

Part B- Governing Processes

5.5 Overview of Process

A closed loop governance process will underpin the flow of funds under 'Money Follows the Patient'. In summary, this will involve the Minister legislatively setting the basis for the calculation of prices. In accordance with that direction, the National Information and Pricing

Office will then use activity and cost data to compute national DRG prices for publication by the Minister.

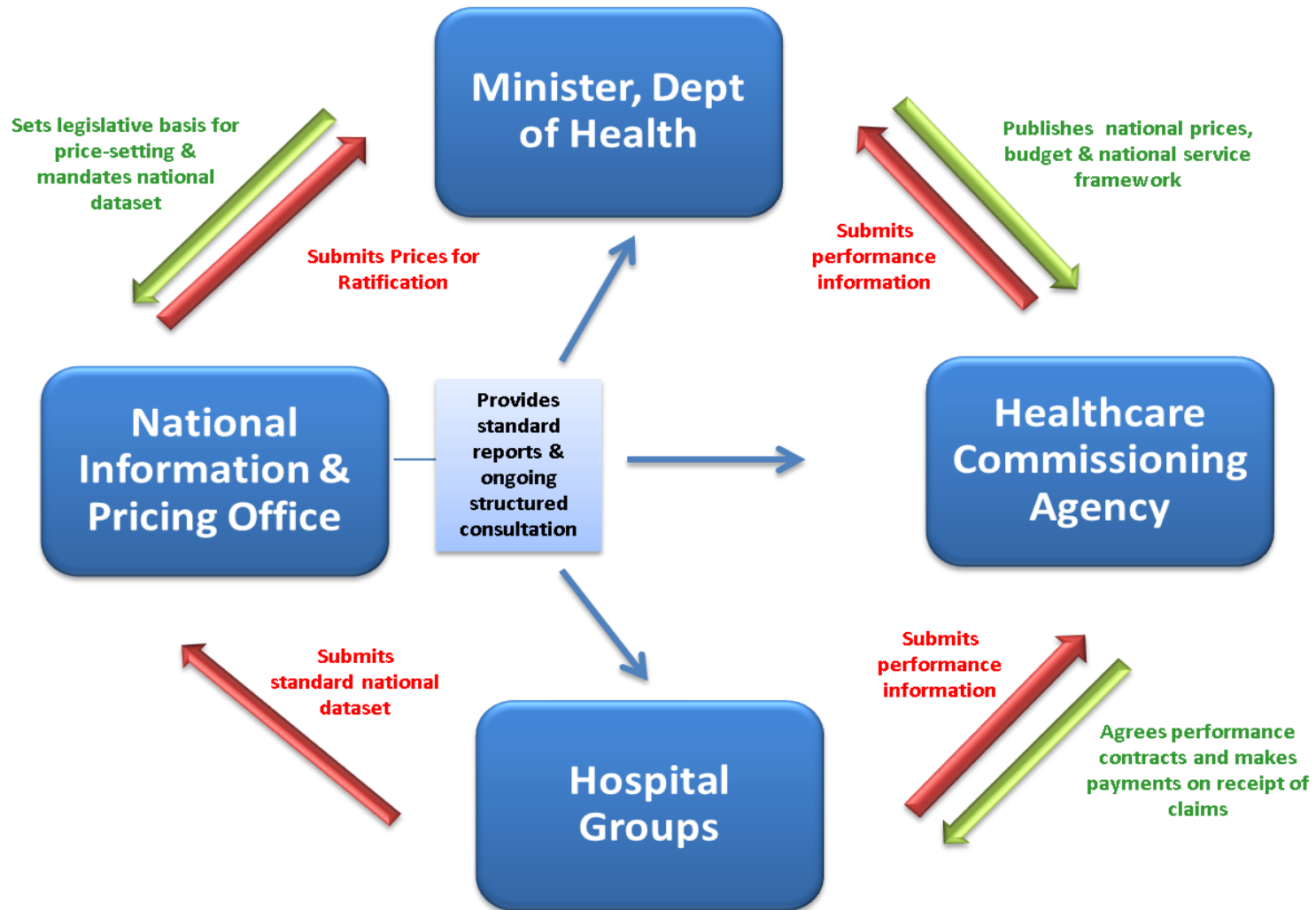
Given the imperative of retaining strict cost control over the system, 'Money Follows the Patient' will be introduced within a fixed budget envelope. The Minister will communicate details of this capped budget, the national pricelist and national service targets and priorities for public hospital services to the independent statutory purchaser, the Healthcare Commissioning Agency.

The Agency will then agree capped cost, volume and quality contracts with each public Hospital Group. These annual performance contracts will set out activity targets by quarter to be funded at the national average DRG price. They will also include quality targets underpinned by financial sanctions. Where the national service framework handed down by the Minister provides funding for additional targeted activity, this will have to be pre-approved by the Healthcare Commissioning Agency and can be paid at rates other than the national DRG price (e.g. it could be priced at the marginal rate plus a small incentive bonus payment). Only hospitals which meet their activity targets in the previous quarter will be eligible to bid for this additional funding. In other words, if a hospital has a waiting list, then people may be taken off it and treated elsewhere but the funding will follow the patient. In all cases, payment will be contingent on the electronic submission of completed claims to the Agency.

In addition to claims information, in the initial phase of the scheme detailed financial performance management information will be obtained from hospitals in relation to profiled and actual expenditure and profiled and actual income. This is intended to support early intervention where hospitals appear to be at risk of expenditure overruns, thereby ensuring robust overall Vote management. However, it is acknowledged that with the development of Hospital Trusts, this level of detailed monitoring and intervention should no longer be necessary.

The information submitted as part of the claim will be subject to audit and will also be used for overall quality regulation. In addition, it will be utilised by the National Information and Pricing Office, in conjunction with patient level cost information, to (i) undertake structured consultation on modification of the DRG system, (ii) recommend any changes to the legislative basis for calculating prices, and (iii) set prices for the coming year. In this way, the health system can be held to account (i.e. hospitals will be funded for what they deliver and unintended consequences such as upcoding can be addressed), while the pricing tools used to hold it to account can also be continually modified so that they are fair and fit for purpose. This governance loop is represented diagrammatically in figure 4 overleaf and is set out in more detail in the remaining sections of this chapter:

Figure 4: The Governance Loop



Finally, it is important to emphasise that the introduction of ‘Money Follows the Patient’ represents a complete transformation of the current performance management process. Under this transformation, the National Service Framework set out by the Minister will be explicitly executed via detailed performance contracts with each Hospital Group. Purchasing will be established on a bedrock of quality and, as such, a co-ordinated and streamlined approach to the monitoring and management of *all* targets - quality, activity and cost - via the performance contracts will be central to success.

5.6 Setting and Approving the Price

It is proposed that a National Information and Pricing Office, encompassing the relevant staff, functions and resources of the National Casemix Office and the ESRI, and with appropriate linkages to the national clinical programmes, would be established. The Office would have multi-stakeholder oversight, thereby facilitating strong collaboration and ongoing engagement across the health system in relation to the development of service definitions and pricing mechanisms.

