

# EUROPEAN HEALTHCARE FRAUD AND CORRUPTION NETWORK

**A communication of UEHP**  
European Private Hospital Union

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# Fraud and corruption, and / or Inefficiencies in Health Care System

- Misuse of corporate assets, Bribery
- Back office advantages
- Personal interests for medical doctors, Black money
- Overbilling and Over-prescription
- Medical malpractice and the cost of Non Quality
- Pertinence and Relevance of procedures : the question of payment by act (fees Vs capitation)
- DRG Creeping, hospital activity control

## Fraud, *Some examples*

- Home works (building house) of a public hospital director were paid by the hospital budget (*France*)
- Black money was asked to patient for treatment in public hospital (*Bulgaria*)
- Treatments of patients were bought using Social Security card in Drugstore during the hospital stay, while a specific fee was paid to the private hospital (*France*)
- Misappropriation of funds : Public assets disappeared while they had to be used by private providers for a new hospital building (*Hungary*)

## In « **Quotidien du Médecin** » (French Medical Newspaper)

- Début juillet, la CNAM avait suggéré un vaste plan prévoyant un rabotage des tarifs de certaines spécialités médicales, des efforts supplémentaires au titre de la maîtrise médicalisée en ville, une intensification des recours contre tiers, un **renforcement de la lutte contre la fraude à l'hôpital**, une accélération de la convergence tarifaire et de la performance hospitalière. (September 2011)
- Selon le ministère, les fraudes sociales détectées en 2010 ont dépassé **457 millions d'euros** (deux fois plus qu'en 2006) dont 156 millions concernent l'assurance-maladie, 90 millions les allocations familiales, 10 millions l'assurance vieillesse, 186 millions l'Acoss (qui pilote le réseau des Urssaf), 9 millions le régime agricole et 6 millions le régime des indépendants. (Jun 2010) 4

# A complex situation during financial crisis

- Press release by the Greek Ministry of Health and Social Welfare and the Ministry of Finance site for the Hellenic Association of Pharmaceutical Companies, June 2011 ([www.sfee.gr](http://www.sfee.gr)). “The [Greek state hospital system] debts of 2007, 2008, 2009 amounting to €5.36bn [£4.4bn, \$6.7bn] will be settled with zero coupon bonds.” The hospital debts lingering from 2007 will be paid with two-year zeros, 2008 with three-year zeros, and 2009 with four-year zeros.
- The Dijon (France) hospital has to pay interest €31 m for toxic assets loan of €111 m. (Source Dexia, by Le Monde)

# Medical devices and hospital DRG payment

## A cross-correlation and interdependence of actors

- P. GARASSUS, in Revue « Santé Décision Management »
  - « Pour une lecture européenne des modes de tarification des établissements de soins »
  - « Le prix des Dispositifs Médicaux et les politiques d'achat dans les établissements de soins en France »
  - « Investissements privés en santé dans l'Union européenne. Points de repères théoriques et pratiques »
  - « Les dispositifs médicaux et leur inclusion dans le tarif des séjours hospitaliers en Europe »  
*(Medical devices costs and European hospital payment methods)*
- Eucomed data : The industry employs nearly 500.000 people,  
annual sales of **€95 billion** (8% invested in R&D = €7.6 bn)
- Evaluation\* of hospital expenses in Europe per year (according to Hope data 2005) :  
**€410billion.**
- Healthcare employees more than 15m\* people in Europe, half in hospital
- *Evaluation\* in 2002 for France : 2/3 of LPP MD in private hospitals Vs public in DRG-like tariffs (total €1.2bn)*

\* Personal data



# Healthcare in Europe

## Elements of sustainable, high-quality and fair models for European healthcare systems

*(Geneva, Mars 2011)*

- Thought provoking experts : A Top-down reform. Is there a best structure for healthcare systems? Can different stakeholders agree on common goals? What needs to change now to move towards an improved system?
  - Pascal Garel, Chief Executive, European Hospital and Healthcare Foundation (HOPE) Jaak Peeters, Chairman, EMEA, Janssen Joanna Groves, Chief Executive Officer, International Alliance of Patients' Organizations. Birgit Beger, Secretary General, Standing Committee of European Doctors
- Financing: who pays? Should the private sector bear more of the cost of healthcare and be more involved with the modernisation of the public sector? Should the individual be prepared to shoulder a higher cost of healthcare?
  - Guillem López Casanovas, President, International Health Economics Association; Member of the Board, Central Bank of Spain and Professor of Applied Economics and Dean, Universidad Pompeu Fabra. Paul Garassus, Vice-president, French Health Economic Society and Member of the Board, European Union of Private Hospitals (UEHP). Josep Figueras, Director, European Observatory on Health Systems and Policies and Head, WHO European Centre on Health Policy



