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How can funding models foster health systems' resilience?

Episode 3 of the Webinar Series
Health Management in action:
Fostering health systems' resilience

This webinar is co-funded by the EU4Health Programme of the European Union. Views and opinions are of the speakers only.

George Valiotis

EHMA Executive Director

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About EHMA

OUR VISION is excellent health management for a healthy Europe.

OUR MISSION is to support the spread of knowledge on effective health management.

OUR VALUES are excellence, quality, inclusiveness, relevance, and respect.

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- We are the **only membership organisation in Europe** to bring together the full health management ecosystem.
- We are a recognised and respected **amplifier of best practices** in the evolution of health management.
- We provide an environment where **evidence, challenge and experience are valued**, and complex debates on current topics can take place.

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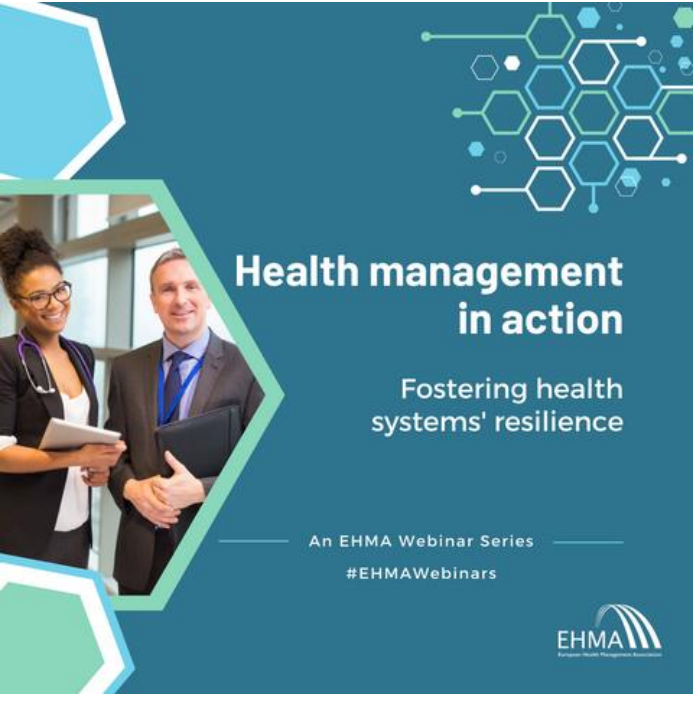

About this webinar series

Our webinar series, ‘Health Management in action: fostering health systems’ resilience’, discusses **health management topics** that are crucial **to improve health systems preparedness and response**.

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Practical information

1. All participant **microphones should remain muted** to keep the audio clear

2. If you have any questions, you can **type them in the chat box**. We will answer them during the Q&A.

3. This webinar is being recorded. **The recording, materials and a summary report will be made available** on the EHMA website - www.ehma.org

4. **We are live-tweeting**. Join us tagging us at @EHMAinfo and using the hashtag #EHMAwebinars

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Agenda

- **13.30 - 13.40 (10 minutes):** Welcome and introduction
- **13.40 - 14.00 (20 minutes):** Presentation by Prof. Americo Cicchetti, Catholic University of Sacred Heart, Italy
- **14.00 - 14.15 (15 minutes):** Q & A

- **14.15 - 14.45 (30 minutes):** Informal networking session

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Our speaker

Prof. Americo Cicchetti

Professor at the Faculty of Economics,
Catholic University of Sacred Heart;
Director at ALTEMS, Italy

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Healthcare systems: the main funding frameworks

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Pluralistic systems	Mutualistic systems	National health services
• Health is valued as a good. • The State doesn't intervene in the funding and the provision of the services, which is regulated by health insurance.	• Health is valued as a good, which is, however, guaranteed. • The State is responsable for the national health policy. • The State can own health facilities.	• Health is valued as a right. • The State is responsable for the national health policy. • The State raises the funds throught general taxation, and allocate helath resources based on health planning.

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Italian healthcare system

In the Italian National Health Service (NHS), with the reform of Title V of the Italian Constitution, health has become a matter of concurrent competence between the **national** and **regional** levels.

Regions are responsible for the organisation and the provision of health services through local health agencies and public or private accredited hospitals.

The central government allocates part of the general tax revenues to health care, defines the health care package (LEA) and exercises a stewardship role.

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Italian healthcare financing mechanisms

The national law annually determines the overall level of resources of the NHS, which is financed by the central government through the **National Health Fund (NHF)**.

The NHF is financed by the following sources:

1. Regional general taxation;
2. Own revenues of NHS entities;
3. The national budget, which finances health needs not covered by other sources of financing.

