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Experts' perspectives on SwissDRG: Second class care for vulnerable patient groups?

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ABSTRACT

On the 1st of January 2012, Switzerland introduced the diagnosis-related group hospital tariff structure (SwissDRG). It was recognised that healthcare provided to the most vulnerable patient groups would be a challenge for the new SwissDRG. Coincident with the implementation of SwissDRG, we explored hospital experts' perceptions of which patient groups are vulnerable under the SwissDRG system, what has changed for this group, as well as solutions to ensure adequate access to health care for them.

We interviewed 43 experts from 40 Swiss hospitals. Participating experts named several vulnerable patient groups who share some common characteristics. These hospital experts were concerned about the patient groups that are not financially profitable and questioned the practicability of the current regulation. At the same time, they highlighted the complexity associated with caring for this group under the new SwissDRG and reported measures at the macro, meso, and micro levels to protect vulnerable patient groups from negative effects.

To curb negative outcomes for vulnerable patient groups after the introduction of the SwissDRG, the Swiss legislation has introduced various instruments including the acute and transitional care (ATC) measures. We conclude that ATC measures do not produce the expected effect the legislators had hoped for. More health data is needed to identify situations where vulnerable patient groups are more susceptible to inadequate health care access in Switzerland.

1. Background

With the introduction of the Swiss diagnosis-related group (DRG) hospital in-patient payment system as of January 2012, the Swiss Federal Council aimed to create an incentive to contain the increasing cost of healthcare [1]. This new tariff structure forces hospitals to produce economically efficient outcomes by reducing the length of stay and the number of services provided as well as maximizing the number of (profitable) cases [2–4]. Scholars and healthcare professionals have feared that its introduction would decrease the quality of care provided to patients, particularly those who would fall within the less profitable DRG groups [5,6], because the increase in the number of cases can lead to medically non-indicated treatments, to inpatient rather than ambulatory treatments and possibly to (too) early discharge from hospital [7–9]. However, a few studies that have examined the effect of SwissDRG conclude that there have been no significant changes to length of stay and quality of care [10,11]. The authors of these studies recommend caution and further monitoring of this developing hospital in-patient payment system in Switzerland before drawing definite conclusions. Thus, the risks remain that there could be an expansion of services for non-medically indicated, but profitable treatments, and provision of fewer services for non-profitable, medically indicated treatments. Such circumstances raise not only economic concerns, but also ethical questions.

The major ethical concerns are the negative effects of this new health care regulation on the welfare of patients, the quality of health care service they receive, and access to health care particularly for vulnerable patients. In response to this possible consequence of the SwissDRG, it was deemed important to examine its consequences parallel to its implementation. Thus, a nationally funded study examining the SwissDRG was carried out between January 2011 and December 2013 in Switzerland, which has resulted in several significant findings [2,12–14]. One of the most valuable finding from an interdisciplinary perspective are its impact on the quality and safety of patient care in general, the state of professional practice of physicians and nurses, changes in incen-

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tives structures and vulnerable groups, and access to healthcare services [12].

International research shows that vulnerable patient groups present a challenge to the DRG system in light of the complex nature of their illnesses. These groups include older patients [15–17], children [18,19], person with multiple morbidities [20], persons with substance use disorder, and prisoners [21–24]. They thus may require longer than average hospital stays and specialized care because of their particular health reasons [15,16,19–21]. Expecting that in the SwissDRG there are vulnerable patient groups who may require special attention, this qualitative study sought to explore the perspectives of experts on the question of vulnerable patient groups, derive concrete recommendations for optimal use of the SwissDRG, and evaluate how its negative impact on patient care could be reduced. Therefore, in this paper, we seek to answer the following research questions using interviews carried out with experts working in the hospitals:

(a) Which patient groups are generally considered to be vulnerable in the Swiss health care system (hospital setting)?
(b) What has changed for these groups since the introduction of the SwissDRG?
(c) How is adequate and fair access to health care for vulnerable groups guaranteed?
(d) What should Swiss hospitals undertake to provide proper treatment to patients belonging to these vulnerable groups?