# WHO, regional office for Europe

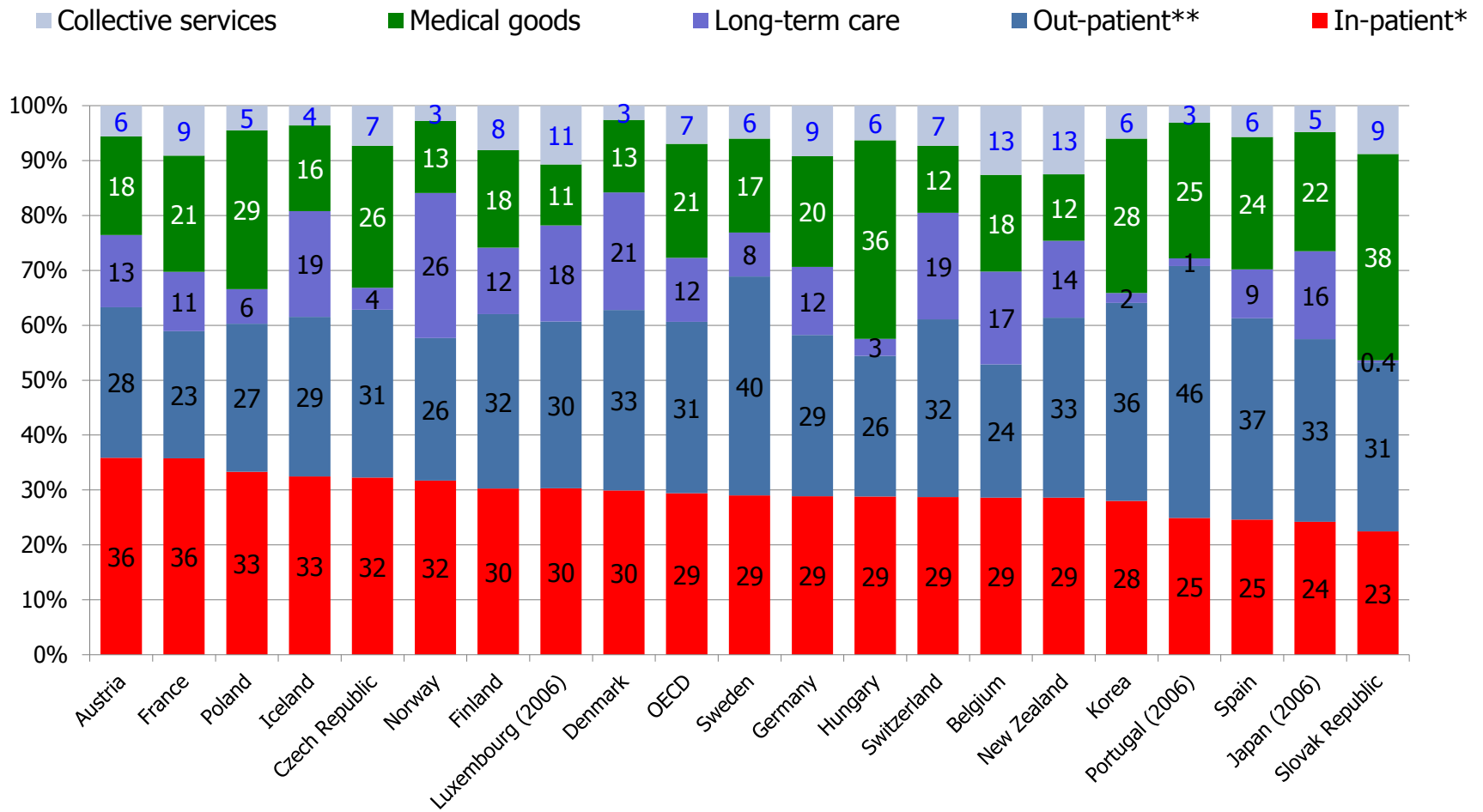
- **What does Eurostat's Labour Force Survey say about health and health inequalities in the European Union?**
- **Stefano Mazzuco**, Department of Statistics, Padua University, Italy
- **Marc Suhrcke**, School of Medicine, Health Policy and Practice, University of East Anglia, United Kingdom



**World Health  
Organization**

REGIONAL OFFICE FOR **Europe**

# OECD - 7.3.1. Current health expenditure by function of health care, 2007



# Public and Private health expenditures in OECD

	Medical services		Pharmaceuticals			Medical services		Pharmaceuticals	
	Public	Private	Public	Private		Public	Private	Public	Private
Mexico	42,5	57,5	11,1	88,9	<b>Germany</b>	<b>79,3</b>	<b>20,7</b>	<b>73,3</b>	<b>29,5</b>
United States	48,7	51,3	24,2	75,2	Slovak Rep	82,9	17,1	73,5	35,7
Korea	55,1	44,9	50,2	53,0	Poland	83,2	16,8	37,9	61,4
Switzerland	58,6	41,4	67,7	34,9	Italy	85,0	15,0	50,2	49,8
Netherlands	71,2	28,7	57,2	48,7	Finland	85,5	14,5	56,3	52,0
Australia	72,8	27,2	57,6	54,1	Japan	85,5	14,5	69,4	33,3
Spain	73,7	26,3	72,5	33,1	<b>France</b>	<b>86,1</b>	<b>13,9</b>	<b>68,9</b>	<b>36,8</b>
Hungary	76,4	23,6	62,7	37,7	Norway	86,9	13,1	58,4	40,5
New Zealand	77,7	22,3	66,0	34,1	Denmark	87,9	12,1	55,8	47,7
<b>Portugal</b>	<b>78,1</b>	<b>21,9</b>	<b>59,0</b>	<b>43,5</b>	Iceland	88,4	11,6	59,5	50,2
Canada	78,3	21,7	38,7	63,0	Sweden	89,9	10,1	69,1	42,5
Austria	78,8	21,2	72,8	31,9	Luxembourg	92,9	7,1	84,0	22,6
	Public	Private	Public	Private	Czech Rep	95,4	4,6	75,5	28,6

# Leaders debate diseases burden

By Andrew Jack in London, Financial Times September 19 2011

- The action is the latest in a series of assertive measures adopted by governments around the globe seeking to tackle the growing economic and social burden of “non-communicable diseases” (NCDs), a theme to be debated for the first time by world leaders at the UN
- The latest estimates from the World Health Organisation suggest 36m of the 57m deaths globally in 2008 were caused by NCDs, with the vast majority in developing countries, where they disproportionately affect people under 60.
- They already cost some countries more than 7 per cent of gross domestic product, according to a review issued this week by the World Bank.

# Big Pharma Relationship with medical doctors

## FINANCIAL TIMES

Last updated: August 29, 2011 8:03 pm

### Pharma groups pay \$150m to US doctors

By Andrew Jack in London



A dozen pharmaceutical companies have paid doctors in the US nearly \$150m so far this year, according to industry data that suggests an increase in these controversial marketing and support practices.

The figures highlight the extent of entertainment, travel, consulting, education and research support to doctors – payments that the industry says are ethical and enhance health outcomes, but which

critics believe can influence prescribing practices.

- Missing data for EU
- Independent experts are required



# DIRECTIVE 2011/24/EU on patients' rights in cross-border healthcare

DIRECTIVE 2011/24/EU OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 9 March 2011,  
**transposition** at october, 25 2013.

- According to Article 168(1) of the Treaty on the Functioning of the European Union (TFEU), a high level of human health protection is to be ensured in the definition and implementation of all Union policies .../... in achieving harmonisation, a high level of protection of human health is to be guaranteed taking account in particular of any new development based on scientific facts.
- As confirmed by the Court of Justice of the European Union on several occasions, while recognising their specific nature, **all types of medical care** fall within the scope of the TFEU.
- This Directive aims to establish rules for facilitating access to safe and high-quality cross-border healthcare in the Union and to ensure patient mobility in accordance with the principles established by the Court of Justice and to **promote cooperation** on healthcare between Member States, **whilst fully respecting** the responsibilities of the Member States for the definition of social security benefits relating to health and for the organisation and delivery of healthcare and medical care and social security benefits, in particular for sickness.