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Italian healthcare financing mechanisms: how the allocation is performed

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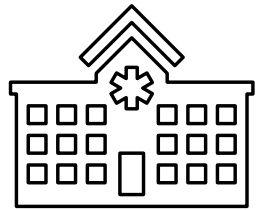
The central level → The regional level → The local level

Using a distribution criteria, based on the historical expenditure for hospital care weighted by sex and age of the resident population, financial resources are allocated to each regions.



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Italian healthcare financing mechanisms: how the allocation is performed

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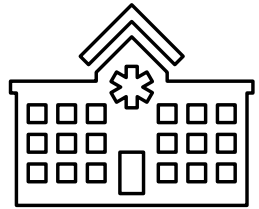
The central level → The regional level → The local level

The regions assign to Local Health Units (LHUs) a weighted capitation quota for hospitals based on demographic, epidemiological characteristics and health needs of the population residing in the reference area.



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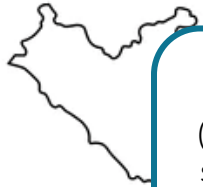
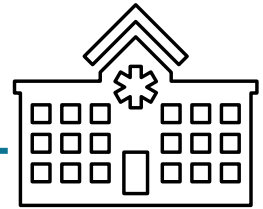
Italian healthcare financing mechanisms: how the allocation is performed

The central level → The regional level → The local level



Each LHU finances hospital services (through the DRG tariff system) provided to its residents by different categories of accredited suppliers.



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Italian healthcare financing mechanisms: how the allocation is performed

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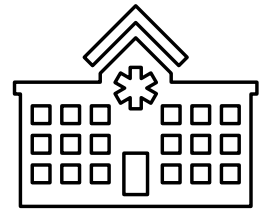

ISSUE

The capitation formula used to distribute funds for health among regions doesn't take into account different conditions in terms of social deprivation, education, employability and family conditions.

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From the financing system to health policies

Given the characteristics of the Italian healthcare financing system, it is crucial for policy makers to define appropriate evaluation tools, in order to allocate in the most appropriate and coherent way the healthcare resources.

With the aim of maximising value, and thus defining value-based decisions, a main tool to support decision-makers is the Health Technology Assessment (HTA), which, based on the systematisation of scientific evidence in the literature on the health technologies under study, justifies the use of the technology.

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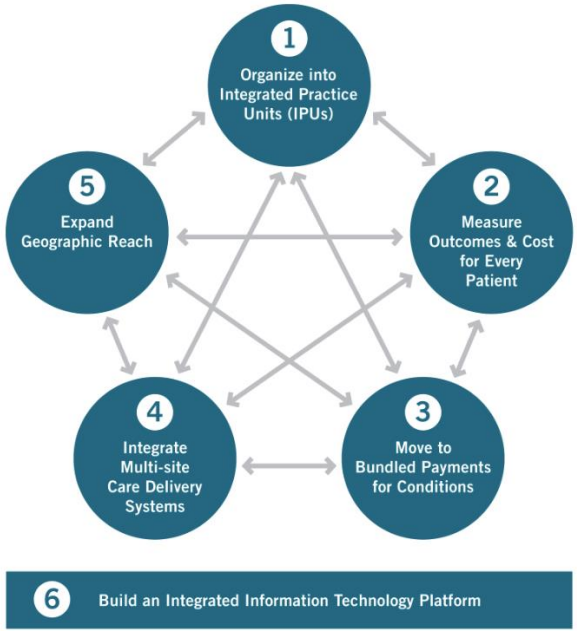
Value-based healthcare



Value-based approaches to organizing health care delivery are widely touted as critical to improving the health outcomes of patients worldwide and controlling runaway health care costs.

The major example of a value-based payment model is the application of managed entry agreements (outcomes-based agreements for medicines) by AIFA. Among them, 'payment by results' is an approach that links the payment of new drugs with largely unknown benefit to the achievement of specific outcomes agreed with the manufacturer in clinical practice

ISSUE

Currently in Italy there is no common method for analyzing the existing approach and embracing value-based healthcare.

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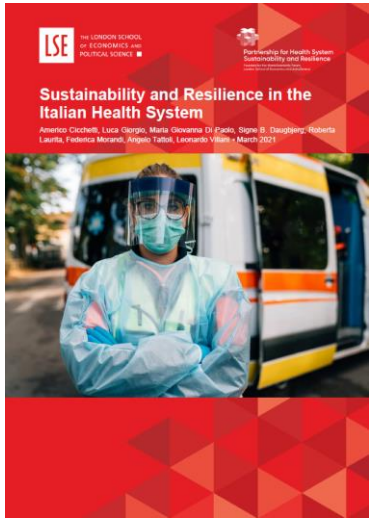
Evidence from Italy



Financing	Sustainability	Resilience
Strengths	• The financing model considers an equalisation fund to ensure equitable access to care in all Regions	• The contribution of prescription charges to the total amount of funding available for healthcare is limited • The system's ability to quickly make funds available for COVID-19 emergency
Weaknesses	• Funding allocation mechanism does not consider social deprivation, education, employability or housing and family conditions • Scarce attention to value-based payments and a system based on 'spending silos' (hospital, outpatient and pharmaceutical expenditure)	• Excessive cost-containment pressures resulted in a lack of adequate provision of hospital beds, staff and technologies

DRGs and Innovation

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Table 3 – Frequency of DRG system updates and time-lag to data used for updates in 12 European countries.

