Introducing Diagnosis-Related Groups in countries with smaller populations

Path towards implementation and typical challenges

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28 September 2022

The DRG landscape

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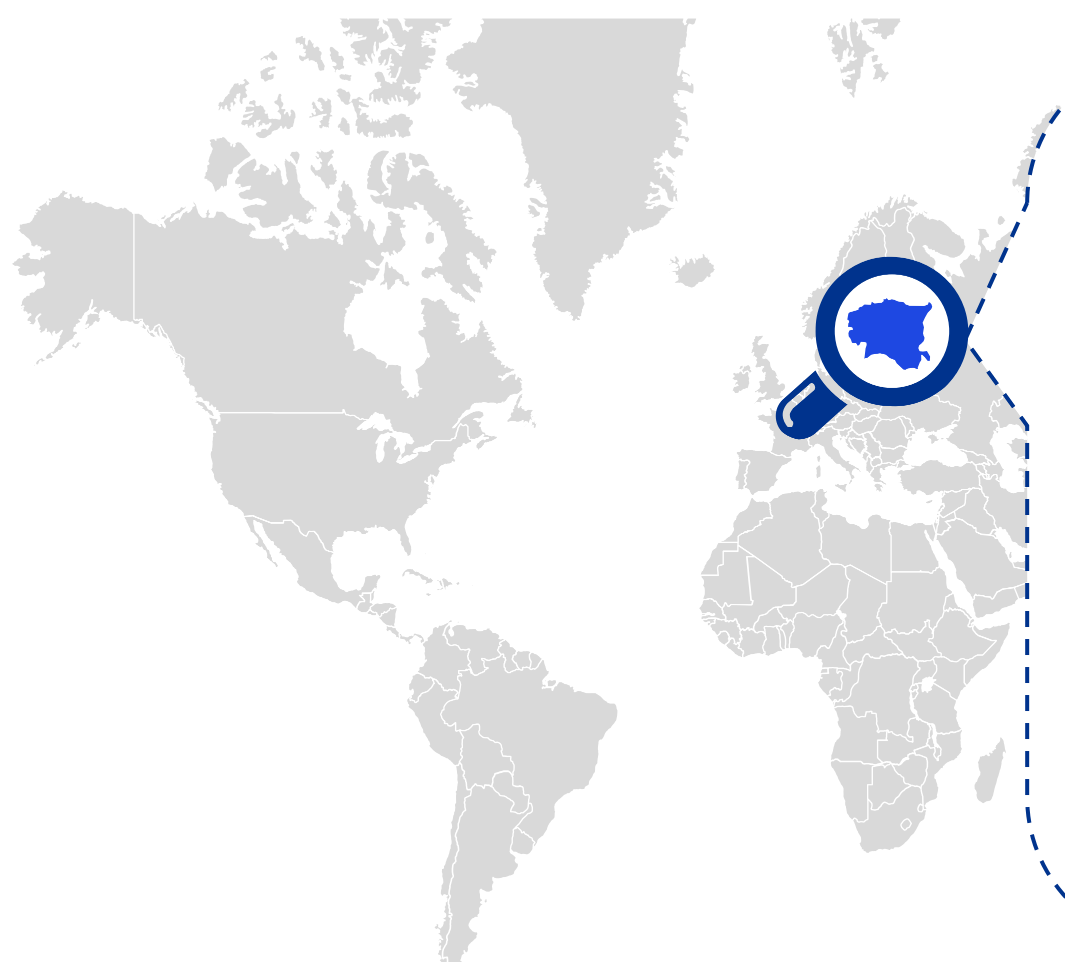
The DRG landscape – Estonia



Estonia

- In 2004, Estonia adopted a version of **NordDRG** system with the aim **to contain costs, limit volume growth, and increase the overall efficiency** and transparency of the hospital sector.
- The share of DRG-based payments has increased in the overall healthcare system, with **DRG holding 70 percent** share.
- The use of pre-existing NordDRG system was **resource-efficient** and there is **no evidence** of up- or wrong-coding.
- The current **challenges** are the increase of the **coding quality**, improvement of **cost information** and the **adjustment** of the DRG system to compensate the hospitals as fairly as possible.