# HOPE data on hospitals in EU

Country ZE15	DE	AT	BE	BG	CY	DK	ES	EE	FI
number hospitals	3 460	272	214	262	96	67	741	51	370
acute care hospitals	2 166	177	146	209	x	22	545	33	x
Acute care beds	531 300	48 800	50 200	38 000	2 900	16 800	115 600	5 700	11 700
% beds public	74,7%	76,2%	35,5%	98,3%	46,8%	96,0%	66,2%	89,9%	96,6%
% beds private	25,3%	23,8%	64,5%	1,7%	53,2%	4,0%	33,8%	10,1%	3,4%
Country ZE15	FR	GR	HU	IE	IT	LV	LT	LU	MT
number hospitals	2 890	319	179	179	1 296	119	181	x	10
acute care hospitals	1 599	268	138	53	1 110	80	80	10	10
Acute care beds	225 900	42 000	59 600	11 900	201 400	12 400	19 100	2 300	1 200
% beds public	65,5%	72,0%	97,3%	na	77,0%	95,0%	99,7%	40,0%	91,1%
% beds private	34,5%	58,0%	2,7%	na	23,0%	5,0%	0,3%	60,0%	8,9%
Country ZE15	NL	PL	PT	CZ	RO	UK	SK	SI	SE
number hospitals	198	844	209	363	416	x	144	29	81
acute care hospitals	110	x	170	200	x	x	100	20	80
Acute care beds	51 000	178 100	32 400	63 300	96 100	x	33 000	7 700	20 000
% beds public	15,0%	96,3%	74,8%	80,1%	99,6%	na	94,9%	99,1%	97,0%
% beds private	85,0%	3,7%	25,2%	19,9%	0,4%	na	5,1%	0,9%	3,0%

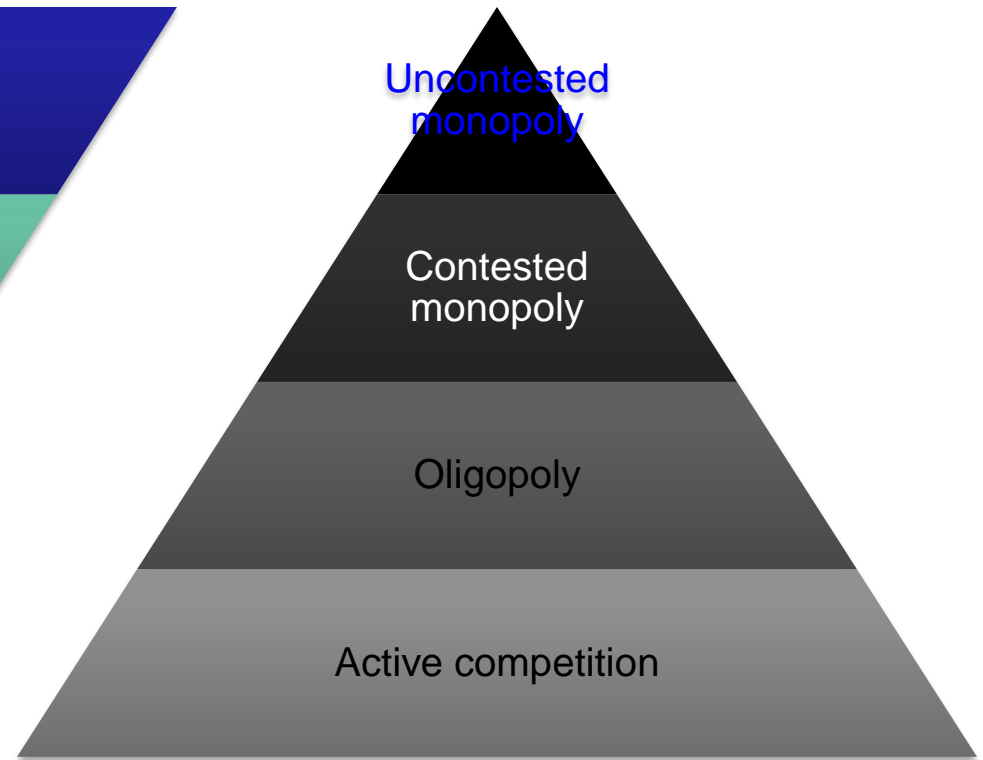
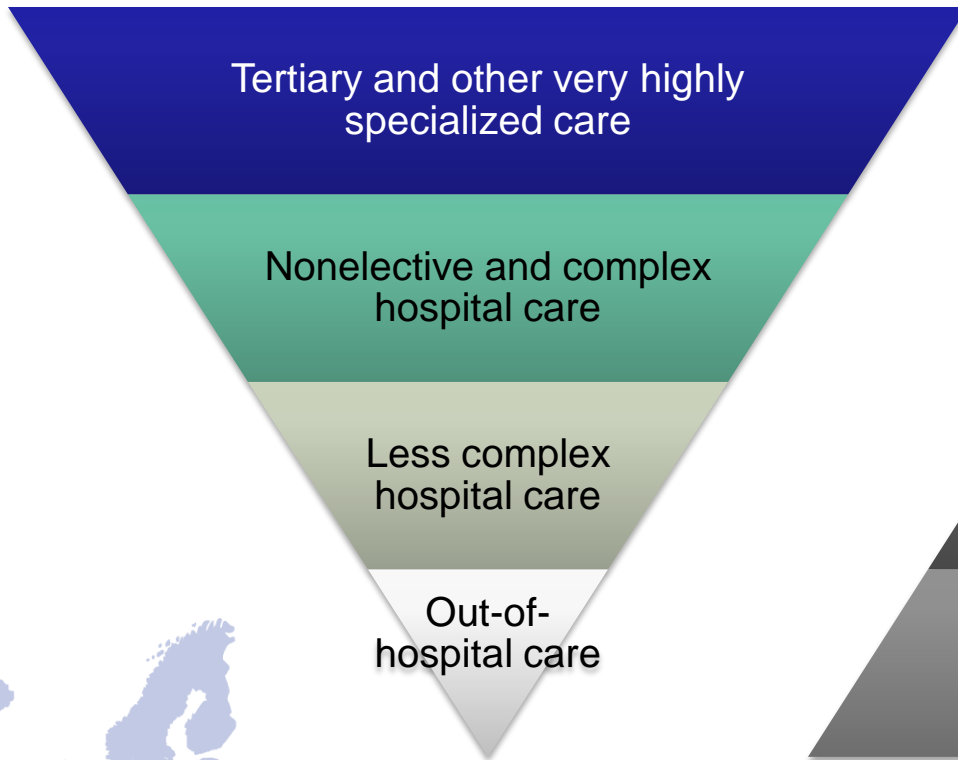
# Public and Private Hospitals in OECD