With regard to ‘Money Follows the Patient’, the Office would have responsibility for:

- managing the HIPE dataset,
- engaging with stakeholders in relation to the dataset (or aspects of it),
- advising the Minister on mandating the national dataset to be collected at hospital level for the purposes of (i) developing DRG prices, (ii) claims submission to the purchaser⁴⁰, (iii) performance reporting on quality⁴¹, (iv) performance reporting on activity, (v) consultant’s contract etc.,
- maintaining coding standards,
- maintaining cost accounting standards (i.e. a standard for devolved accounting including detailed instructions on treatment of different costs),
- centrally collecting patient level cost data,
- managing the development of a Medical Data Dictionary,
- setting national DRG prices based on HIPE and patient level cost data, and
- undertaking structured consultation with stakeholders on price-setting (i.e. splitting, modifying or creating DRGs to take account of genuine cost differentials or innovation).

A key principle underpinning the work of the Office would be that, at the hospital level, data should be collected and transmitted once but then used for multiple purposes by different strategic stakeholders. In other words, the Office would have a duty to reduce the administrative burden placed on the health system in relation to data collection, while simultaneously maximising the potential uses and value added of that data to guide national

⁴⁰ This would be developed in close collaboration with the interim purchaser.

⁴¹ This would be developed in conjunction with the CMO’s Office.

planning, policy-making, performance management, procurement and operational management.

With regard to its price-setting role, the National Information and Pricing Office would be bound by legislation setting out the policies and principles for calculating prices. Each Hospital Group would be required to submit cost data from the previous financial year to the National Information and Pricing Office by a specified date each year. This data would be used to determine a national DRG pricelist for submission to, and ratification by, the Minister. In all cases, DRG prices would be set net of the patient charge (i.e. the current statutory charge of €75 per night capped at €750 per annum)⁴².

The Minister would be required to lay the pricelist before the Houses of the Oireachtas by the 30th September each year and to provide transparent information on the process used for setting prices. Ultimately, prices would be set by reference to actual efficient or best practice costs and only adjusted in relation to changes in input costs over the period between the year to which the costs relate and the year to which the price relates. This approach allows all hospitals to have full sight of prices and to consider their costs and underlying work practices in advance of finalising performance contracts. As such, it allows them to engage in a meaningful manner in the contracting process, to prepare for the year ahead and to drive efficiency from the outset. It also meets the policy objectives of fairness and transparency in terms of paying a fair price which reflects actual cost.

5.7 Setting the Budget and National Service Priorities

As noted in international literature, uncapped activity based funding is simply not an option in times of financial crisis. As such, a capped budget should be identified from within the overall health expenditure voted by Government⁴³.

The first step in the contracting process should involve the Minister setting out an Annual National Service Framework for the public health service. In the case of hospital services, this would require the Department of Health, on behalf of the Minister, to establish the overall acute hospital budget and, within that quantum of funding, the proportion that is allocated to the ‘Money Follows the Patient’ initiative. Aligned with this, it would need to establish the activity which the Minister wishes to fund for the coming year. All of this will require intensive liaison with the Healthcare Commissioning Agency to understand the impacts of different budgetary and performance targets.

⁴² Currently allocations to voluntary hospitals are net of income from statutory or other charges. Statutory HSE hospitals receive a gross allocation and income is recorded centrally. This approach will have to be standardised as we move to the creation of Hospital Groups, some of which will encompass a mixture of voluntary and statutory hospitals.

⁴³ It may be that funding for ‘Money Follows the Patient’ will have its own subhead or that all hospital funding would be contained within a single subhead. In either event, it would be a matter for the Government to determine this level of funding as part of the annual Estimates and budgetary process.

On completion of this process, the Minister would be in a position to finalise the National Service Framework and formally notify the Healthcare Commissioning Agency of the approved allocation for ‘Money Follows the Patient’, the national pricelist, details of national performance targets to be achieved by the hospital system and details of any particular policy priorities to be funded from additional ringfenced resources.

A key tension here is the timeframes for the Estimates process versus the timeframes which are required for detailed performance contracting under ‘Money Follows the Patient’. In practice, this may require an approach where significant discussions and preparatory work would be undertaken in quarters 3 and 4 of each year albeit that allocations and performance contracts would not be capable of being finalised until after the conclusion of the Estimates process.

5.8 Agreeing Performance Contracts

As noted in section 5.4, it is proposed that the Healthcare Commissioning Agency would be grown from within the HSE (an ‘agency within an agency’) prior to creating a statutory commissioning entity. As such, it is suggested that key resources within the HSE and NTPF might be aligned and supplemented by necessary additional expertise to create the Agency.

In order to contract effectively, the Healthcare Commissioning Agency will need to know the global expenditure envelope for ‘Money Follows the Patient’, the price per DRG, overall activity and quality targets, and any policy priorities or targeted additional funding. It will then need to convert these national metrics into detailed performance contracts at individual Hospital Group level. Different countries have adopted different approaches for managing this negotiation process. However, as emphasised above, in a time of budgetary contraction, the only option available to the Agency will have to involve capped cost and volume contracts.

It is suggested that the Agency would agree activity up to a particular level with each Hospital Group which it would fund at the national DRG price (“hereafter referred to as the base activity”). Performance contracts would be broken down into quarterly segments, each of which would set out pre-agreed base activity targets. Key quality targets, explicitly linked to funding adjustments, would also be encompassed within the contracts.

All additional public activity above the agreed base level would have to be pre-approved for funding. This process would involve the Agency publishing additional service requirements and inviting hospitals to bid for this surplus work. By targeting and pre-approving the activity to be funded, the Agency should be in a position to respond to population need and mitigate the potential for supplier induced demand. As such, it can strongly underpin the performance improvement work of the SDU by driving efficiency in the first instance and

then targeting waiting lists where they persist. Furthermore, it is suggested that, in contracting for this additional work, the Agency would not be bound by the national DRG price but could choose the rate which it wishes to pay.

As mentioned, performance contracts would be broken down into quarterly activity targets. Where a hospital fails to meet its activity target for a quarter, it can still roll this activity over to the following quarter and get paid for it. However, it is precluded from bidding for additional work in the following quarter. In other words, if that hospital has a waiting list, then people may be taken off it and treated elsewhere but the funding will follow the patient. Similarly, it cannot take patients from other hospitals over and above its activity target and obtain funding in respect of their treatment. Once a hospital is back on schedule with regard to its activity target for the overall year, it is free to bid for additional activity.

In the early years of ‘Money Follows the Patient’, contracts should acknowledge estimated private activity and income (as this will be relevant in terms of a hospital’s overall average costs and revenue). However, all activity targets and funding agreed as part of the contract should relate solely to public patients. As mentioned in the opening chapter, the introduction of ‘Money Follows the Patient’ must take full account of private income issues and the need for a corresponding regime of case-based charges for private patients in public hospitals. Detailed policy and implementation proposals in relation to this issue are currently under preparation.