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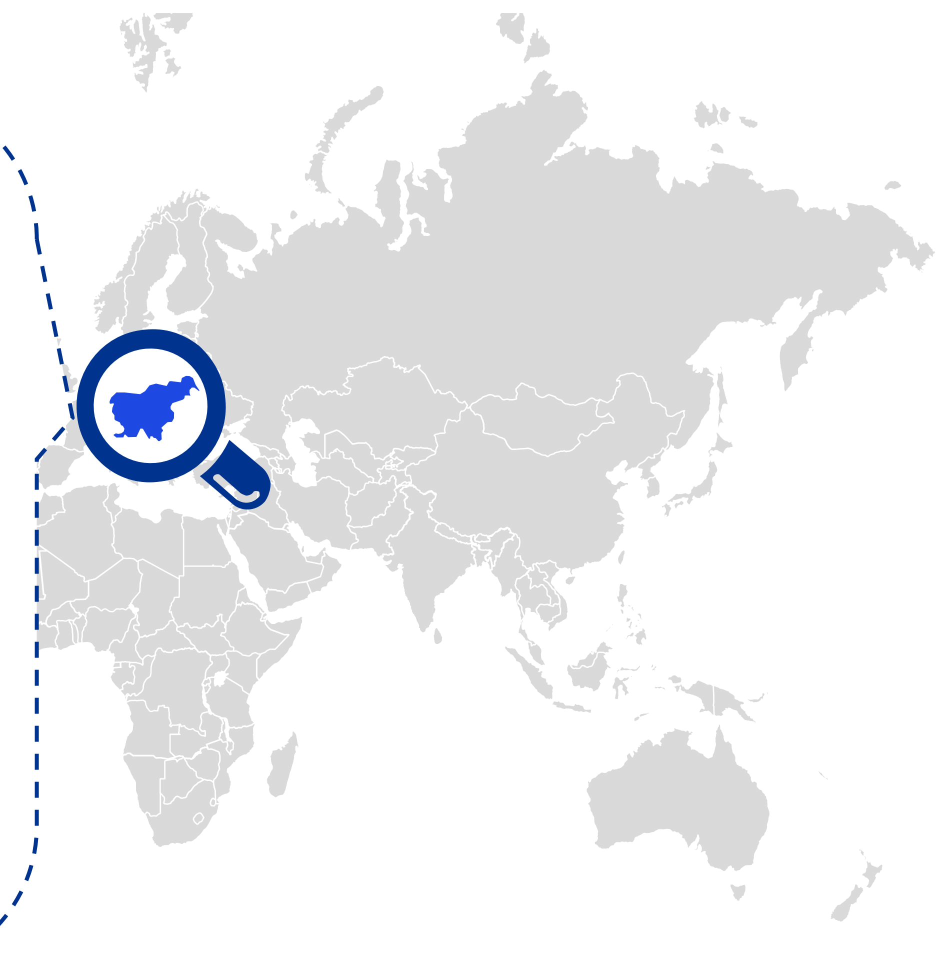
The DRG landscape – Slovenia

Slovenia

- In 2004, Slovenia introduced DRG based on the Australian **AR-DRG** payment model.
- Health care system is primarily **financed by a single health insurance scheme**, the Health Insurance Institute of Slovenia.
- DRG system **reduced waiting times** as the average LoS declined and organizational changes at the providers' level were conducted by implementing DRGs.
- The key **challenges** were the **weak** institutional support to keep the system up to date and the **unavailability of national cost data** for adjusting the DRG weights.
- Financial statements across hospitals are **not standardized**.



