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# **The Impact of DRGs in Hungary – Why Hospital Utilization Rates Have Not Changed**

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# Short History of developing, implementation and using the DRG-based reimbursement for hospitals

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- 1986 Start to develop DRGs-like system for reimbursement of hospital, collecting data of the resource consumption at patient's level
- 1992 Collect of the discharge data (from every hospitals on every discharge) due to implement the new reimbursement system based on DRGs
- 1993 Implementation of the totally DRGs-based payment system for hospitals acute care.
- 1997 Implementation of the general base-rate, refinement version of HBCs (Hungarian case-grouping system)

# Targets of implementation of DRGs like system

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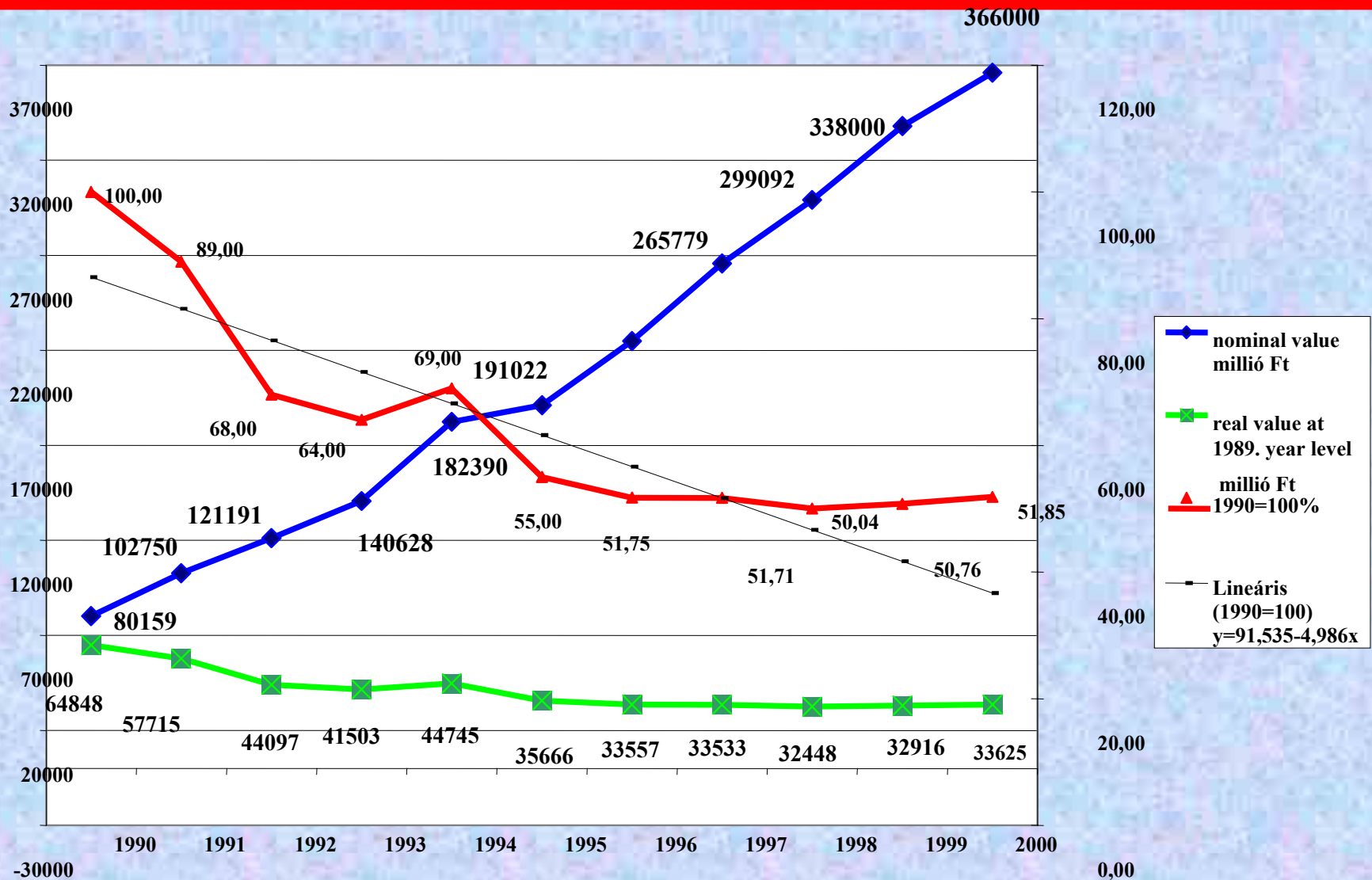
- **More accountable system (cost-containment pressure within the hospital)**
- **More accessible system (demand oriented system)**
- **More equitable system (the same money for the same treatment and the money follow the patient: use the national ID number for patient's record)**
- **More manageable system**
- **More cost- effective system (reduce of length of stay, push the cases from active care to chronic care, normative system, output-oriented system, reduce the unnecessary treatment, etc.)**