	DRG-based hospital payment system			
	Patient classification system		Payment rate	
	Frequency of updates	Time lag to data	Frequency of updates	Time lag to data
Austria	Annual	2–4 years	4–5 years (updated when necessary)	2–4 years
England	Annual	Minor revisions annually; irregular overhauls every 5–6 years	Annual	3 years (but adjusted for inflation)
Estonia	Irregular (first update after 7 years)	1–2 years	Annual or following update of FFS fees	1–2 years
Finland	Annual	1 year	Annual	0-1 year
France	Annual	1 year	Annual	2 years
Germany	Annual	2 years	Annual	2 years
Ireland	Every 4 years, linked to Australian updates of AR-DRGs*	Not applicable (imported AR-DRGs)	Annual - linked to Australian cost weight updates	1–2 years
The Netherlands	Irregular	Not standardized	Annual or when considered necessary	2 years, or based on negotiations
Poland	Irregular – planned twice per year	1 year	Annual update only of base rate	1 year
Portugal	Irregular	Not applicable (imported AP-DRGs)	Irregular	2–3 years
Spain (Catalonia)	Biennial	Not applicable (imported 3 year old CMS-DRGs)	Annual	2–3 years
Sweden	Annual	1–2 years	Annual	2 years

AR-DRGs, All patient (AP-)DRGs; CMS-DRGs, Centers for Medicare and Medicaid Services DRGs; DRGs, diagnosis-related groups; FFS, fee-for-service.

Scheller-Kreinsen, D., Quentin, W., & Busse, R. (2011). DRG-based hospital payment systems and technological innovation in 12 European countries. Value in Health, 14(8), 1166-1172.

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Recommendations for policy and management to improve the level of health system resilience

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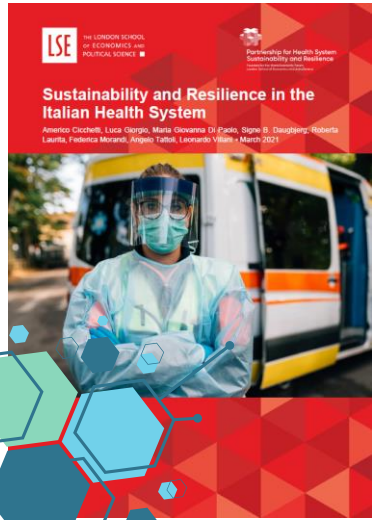
2A **Enrich** the **fund allocation** formula to take into account differences in terms of social deprivation, education, employability, and housing and family conditions that still exist among Italian regions



2B **Reduce out-of-pocket private expenditures** and facilitate access to integrated funds via tax incentives

2C **Introduce value-based payment models** and measures to mitigate budgetary siloes, and develop a health expenditure forecast model

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Q & A

Type your questions in the chat box
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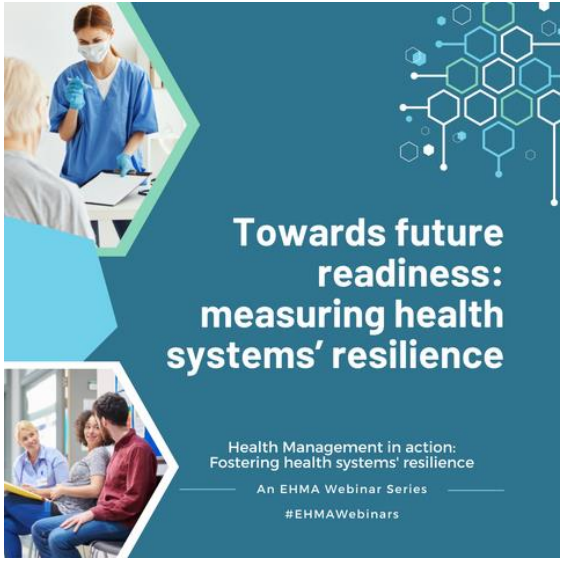
Next webinar



Towards future-readiness: measuring health systems' resilience

When: **Wed., 5 October 2022**, 13.30-14.15 CEST

Speaker: **Ms Lucy Morgan**, Senior Researcher, Health Policy Partnership, United Kingdom

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90-second survey

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