Frankfurt School of Finance & Management

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**Deutsch-Chinesische Gesellschaft für Medizin e.V.**

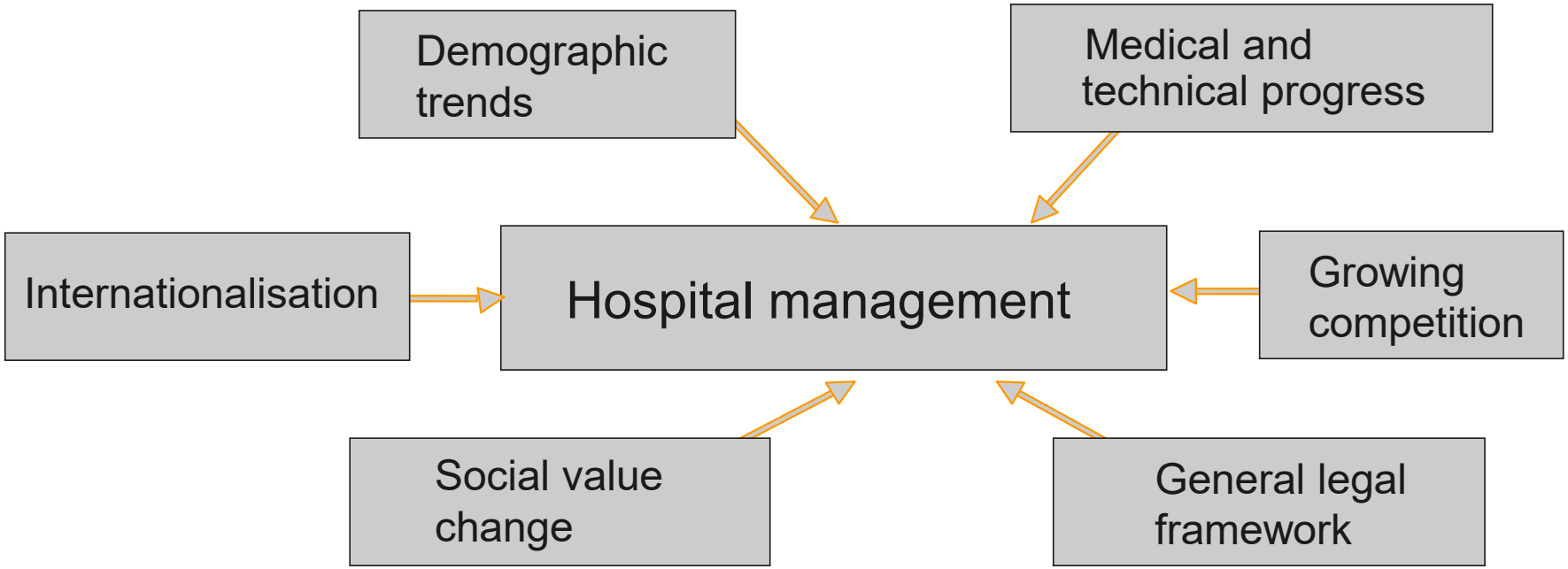
# DRG - Chancen und Risiken einer Krankenhausvergütung nach Fallpauschalen