OECD 2007	Acute beds per 1000	% Public	% Not profit	% Private	OECD 2007	Acute beds per 1000	% Public	% Not profit	% Private
Australia	3,5	70	14	16	Korea	7,1	10	65	25
Austria	6,1	73	19	9	Luxembourg	4,4	68	29	3
Belgium	4,3	34	66	x	Mexico	1	65	x	35
Canada	2,7	100	x	x	<b>Netherlands</b>	<b>3</b>	<b>x</b>	<b>100</b>	<b>x</b>
Czech Republic	5,2	91	x	9	New Zealand	x	81	10	10
Denmark	2,9	100	x	x	Norway	2,9	99	1	x
Finland	3,7	89	x	11	Poland	4,6	95	x	5
France	3,6	66	9	25	Portugal	2,8	86	7	8
Germany	5,7	49	36	15	Slovak Republic	4,9	60	x	40
Greece	3,9	69	3	28	Spain	2,5	74	17	9
Hungary	4,1	n.a.	n.a.	n.a.	Sweden	2,1	98	x	2
Iceland	x	100	x	x	Switzerland	3,5	83	5	13
Ireland	2,7	n.a.	n.a.	n.a.	Turkey	2,7	90	x	11
Italy	3,1	82	17	2	United Kingdom	2,6	96	4	x
Japan	8,2	26	74	x	United States	2,7	n.a.	n.a.	n.a.

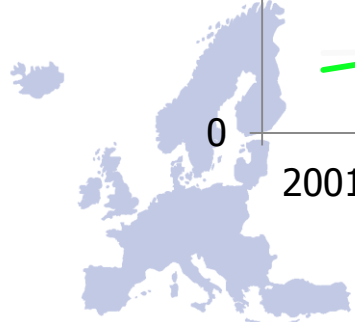
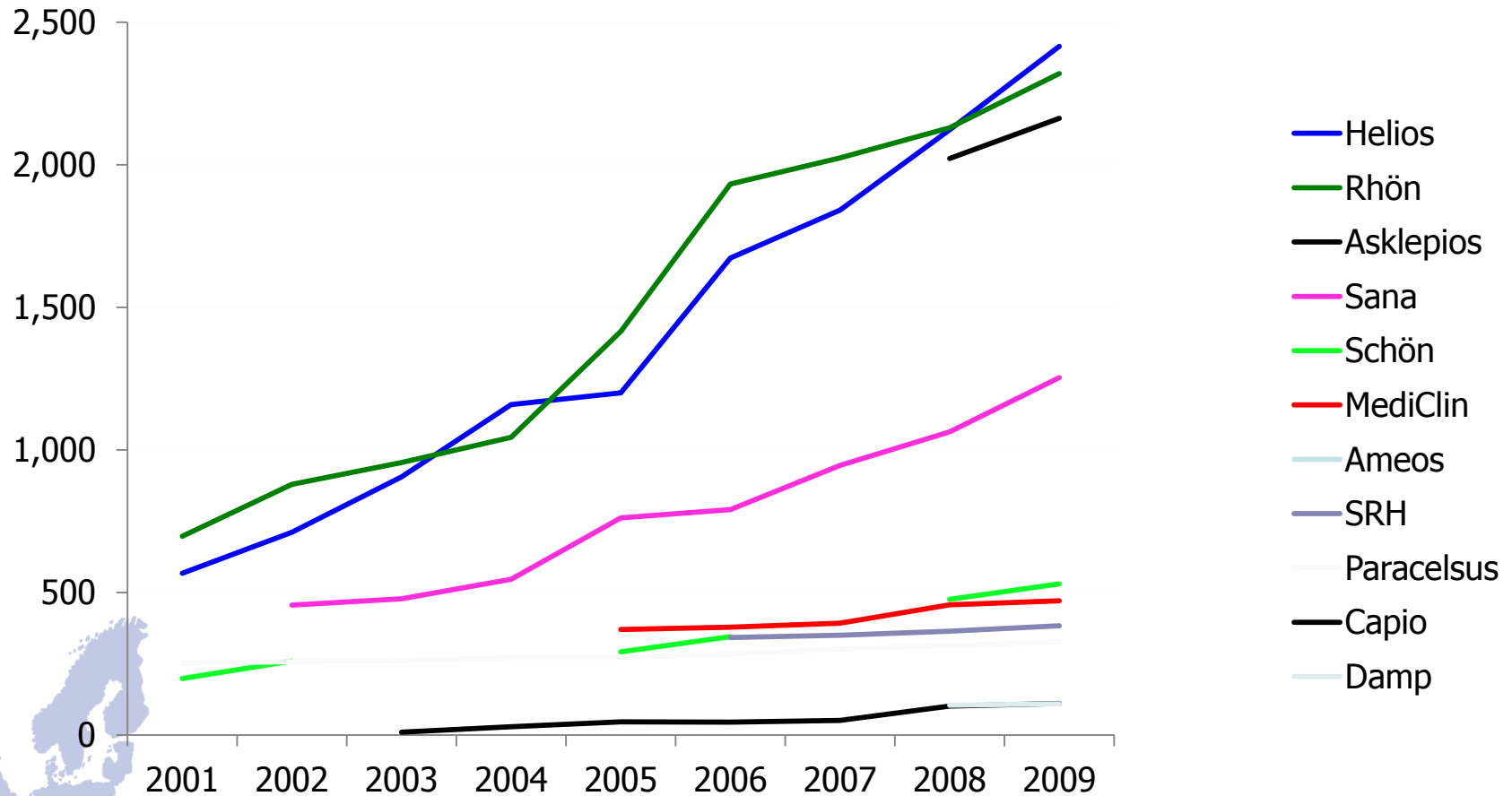
# Towards a balanced cooperation of public and private actors EAHM. *Medica, Düsseldorf Nov.20 2009*