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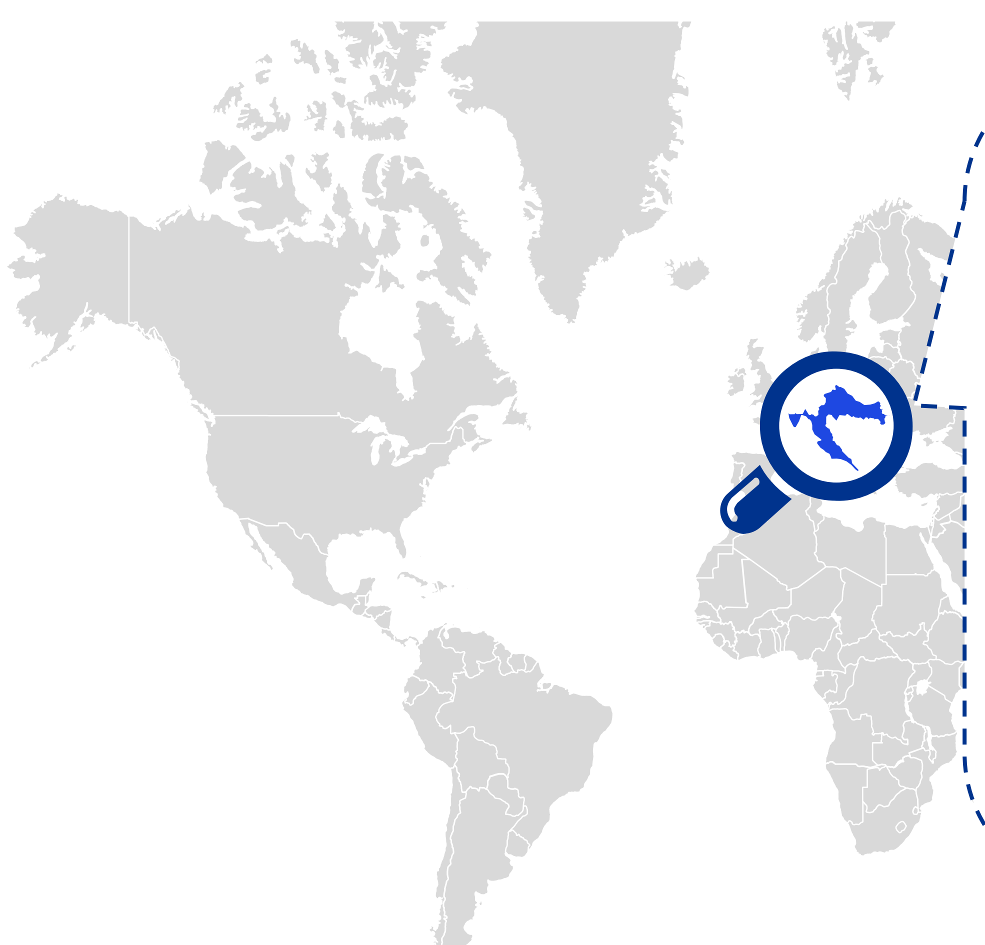
The DRG landscape – Croatia



Croatia

- In 2002, the HZZO started to shift towards a DRG-based payment system.
- Since around 2006, Croatia gradually moved towards the adoption of the **Australian AR-DRGs** payment system.
- Since 2009, **almost all inpatient services and day surgeries** are paid based on DRGs, and approximately **90 percent** of hospital revenue comes from the HZZO.
- The introduction of DRG in Croatia led to **increased efficiency** without undermining quality.
- **Challenges** remain in implementation such as lack of training for medical coders and inadequate hospital computerization.