- Jahrestagung CDGM/DCGM -

**Prof. Dr. Rainer Sibbel**

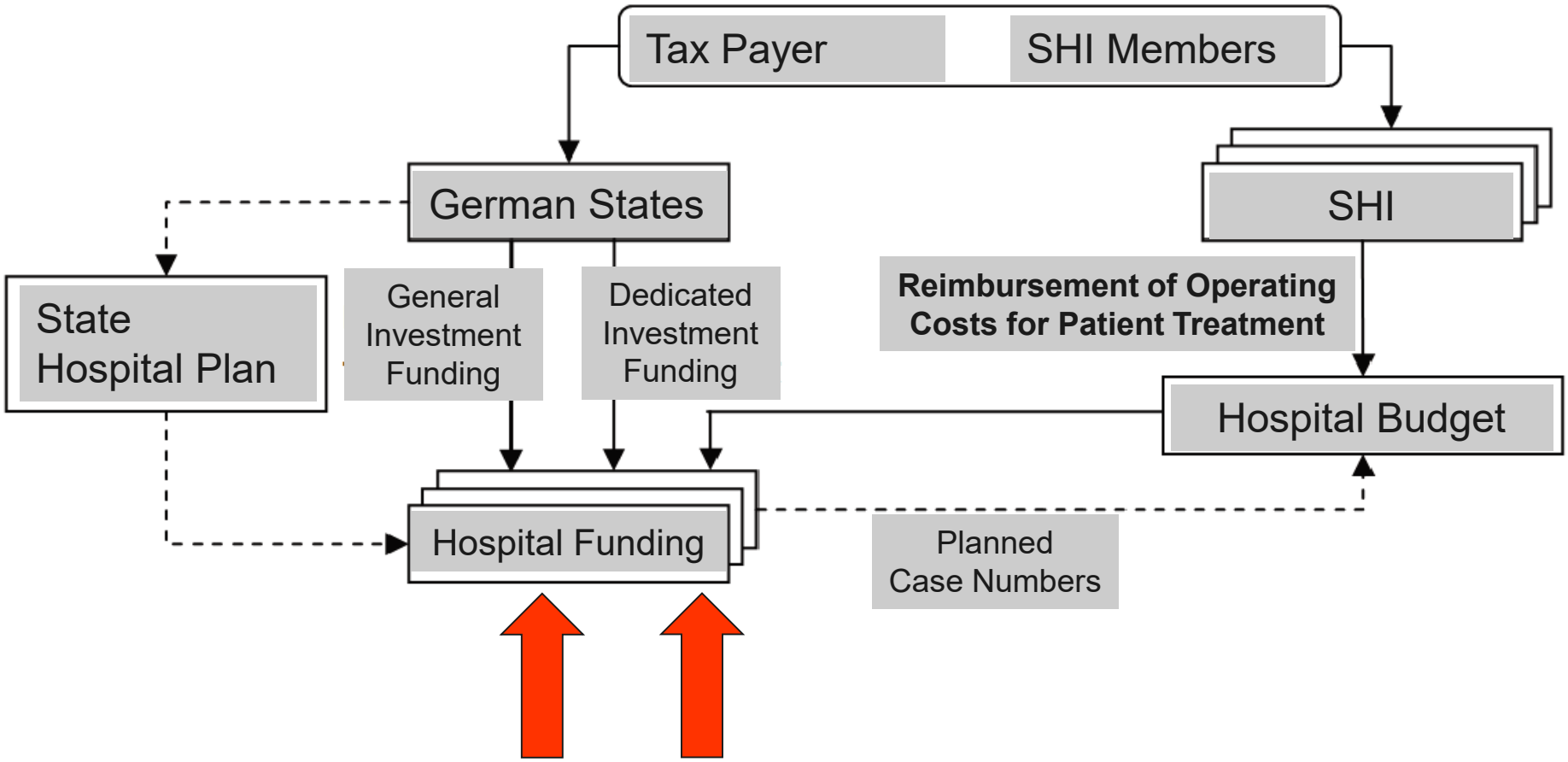
Shanghai, 2. November 2018

# Drivers of structural changes in healthcare




- Increasing demand, potentials and expectations versus financing constraints
- Introduction of the G-DRG-system to increase market orientation and cost pressure in the hospital sector

