DRGs in Germany: implement quickly and refine at leisure

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In this commentary, I will describe the circumstances that led to Germany deciding to move to per case payment by DRG over the next few years, and point out some of the immediate challenges. I will conclude by arguing that the challenges are such that Germany is unlikely to have the time or the inclination to make any significant modifications to DRGs in the near future.

The starting point of a DRG system in Germany was a desire to fund hospitals at rates that more closely reflected reasonable costs of care. Before 1992, the total budget of each hospital was negotiated between insurers and the single hospital on the basis of expenditure history. There was no cap on rate increases and total expenditures were growing at a rate that worried the government.

Starting in 1993, the total budget for each hospital was set at the actual budget in 1992 plus an annual fixed increase. Every politician declared it was only a temporary arrangement, but representatives of hospitals and clinicians continue to wait in vain for a return to paradise.

There were and largely continue to be no descriptions of hospital outputs other than the number of inpatients and their average length of stay. Before 1995, the product of both figures determined the daily fee of a hospital. For example, a hospital with 20,000 inpatients having an average LOS of 7 days would be funded for 140,000 patient days. Assuming a total budget of DM70 million, the daily fee would have been DM500 per patient day. There was no relation to the department in which the patient was treated, much less to the diagnoses or the procedures. Every hospital day had the same average price.

Under these rules, unfair allocation of resources became even more of a problem. Hospitals that came from a relatively high and inefficient budget in 1992 became winners, and those who had been underfunded became losers.

In addition, the number of German hospitals is much higher than in Australia. Every patient is within easy reach of several hospitals. This has given rise to use of the term “patient tourism’: smaller hospitals send patients who seem likely to be costly to larger hospitals to protect their budgets. The larger hospitals have to manage a larger number of patients with a higher casemix index (as one would say in Australia) under a capped budget.

Waiting lists emerged for the first time: they were something completely new to Germany except for organ transplantation and other high-technology and high-cost services. There continues to be little comprehension or acceptance of waiting lists by clinicians and patients.

Given the circumstances - capped individual hospital budget, and average per day funding without any relation to the individual patient - it is not surprising that the data concerning patients in German hospitals were very poor before 1995. The only exceptions were clinical studies concerning single case types. All benchmarks and comparisons failed when the heads of departments claimed that their patients were those with the highest complexity and comorbidity level. No party could prove or disprove these claims.

The product costing data were even more inadequate. It was sufficient to compare the total cost with the total budget. There were no software tools for hospitals to improve this situation. In the absence of demand for such tools, there was no supply.

This was the situation until 1995, only six years ago. It is still fixed in the heads of the large majority of German hospital staff.

In 1996, it was decided to replace per day payment with per case payment for certain diagnoses and procedures. This measure had little effect for several reasons including these:

- the total budget for the hospital was still capped (and merely partitioned into different internal budgets)
- per case rates only applied to about 20% of the inpatients. All others were still paid per day. However the average daily fee was now determined separately for each department.

To identify those patients to be funded on a per case basis, it became necessary to code the principal diagnosis and the principal procedure. This was the beginning of coding in German hospitals (1996!!), and applied only to a minority of cases. This remained the practice for many German hospitals until the end of 2000. As it was not necessary and not funded, many clinicians acted rationally in deciding to code as little as possible.

A study of about 6.9 million inpatient records from about 670 German hospitals was undertaken in 1999, which showed that the average number of diagnoses coded per inpatient episode was 1.89. In 50.3 % of the cases, only the principal diagnosis was coded.

It follows that a database that could be used to explore improvements in the structure of DRG systems for Germany is far away. Only a few studies exist concerning single topics, as mentioned by Hindle (2001). They may be useful to criticise the existing DRG rules but not to create systematic improvements.

In total, German hospitals are not able to describe their production. There is even less ability to calculate their product costs.

We are at the beginning: only few insiders are engaged in thinking about a comprehensive system of per case payment by DRG. The German hospital associations (Federal and State) recently decided to start a program to prepare German hospitals. As mentioned above, the 1999 study involved about 670 hospitals. For 2000, there will be about 850 hospitals (of a total of about 2,100).

Those few who are engaged in the development work are having in-depth discussions about the future system. The decision to change to the Australian definition of the principal diagnosis took several months. There is still the fear that a severe disease with high cost may be hiding behind a relatively uncomplicated reason for admission.

The same people spent a long time discussing the best way to calculate the German cost weights directly - instead of using the Australian weights and adjusting them as necessary to reflect German circumstances. Some weeks ago a pre-test started that will be scientifically evaluated. The real calculation should start in 2002, although already the pre-test proves that the costing data of German hospitals are poor.

In view of all the issues of detail which still are not resolved, the Federal German Hospital Association has proposed a one-year delay of the starting date to January 2004. If this were to happen, some people claim it would represent a victory for German thoroughness!

However, politicians and insurers remain committed to January 2003. They note that the law provides for two years of budget neutrality for each hospital and two more years for adapting the budgets to the coded casemix of each hospital. Given the shortage of data and the many payment design issues remaining to be resolved, there is no reasonable opportunity for considering a revolutionary change in the DRG system structure.

It should be noted that most hospital staff still know hardly anything about the details of AR-DRG version 4.1, which will be used at the start of per case payment implementation. The clinicians are afraid that their status may change and that the individuality of treating patients could be disturbed. They are afraid that the new transparency may show many weaknesses in their practice. Therefore they are looking for arguments to prove that it is not a perfect system. Again, there are more criticisms than serious proposals to improve.

Indeed, some hospital representatives still hope that they will wake up and find everything was a bad dream. As there will be Federal elections in Autumn 2002, there still is the hope that the government could change and the DRG system may not come.

There is an expectation that the officials of the German hospital associations and the German insurance companies will produce a system design that may help even the weakest to survive. The German hospital representatives in a huge majority do not know exactly what will happen. Only a few are interested in a

progressive way of hospital funding. Those few do not have the databases to improve the DRG system. They complain of the same kinds of problem mentioned by Hindle, but they will need some more years before they are ready to act.

Only a few German insiders are engaged in the topics Hindle mentioned in his article, and most are scientists in German universities with only recent interest in this topic. Their research depends on data, and therefore their work thus far is no more than theoretical. The fear that Germans would improve the DRG structure and could overtake the Australians is not realistic.

The focus on the immediate is understandable. However, one obvious risk is that, if changes are delayed until the payment system is established, there will subsequently be much greater inertia — and consequently more difficulty in making changes — because of the fear of major unintended shifts in revenues.

It would therefore make sense for Germany to find opportunities to do common research with Australians, who have a much longer experience and much better databases. Together it could be possible to create really new structures that could have immediate benefits for Australia and help Germany to set its longer-term goals.

Reference

Hindle D 2001, 'The Australian DRG classification: are we ready for structural changes?', *Australian Health Review*, vol 24 no 3.