- Most countries in Europe have evolved to a mixed system with 2 or 3 types of hospitals: public, private not-for profit and private for profit hospitals.
- Hospital managers in the different countries are making experiences with public and private activities. Private hospitals have often the obligation to take part in the public service while public hospitals are trying to develop private activities to remain within their budget.
- The hospital managers experience also different pressures, from financial constraints to external accountability. Therefore it would be interesting for the hospital managers to benchmark the different possibilities for organizing the current and future delivery of care in their hospital.
- What are the differences (and impact) on the level of quality, equity, budget...? What is the best solution for the patient? Is outsourcing of specific activities of public hospitals a good solution? What is the best evolution for organizing healthcare given the financial crisis? What is the impact of the financial crisis on the working conditions for private and public hospitals?
- The purpose of the seminar is to create understanding by introducing the different models. The seminar wants also to help the participants in their search for options which are best for their situation and system. Learning from the different systems by analysing the different options, EAHM hopes the participants will be better prepared for future decisions.

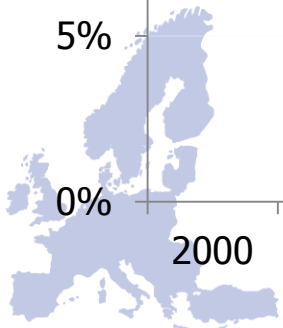
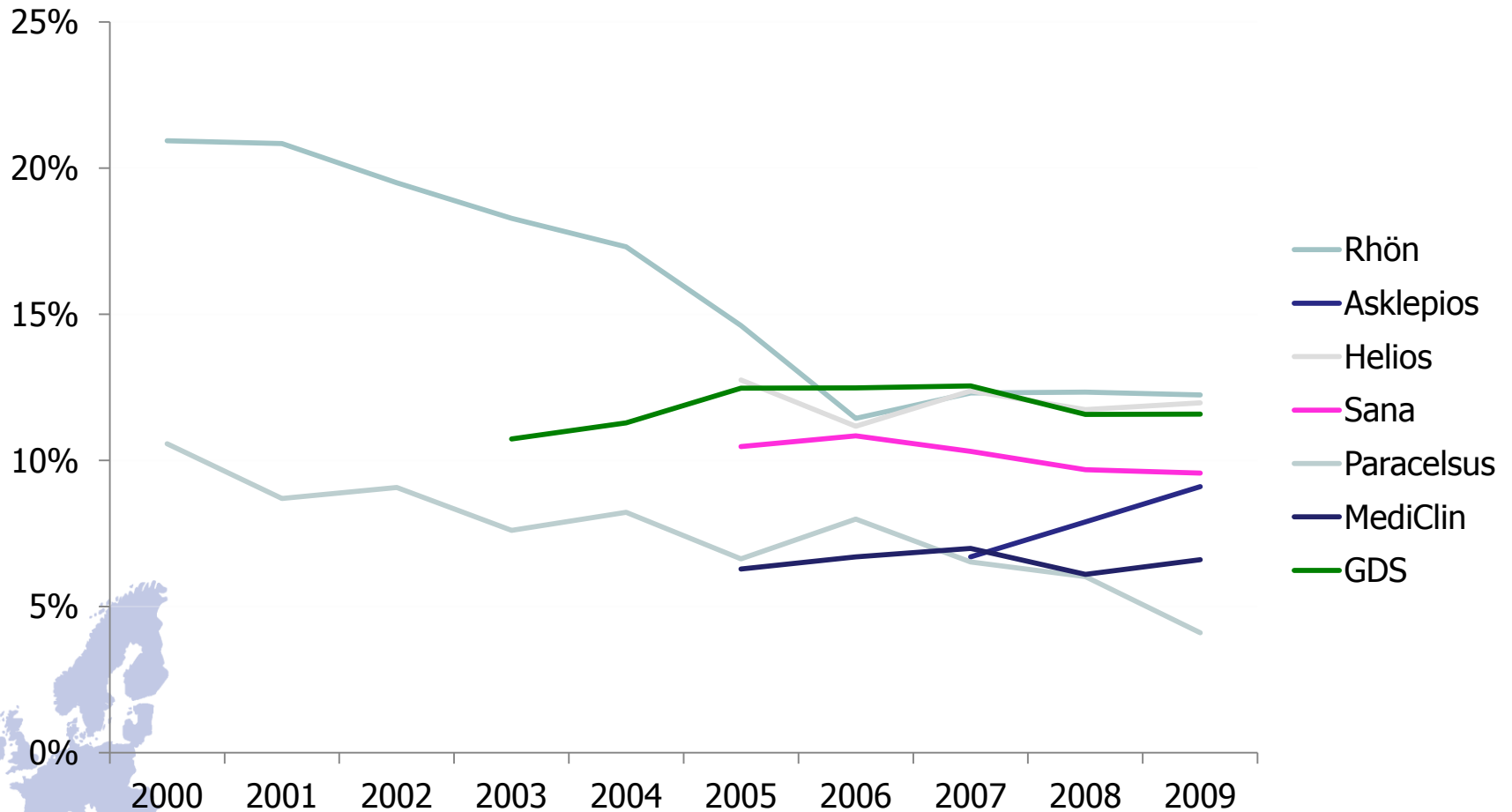
# Competition between public and private hospitals



# Evolution of Turnover in private hospital German groups (€m) Accounting data IFRS



## Evolution of EBITDA / turnover ratio in European private hospital Groups (IFRS)



# Ratio Investment / turnover

Investment / turnover	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Helios						12,8%	15,7%	21,8%	9,4%	11,2%
Rhön	13,8%	12,5%	19,1%	11,8%	9,6%	20,5%	20,4%	8,9%	13,1%	<b>17,9%</b>
Sana			22,4%	6,9%	8,8%	9,6%	12,6%	9,6%	13,2%	7,9%
Paracelsus	16,4%	17,8%	6,6%	16,8%	4,2%	5,2%	8,6%	13,3%	4,7%	6,4%
Asklepios								10,7%	10,7%	9,4%
GDS						10,3%	12,9%	9,6%	8,4%	6,6%