# Dual Hospital Financing System



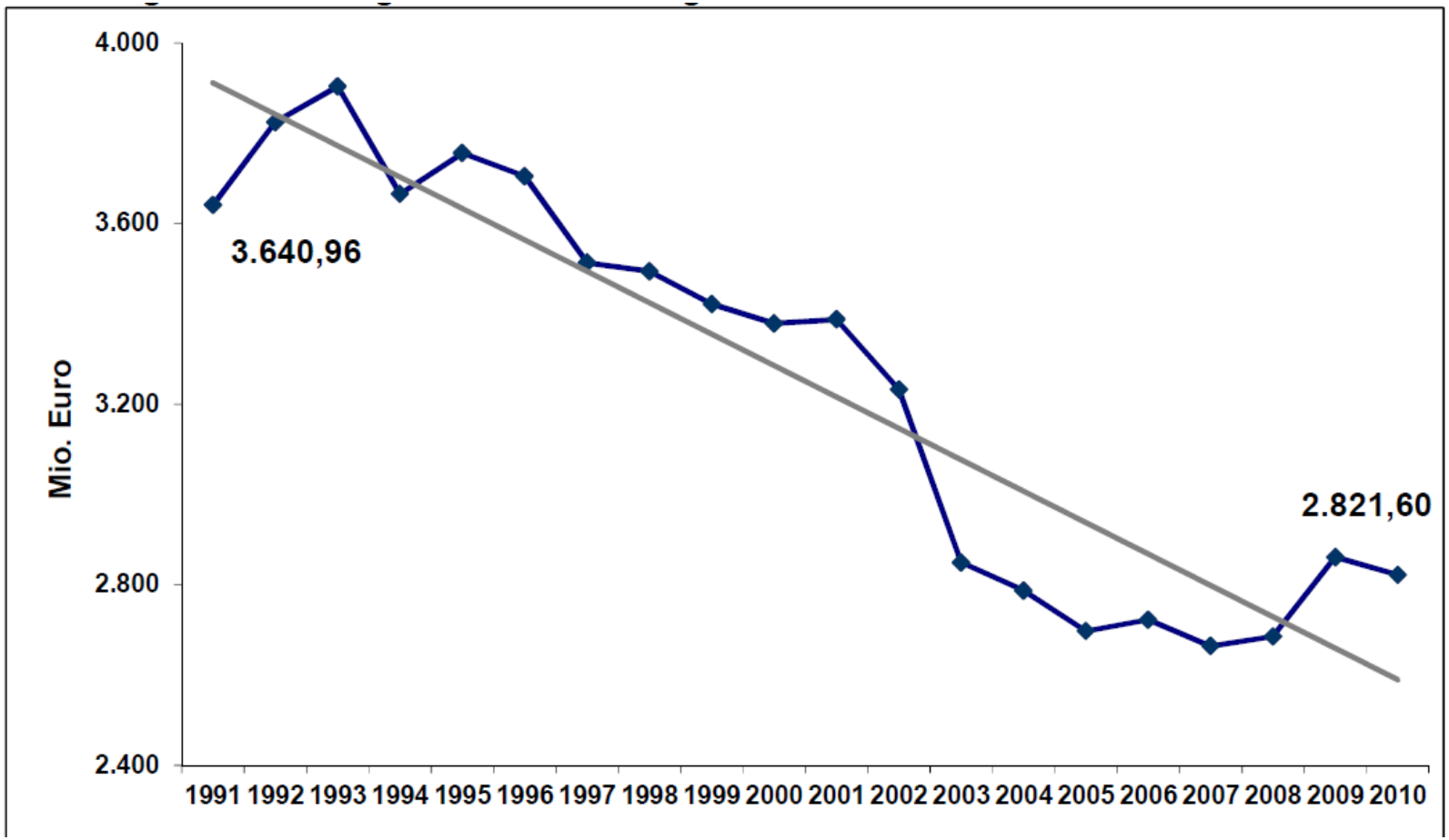

Public Investment Financing

**G-DRG-System**

+ Out of Budgetary Services

Quelle: Neubauer/Ujlaky (2006)

# Development Public Investment Financing

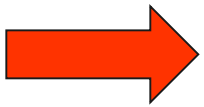



Quelle: DKG

# Essentials German DRG System

- Introduction of a **consistent, performance-oriented, lump-sum based compensation system**
- **Complexities and comorbidities** are to be considered
- Practicable degree of differentiation
- For **all inpatient and daycare services**
- Case groups and costweights **nationwide**
- Base rate are different in each state
- **Classification of patients in exactly one of the categories of the DRG-catalog based on a computerized algorithm (Grouper)**

→ **Clinical significance and economic homogenity are desired**



Money follows patients and performance!

