Editorial

Hospital Funding: Case-mix or Global Budgeting System

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The rapid shift towards universal health coverage depends on the efficient utilization and improved recruitment of resources.[1] During the past decades, equitable access to the most cost-effective healthcare services is one of the major challenges faced by policy-makers, providers, and patients. The current evidence suggests that the wrong utilization of payment methods may lead to the misuse of limited resources.[2] The aim of this study is to compare the funding of hospital using global budgets and case-mix funding in terms of their method, pros, and cons, and also to enumerate the implementation and monitoring challenges of the two systems.

PAYMENT METHODS

There are two basic approaches to payment systems which are retrospective and prospective.[3] In the retrospective payment system, the provider's own cost is partially or fully reimbursed ex-post while opposite to this the payment budgets or rates of providers are determined ex-ante in the prospective system.[4] The prospective method includes the case-mix system, capitation payment, and global budget while the fee-for-service and payment per itemized bill are included in retrospective systems.[3]

CASE-MIX SYSTEM

The purpose of introducing diagnosis-related groups (DRGs) is to measure what hospitals actually do to define hospital products.[5] Case-mix system is used to classify people into classes that are homogeneous in the respect of resources used with meaningful clinical descriptions of these individuals as it is a reflection of the total risk of all individual patients within a hospital.[3,6] It has been implemented worldwide in more than 40 countries including Asia.[7] The two basic components of this system are disease classification which includes coding for diagnosis and procedures and cost analysis which comprises top-down costing, clinical pathways, and activity-based costing.[8]

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IMPLEMENTATION AND MONITORING

The two main issues in implementation and adaptation are costing methods and patient classification.[9] In this system, the accuracy of the coding is crucial, a wrong code will relate to an incorrect assignment of the DRGs code which may have an adverse impact on hospital income in countries, thus the accuracy coding is ensured through coding audits.[8,10] It involves difficult technical choices to maintain and design this system as there is a need to monitor the wrong effects of the endowment system and take account of changes in health technology.[10] The substantive responsibility of direct expenses in most low and middle-income countries and the lack of correct data on the share of financing of each mechanism render the task of assessing the overall progressivity of Asian health care systems more difficult than in Europe.[11]

ADVANTAGES

This system provides incentives for hospitals by which it improves efficiency as it treats more people and limits the service per patient.[5] It proves economically beneficial for both the patient and a hospital's budget setup, as it reduces the average stay duration of patients in hospitals and eliminates as much the need for the hospital to provide many items of service.[12]

DISADVANTAGES

There are also several drawbacks which are the intensive need for technical skills in designing case-mix system, disease coding quality is also affected and the information about the costing data is also limited.[13] Upcoding, cherry-picking, dumping, frequent readmissions, and overtreatment are the other potential unintended consequences of DRG-based hospital payment. Cherry-picking occurs if certain patients are systematically more costly than others within one group leading incentives for hospitals to select more profitable cases which are less costly and to avoid or transfer unprofitable ones (dumping).[5]

GLOBAL BUDGETING SYSTEM

In a global budgeting system, a hospital-acquired lump sums to cover all particular services throughout a specified period as it allows managers real flexibility when they are strictly enforced.[14] It is used by some types of outpatient care facilities as well as by government or insurers to pay hospitals.[15]

IMPLEMENTATION AND MONITORING

An operational framework requires for implementing the global budgeting system which includes how payers will participate and how an effective structure for administration and governance will be established.[16] In addition, it also needs information about the patient population, the type of services included in the system along with monitoring of its performance.[17] It can result in high overall spending by transfer of services from hospitals to non-hospitals providers in their area as payer would be paying both for care that has shifted and fixed budget of target hospital.[17] So the two important considerations are important for obtaining micro-efficiency include responsibility and decentralization of management capacity.[18] Effective monitoring of payment patterns and trends depends on per capita spending, service volume, and high-quality data on service prices. The health insurance purchasing cooperatives (HIPCs) and health plans need data on costs, volume, and service pricing at the local level as it is crucial for internal use. There is also the need for information on the quality of care, practice patterns, and patient outcomes to assist HIPCs in identifying the most cost-effective practices where such standards do not yet exist and in monitoring health plans compliance with accepted practice standards.[19]

ADVANTAGES

The major benefit of the global budgeting system is that it gives cheaper and easier administration, assurance of funding, and better management of services.[18] It can promote the addition of incentives and the improvement of changes to service delivery patterns to reward efficiency, suitable clinical practice, and quality. It can manage and control the cumulative overall spending on a particular service by the healthcare institution and program.[18] By limiting the total expenditure global budgets contain costs but run the risk of hospitals not producing enough services to meet patient needs.[5]

DISADVANTAGES

Global budgeting system may have unintended consequences if the effects are too strong. For example, it is intended to reduce the cost of treatment and length of stay but the quality of care may reduce due to excessive reduction in length of stay.[5] It results in the waiting when the target volume is exceeded and creates a situation in which either the hospital will reject to do additional work or as to give extra cash and the lack of incentives to get better efficiency is one of the major restrictions which can be faced by using this model.[20]

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