# Turn-over German and French Private Groups

Turn-over in €m	Own	2001	2002	2003	2004	2005	2006	2007	2008	2009
<b>Helios</b>	GER	568	712	905	1 160	1 200	1 673	1 841	2 123	2 416
<b>Rhön</b>	GER	697	879	956	1 045	1 416	1 933	2 025	2 130	2 320
<b>Asklepios</b>	GER								2 022	2 163
<b>Générale de Santé</b>	FRA			1 132	1 250	1 436	1 742	1 906	1 984	2 046
<b>Ramsay Healthcare</b>	WOR									# 2 000
<b>Capio Europe</b>	EU					1 226				1 628
<b>Sana</b>	GER		456	478	546	761	791	946	1 064	1 254
<b>Vitalia</b>	FRA						240	650	650	650
<b>Capio France</b>	FRA			136	205	227	300	450		535
<b>Schön</b>	GER	198	259			292	345		476	530
<b>Médipartenaies</b>	FRA				204	285	309		470	x
<b>MediClin</b>	GER					370	378	392	457	471
<b>Ameos</b>	GER									387
<b>SRH</b>	GER						342	350	364	384
<b>Vedici</b>	FRA					85	120		280	350
<b>Paracelsus</b>	GER	252	258	260	271	273	284	302	314	327
<b>Kapa</b>	FRA		29	39	44	50	68	76	97	141
<b>Proclif</b>	FRA						100		135	133
<b>Capio Germany</b>	GER			9	29	47	45	51	102	111
<b>Damp</b>	GER								105	109

# Summary on international Groups



EUROPEAN HEALTHCARE  
FRAUD & CORRUPTION NETWORK

Brand	€ in millions	2005	2006	2007	2008	2009	2010	Hospitals	Land
HCA	Income €m		17 961,3	18 934,9	20 003,7	21 186,7	21 631,5	164	USA
Tokushukai	Income €m	2 167,6						116	Japan
Ramsay	Income €m					2 262,1	2 385,3	116	Australia
	EBITDA					288,8	329,0		
Netcare	Income €m					2 323,2	2 247,4	73	South Africa
	dont GHG			766,4	899,0	967,6	994,4		
	EBITDA					492,7	486,5		
	EBITDA GHG			193,1	237,3	257,0	250,0		
Bupa	Income €m	4 511,3	4 940,4	5 053,2	6 889,5	8 072,8		X	UK
	Care, health,				1 694,0	1 816,7			
	EBITDA	415,2	385,0	1 463,1	223,3	485,0			
Geisinger	Income €m					1 484,0	1 642,4	3	USA
	Income €m	312,2	480,2	481,7	506,7	542,4			
Parkway	Hospital	230,6	329,8	352,2	349,9	372,7		76	Singapore
	EBITDA	79,0	104,7	107,9	120,6	131,3			
Apollo	Income €m	192,5	232,4	290,7	372,2	478,4	600,7	50	India
	EBITDA	0,0	28,5	43,8	46,9	55,7	71,8		
Bumrungrad	Income €m	159,9	185,4	201,1	208,7	219,4		X	Thailand
	EBITDA	39,2	45,8	48,7	50,7	53,1			
Fortis	Income €m					104,9	157,2	X	India
	EBITDA					18,2	30,3		

## Bupa Care, health and other revenues = 22,5% in 2009

*Bupa is a private company limited by guarantee. As such it has no shareholders and all of its surpluses are reinvested back into the business*

revenues in €m	2009	2008	2007	2006	2005	2004	2003	2002
Gross insurance premiums	6 330,8	5 276,3						
Premiums ceded to reinsurers	-97,6	-101,3						
Net insurance premiums earned	6 233,2	5 175,0						
Revenues from life investment contracts	17,9	13,1						
Revenues from service contracts	5,0	7,3						
<b>Care, health and other revenues</b>	<b>1 816,7</b>	<b>1 694,0</b>						
Care, health and other revenues	22,50%	24,59%						
total revenues	8 072,8	6 889,5	5 053,2	4 940,4	4 511,3	4 218,2	3 917,0	3 272,7
Surplus before taxation	485,0	223,3	1 463,1	385,0	415,2	211,7	155,8	125,6
Surplus before taxation %	6,01%	3,24%	28,95%	7,79%	9,20%	5,02%	3,98%	3,84%

# DRG prospective payment reforms in European hospitals

- DRG creeping
- Control of DRG determination
- Opportunities of new fees, hospital accounting rules
- “In” or “Out” patients
- Coordination of caregivers
- P4P and P4O programs
- Investment for quality : outcome depends on income...

# DRG Creeping and TAA reform in France + 7,9 % (public) versus + 7,7 % (private)

	2002	03 / 02	04 / 03	05 / 04
<b>Public</b>				
<b>All activities</b>	%	+ 1,55%	+ 3,23%	+ 3,11%
	1	1,015	1,048	1,079
GHM > 48 hours	%	- 0,25%	+ 1,22%	+ 1,97%
	1	0,997	1,010	1,029
GHM < 48 hours	%	+ 4,19%	+ 6,05%	+ 6,10%
	1	1,042	1,102	1,163
<b>Private</b>				
<b>All activities</b>	%	+ 1,59%	- 0,54%	+ 6,62%
	1	1,016	1,010	1,077
GHM > 48 hours	%	- 1,68%	- 3,89%	+ 0,23%
	1	0,983	0,944	0,947
GHM < 48 hours	%	+ 4,80%	+ 2,54%	+ 13,70%
	1	1,048	1,073	1,210

**(IMF)** Expenditure reforms should be guided by two objectives :  
*Improving the efficiency of spending AND Ensuring equity*

- Under the assumption that relative prices for health services will continue to rise in line with recent trends, staff projects that public spending on health will also continue to rise at a fast pace in both advanced and emerging economies
- Various reforms to contain spending growth and/or improve the efficiency of spending could be considered :

**Supply-side**

- Reimburse providers using case-based payment or global budgets rather than fee-for-service.
- Reduce the generosity of the publicly financed benefits package.
- Strengthen evaluations of the cost-effectiveness of medical treatments and Technology
- Implement health information technology (IT) to increase the efficiency of service delivery.

**Demand-side**

- Increase cost-sharing to discourage moral hazard
- Reduce tax expenditures for private health insurance.



