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TECHNICAL REPORT

Funding intensive care – approaches in systems using diagnosis-related groups

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Prepared for the Department of Health
within the PRP project "An 'On-call' Facility
for International Healthcare Comparisons"

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Executive summary

This report reviews approaches to funding intensive care in health systems that use activity-based payment mechanisms based on diagnosis-related groups (DRGs) to reimburse hospital care. The report aims to inform the current debate about options for funding intensive care services for adults, children and newborns in England.

Funding mechanisms reviewed here include those in Australia (Victoria), Denmark, France, Germany, Italy, Spain, Sweden and the United States (Medicare). Approaches to organising, providing and funding hospital care vary widely among these countries/states, largely reflecting structural differences in the organisation of healthcare systems.

Mechanisms of funding intensive care services tend to fall into three broad categories:

- those that fund intensive care through DRGs as part of one episode of hospital care only (US Medicare, Germany, selected regions in Sweden and Italy)
- those that use DRGs in combination with co-payments (Victoria, France)
- those that exclude intensive care from DRG funding and use an alternative form of payment, for example global budgets (Spain) or per diems (South Australia).

Approaches to funding paediatric and neonatal intensive care largely reflect the overall funding mechanism for intensive care. Evidence reviewed here indicates a general concern of potential underfunding of intensive care. These problems may be particularly pertinent for those settings that provide neonatal and paediatric care because of the very high costs and the relatively smaller number of cases in these settings compared with adult intensive care. Similar issues apply to highly specialised services in adult intensive care, such as treatment of severe burns.

Given the variety of approaches to funding intensive care services, this review suggests that there is no obvious example of "best practice" or dominant approach used by a majority of systems. Each approach has advantages and disadvantages, particularly in relation to the financial risk involved in providing intensive care. While the risk of underfunding intensive care may be highest in systems that apply DRGs to the entire episode of hospital care, including intensive care, concerns about potential underfunding were voiced in all systems reviewed here. Arrangements for additional funding in the form of co-payments or surcharges may reduce the risk of underfunding. However, these approaches also face the difficulty of determining the appropriate level of (additional) payment and balancing the incentive effect arising from higher payment.