# The Current Acute Hospital Reimbursement System

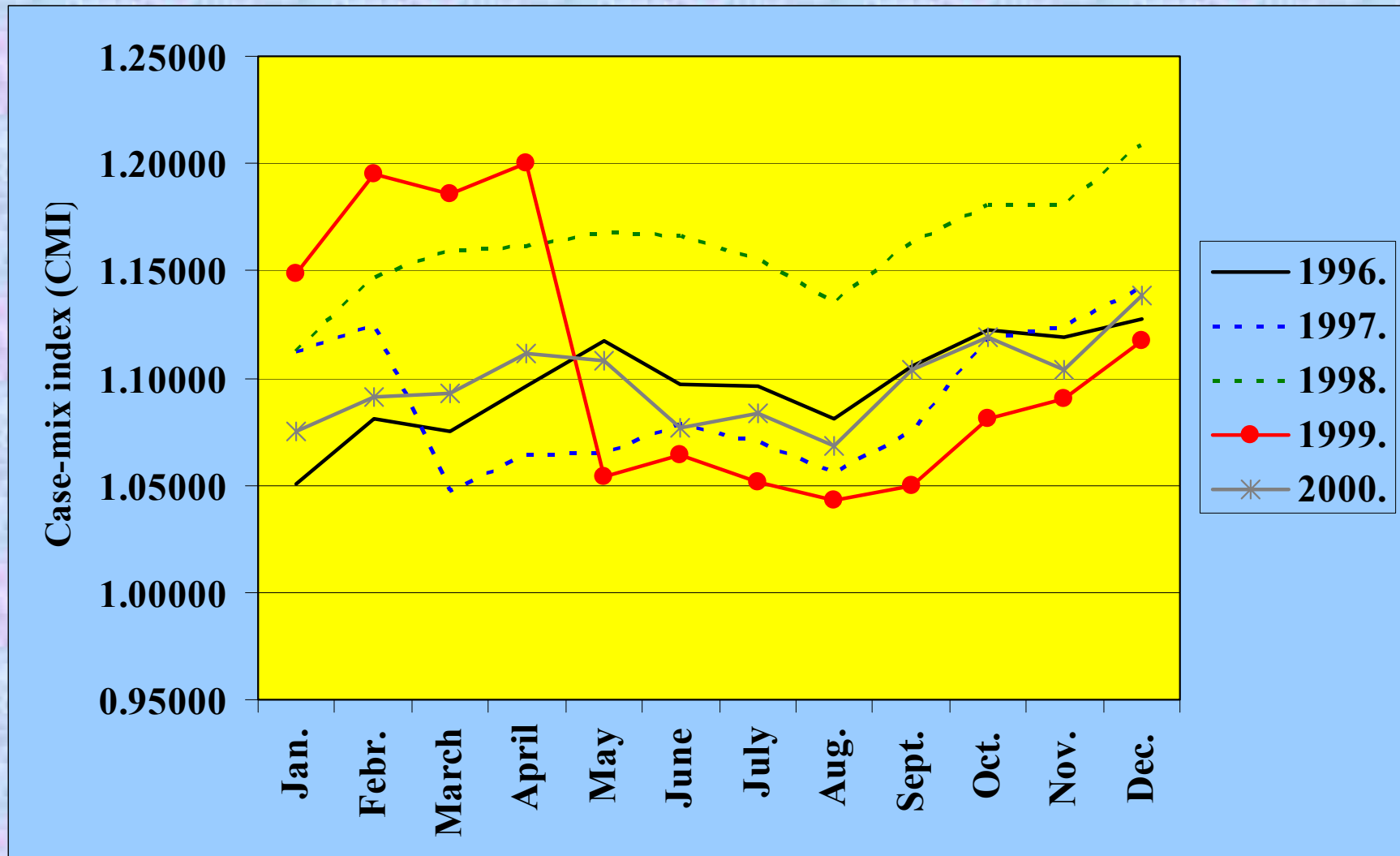
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- a) Reimbursement system is totally output-oriented system, no fixed elements.
- b) The number of DRG (HBCs) groups is: 777
- c) The base rate (reimbursement fee for HBCs with 1,00 cost-weight) is the same nation wide and prospectively defined
- d) Day – outliers are paid based on daily rates (different for intensive and normal care).
- e) There are some important rules related to HBCs as conditions of reimbursement (not every hospitals have a license for all HBCs)
- f) Some hospital services are paid on a fee-for service basis (graft, some special implants, transplantation, dialysis, etc.)
- g) The HBCs system includes outpatient services like one-day clinical and surgical cases, sort- urgent cases (6-24 hours treatments) and serial out-patient cases (chemotherapy, etc.) are also involved

