



DIAGNOSIS RELATED GROUPS: LEADING THE DEBATE

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Hospital Financing: Diagnosis Related Groups – Leading the Debate.

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The system perspective.

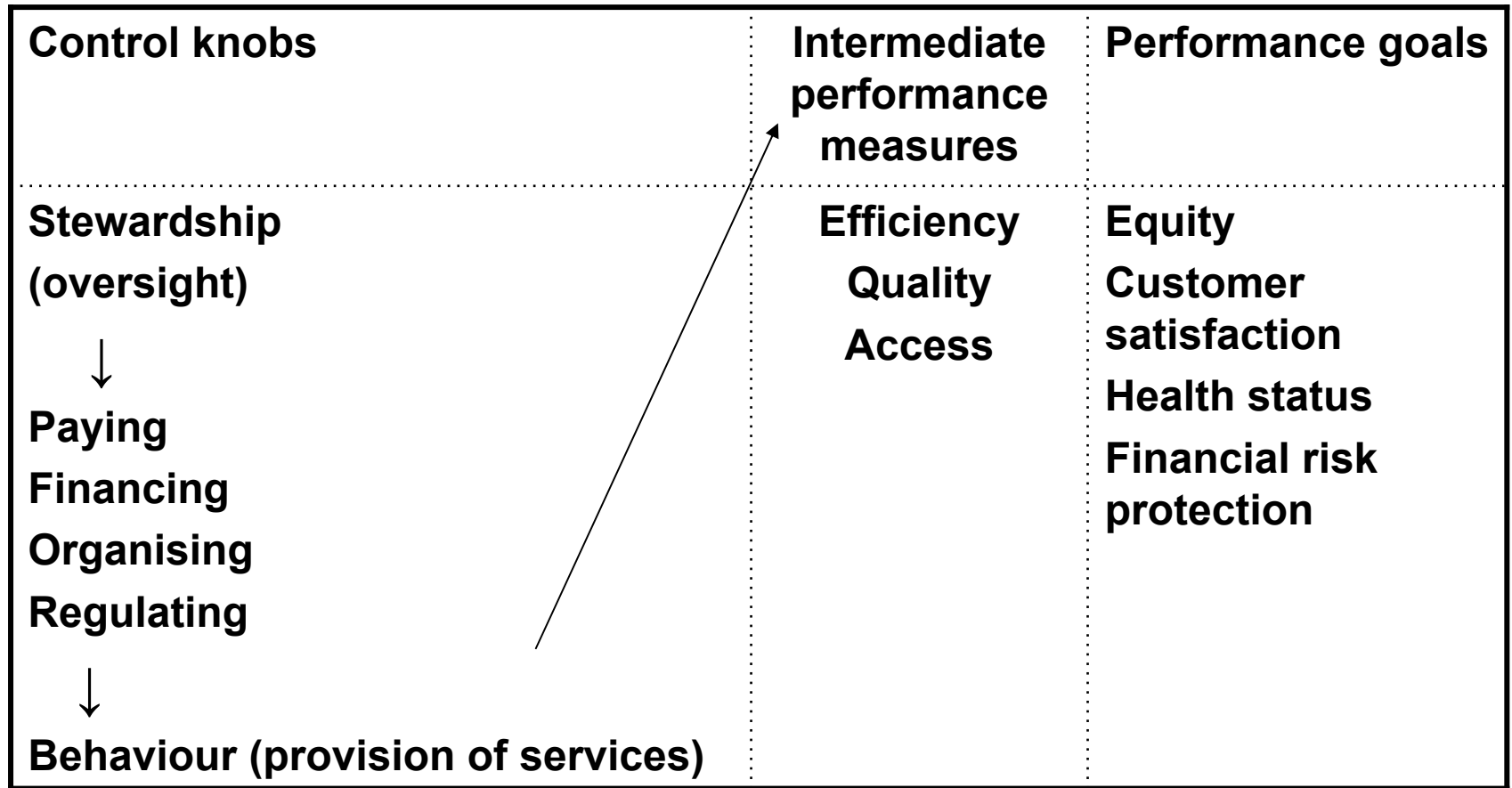


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- What is a health system
- Possible effects of using DRGs on the elements of the system
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What is a health system (1,2)

