Regulatory constraints of national tariffs setting process in Poland

Authors: Urszula Ceglowska¹, Anna Chodacka¹, Gabriela Sujkowska¹, Agnieszka Wlodarczyk¹

Introduction

National tariffs setting process for health care services in Poland started from 1st January 2015 by establishing new department in the Agency for Health Technology Assessment - the government institution and the advisory body to the Ministry of Health regarding financing health care technologies and services from public resources.

Since then, the Agency for Health Technology Assessment and Tariff System (AOTMiT) work on developing methods for calculating national tariffs and toolkits for collecting cost data from healthcare providers. Mental health has been chosen as a first area where national tariffs will be calculated. The deadline for data analysis was May 2015 and then postponed to September 2015 due to difficulties with data collection. AOTMiT's activities related to calculating national tariffs are financed through deduction from health insurance premiums (0,07% annually). Health care providers who signed contract with AOTMiT for data submission are paid on the basis of number of records provided for finished inpatient episodes and number of records for particular services (e.g. consultations with specialists, home visits) delivered in outpatient settings. Separate fees are paid for patient-level data which are manually drawn from patient discharge cards for inpatient care and from available medical documentations for outpatient care. Besides, fixed fee is paid for accounting data from each cost centers (e.g. ward, emergency room) for which the data about delivered health care services was submitted. Health care providers faces financial penalties due to inaccuracies in submitted data. Crucial assumptions for data collection process were to collect retrospective data on clinical costs related only to completed hospitalizations for the period of last 2 years and for the sample of mental health care providers not less than 10%. The goal is to describe regulatory constraints faced during the first national tariffs setting process in Poland.

Methods

Descriptive analysis of national tariff setting process based on key documents regarding regulation of clinical costing and cost data collection as well as experience gathered during the first process of setting the national tariff for mental health services.

Results

The situation facing currently in Poland is a lack of clinical costing standards and non-mandatory use of electronic cost databases. Considering that good quality of the input data is the key to ensuring the quality of the final costing outputs, therefore it is important to introduce unified clinical costing standards. However, according to Ministry of Health regulation on mandatory requirement for health care providers to follow clinical costing standard will come into law in 2020. Furthermore, weak computerization of Polish health care providers first of all hamper the process of data collecting at hospital level and secondly do not allow providers to participate in data collection process for national tariff calculation. Other major limitation of calculation tariffs is that submitting cost data is not obligatory for health care providers. The only incentive that AOTMiT can use to encourage health care providers to submit data is revenue.

Initially, clinical cost data has been collected from 74 mental health care providers (approximately 5% of the total sample), some of which are private or public. Whereby, the data collection stage has been extended to get required 10%. After failed data collection process the survey aimed at understanding the reasons of withdrawal from signing the contract with AOTMiT was send to health care providers. Between reasons for withdrawal from data collection process healthcare providers indicated mainly three reasons - low revenue (88,8%), too complicated data template files (70,4%) and contract penalties (66,6%). Considering the feedback from health care providers the data template files were simplified and contract penalties were withdrawn. Those assumptions refers only to mental health tariff calculation. For the purpose of the next national tariff setting separate procedures will be developed in order to facilitate the process for the providers while retaining appropriate data detail.
Conclusions
Without regulatory obligations for health care providers to cooperate with AOTMiT the data collection process is challenging. Another obstacle is lack of obligatory and unified system of data collecting what significantly hamper gaining consistent data and reliable cost comparison. Moreover, most health care providers in Poland do not have electronic system for collecting cost data and therefore cannot participate in data collection process. To sum up, clinical costing standards should be mandatory established together with obligatory electronic system for cost data collection. A consistent costing approach should be followed across all healthcare providers to enable reliable comparison.

1. Agency for HTA and Tariff System, Warsaw, N/A = Not Applicable, Poland.