Finally, the fundamental purpose of ‘Money Follows the Patient’ is to transform how we fund public hospital services in order to achieve the immediate policy goals of efficiency, transparency and fairness, and in order to prepare the system for the introduction of universal health insurance. In moving from block grant funding to prospective case-based funding of public hospitals, particularly against a backdrop of contracting health sector budgets, we must have regard to the fact that current Exchequer funding must cover fixed public sector costs. As such, the only feasible means of sustainably introducing ‘Money Follows the Patient’ is to focus initial performance contracts for base activity on public Hospital Groups. That said, it is suggested that the Healthcare Commissioning Agency should have the discretion to contract with public or private providers for any additional work, subject to providers meeting all necessary contracting requirements.

5.9 Submission and Approval of Claims and Management of the Payment Process

Payment for agreed activity would be contingent on the submission of completed claims to the Healthcare Commissioning Agency. In the initial phased implementation years, this might simply consist of directly transmitting HIPE data using the web portal. However, it should ultimately involve auto-population from the HIPE system into the hospital’s claims management system which would then be electronically submitted to the Agency. Within the

Agency, the submission and the payment of claims must involve a fully integrated and electronic process.

Claims would include all required clinical and demographic data and would also provide details of the patient's status in terms of qualifying for an exemption from statutory charges.

Hospitals would be encouraged to achieve a maximum of 7 day turnaround times from date of discharge to date of claims submission. As payment will be contingent on the submission of claims, hospitals will have an automatic incentive to meet this recommended timeframe.

With regard to managing the payment process, it is worth emphasising that policy and operational protocol in respect of the 'Money Follows the Patient' payment process is dependent on the location of the Vote. Ultimately, the Healthcare Commissioning Agency will receive an allocation in respect of hospital services from the Department of Health and will be accountable for payment of funding in relation to core hospital services (Emergency Department, Inpatient, Daycase and Outpatient), teaching and research and any other ancillary services. In the case of all services funded on a 'Money Follows the Patient' basis, payments would comprise the national DRG price plus the patient charge in cases where the patient was exempted from same. For all services falling outside of the 'Money Follows the Patient' initiative, the Agency would authorise and make block grant payments. Finally, it is suggested that overall adjustments should also be made to funding based on the achievement of quality targets.

5.10 Financial Reporting & Troubleshooting

Detailed financial reporting will be required under the new financing system.

Firstly, in line with the Minister's intention to return the Vote to the Department, there will be a need for the Department to report cash expenditure against the Vote on a monthly basis. In the case of hospital services, the Department's expenditure will involve the transmission of agreed periodic allocations to the Healthcare Commissioning Agency. The Agency will need to manage within this allocation while also ensuring that it pays hospitals in a timely manner (i.e. it will not want to generate cashflow problems at hospital level).

The Healthcare Commissioning Agency will make payments based on pre-agreed activity targets and prices and on receipt of submitted claims. This information will allow the Agency to project expenditure over the financial year and to monitor actual spend against that projection in a detailed and robust way. However, in addition to this, the Agency will need to estimate spend incurred but not yet notified (i.e. outstanding claims) in order to ensure that it draws down sufficient funding in each quarter and that it can flag possible activity (and therefore expenditure) overruns at hospital level.

While hospitals theoretically bear the full risk for any such overruns, in reality, the State is likely to come under considerable pressure to underwrite such debts⁴⁴. This, in turn, will undermine the validity of the entire ‘Money Follows the Patient’ initiative and could leave it highly vulnerable. Thus, in order to safeguard the sustainability of the public hospital system throughout the early years of the new scheme, the State will need to monitor expenditure at Hospital Group level and intervene sharply if hospitals appear to be at risk of expenditure overruns⁴⁵. This suggests that the State, via the Healthcare Commissioning Agency, will require the following hospital level information:

- A profile of estimated expenditure by month for the financial year
- Details of actual expenditure incurred on a monthly basis
- A profile of estimated income raised by month for the financial year
- Details of actual income raised broken down by (i) value of claims submitted and paid, (ii) value of claims submitted and not paid, (iii) value of claims not submitted
- Cashflow projections and actual cash position on a monthly basis

Finally, in the short-term, there is a need to transform performance reporting from ‘actual versus budget’ to ‘income versus expenditure’. For ‘Money Follows the Patient’ services, the budget for the hospital is effectively the estimated income which it will receive in each month and its expenditure must remain at or below that level.

5.11 Quality and Regulatory Mechanisms

Within the overarching governance system, it is imperative that there are strong regulatory mechanisms to support the delivery of quality services, and to combat the unintended consequences and perverse incentives which can be associated with DRG systems. These unintended consequences may be summarised under five broad terms as follows:

- **Dumping:** This involves shifting the costs associated with treatment onto other service areas or service providers.
- **Skimping:** This relates to inappropriate early discharge or under treatment.
- **Cream skimming:** This refers to risk selection of low-cost patients within DRGs.
- **Upcoding:** This involves fraudulent reclassification of patients so that they are assigned to a higher DRG, e.g. by falsely adding secondary diagnoses.

⁴⁴ It is accepted that the concept of Hospital Trusts and a universal health insurance system may involve hospitals gaining full financial independence.

⁴⁵ It is suggested that the work of the SDU with its principles of escalation processes and earned autonomy is pertinent here. Where hospitals show early indications of financial difficulties, contingency plans should be drawn up and there should be systematic engagement with hospitals on a stepped basis to drive efficiency and cost reduction. Furthermore, fundamental issues which stand to be considered when creating Hospital Groups are (i) requirements to maintain financial reserves, (ii) authority to run an overdraft and (iii) how to deal with underlying financial deficits.

- **Gaming:** This concerns the provision of services which will lead to a reclassification of the patient into a higher DRG, the admission of patients for unnecessary services or the treatment of a patient in a more expensive setting in order to attract a higher payment rate, i.e. all forms of supplier induced demand.

There are several policy measures which can be invoked in order to ameliorate these perverse incentives. However, it is worth highlighting that the intended and unintended consequences of DRG payment systems are deeply intertwined and this means that regulation is a delicate balancing act. For example, one potential response to cream-skimming is to split DRGs so that they more accurately capture and reward higher cost cases. Unfortunately, this could, in turn, encourage different perverse incentives, namely upcoding or gaming. Notwithstanding this caveat, the following four regulatory measures should play a critical role in supporting effective management and good governance of the system.

Integrated Performance Management System: As mentioned at the outset, it is proposed that there should be a single national dataset which would be collected and transmitted once but used for multiple purposes. Furthermore, it is proposed that there should be detailed performance contracts with each Hospital Group. These contracts would outline quality and activity targets to be delivered in return for payment of State funding and to be measured by reference to the national dataset. This integrated approach has the potential to provide a powerful tool for managing performance across all domains. By having the same dataset and data managers for pricing and quality, hospitals will have an inbuilt incentive not to skimp on quality as the data will reveal this⁴⁶. Similarly, hospitals may be less likely to provide unnecessary and potentially harmful secondary procedures (gaming) if they know that data is being reviewed from a quality perspective by clinical managers⁴⁷. The imposition of financial sanctions will further ensure that the financial aspects of the performance contracting process underpin and reinforce the quality aspects.

