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FINANZIERUNG DES GESUNDHEITSWESENS

Effizienz und Gerechtigkeit

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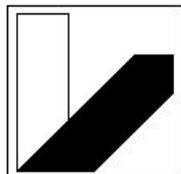
Deutschen Gesellschaft für Gesundheitsökonomie

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react to the different reimbursement approaches identified in Europe. More research explicitly considering the incentives of different reimbursement instruments and mechanisms of technological innovation in the context of DRG-type payment systems and their effects on health care management practices could fill this gap and enable better informed health policy making.

Alexander Geissler, Siok Swan Tan und Mona Heurgren

EuroDRG session: Presentation IV. Diagnosis related groups and cost accounting across Europe: which is driving which?

Vortragende(r): Alexander Geissler, TU Berlin

Background: Results of the HealthBASKET research project have drawn attention to the difficulty of comparing costs and prices for inpatient services across Europe. In particular a wide variation in the size of costs for overhead functions in hospitals across Europe was identified, which is likely to be related not only to actual differences in costs but also to different cost accounting practices. In the framework of the EuroDRG project the question of different cost accounting systems became central because of the importance of cost information for the development of DRG systems. Objectives: (i) describe whether and how cost data from hospital cost accounting systems is used to define DRGs and to determine hospital payment for DRGs. (ii) compare types and methods of cost accounting in relevant hospitals. (iii) elaborate the effects of DRG systems on cost accounting systems. Methods: In the first stage of the EuroDRG project, a DRG questionnaire was developed in order to systematically derive insights about the heterogeneity of DRG systems across Europe. Researchers from each of the twelve participating countries (i.e. Austria, England, Estonia, Finland, France, Germany, Ireland, Netherlands, Poland, Portugal, Sweden, and Spain) were asked to write country reports based on a standardized questionnaire. Thereby, the cost accounting methodology in each country was of special interest. The country reports were reviewed and commented by international experts. Results: The design of cost accounting systems and the quality of cost data produced vary not only across countries, but even within hospitals of the same country. We identified that many national DRG systems set their tariffs on the basis of insufficient cost accounting systems. This is particularly problematic as the tariff may then fail to adequately reimburse hospitals for provided services. Furthermore, lacking quality of cost data reduces the accuracy of economic evaluations and may mislead investment decisions about the introduction of innovations into hospitals. Furthermore, the lack of quality cost information at provider levels has further implications. Quality cost information is vital for making informed decisions about how to increase efficiency of care provided in hospitals. Conclusion: Currently, management decisions are often opposed by clinicians as they feel that decisions are based on intransparent and insufficient information about costs. Improved quality of cost information that relates costs to activities is likely to contribute to increased clinician engagement in management. Therefore there is high demand to improve quality of cost information at various levels. Further research in this area is timely, as it could enable to bundle efforts and propose guidance for decision-makers on quality of cost information and design of cost information systems at European, national and service provider level. Ultimately this improves quality of cost data, its relevance for decision-making and thereby the efficiency and effectiveness of in-patient services.

Conrad Kobel, Josselin Thuilliez, Karl Peter Pfeiffer und Martine Bellanger

EuroDRG session: Presentation II. Diagnosis Related Group (DRG) systems and similar Patient Classification Systems in Europe

Vortragende(r): Conrad Kobel, Innsbruck Medical University

Background: During the last decades major reforms of health care systems have been implemented or are still ongoing in almost all European countries. Concerning the inpatient sector, these reforms were in most cases combined with the introduction of diagnosis-related group (DRG) systems and

corresponding patient classification systems (PCS). In the ten EU member states taking part in the FP7 EuroDRG project (i.e., Austria, England, Estonia, Finland, France, Germany, the Netherlands, Poland, Spain, Sweden), the reasons for applying such systems have been plentiful. The aim of this presentation is to compare the different PCSs and examine their purposes and developments, both within and between countries. Methods: Historical developments of patient classification systems in Europe were assessed. Taking into account the purposes of the DRG system in the respective countries, cross-country comparisons of grouping algorithms were carried out. These were based on national DRG system reports and on literature review, and mainly focus on algorithm variables, in particular how they are used and at which stage. Results: While most countries have adopted either the HCFA-DRG system or the Australian AR-DRG system (e.g., France, Germany), some countries have developed their own systems according to their needs (e.g., Austria, the Netherlands). All systems based on the HCFA-DRG system or the AR-DRG system use the concept of major diagnostic categories (MDC) to group patients according to their respective main diagnosis. Self developed systems use different grouping criteria (for instance, in the Netherlands an “episode-driven” system is used). Complications and comorbidities are mostly handled by either defining system wide severity levels or by a CCL-matrix that assigns severity levels for each combination of diseases separately. Over the years the number of groups has increased in most systems, varying currently from around 500 groups in Spain and Poland to more than 2,000 in France and more than 30,000 in the Netherlands. Conclusion: In a unified Europe with increasing patient mobility, the need for harmonization of health care systems and in particular of DRG systems is indispensable. Even though one European-DRG system seems unrealistic in the medium term, several steps are required for the necessary degree of harmonization. Solutions proposed include in a first stage the mapping of coding, especially coding of procedures, and the creation of an European standard of collected discharge data.

Wilm Quentin, David Scheller-Kreinsen und Alexander Geissler

EuroDRG session: Presentation III. Appendectomy across Europe: Patient Classification and Reimbursement in European Diagnosis Related Group (DRG) like hospital payment systems

Vortragende(r): Wilm Quentin, TU Berlin

Introduction: Diagnosis Related Group (DRG) like Patient Classification Systems (PCS) aim to consider as classification variables the most important determinants of resource consumption in order to assure homogenous groups of patients. However, different countries use different DRG-like PCS, and in most countries DRGs form the basis of hospital payment. In a context of increasing cross border movements of patients, incompatible DRG systems complicate reimbursement of hospitals across borders. Furthermore, varying definitions of hospital products obstruct cross-border comparisons of hospital prices and performance. Objectives: (i) to analyse classification of patients with appendectomy in European DRG systems. (ii) to compare variation in reimbursement levels for six case vignettes of patients with different combinations of demographic, diagnostic and treatment variables. Methods: As part of the EuroDRG project, researchers from ten European countries (i.e. Austria, England, Estonia, Finland, France, Germany, Ireland, Netherlands, Poland, Sweden, and Spain) agreed on a common definition for an appendectomy “episode of care” (EoC). National or regional databases were used in order to identify appendectomy cases in each country. Detailed comparative analyses of grouping algorithms were performed for those DRGs comprising at least 97% of appendectomy cases. Cost weights or similar indicators of resource consumption were compared for each DRG system to an index case of uncomplicated appendectomy in adult patients. Furthermore, six standardised case vignettes of patients with different combinations of primary and secondary diagnoses, procedures, age and length of stay were defined, and shadow prices for patients according to national DRG-type hospital payment systems were ascertained. Results: Patient classification systems vary widely across Europe: Even when considering only the most important DRGs, European PCS classify patients according to different sets of variables (between two and six classification variables) into diverging numbers of DRGs (between two and eleven DRGs). The most complex DRG is valued as 5.23 times more resource intensive than the index case in France but as only 1.11 times more resource intensive than the index case in Finland. Comparisons of shadow prices for the case