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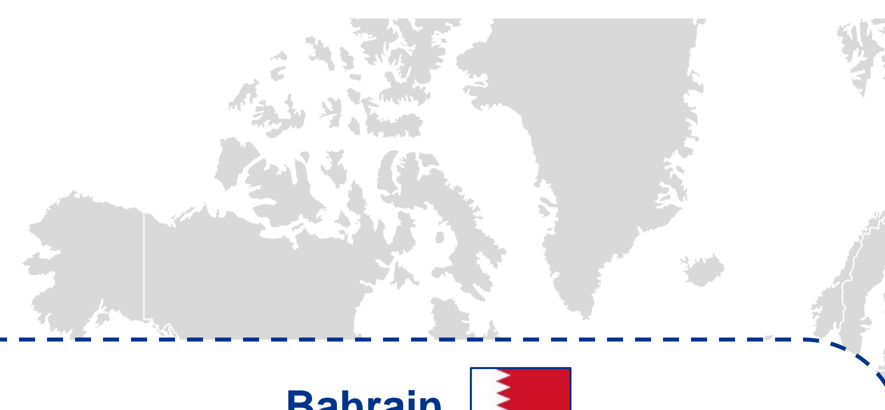
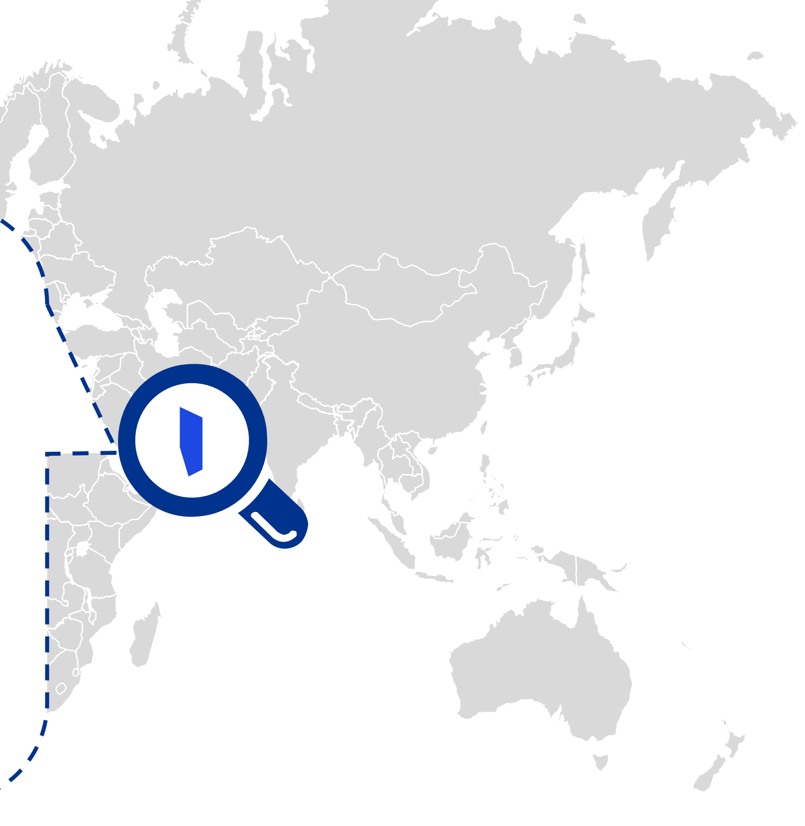
The DRG landscape – Bahrain





Bahrain

- In 2018, Bahrain attempted to adopt a DRG system as part of **the SEHATI transformation** and the introduction of a National Health Insurance Program.
- This includes **changes to the financing methodology.**
- The health system is relatively **well functioning** and **encompassing**.
- The current **challenge** is the implementation **of more decentralized and private provision of health care services** to reduce public spending.

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The DRG landscape – Qatar

Qatar

- In 2013, Qatar introduced a **national health insurance scheme, called "Seha"** which is managed and operated by the government-owned National Health Insurance Company (NHIC).
- In 2014, the **scheme was expanded** to provide coverage for all Qatari nationals, and also expanding the range of providers involved in the scheme.
- Qatar follows **ICD-10-AM** and **AR-DRG**.
- Seha's **challenges** include **expanding the scheme to a wider range of providers**, including "stand" alone providers and addressing the **limited availability of activity and cost information** from the private sector.

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Lessons learned from DRG implementation in small countries

Coding standardization

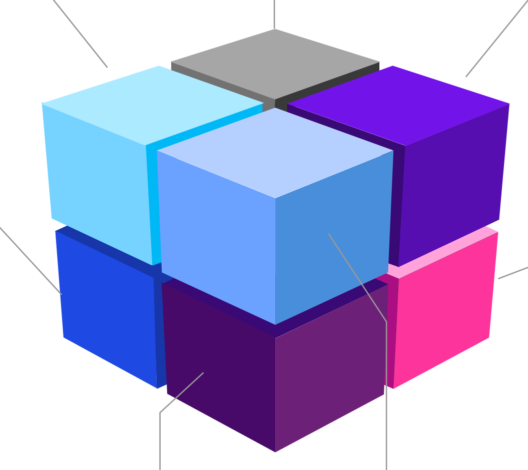
- Defining a **„standardized package“** is challenging
- **Procedure coding** needs to be equally standardized

Resource availability

- Experienced and skilled resources are rare
- Timely decision making

Implementation roadmap

- Takes **time** a) to plan, to ensure that the system fits the country b) to get stakeholders ready and c) to take the system fully live
- Realistic and achievable **milestones** must be set



Organization environment

- The number of hospitals may be insufficient to ensure that **prices** are **independent** of each hospital's costs

Data availability and IT requirements

- Need of **standardized cost** accounting and data collection

Provider readiness

- Interdependencies need to be identified
- Awareness and incentives mechanisms to support a **cultural change**
- **Special attention** must be paid to the main providers

Change Management

- Essential to involve **all stakeholders** at an early stage and on an ongoing basis

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The eight policy components form the general framework for the project approach

DRG Framework

DRG Coverage

Costing and Pricing

Data Collection

Hard policy components:

Defining the key framework for the future DRG system.