Auditing: A robust auditing function is central to fair and effective claims management, particularly in relation to addressing upcoding. HIPE data is already subject to audit by trained staff located within the ESRI. However, it may be anticipated that this function would need to be strengthened and expanded.

Contracting process: The strict activity limits set as part of performance contracts are an important tool in controlling supplier-induced demand (gaming). Moreover, these should be aligned with a strategic purchasing focus which compares activity delivered across different hospitals and uses this to determine the allocation of additional work/ future activity targets. In particular, the Healthcare Commissioning Agency, in conjunction with the National Information and Pricing Office, should undertake comparison of patient profiles (by

⁴⁶ Anecdotally, it is understood that the use of separate datasets for quality and pricing in Germany resulted in discrepancies in reporting with the result that data is now being shared across relevant statutory authorities.

⁴⁷ Over time, data on diagnosis could perhaps be linked with primary care records to support targeted investigation.

comparing key demographic variables and each hospital's Casemix Index) for evidence of cream-skimming. Where evidence of such behaviour exists, this should be fed back into the contracting process and influence decisions on allocation of additional work. Payments in respect of outliers should also provide some degree of buffer against cream-skimming.

In the longer term, the policy intention to set prices independent of setting where possible and to move towards bundled payments should also systematically discourage gaming.

Structured consultation and continuous updating of the system: The structured consultation ('structured dialogue') process will allow all clinicians, hospitals and other stakeholders to provide evidence where they feel that a DRG does not fairly compensate the costs of a particular service, i.e. is not sufficiently homogenous. The process will enable DRGs to be split where there is evidence of large cost variances, possibly supporting cream-skimming. As such, it will enable continuous updating of the DRG system and the corresponding prices. This regular readjustment of payment rates has been noted to act as an effective mechanism for cost control although does not replace the need for thorough auditing of hospital coding activities.

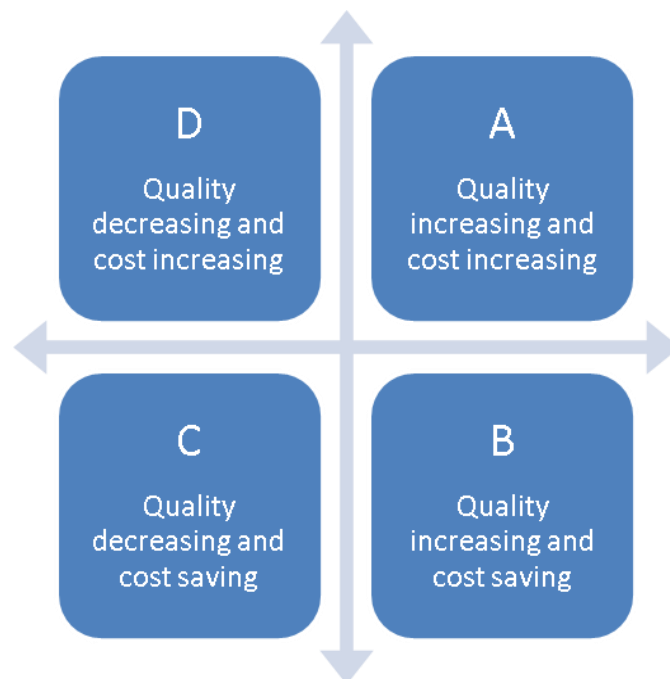
Finally, while the administrative complexity and associated burden of any financial system must be continually assessed, it would be worth undertaking a technical examination as to whether the funding policy should also incorporate principles of (i) no payment for readmission for the same condition within 30 days (dependent on a unique identifier) and (ii) penalties or non-payment at individual patient level in respect of hospital acquired infections or conditions.

5.12 Innovation and the Feedback Loop

Innovation

Continuous technological innovation is a feature of clinical practice with the potential for huge health benefits over time. However, innovation can also have the potential for significant cost increases in healthcare. Given these cost implications, hospital payment systems can naturally influence the implementation of innovation in the health sector. It is, therefore, important to consider the impact of a DRG system on technological innovation. As a starting point for this, researchers on the EuroDRG project note that there are four different theoretical combinations of cost and quality that can result from the introduction of technical innovation, as represented overleaf:

Figure 5: Effect of Innovation on Costs and Quality



Source: Adapted from Quentin et al in Busse et al, Diagnosis-Related Groups in Europe: Moving towards transparency, efficiency and quality in hospitals, 2011

Having regard to the above matrix, it is immediately apparent that technological innovations falling into sector D provides no societal benefit. It is also apparent that innovation within sector B provides an unquestionable benefit and should be naturally supported by a DRG-based payment system which will encourage identification of cost savings.

Sectors C and A are where trade-offs between cost and quality occur. The proposed DRG system will need to guard carefully against inappropriate innovations within sector C and, indeed, section 5.11 has already spoken to the need to ensure that quality and other regulatory measures are embedded into the overall funding model. In the case of sector A innovations, the continual updating of the DRG system will certainly ensure that innovation is incorporated within the payment system in the medium to long-term. However, in the short-term, some countries with DRG-based systems provide supplementary payments as a means of short-term support for innovation.

Where technological innovation has significant cost implications, these often relate to capital or pharmaceutical costs. In this regard, it is firstly noteworthy that earlier chapters have recommended that research and capital costs would not be encompassed within the DRG price in the first instance. Furthermore, a number of major existing initiatives must be taken into account when considering whether supplemental payments should be provided in respect of innovation. These include the work of the National Clinical Effectiveness Committee, the work of HIQA in relation to health technology assessment and the work of the clinical programmes. In light of the fact that capital and research will be funded separately to the DRG system and in light of these other related initiatives, **it is clear that further detailed**

deliberation and consultation is required on any specific payment measures to support innovation.

The Feedback Loop

In addition to updating the system to take account of innovation, the system will also be regularly updated in a number of different ways.

Firstly, and most obviously, activity and patient level cost data will be regularly collected by the National Information and Pricing Office and used to set prices for the coming year. Information on quality, activity and cost will also feed back into national policy-making and service planning.

In addition, the National Information and Pricing Office will be responsible for leading a regular structured consultation process with stakeholders. This process will involve inviting interested parties to submit evidence in support of changes to the DRG system. All submissions would be referred to a technical expert reference group which would review them and offer recommendations to the Minister. The expert reference group will be carefully composed in order to take account of necessary skills requirements and principles of probity and impartiality.

Where a proposed change to the system can be backed up by robust evidence, then the National Information and Pricing Office, with the approval of the Minister, will have the authority to modify the system in accordance with the proposal. A key example of this approach is where stakeholders are able to provide robust evidence of a significant and consistent cost differential between patients falling into the same DRG and to prove that this differential relates to patient characteristics/ clinical needs rather than individual hospital cost structures.