## Hospital care - OECD data [45]

- The implementation of a DRG system in many OECD countries offers a potential avenue for deriving aggregate output measures adjusted for case severity for the hospital sector.
- The information on individual hospital outputs (measured through discharges or patient days) could be used to derive aggregate output measures by weighting the number of discharges (or patient days) for individual DRGs.
- Drawing international comparisons on the basis of such output measures would, however, raise at least three issues :
  - **First**, although a considerable number of countries have introduced a DRG system, there are important differences in systems implemented.
  - **Second**, DRG systems are not implemented for all hospitals in some countries.
  - **Third**, there is no universal set of cost-weights.



## **Paying for Outcomes, Not Performance: Lessons from the Medicare Inpatient Prospective Payment System.**

*Richard F. Averill, M.S.; John S. Hughes, M.D.; Norbert I. Goldfield, M.D. The Joint Commission Journal on Quality and Patient Safety, Vol 37, N° 4, pp 184-192 . April 2011.*

- The three interrelated goals of the Affordable Care Act (ACA) of 2010 are to improve access, improve quality, and contain the costs of health care in the United States.
- **Pay-for-performance** (P4P) initiatives have been the primary approach used to link payment and quality.
- This article focuses on **P4O for inpatient care** and distills the lessons learned from the successful implementation of the Medicare Inpatient Prospective Payment System (IPPS)
- The first priority of P4O reforms should be **to reduce or eliminate any increase in payment resulting from negative outcomes** caused by quality failures, such as preventable admissions (for example, ambulatory sensitive conditions), readmissions, complications, and emergency department visits.



## The \$17.1 Billion Problem: The Annual Cost Of Measurable Medical Errors

Jill Van Den Bos<sup>1,\*</sup>, Karan Rustagi<sup>2</sup>, Travis Gray<sup>3</sup>, Michael Halford<sup>4</sup>, Eva Ziemkiewicz<sup>5</sup> and Jonathan Shreve<sup>6</sup>

*Health Aff April 2011 vol. 30 no. 4 596-603*

- At a minimum, high-quality health care is care that does not harm patients, particularly through medical errors. The first step in reducing the large number of harmful medical errors that occur today is to analyze them. We used an actuarial approach to measure the frequency and costs of measurable US medical errors, identified through medical claims data. This method focuses on the analysis of comparative rates of illness, using mathematical models to assess the risk of occurrence and to project costs to the total population.
- We estimate that the **annual cost of measurable medical errors that harm patients was \$17.1 billion in 2008**. Pressure ulcers were the most common measurable medical error, followed by postoperative infections and by postlaminectomy syndrome, a condition characterized by persistent pain following back surgery. A total of ten types of errors account for more than two-thirds of the total cost of errors, and these errors should be the first targets of prevention efforts.

# Cost effectiveness By Jens Wernick, 2010 BDPK

German Hospitals	Private	NGO	Public*
Expenditure on material (% of turnover)	24,9	26,3	26,2
Personel expenditures (% of turnover)	57,4	69,2	70,8
Investments in assets (% of assets)	11,5	9,9	8,6
Quota of special reserves (% of balance sheets)	33,6	38,7	47,6

(\* )University Hospitals not included

Source: The impact of hospitals in private ownership on the supply of hospital care in Germany;  
RWI Essen/Institut für Gesundheitsökonomik (IfG), München, Berlin, 2009

- Private hospital carriers tend to invest more than other groups in improvement of structures
- Investment is being made regardless of availability of public subsidies. In this way, necessary changes can be made quicker and more cost-effective
- Thus savings can be made faster, performance can be improved faster and the hospital can adapt quicker to requirements of the market
- This leads to a significant competitive advantage for private hospital-owners

## Tariffs comparison 506 DRGs = 85 % French case-mix

*Paul GARASSUS, in Santé et Systémique 2006 Vol 9, n°3-4, pp135-168*

tariffs DRG 2003	Italia public	Portugal public	France private	France public
ratio 1	0,826	0,640	0,612	1
1 / PPP	1,058	1,338	1	1
<b>Group 1</b>	<b>0,874</b>	<b>0,857</b>	<b>0,612</b>	<b>1</b>
ratio 2	0,946	0,803	0,651	1
1 / PPP	1,058	1,338	1	1
<b>Group 2</b>	<b>1,001</b>	<b>1,075</b>	<b>0,651</b>	<b>1</b>
ratio 1+2	0,874	0,705	0,628	1
1 / PPP	1,058	1,338	1	1
<b>Group 1+2</b>	<b>0,924</b>	<b>0,943</b>	<b>0,628</b>	<b>1</b>

## **Early Lessons From Accountable Care Models In The Private Sector: Partnerships Between Health Plans And Providers**

[Aparna Higgins<sup>1,\\*</sup>, Kristin Stewart<sup>2</sup>, Kirstin Dawson<sup>3</sup> and Carmella Bocchino<sup>4</sup>](#)

*Health Aff September 2011 vol. 30 no. 9 1718-1727*

- New health care delivery and payment models in the private sector are being shaped by active collaboration between health insurance plans and providers. We examine key characteristics of several of these private accountable care models, including their overall efforts to improve the quality, efficiency, and accountability of care; their criteria for selecting providers; the payment methods and performance measures they are using; and the technical assistance they are supplying to participating providers.
- Our findings show that not all providers are equally ready to enter into these arrangements with health plans and therefore flexibility in design of these arrangements is critical. These findings also hold lessons for the emerging public accountable care models, such as the Medicare Shared Savings Program—underscoring providers' need for comprehensive and timely data and analytic reports; payment tailored to providers' readiness for these contracts; and measurement of quality across multiple years and care settings.