# Budget for public health services paid by the Health Insurance Fund



# Case-mix index 1966- 2000 with different version



# Changes Seen in the Hospitals

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- **Behavior**: Enterprise like, looking after more patients, do economical analyses
- **Development of internal regulation**: Focusing on creation of income and cost centers, development of internal accounting, internal interesting system
- **Organizational changing** : Development of controlling organization and information groups some structural changes due to the DRGs` incentives
- **Management function**: More data to planning, controlling the activity and resource consumption
- **Quality of the management**: Several special education, increase of quality

# Effects of HBCs system at national level

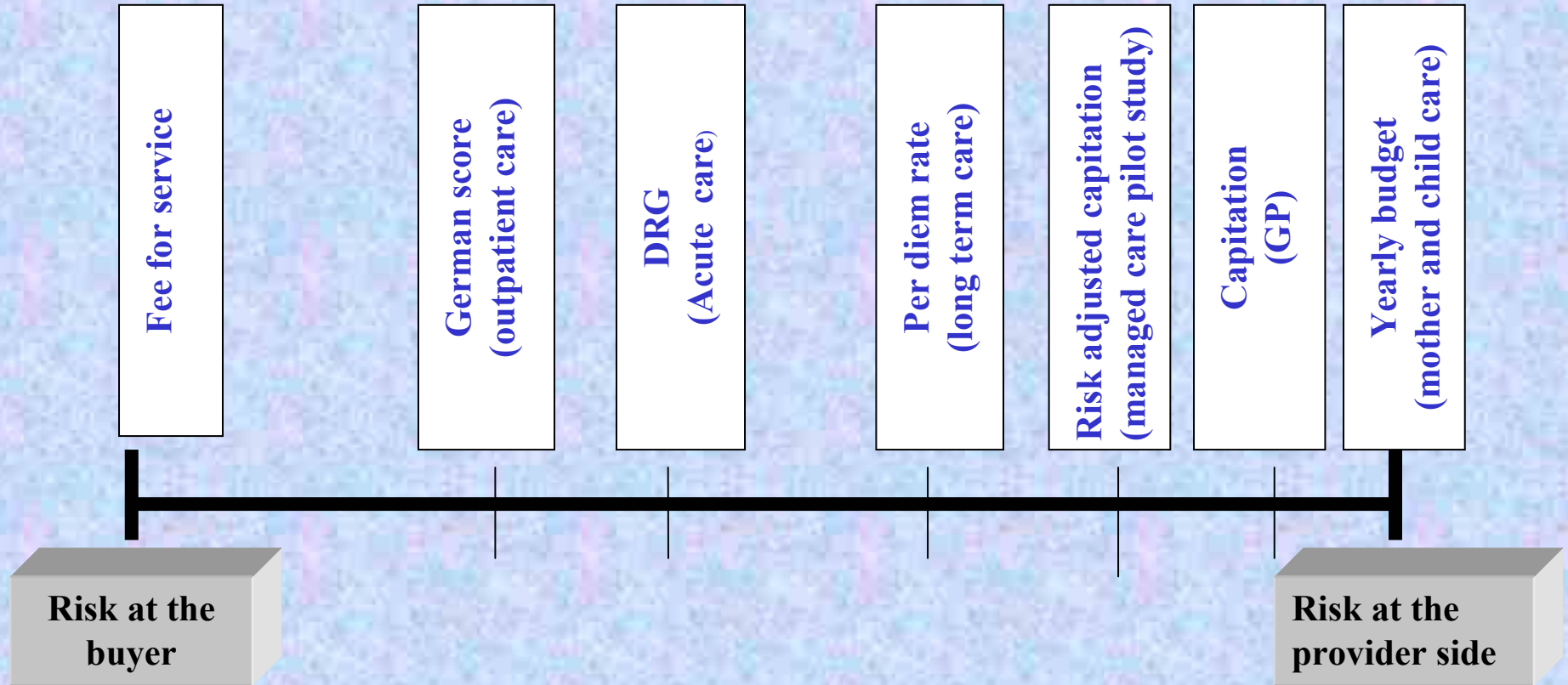
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- **HBCs is appropriate tool to create frame for cost-containment at national and hospital level, for optimal risk sharing between hospitals and insurance institution.**
- **The HBCs could support cost-effective issues at hospital level and alone (not considering the other elements of health system) at national level too with certain limitation.**
- **The HBCs could support the health priority and policy issues.**
- **Number of hospital beds, average length of stay was reduced, but the activity of hospital care was continuously increasing.**
- **No waiting list, no unmanageable problem at technical level to send the necessary information.**

**Final result: during the last 12 years the real value for hospital care was decreasing but the activity of hospital sector was increasing.**



# ***Risk sharing Model***



# ***Risk analysis: the case of the DRGs***

## Risk of the purchaser

- a) Increasing (un-appropriate) inpatient cases