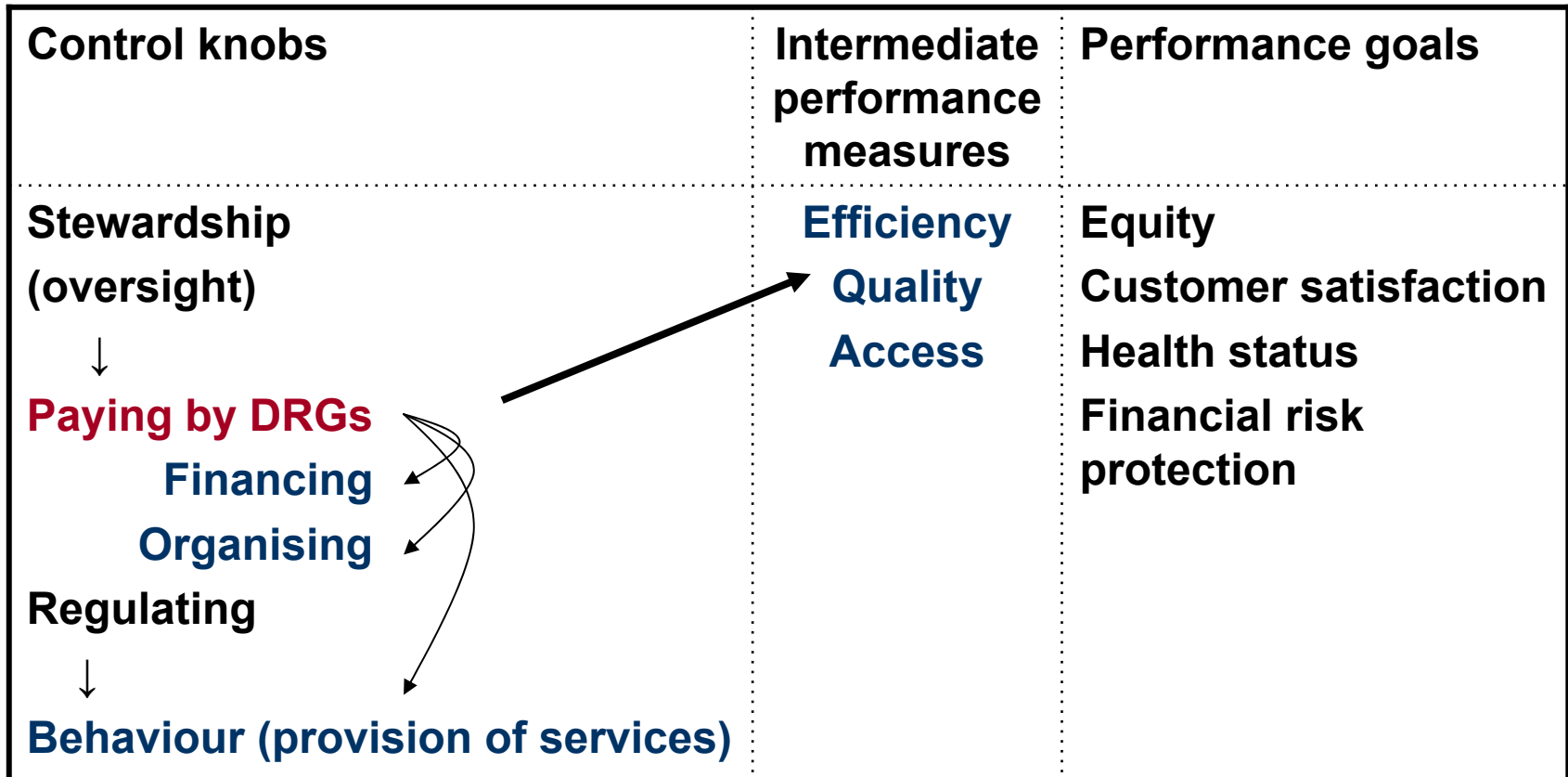


Modified from WHO: The World Health Report 2000 and Roberts 2004.

