Funding Hospitals in a moving environment: international perspective

Since 40 years the hospitals funding has changed from a supply to a demand based process due to the use of DRG or Casemix in most countries of the world. This standardized way to measure and compare resource needs for hospital patient population has pinned up the way in some countries to a health care funding based on the whole population resources needs in an integrated care system.
This standardized way of measure is dependent of clinical coding which on one hand is facilitated for diagnosis by the availability of the WHO International Classification of Diseases and Health Problems 10th revision with national adaptations but on the other hand hampered by the Babel tower development of national procedures by different countries when some other countries have decided to use the procedures coding systems supporting the 2 world most used DRG systems: the United States ICD10 CM/PCS and the Australian ICD10 AM/ACHI.
For the future WHO has decided to approve the NordDRG grouper supported by the Nordic Classification of Surgical Procedure (NCSP) and ICD10 as a comparative tool but supported by ICHI and ICD11.
We present the updated international view of the situation and the case of countries using a DRG Casemix system initially developed with a procedure coding system with another procedure coding system.
We discuss the consequences of the procedures coding system choice for the use of the Casemix system: Resource Allocation, Reimbursement, Performance comparison, effectiveness and efficiency of health care policies.
Finally we propose to extend the Casemix methodology to manage the health integrated care