How to frame?

Audit, control and payment mechanisms

Evaluation of necessary legal changes

Phase-in approach

Knowledge sharing and communication

Soft policy components:

Components that are needed to transition to the new system and ensure its sustainability

How to implement?

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The first set of policy components define the context and data structure of the DRG system

DRG Framework

Includes **overall goals** of the DRG system, the **base DRG** and the **governance and management body**.

DRG Coverage

Includes **types of hospitals**, **types of services** reimbursed (e.g. surgical day cases) as well as the **applicability of the payment scheme.**

Costing and Pricing

Includes **cost allocation methods**, **in- and exclusion of costs** for the DRG scheme and the **shaping** of the base DRG system **to the countries needs.**

Data Collection

Definition of **minimum data sets** and the **roles and responsibilities** within the related governance body.

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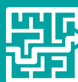
The second set of policy components focus on the necessary regulatory and DRG introduction steps

Audit, Control and Payment Mechanisms

Includes the responsible **auditing body for claims** and the required **functions, roles and responsibilities.**

Evaluation of Necessary Legal Changes

Changes to the reimbursement policy need to be framed in regulatory action.



Phase-in Approach

Decisions will cover the definition of **pilot hospitals** to be used for testing of the new reimbursement mechanism (incl. **duration, process, and shadow-billing).**

Knowledge Sharing and Communication

Focus on the **enablement of all stakeholders** to work in the new payment scheme through a **communication strategy** (incl. central support **for education and training**).

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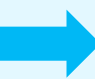
From DRG to Value-Based Health Care (VBHC)

DRG

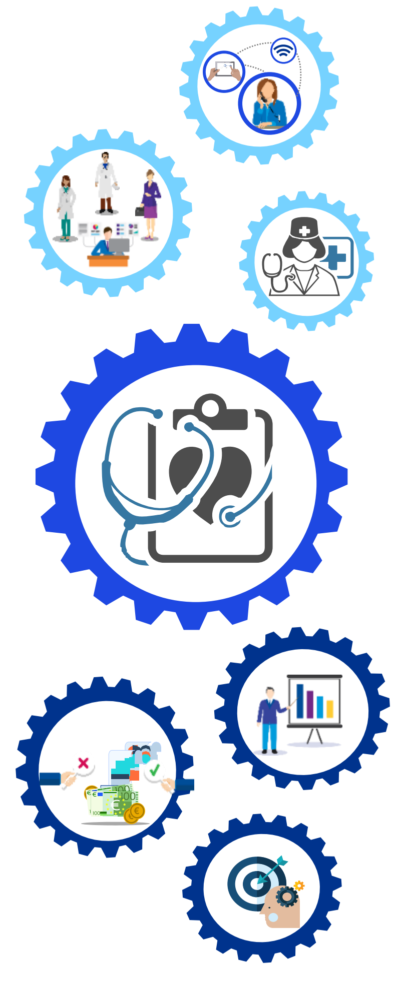
- DRG sets incentives for hospitals to **reduce** the cost per stay, irrespective of outcome.
- There are concerns that DRGs may narrowly focus on **cost containment** while **undermining quality of care.**

Specifically, DRGs may **undermine quality** by setting incentives for hospitals to:

- discharge patients earlier than clinically appropriate
- omit medically indicated tests and therapies
- over-provide certain services
- push patients into a higher paying DRG (up-coding)



Approach: Value-Based Health Care (VBHC)



Value-Based Health Care (VBHC)

- Despite challenging circumstances, the **focus** should always be on **benefits** for patients.
- If **value improves**, patients, payers, providers, and suppliers can all benefit while the **economic sustainability** of the health care system increases.
- However, the **notion of value is contested**. May include 1) allocative value, 2) technical value, 3) personal value, and 4) societal value.
- Value and health outcomes may be measured by **quality indicators.**
- **Example for VBHC** in practice: **'Integrated care' contract** between the Techniker Krankenkasse (German sickness fund) and the Karlsruhe heart surgery hospital.

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