2. Methods

Participant recruitment for this study began in February 2012 and the last interview took place in December 2012. We purposively recruited a sample of 43 experts working in 40 hospitals in Switzerland. The first author contacted all prospective study participants via letter informing them about the study and requesting their participation. All of the 43 experts contacted, agreed to participate in this study. The 40 hospitals were classified as follows: 7 university hospitals (including children hospital), 28 public hospitals, and 5 private clinics. They were located in 24 of the 26 cantons in Switzerland. The 43 experts were hospital directors and persons responsible for quality, coding, finance, and medicine controlling. All experts gave written consent to participate in the study. Repeat interviews were not done for the study.

The first author conducted these interviews either in German or French during which no other person was present other than the interviewer and the interviewee. These interviews took place at their work place and were on average 80 min long. A semi-structured interview guide incorporating questions on experts' perception of changes after the introduction of SwissDRG were used to frame the discussion. Examples of questions included: "How is fair and appropriate access to health care for different patient groups (esp. marginal groups) ensured?"; "To what extent do you think lump compensations are accompanied by forms of rationing?"; "Can you explain to me what your understanding of rationing is?". Data saturation was reached by the 36th interview. However, remaining scheduled interviews were carried out to ascertain that no new concerns related to the SwissDRG remain unexplored.

All interviews were tape-recorded and transcribed into the language of the interview. The first author read the transcripts several times and during this preliminary analysis, the topic of vulnerable patient groups and what has changed for them since the SwissDRG emerged as an important topic. We used a thematic approach to analyze the data for this manuscript [25,26] because of the explorative nature of the study. We utilized qualitative analysis software Atlas.ti to support the thematic coding procedure. The first author carried out the initial coding procedure and derived the coding tree with the themes and sub-themes for this manuscript. All authors discussed the themes and sub-themes coded within this topic and agreed on the findings presented below. Quotes from the experts are used in the results to exemplify the findings. All information in [] mean that it is added to give meaning to the entire sentence since we are presenting the gist of what was said and not the entire interview. An independent assistant fluent in all languages translated these quotes from German or French to English, and one of the authors checked the translations.

2.1. Study limitations

The study began collecting data in February 2012, only a month after the introduction of the SwissDRG, so this start date could be a limitation. However, many of our participants worked with this hospital billing system before its official nationwide implementation. Also, several participants had many years of experience with DRG, as some hospitals had already started using it in Switzerland [10]. As a qualitative study, it presents the experiences and opinions of the experts, and does not claim any generalizations. The inclusion of healthcare experts working in different levels of hospital management highlights the appropriate diversity of opinions surrounding this topic. Furthermore, this study carefully evaluates informants' perceptions about the SwissDRG at the time of its implementation. In doing so, it highlights what our study participants perceived to be happening right after the new hospital tariff structure came into force. It however does not tell what happened later and over time, which would require another set of research questions and interviews. Our study thus paves the way for such and other future studies, including quantitative examination of the SwissDRG.

3. Results

Our analysis of the topic, vulnerable patient groups, and the SwissDRG resulted in three themes: (a) description and awareness of vulnerable patient groups; (b) changes after the implementation of the new tariff structure; and (c) measures to ensure an adequate access to health care.

3.1. Descriptions and awareness of vulnerable patient groups

Participating experts reported that there are various groups of vulnerable patients in routine hospital practice. These patients were deemed vulnerable due to different factors, including their (a) health status[I]; (b) age[II]; and (c) socio-economic background[III]. Those who were vulnerable due to their health status consisted of patients with multiple morbidities, those with dementia or rare disease, and patients in need of expensive medications or intensive nursing care (which extends the lengths of stay in hospital). Also classified in this category were patients requiring palliative care and patients for whom care after a hospital stay could not be organized easily. Included in the vulnerability due to age were very old patients, newborns, and children in general. Finally, patients deemed vulnerable in association to their socio-economic background comprised persons with disabilities, alcohol and drug problems, living with HIV-AIDS, prisoners, homeless, immigrants, asylum seekers, person without residency permits, stateless persons, individuals ineligible for Swiss social insurance, and patients with lacking language skills[IV].

[I] «. . . *the multimorbid, highly complex cases are actually not well enough compensated, [in the case of] all the seriously ill, costly and time-consuming patients, one could say these expensive' outliers are currently poorly compensated* . . .» (P 36)

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