The structured consultation will be central to ensuring that the DRG case-based system remains continually relevant, fair and fit for purpose as a funding model for our health system. In short, it is the means whereby the system holds *itself* to account and remains responsive to the frontline and the patient.

6. Implementation

The previous chapters set forth an ambitious policy to guide the reform of public hospital financing. This chapter identifies the core building blocks required to translate that policy into practice and maps out the first steps of the journey.

6.1 Core Building Blocks for ‘Money Follows the Patient’

A number of core building blocks must be put in place in order to implement ‘Money Follows the Patient’. These are depicted in the figure 6 and are briefly described below.

Figure 6: Major Building Blocks to support Delivery of ‘Money Follows the Patient’



Funding Policy, Financial Management Strategy and Communication Strategy

This document sets out draft policy proposals as a basis for *initial* engagement with all stakeholders on plans for ‘Money Follows the Patient’. However, *ongoing* communication will be the cornerstone of successful implementation of the new funding model. ‘Money Follows the Patient’ can only be delivered through the active engagement of clinicians, hospital CEOs, finance managers and others. This is not only recognised within our internal Communications Strategy but also embedded within the funding system itself with its commitment to ongoing structured consultation.

Coding Classification System

The current coding classification system for inpatients and daycases is in place in 57 hospitals with coding deadlines of 90 days from month end. Outpatients and Emergency Department attendances are not currently coded. Moreover, with the development of new service models

such as Medical Assessment Units, the need for a national medical data dictionary to ensure fair and consistent coding of services across providers is vital.

Critical Actions:

- Reduction of coding deadlines for inpatients and daycase activity
- Extension of coding classification system to capture outpatient activity which is comparable to daycase activity
- Development of a medical data dictionary

Grouping System

The current AR-DRG system groups data on inpatients and daycases into 698 DRGs and is ready for use in the new system. However, procedures carried out in outpatient departments are not currently captured in the Grouper system and so it will be necessary for the classification and grouping system to evolve so that efficient prices can be determined and used to fund certain treatment irrespective of setting. Furthermore, the structured consultation process will enable ongoing development of the Grouper system in response to clinical practice.

Critical Actions:

- Development of the DRG system so as to support the policy of prospective case-based funding of inpatient, daycase and comparable outpatient activity based on best practice prices.

Patient Level Costing

A patient level costing (PLC) system is essential to enabling hospitals to understand their costs per DRG and, therefore, to operate effectively in a prospective, activity-based funding environment. Furthermore, in terms of price-setting, the PLC process will ultimately replace the current speciality costing methodology⁴⁸.

Although a pilot PLC project has been underway since 2010, the PLC function must now be embedded across all Hospital Groups. This will require investment in skills and also in PLC IT systems and feeder IT systems to improve cost collection.

In addition, a standard costing manual is necessary in order to support the PLC process and work on this is already underway. Engagement with the accountancy bodies on a standard for devolved accounting is also required.

State of readiness:

- Publication of a Standard Costing manual.
- Agreement on a Standard for devolved accounting.
- Development of PLC expertise and infrastructure.

⁴⁸As an interim measure some hospitals will continue to undertake speciality costing returns.

Price-setting

Within the Irish system, the capability to undertake price-setting is already well established. However, the new policy demands the removal of the existing hospital categorisation system, a new methodology for stripping out Emergency Department, teaching and research costs, the inclusion of clinical indemnity costs etc. In addition, formal structures for the new National Information and Pricing Office need to be put in place to support full roll-out of ‘Money Follow the Patient’.

Critical Actions:

- Development of new methodologies for price-setting.
- Creation of the new National Information and Pricing Office.

Commissioning Expertise

Under ‘Money Follows the Patient’, performance contracts will have to be concluded with each provider. This may be expected to be a time consuming process which will entail significant specialist expertise⁴⁹.

Critical Actions:

- Harnessing and development of expertise in the area of commissioning.
- Agreement of performance contracts with all Hospital Groups.

Claims Management Function

It must be emphasised that the move to ‘Money Follows the Patient’ involves radical re-engineering of current financial management processes. Ensuring that systems and structures are in place to manage this transition will represent a major challenge.

Electronic claims management is absolutely essential for the effective operation of ‘Money Follows the Patient’. Given the magnitude of transactions in terms of claims volume and value, it is simply imperative that a robust claims management system is operational prior to full roll-out. This will require embedding electronic claims management systems within each Hospital Group, procuring a central claims management system and then establishing an electronic interface between the local and central systems. This is coupled with a need at central level for the correct expertise to examine and adjudicate on the claims data submitted.

At hospital level, electronic claims management systems are already in place in eleven hospitals. Systems are currently being rolled out to further sites, with an expectation that six new sites will be operational by the end of Q1 2013.

⁴⁹ Financial expertise, claims management/ reimbursement expertise, negotiation skills, legal expertise and contracts management expertise will be required.

Critical Actions:

- Roll-out of electronic claims management systems across all Hospital Groups.
- Development of a strong claims management function at central level and development of an electronic interface between the hospital and central systems.

Auditing

A robust auditing function is fundamental to safeguarding against gaming and ‘coding creep’. In addition, auditing will be important to ensure that quality of care is not adversely impacted by the introduction of this new system. While specialist auditing expertise already exists within the ESRI, additional capacity will be required to support the auditing of costing returns which are used to set prices.

Critical Actions:

- Development of additional auditing expertise including, as appropriate, the development of business rules within claims management systems to ensure a high degree of ‘front end’ accuracy.

Conclusion

As can be seen from the above brief outline of major building blocks, the Irish health system already demonstrates a strong capability to set prices and to classify and report activity in respect of inpatient and daycase services. However, timeliness of coding will have to improve dramatically in order to support the safe and successful introduction of ‘Money Follows the Patient’ and the classification system will have to evolve to fully articulate policy intentions. In addition, significant capacity and infrastructure must be developed in relation to financial and claims management both at central and hospital level, and this will require intensive work throughout 2013. Coupled with this, ‘Money Follows the Patient’ can’t be considered in isolation from the wider reform programme. To this end, a number of critical interdependencies exist in relation to other reform initiatives and these are mapped out in section 6.2 below.

6.2 Critical Dependencies**Context for Introduction of ‘Money Follows the Patient’**

The introduction of ‘Money Follows the Patient’ represents a radical move away from a historical block grant allocation process which has been in place for many years. This radical shift is being implemented against a backdrop of major financial constraint and decreasing budgets within the acute hospital sector. Since 2008, hospitals have absorbed budget reductions in the region of 20+%. Moreover, hospitals are also the subject of major structural reform plans with the creation of Hospital Groups.

In addition, the Government has indicated its intention to return the vote to the Department of Health and to move towards the charging of all private patients in public hospitals.