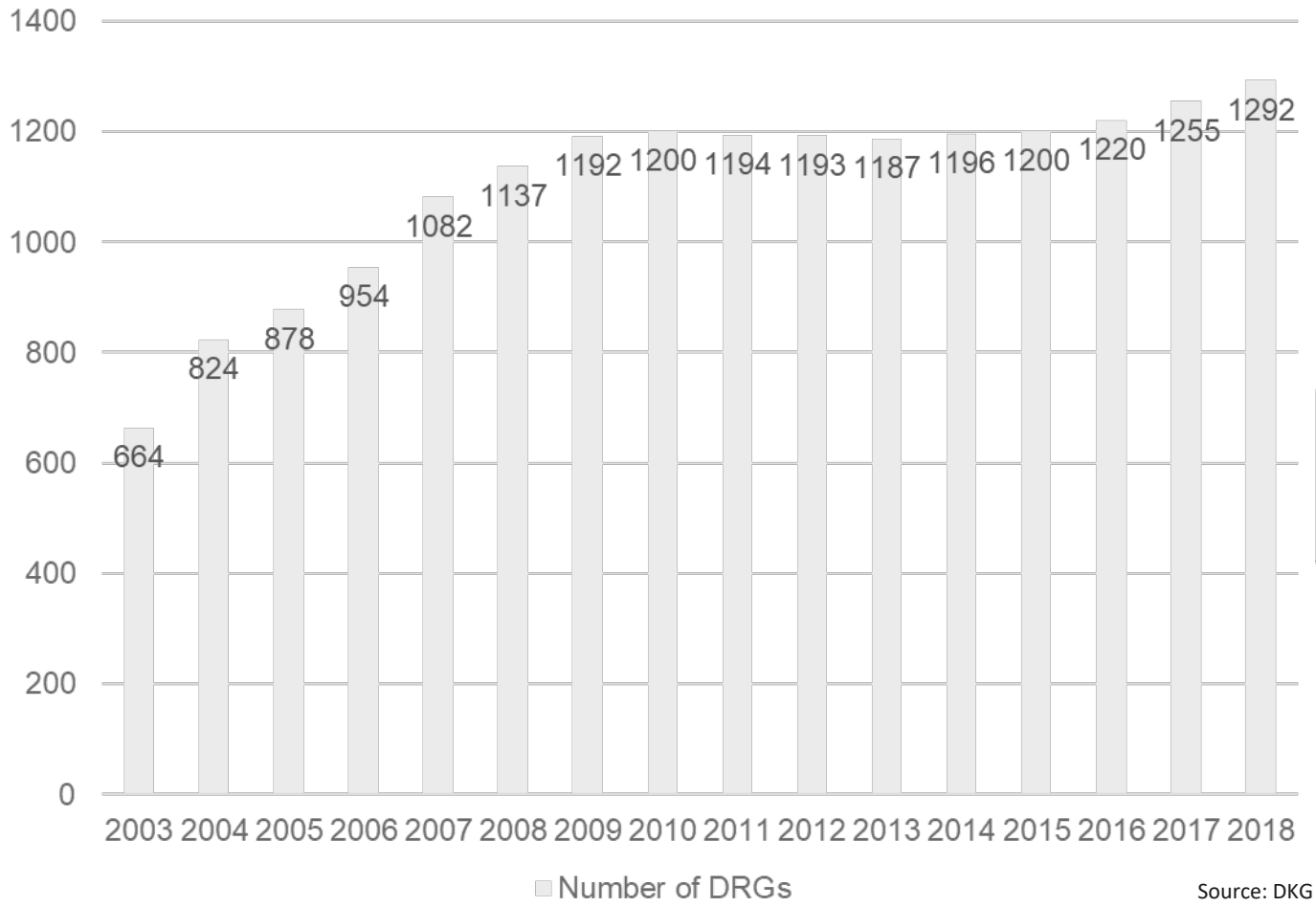
# Effieciency promoting effects of DRGs

- Improved **performance documentation**
- **Comparability** of performances between hospitals
- **Transparent understanding of performances and costs**
- Hospitals have **financial pressure** and adjust internal structures:
  - Restructuring measures of setup and cutback organization will be implemented (e.g. cooperative relationships, use of IT, application of managerial accounting)
  - Build up of new departments and hiring of new professional groups (Medical managerial accounting, clinical coders, case manager)
- **Promotion of standardization and treatment paths**
- **Shortening the length of stay**
- **Depletion of inefficient capacities**
  - Bed reductions
  - Concentration of sites

