Séance : « Données administratives et santé au Québec »

Communication #1

Titre

Concentration des dépenses médicales en milieu hospitalier : Résultats canadiens

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Codes JEL

I10, I13, I18

Mots-clés

Dépenses médicales, concentration, fin de vie

Résumé

Cet article présente des résultats concernant la concentration des dépenses médicales effectuées en milieu hospitalier au Canada. Nous documentons, à l'aide de données administratives longitudinales provenant du Québec, la concentration des dépenses médicales à un moment donné dans le temps (concentration transversale), à travers le temps (concentration longitudinale) et près de la fin de vie lorsque celle-ci survient à l'hôpital. À partir de 50 ans environ, les dépenses moyennes augmentent rapidement avec l'âge et sont concentrées chez un petit groupe d'utilisateurs de soins qui présentent des coûts élevés. Par exemple, les 1% d'hommes et de femmes pour lesquels sont effectués le plus de dépenses représentent respectivement 55,5% et 54,8% du total des dépenses en milieu hospitalier. Les coûts importants sont assez faiblement persistants chez les individus : moins de 3% de ceux dans le quintile supérieur de dépenses hospitalières d'une année restent dans ce même quintile l'année suivante, tandis que moins de 5% des utilisateurs de soins dans ce quintile de coûts engendrent la moindre dépense l'année suivante. Enfin, les dépenses hospitalières des individus dans leur dernière année de vie comptent pour 11,1% de ces dépenses pour l'ensemble de la population. Plus de 80% de ces dépenses en fin de vie sont encourues durant le dernier mois de vie.

Article

Non disponible.

Communication #2

Titre

Does clinical guidelines affect healthcare quality and populational health: Quebec colorectal cancer screening program

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Codes JEL

I14, I18, C36, C41

Mots-clés

multi-state model, healthcare quality, difference in difference, transition probability, competing risks model

Résumé

In Quebec, colonoscopies volumes have continued to rise in recent years in the absence of effective monitoring mechanism for the appropriateness and the quality of these exams. In 2010, November, Quebec Government introduced the colorectal cancer screening program in the objective to control for volume and cost imperfection. This program is based on clinical standards and was intiated for first group of institutions. One year later, Governement add financial incentives for participant institutions. In this analysis, we want to assess for the causal effect of the two components of this program : clinical pathways and financial incentives. Especially we assess for the reform effect on healthcare quality and populational health in the context that medical remuneration is not directly dependent on this additional funding offered by the program. We have data on admissions episodes and deaths for 8 years. We use multistate model analog to difference in difference approach to estimate reform effect on the transition probability between different states for each patient. Our results shows that the reform reduced length of stay without deterioration in hospital mortality or readmission rate. The program also contributed to decrease the hospitalization rate and a less invasif treatment approach for colorectal surgeries. This is a sign of healthcare quality and population health improvement. We demonstrate in this analysis that physicians behaviour can be affected by both clinical standards and financial incentives even if offered to facilities.

Article

Voir pièce jointe au courriel.

Communication #3

Titre

Impact of hospital financing on Patient Outcomes: Evidence from Surgery in Quebec

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Codes JEL

I11, I18

Mots-clés

Hospital financing, Hospitalisation, length of stay, readmission, Waiting time, duration model

Résumé

The question of how financial incentives affect hospital decision-making has been a frequent subject of research in both economy and medicine. Do hospital decision makers base their medical-care decisions only on what is in the best interest for their patients, or do they behave as homo economicus ? In this case, does healthcare funding affect a hospital's decision and the quality of services ? In other words, how do hospitals respond to financial incentives?

This paper analyzes the impacts of hospital funding on patient outcomes, such as inpatient length of stay (LoS), risk of readmission post dis-charge and waiting time. To do so, we exploit the Access to Surgery Program (ASP) implemented in Quebec and a major reform on the funding of this program. In 2004, a ASP was implemented in Quebec in order to reduce waiting lists through financial incentives and to contribute to what the waiting time of some surgeries does not exceed the medically required time frame. But over years, gaps were noted in this program. In April 2011, The Quebec government reformed the way of payment of this program. Differences of tariff between technical platforms were removed for similar surgeries. The remuneration of most surgeries was reduced. Our analysis focuses on the impact of these financial disincentives.

Most empirical studies on hospital responses to various funding schemes focus on volume of services, or productivity (Ellen et al., 2015 ; Jurgita et al., 2015 ; Byrne et al., 2007 ; Biornet al., 2003). For optimizing resources, it is essential that hospitals offer quality services. The quality of health services can be analyzed by LoS in hospital (Chalkley and

Malcomson, 2000). Indeed, an increase in LoS in hospital may indicate that physicians spend more time identifying the nature of their patients' health problem and improving the quality of treatment. Of course, an increase in LoS in hospital may just indicate the fact that physicians spend_ Ph.D. Student in Economics at Université Laval1less time with their patients and more time on non clinical activities (e.g., teaching, research and administrative tasks). In this case, the quality of service can't be improved, at least in the short run, all else being equal. Also, a longer LoS in hospital can reduce the risk of rehospitalisation post-discharge. The readmission in hosptial, is a natural measure of adverse outcome and is often used as a proxy for morbidity (Cutler, 1995). So, LoS in hospital affects readmission rates. In addition, LoS in hospital is generally considered as a major determinant of hospital costs per patient. An increase in LoS in hospital is likely to reduce alternative care costs, given the potential substitution between hospital and post-hospital care such as convalescent home, home care. Finally, LoS has an impact on waiting list and waiting times.

The empirical analysis is based on repeated cross-sectional data from the public hospital in Quebec Med-Echo (Maintenance et exploitation des données pour l'étude de la clientèle hospitalière). This database is used to collect clinical and administrative data on acute hospital stays and day surgery, including general, specialized, and psychiatric care. Med-Echo is a provincial database and is under the purview of the Ministry of Health and Social Services. For the analyis we considered only patients who stayed in hospital one day or more. Each patient discharged from hospital was registered in the database over a period of 8 years (1stApril 2006 to 31 March 2014 : 5 years before the reform and 3 after) with their precise date of admission to hospital, age, gender and the department of admission, as well as the time when the patient left the hospital and other patients' and hospitals' characteristics. The analysis covers all knee, hip and bariatric surgeries of ASP. There are also other types of surgeries with hospitalization.

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