Critical Dependencies

These wider contextual factors translate into a number of critical dependencies which represent the core foundations for the new funding system, namely:

- the development of a **comprehensive financial management plan** which will provide safeguards to ensure financial stability and sustainability of the hospital system (including responsible cashflow management);
- the creation of **Hospital Groups**, with devolved Group budgets and fully functioning Group management teams, as the contracting entity for ‘Money Follows the Patient’⁵⁰;
- the **transition of Vote management to the Department** in a manner which supports the timely creation of the new purchasing structures envisaged under ‘Money Follows the Patient’, and
- the introduction of a sustainable mechanism for meeting the **cost of private patients** in public hospitals⁵¹.

In conclusion, the issues outlined above all represent **core foundations which are necessary for building a stable and sustainable new funding system**. Beyond this, in seeking to transform organisational (Hospital Groups) and financial (public and private funding) structures, it is essential that we understand the interdependencies between these various change agendas, that we model the multiple effects and that we ensure robust implementation strategies and safeguards are in place throughout the transition period.

All of these issues must be taken into account when deciding on our starting point.

6.3 Getting Started and Building Capacity

An important precursor to the introduction of ‘Money Follows the Patient’ is the **Pilot Project on Prospective Funding of Certain Elective Procedures at Selected Sites**. This

⁵⁰ The Groups represent an exciting opportunity in terms of the efficient and effective introduction of the new funding initiative insofar as they (a) allow important and expensive infrastructure for patient level costing and claims management to be established at the Group level, (b) allow critical financial management capacity to be established at the Group level, (c) ensure that clear hospital budgets are identified and that authority for managing those budgets is delegated to Hospital Group level, (d) provide a larger funding base over which to manage financial risk than the existing hospital organisational structures thereby potentially facilitating the quicker introduction of prospective case-based funding and (e) allow hospitals to leverage greater efficiency by configuring services across the Group.

⁵¹ As noted in chapter 2, a significant proportion of private patients in public hospitals are not charged for their treatment due to current bed designation rules. Under a ‘Money Follows the Patient’ system, these patients would become an uncompensated cost. This underscores the need to find a sustainable means of moving to charging full economic cost for all private patients in public hospitals.

pilot was undertaken from July 2011 to July 2012 and involved prospectively setting prices and activity levels for four elective DRGs at selected sites. The sites were then funded for those procedures on the basis of coded information returns which confirmed the delivery of the agreed activity. The pilot demonstrated positive results in terms of enhanced efficiency (as measured by day of surgery admission rates and average length of stay) and was an immensely valuable learning experience.

The next step must now be to plan for the move to full, system-wide implementation. In making this move, it is essential that **a whole system approach is adopted**, i.e. that roll-out of ‘Money Follows the Patient’ is not firstly limited to particular specialities or to elective work only. This is vitally important in terms of limiting the potential for cost shifting and dumping, and in order to understand the full impact of the new funding initiative on hospital services. Notwithstanding this approach, it will be necessary to begin the system with **inpatient and daycase activity** in order to allow time for the evolution of the coding system to other settings.

Shadow Funding

As noted in section 6.1, in order to introduce ‘Money Follows the Patient’, there are a number of issues to be addressed at hospital level, including the faster coding of HIPE data, the development of financial management and informatics capacity and the introduction of IT infrastructure for patient level costing and claims management. At a central level, significant issues also stand to be addressed in terms of commissioning expertise, the transition from cash to claims management and the development of a robust electronic claims management function which can efficiently and effectively manage the vast quantity of claims which will be generated under the new system.

These implementation issues, coupled with the current budgetary challenges and the significant structural transformation agenda planned for hospital sector, all mean that the best approach is to **start ‘Money Follows the Patient’ in shadow form in 2013**. This will involve hospitals continuing to receive their existing base budget under a vote cashing system. However, a process would be put in place to compare, on a systematic and periodic basis, (i) actual hospital activity against pre-agreed baseline activity targets and (ii) hospital expenditure against pre-agreed DRG prices. In this way funding variances and potential impacts would be highlighted although no changes would be made to a hospital’s budget on foot of the exercise.

In order to ensure that the structural and financial reform agendas for the hospital sector are fully aligned, shadow funding will be rolled out in 2013 to **the Hub hospital of each Hospital Group**. By focusing on the Hub hospital, this approach allows Hospital Groups time to develop while still facilitating shared learning across the entire Group. It also enables the health system to leverage maximum efficiencies and economies of scale when investing in necessary resources, thereby reinforcing the optimally efficient service delivery model envisaged in the creation of Hospital Groups. Finally, it ensures that, from the outset,

Hospital Groups are acknowledged and nurtured as the contracting provider entity under 'Money Follows the Patient'.

In short, the shadow funding approach enables early momentum in the implementation of 'Money Follows the Patient' albeit in a safe environment which acknowledges the need for learning and capacity building, and the need for time during 2013 to craft new Hospital Group structures.

6.4 Implementation Timetable

It is intended to move from shadow funding to full phased implementation of 'Money Follows the Patient' from 1 January 2014. However, in order to protect the stability of the public hospital system, the new model will be carefully rolled out over a number of years in accordance with a clear, published timetable. Significant stakeholder engagement and detailed financial modelling at both hospital and national level will be undertaken prior to finalising the implementation timetable. This will ensure that risks can be clearly identified and appropriate strategies deployed to guarantee a smooth and stable transition.

7. Next Steps and the Journey Ahead

7.1 Consultation

The introduction of ‘Money Follows the Patient’ represents a sea-change for the Irish hospital system. The new funding model integrates governance, performance management and financing into a fully integrated process that is centred on the patient and driven by communication of patient level information. Communication is at the heart of the system and so, not surprisingly, the next step in developing this policy will involve engagement with stakeholders throughout the health service in order to support consultation on the draft policy and preparation of detailed implementation plans.

Communication will not end with formal consultation on the policy document. A commitment to ongoing engagement is central to the successful introduction of the new ‘Money Follows the Patient’ system and is a core element of the system itself. Indeed, as noted in earlier chapters, it will only be through regular structured consultation that the funding model can remain responsive, fit for purpose and in the ownership of all those within our health service.

7.2 Future Evolution of Policy

Future Health: A Strategic Framework for Reform of the Health Service 2012- 2015 sets out a vision for the future of our health service. At the heart of this vision is a new integrated model of care which treats patients at the lowest level of complexity that is safe, timely, efficient and as close to home as possible.

The successful transformation of our care delivery model requires a corresponding transformation of our funding model. This policy document represents an important first step in that transformation process. However, the journey must not end there and, as stated above, it is vital that the policy continually evolves so as to create the correct incentives to deliver optimal care for the Irish population. As such, we will continue to develop policy so that money can *follow* the patient out of hospital settings where appropriate and towards the provision of safe, timely treatment in primary care. We will also develop policy in relation to integrated payment systems which support integrated, patient-centred delivery of an episode of care across different settings.

While these tasks will be challenging and the journey will take time, the reward will be a fairer funding system which better supports the health service to do its job in caring for our citizens.