## Dropped Medical Malpractice Claims: Their Surprising Frequency, Apparent Causes, And Potential Remedies

Dwight Golann<sup>1</sup>

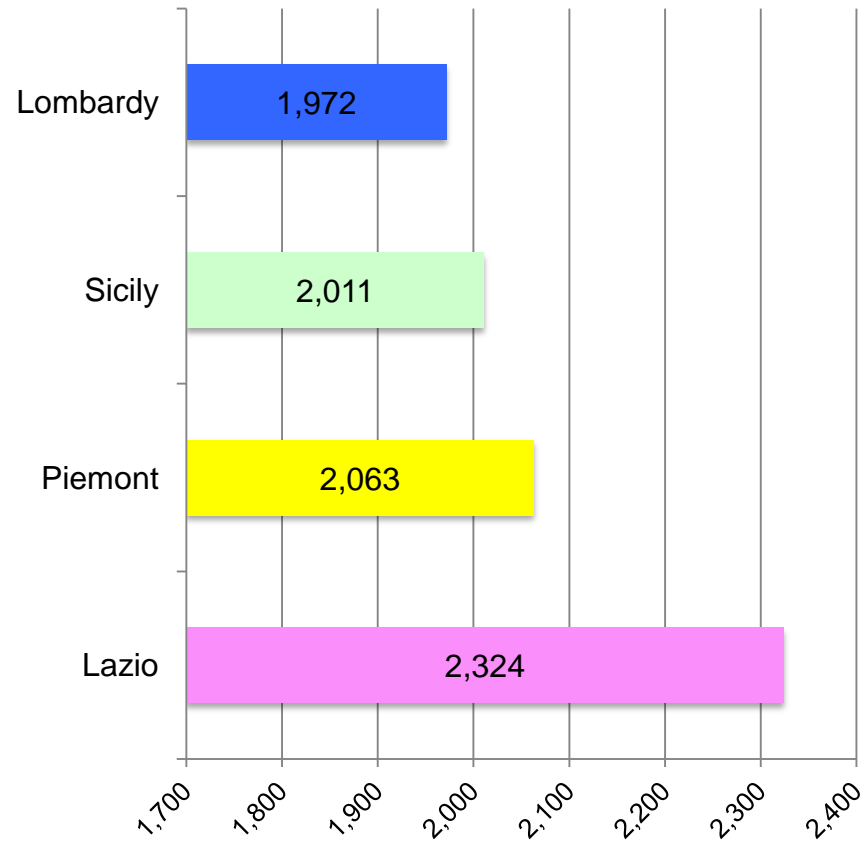
*Health Aff July 2011 vol. 30 no. 7 1343-1350*

- Most medical malpractice claims are neither settled nor adjudicated. Instead, they are abandoned by the plaintiffs who bring them. This study measured the frequency and cost of abandoned claims and gathered opinions from attorneys and other experts on why plaintiffs drop claims. Plaintiffs in the study abandoned 58.6 percent of claims against defendants, while settling only 26.6 percent and adjudicating 14.8 percent. Claims are not dropped because a large percentage of them are frivolous, but for other reasons.
- **The most important is that as plaintiffs acquire more information in the course of a lawsuit, they often conclude that a claim is weaker than they had first thought.** The author recommends that insurers and hospitals adopt new procedures to encourage both plaintiff attorneys and defense representatives to exchange information more efficiently, discuss the merits of malpractice cases more candidly, and resolve cases quickly. Such reforms would greatly reduce both the frequency and the duration of cases that are dropped, and thus the cost of malpractice litigation.

# Wall Street Journal (13 April 2010)

## Competitive Care by Margherita Stancati

- In 1997, when Italy's national government decentralized the country's health-care system
- Public and private hospitals on an equal footing by making each equally eligible for public funds
- Around 30% of hospital care in Lombardy is private now—more than anywhere else in Italy
- Lombardy over the past six years has underspent its annual budgets by a total of more than €200 million (\$270 million)
- Around 10% of Lombardy's hospital patients come from elsewhere in the nation



# When Clinicians lead



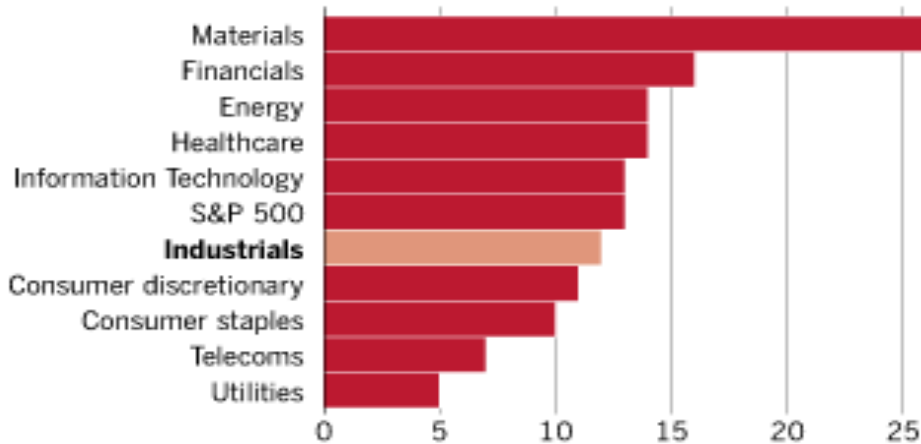
- The McKinsey Quarterly : When clinicians lead FEBRUARY 2009 HEALTH CARE
- Health care systems that are serious about transforming themselves must harness the energies of their clinicians as organizational leaders. By James Mountford and Caroline Webb



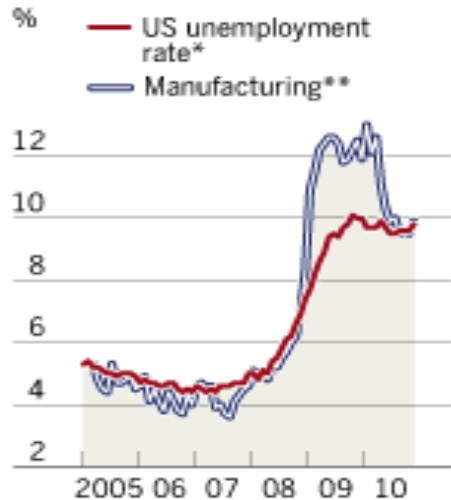


## S&P 500 earnings forecast for 2011

Operating EPS growth (Annual % change)



## US unemployment rate



## ISM Purchasing Managers' index

Figures above 50 represent economic expansion



\* Seasonally adjusted \*\* Not seasonally adjusted

Sources: Standard & Poor's; Thomson Reuters Datastream

## Forecast FT December, 28 2010

- Healthcare sector will still remain over performing
- Cost pressures also play a role in decision to invest in and procure from developing markets
- “Drive for efficiencies leaves jobs unreplaced”

# ¥€\$ or No

- Money in Health Care System : a chance or a risk ?
- Times are changing – Regulation is becoming a key word
- Risk management, Provider competition, Concurrence, Investment, Innovation, Patient mobility
- P4O : the new DRG paradigm for hospital prospective payment
- Referential : IQWiG (Germany), Nice (UK), HAS (France), etc. By independent experts
- Laws and Control – Alpha and Omega

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