# Feared unexpected effects of DRGs

- Single-sided **economization** of hospital treatment leads to:
  - **Limiting** to the most necessary
  - Premature (‚**bloody**`) **discharge**
  - Case **splitting** (‚revolving door effect‘)
  - Patient **selection** (‚cream skimming‘)
  - Economic pressure leads to **downsizing**
  - Revenue-oriented **coding** (upcoding)
  - Direction of **range of services** based on economic considerations
  - Increasing **number of cases** that is not medically justified (Shall doctors generate revenue?)
- Charged costs independent of **capacity utilization** (Securing care)
- Different contribution to **emergency care**

# G-DRG-System: a learning system




Source: DKG (2018)

**Number of DRGs has almost doubled!**

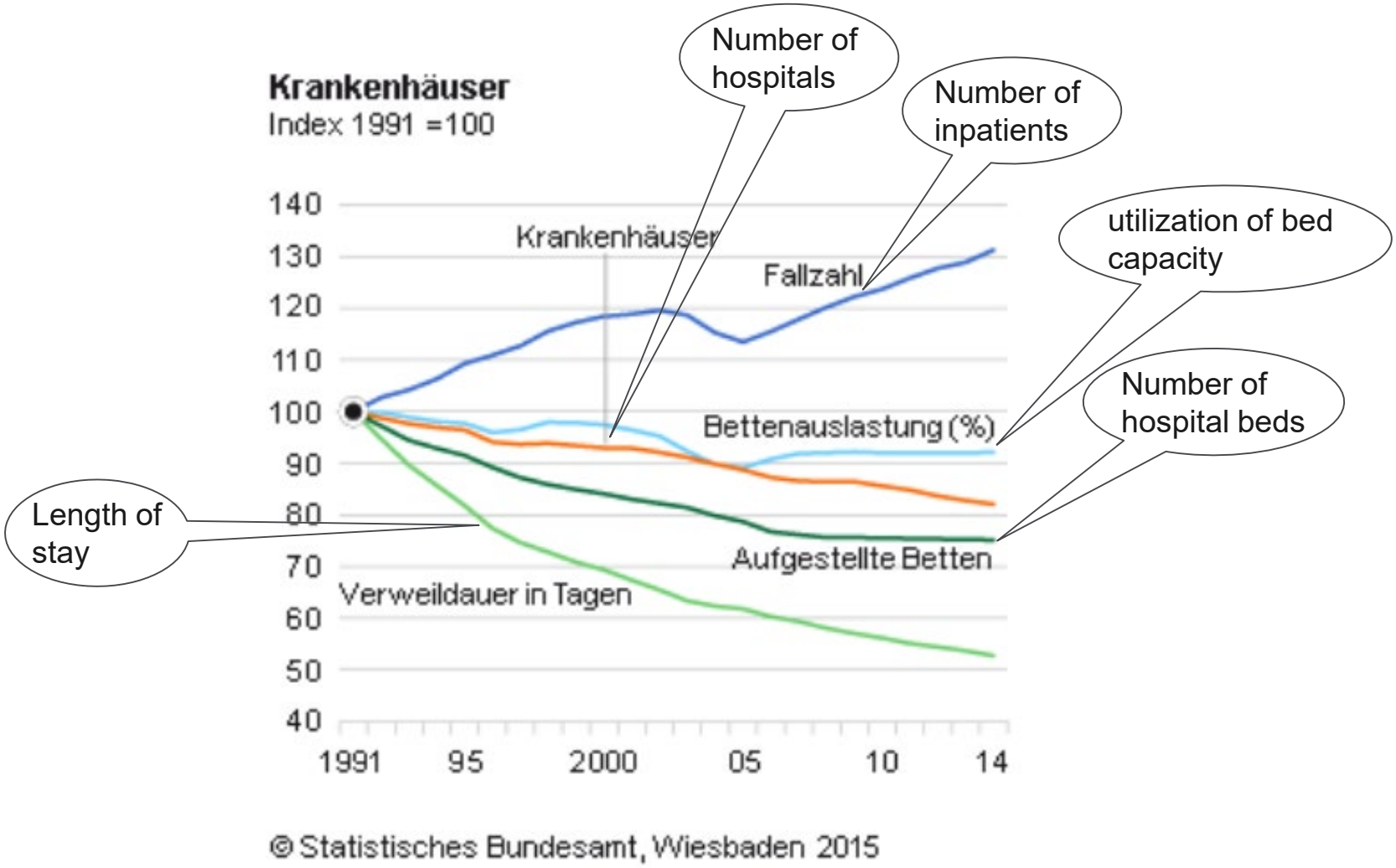
# Introduction of the G-DRG system: issues of change