Appendix A: Hospital Categorisation

Category 1 Hospitals - for the Purposes of Bed Designation	Categorisation of Hospitals in the National Casemix Model by Group
	Group
Beaumont	1
Cork University Hospital	1
Connolly Hospital	1
Mater	1
St James	1
St Vincents	1
AMNCH Tallaght	1
UCHGalway	1
Limerick Regional	2
Mercy	2
Our Lady of Lourdes, Drogheda	2
Sligo	2
South Infirmary Victoria	2
Waterford Regional	2
Cappagh	2
Coombe	M
Holles Street	M
Rotunda	M
Crumlin	P
Temple St	P
Category 2 Hospitals - for the Purposes of Bed Designation	Categorisation of Hospitals in the National Casemix Model by Group
	Group
Cavan	2
Naas	2
Croom	2
Gurranebraher	2
Letterkenny	2
Louth	2
Mallow	2
Mayo	2
Mullingar	2
Navan	2
Portiuncula	2
Portlaoise	2
St Columcilles	2
St Lukes Kilkenny	2
Tralee	2
Tullamore	2
Clonmel (South Tipperary)	2
Wexford	2

Category 3 hospitals for the purposes of bed designation comprise of HSE district hospitals and they are not included in the National Casemix Programme.

Appendix B: Current Legal Framework for Raising Statutory Charges

Emergency Department Charges

A charge of €100 applies for attendance at an A&E Department except in the following cases:

- (a) persons with full eligibility;
- (b) women receiving services in respect of motherhood;
- (c) children up to the age of six weeks;
- (d) children suffering from diseases or disabilities prescribed under section 56 (3) of the Act;
- (e) children in respect of defects noticed at a health examination held pursuant to the service provided under section 66 of the Act;
- (f) persons receiving services for the diagnosis or treatment of infectious diseases prescribed under Part IV of the Health Act, 1947 ;
- (g) persons undergoing tests for the purpose of ascertaining the presence of a disease, defect or condition that may be prescribed under section 70 of the Act;
- (h) persons who are deemed, pursuant to section 45 (7) of the Act, to be persons with full eligibility in relation to an out-patient service;
- (i) persons who have a letter of referral from a registered medical practitioner;
- (j) persons whose attendance results in admission as an in-patient,
- (k) Health (Amendment) Act Cardholders.

The legal basis for charges is set out in the Health (Out-Patient Charges) (Amendment) Regulations 2008 (SI 544/2008) made under section 56 of the Health Act 1970.

Inpatient Services for Public Patients

The current statutory inpatient charge is provided for by the Health (In-Patient Charges) (Amendment) Regulations, 2008 (SI No. 543/2008). These regulations amend article 4 of the Health (In-Patient Charges) Regulations, 1987 (SI No. 116 of 1987) so that the charge stands at €75 per day subject to a maximum of €750 in any period of twelve consecutive months. The 1987 regulations provide for the following exemptions:

- (a) persons with full eligibility
- (b) women receiving services in respect of motherhood,
- (c) children up to the age of six weeks,
- (d) children suffering from diseases prescribed under section 52 (2) of the Act,
- (e) children in respect of defects noticed at a health examination held pursuant to the service provided under section 66 of the Act,
- (f) persons receiving services for the diagnosis or treatment of infectious diseases prescribed under Part IV of the Health Act, 1947 ,
- ~~(g) persons who are subject to a charge under the Health (Charges for In-patient Services) Regulations, 1976 (S.I. No. 180 of 1976), (revoked by SI No. 276/2005)~~
- (h) persons who are deemed, pursuant to section 45 (7) of the Act, to be persons with full eligibility in relation to an in-patient service,
- (i) Health (Amendment) Act Cardholders.

The regulations are made under section 53 of the Health Act 1970.

Daycase Services for Public Patients

The statutory inpatient charge also applies to daycase services (see SI 38/1994).

Inpatient Services for Private Patients

Under section 55 of the Health Act 1970, the HSE must charge for services provided in private and semi-private beds to private patients in accordance with the directions of the Minister. The current rates are set out below and are **in addition to** a daily charge of €75 per day subject to a maximum of €750 in any period of twelve consecutive months charges.

Rates in 2012 are:

Hospital Category	Private	Semi-private	Day-care
HSE Regional Hospitals and Voluntary and Joint Board Teaching Hospitals	€1,046	€933	€753
HSE County Hospitals and Voluntary Non-teaching Hospitals	€819	€730	€586
HSE District Hospitals	€260	€222	€193

Daycase Charges for Private Patients

As above

Outpatient Charges for Public and Private Patients

Where an individual attends a consultant in a private capacity, s/he is liable for the private consultant fee.

Apart from the private consultant fee, the only other fee payable by a private patient when attending the outpatient department in certain public hospitals is the charge for MRI scans. This charge is payable under section 4 of the Health Services (Out-Patient) Regulations, 1993 (SI No. 178/1993) which are made under section 56(5) of the Health Act 1970.

NTPF

Where the NTPF purchases treatment for a public patient in a public hospital, that person is not charged the statutory inpatient charge.

Long-Stay Services

Where inpatient services are provided for more than 30 days the following statutory charges apply:

- (i) where 24 hour nursing care is provided, a maximum of €153.25 per week,
- (ii) where 24 hour nursing care is not provided, a maximum of €114.95 per week.

The legal basis for the charges is set out in SI 521/2008 which amends the Health (Charges for In-Patient Services) Regulations 2005 (SI 276 of 2005) made under section 53 of the Health Act 1970 as amended by the Health (Amendment) Act 2005. Section 53(3) of the Health Act 1970 provides for the following exemptions:

- (a) a person under 18 years of age,
- (b) a woman in respect of motherhood,

- (c) a person detained involuntarily under the Mental Health Acts 1945-2001,
- (d) a person who is in a hospital for the care and treatment of patients with acute ailments (including any psychiatric ailment) and requires medically acute care and treatment in respect of any such ailment, or
- (e) a person who pursuant to section 2 of the Health (Amendment) Act 1996, in the opinion of the HSE, has contracted Hepatitis C directly or indirectly from the use of Human Immunoglobulin Anti-D or the receipt within the State of another blood product or a blood transfusion, or
- (f) people receiving services for the diagnosis and treatment of diseases prescribed under Part IV of the Health Act, 1947.

Charges under the Nursing Homes Support Scheme Act

The Nursing Homes Support Scheme Act defines “long-term residential care services” as essentially encompassing maintenance, health or personal care services provided for more than 30 days in (i) approved nursing homes, where 24 hour nursing care is provided, or (ii) facilities which as designated in writing by the HSE as being predominately for the care of older people and where 24 hour nursing care is provided. A person is responsible for meeting the costs of their long-term residential care but can apply to the HSE for financial support. In order to qualify for support, a person must undergo a care needs assessment to determine whether they need long-term residential care. They must also undergo a means test which will work out their ability to meet the cost of such care. Essentially, a person will be expected to contribute up to 80% of their disposable income and 5% of the value of assets above the asset disregard towards the cost of care (‘personal contribution’). The State will meet the full balance of cost over and above the personal contribution.