- b) Gaming with the codification (increasing Case Mix Index)

## Risk of the provider

- a) Extra expensive cases (cost outlier cases)
- b) Bad distribution of the high-cost cases within a group

## Risk handling:

Capacity control  
Volume-contracts based on prospective weight-numbers

Controlling system development,  
Dynamic structural institutional policy

# **Future development issues**

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- **Regulation against unnecessary increasing of activity**
- **Refinement of HBCs (improvement of cost analyses)**
- **Development of case classification for chronic care**
- **Adaptation and partly implementation of other patient's classification system (APGs, ACGs, DCGs)**
- **Developing other elements of regulated hospital and health market (capacity-volume regulation, benefits regulation, quality assurance schemes, etc.)**
- **Enhancement of gate-keeper functions and managed care methods in the outpatient care**

# Conclusion

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- **DRGs like system is the most appropriate way to express hospital responsibility in the treatment process and to use as reimbursement unit actually**
- **DRGs system supports the quality issues, health policy but of course just one very important element of the total regulation and not replace other necessary regulation.**
- **The information system required is technically carriable.**
- **The regulation frame influence very well the real effect the DRGs like reimbursement system.**
- **There are some pozitive effects and change in the health system related to using HBCs**
- **But continuous refinement of HBCSs and seeking of best reimbursement schemes are essential**