- Professionals (esp. physicians) anticipated introduction with reservations
- Economic influence on medical practice was regarded as unethical
- Fear of change
- Medical associations slowly developed interest
- New professions evolved (e.g. medical controller, coder)
- Medical professionals were integrated into management (hospitals, insurers)

➔ Management considers medical issues

➔ Medical professionals learned to consider economic consequences

# Performance indicators




Quelle: destatis, https://www.destatis.de/DE/ZahlenFakten/GesellschaftStaat/Gesundheit/Krankenhaeuser/Krankenhaeuser.html,, Download am 14.10.2015

# Development of the SHI expenditures


16.8 million patients


19.4 million patients

SHI expenditures: 148 billion €

Thereof:
Hospital treatment

33.7 % (49.93 billion €)

SHI expenditures: 230.39 billion €

Thereof:
Hospital treatment

32.2 % (74.14 billion €)

Source: Federal Ministry of Health (2018)

# G-DRG: Main Results

## Set goals achieved:

- **Performance-based payment system**
- **Transparency** about **and optimization** of the cost and benefit structures
- Stronger **incentives to economic behavior**
- **Shorter length of stay** and more competition
- **Professionalization of hospital management**

## Competition for Quality

- Specialisation and **positioning** based on cooperations, mergers and acquisitions, hospital networks and chains

## Noticeable **changes on the structure and process organisation**

- Interdisciplinary **clinical pathways**
- Focusing on core processes
- **Admission and discharge planning**
- Referrals as interface
- **Work compression and intensification**

# G-DRG: Main Experiences

## Significant effort of conversion to the DRG-System

- New requirements for medical documentation
- Application of accounting rules
- Development of the necessary IT infrastructure
- High amount of bill checks

## Promotion of new professions

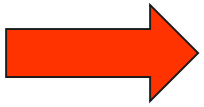
- Documentation assistance
- Medical controlling
- Case Management
- Reallocation of tasks

→ **Meanwhile, widely accepted system, but: still substantial need for correction**

# G-DRG: Outlook

**Work-In-Progress:**

- **More value/quality than volume (P4P)!**
- Correction of Classification system with focus on
  - Misdirected incentives for cases with high costs for medical devices or material costs
  - Extreme cost-intensive cases (outlayers)
  - Deductions for ecomomic driven increase of cases
- „Slow“ response of the DRG system: meaningful changes and innovations are realizable only after a lag of 1 to 2 years
- Incentives and acitivities to reduce capacities
- Dynamic of costs
- Representive calculation sample of hospitals
- Minimum case numbers for specific DRGs
- …



Main hospital issues are driven by the financing framework!

***„Everything, which is not documented, has not been delivered!“***

Hospital CEO

謝謝!

**Prof. Dr. Rainer Sibbel**

Frankfurt School of Finance & Management
Institute for International Health Management
Adickesallee 32-34
60322 Frankfurt am Main, Germany
Fon: +49 (0) 69/154 008 740
Fax: +49 (0) 69/154 008 4 740
E-mail: r.sibbel@fs.de
www.fs.de