Where a person enters public long-term residential care, the HSE shall charge the person the full economic cost of the services provided to them. However, that cost is obviously offset by the amount of financial support provided through the Nursing Homes Support Scheme.

Charges in respect of Road Traffic Accidents

Section 2(1) of the Health (Amendment) Act 1986 allows the HSE to recover the costs of hospital services provided at the full economic cost from a person who received or is entitled to receive damages or compensation arising from a road traffic accident. The Act does not withdraw eligibility for public hospital services from road traffic accident victims, but allows the HSE to recover the costs of hospital services provided at the full economic cost. The economic cost is calculated on the basis of an Annual Daily Charge (ADC) which is arrived at by dividing a hospital’s total expenditure by the number of bed days for a calendar year.

Charges in respect of Delayed Discharges

Where a person in a hospital setting is certified as no longer requiring acute care and has not applied for a care needs assessment within 15 working days of being notified of, and provided with an application form for, the Nursing Homes Support Scheme, then a charge equal to the average cost of public nursing home care may apply. The legal basis for this charge is set out in section 53A of the Health Act 1970. This is supported by a HSE "National Standard Operating Procedure: NHSS Acute Hospital In-patient Charges".

Appendix C: English Experience of Best Practice Tariffs

Best Practice Tariffs (BPTs) have been introduced in the NHS in England with the aim of having “tariffs that are structured and priced appropriately both to incentivise and adequately reimburse providers for the costs of high quality care”⁵². The areas where BPTs have been introduced on a phased basis are set out below:

2010	2011
Cataracts	Adult Renal Dialysis
Cholecystectomy	Daycase Procedures for Breast Care, Hernia Repair, Orthopaedic Surgery, Urology & Gynaecology
Fragility Hip Fracture	Interventional Radiology
Acute Stroke Care	Paediatric Diabetes
	Hip & Knee Replacement
	TIA/ Mini Stroke

BPTs are built upon widely accepted clinical evidence and involve clinical and financial engagement. BPTs may have different payment structures, for example, a tariff may be set to encourage a procedure to be carried out in a daycase/outpatient setting or the tariff may consist of a base tariff and additional payments made if the care delivered meets specific conditions to ensure best practice care is met.

⁵² A Simple Guide to Payment by Results, Department of Health, UK

Appendix D: Background Paper on Quality and DRG Systems

Overview

DRG based payment systems have been implemented across many European nations because they are acknowledged to have a positive effect on the efficiency and quality of hospital services. However, the impact on quality is not straightforward. Although the funding system can create incentives to improve quality, there is also the potential for it to negatively impact on the quality of care provided.

Under a DRG based payment system hospitals are incentivised to reduce their costs to be more efficient. In doing so, hospitals will often seek to reduce average length of stay rates, reduce the intensity of services provided and may also seek to select the patients that they treat. This will impact on quality in different ways.

Reducing average length of stay, can improve quality if the clinical processes and management of patients are improved through developing best practice care pathways. However, this must be carefully balanced so that incentives do not lead hospitals to inappropriately discharge patients in a manner which may not be compatible with clinical best practice. Hospitals may also be encouraged to reduce the intensity of services provided, which may improve quality by reducing the number of unnecessary tests and treatment provided to patients. However, if hospitals are incentivised to withhold necessary treatments, this would reduce the quality of care provided. Similarly, while specialisation could improve efficiency and quality, regulators and payers must be cautious of the potential for ‘creamskimming’.

Incorporating Quality into DRG Systems

The design of the payment system is vital to ensuring that it creates the right incentives to improve the quality of care provided in the system. The literature suggests that there are 3 options for adjusting DRG based payment systems on the basis of quality of care:

- At the hospital level
- At the level of the DRG
- At the individual patient level

1 Hospital Level

Total hospital income could be adjusted on the basis of hospital-level quality indicators, thereby rewarding hospitals for improvements in the quality of care provided. An example of this is in England where the Commissioning for Quality and Innovation Framework enables commissioners of services to reward high quality by linking a proportion of providers’ income to the achievement of local quality improvement goals⁵³.

⁵³ In 2010/2011 the Commissioning for Quality and Innovation payment framework covered 1.5% of a providers annual contract income.

An alternative approach utilised by Medicare in the USA involves applying lower DRG based payments for all patients in hospitals that have above average readmission rates for certain medical conditions.

2 At the level of the DRG

When patient level data on outcomes and/or treatments is available it is possible to adjust certain DRG payments based on the quality of all patients treated within that DRG. This involves moving away from payments by reference to average costs to payment based on best practice. England has introduced best practice tariffs for certain HRGs whereby payment is made dependent on whether or not the treatment was provided in the most appropriate setting or whether the best practice clinical treatment was provided.

Another example of this is in Germany where a quality adjustment forms part of a contract between a sickness fund and a hospital that treats coronary bypass surgery patients. The hospital receives higher payments for coronary bypass patients if it scores above the national average on a set of heart surgery quality indicators, collected by the German external quality assurance system.

3 At the level of the Individual Patient

Providing adjustments at the individual patient level requires reliable indicators of patient outcomes which are not always easily identifiable and can often be controversial. An example of where this is applied is the USA. In Medicare a 'present on admission' code is applied for primary and secondary diagnosis. If the diagnoses were contracted during a hospital stay, Medicare will not pay for the extra costs of hospital acquired infections.

Quality can also be integrated into the DRG payment for the individual patient by extending the treatment episode for which a DRG based payment is granted e.g. to include outpatient, readmission etc. In England and Germany hospitals do not receive a second DRG payment if a patient is readmitted within 30 days for the same condition – this helps to overcome the incentive of inappropriate early discharge. Similarly in France in order to guard against early discharge per diem based deductions below the defined lower length-of-stay thresholds are applied.

Other Measures to Improve Quality

Few countries actually seek to explicitly adjust DRG-based payments on the basis of information on quality. Other measures are also used to drive the quality care agenda. In France funding is provided separately for infection control programmes for example, whilst in Germany in order to ensure that providers are not incentivised to increase profits with little regard for quality of care, regulatory measures were introduced including production of hospital quality reports to support comparisons across hospitals and hospitals must also participate in a quality assurance programme. In Ireland, the introduction of Licensing Legislation for all healthcare providers will enhance patient safety by ensuring that providers do not operate below core standards which are applied in a consistent and systematic way.

Information on quality outcomes of care is crucial and some hospitals are financially incentivised to provide this information. For example, Medicare in the USA encourages hospitals to report information on 10 quality measures. Failure to do so results in a 0.4% reduction on their DRG prices. In Germany, hospitals are penalised if they report quality information for less than 80% of their treated cases.

Summary

DRG case-based payment systems have introduced transparency to the funding process and have helped to improve the efficiency of the delivery of hospital services. Achieving greater efficiency can improve quality through the development of best practice clinical care pathways and the use of new innovative technologies. Nevertheless, it is critical that the DRG case-based payment system is designed to guard against perverse incentives that would negatively impact on quality, such as early discharging, under treatment and creamskimming.