What is a health system

Elements of a system interact and are interdependent

Possible interactions are:



Possible effects of paying by DRGs

1 Behaviour – provision of services:

Assumptions:

- a) **DRGs allow for a more efficient allocation of resources amongst hospitals according to their case-mix *and* productivity**
- b) **Paying by DRGs improves technical efficiency and productivity within hospitals**

Income (I) for each hospital ⁽³⁾ : $I = CMI \times N \times R$

CMI: case-mix index; N: number of patients; R: budget rate

Because hospitals (and services within) want to maintain or increase their income

Possible effects of paying by DRGs

1 Behaviour – provision of services:

Possibilities for a hospital to maintain or increase their income...

- **Decrease Length of Stay (LOS) ^(4,5,6,7)- Increase number of cases, turnover**
 - ▶ **increased productivity, decreased waiting lists**
- **DRGs creep ⁽⁶⁾– changing registration, increasing CMI (honest or income related), increase surgery activities**
- **Provide less services or tests ⁽²⁾**

Possible effects of paying by DRGs

1 Behaviour – provision of services:

If providing less services or shortening LOS:

- Risk for quality of care within hospital
 - Patients discharged more “unstable”:
 - risk for quality if community resources are not enough (home care, elderly residences, social services)
 - risk of hiding real total costs:
 - More readmissions (planned or not)
 - Part of the costs transferred outside the hospital (Although presumably lower costs)
- Do not assume *quality* and *efficiency* (in terms of societal costs per utility produced)

Possible effects of paying by DRGs

2 Financing:

If productivity (number of patients) increases, total expenditures of hospitals will also increase, unless...

- There are ceilings in prices or number of patients (see Nordic experience)
 - Rebound effect (Swede experience) or “regression to the mean” in productivity and waiting lists
 - Hospitals may be aiming at maintaining their income, not productivity by itself
- Downsize facilities
 - Questions about “quantum” effects
 - Questions about geographical access and *equity*

Possible effects of paying by DRGs

3 Organising:

- **Shorten times for a diagnosis, reorganise processes within hospitals**
- **Transfer activities to outpatient facilities (surgery)**
- **Increase referrals to community care – primary care, home care, elderly homes, long term facilities, social services**

The need for additional - systemic measures

- **Technical quality control (if not quality improvement)**
 - Related to risks (shorter LOS, less services)
 - Related to improvements (process management, outcomes)
- **Measure total societal costs per patient**
 - Including outpatient and ambulatory care
- **Verify access and equity**
- ▶ **Take the point of view of the objectives and goals of the system**
 - Analyse the coherence of different “control knobs” with stated objectives and with each other**
- ▶ **Improve information systems and obtain and use empirical evidences**

The need for additional - systemic measures

The need for systemic measures in whatever the payment mechanism (2):

Payment mechanism	Impact on medical decisions and costs
Fee for service	Providers prefer it; increase quantity of services per patient and total supply; quality may decrease due to over-treatment
Per case (as DRGs)	Improves efficiency of hospital services; increases admissions; quality may decrease because too short LOS and under-use of tests
Per diem	Increases LOS; less inflationary than fee for service
Capitation	Reduces unnecessary services; improves efficiency; patients may be under-treated; risk selection by providers
Global budget	Improves efficiency; most effective to control inflationary costs; quality may decrease;
Salary	No incentive to over-treat patients; quantity of output per hour may decrease; quality may decrease; self-referral to their private practice

Overall effect and future trends

- **Increased awareness of the interdependence of the mechanisms of control of health systems**
- **Increased awareness of the need to analyse health systems (not only hospitals) and the social sector.**
 - **Assess the need to enhance other parts of the health system (primary care, long term care) or the social system**
 - **Assess the need for better coordination of different parts of the health system and with the social sector as well**

Overall effect and future trends

And at the same time

- **Need for much more powerful (micro)-management tools linked to quality management of clinical procedures**
 - **Increase awareness of the need for empirical information (including DRGs) as opposed to pre-established ideas**
 - **Take advantage from DRGs driven information system ^(8,9), especially new grouping methods that provide clinically relevant information**
 - **Improve process management and monitor outcomes**

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Thanks very much for your attention!

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