Payment Based On Diagnosis-Related Groups Differs In Europe And Holds Lessons For The United States

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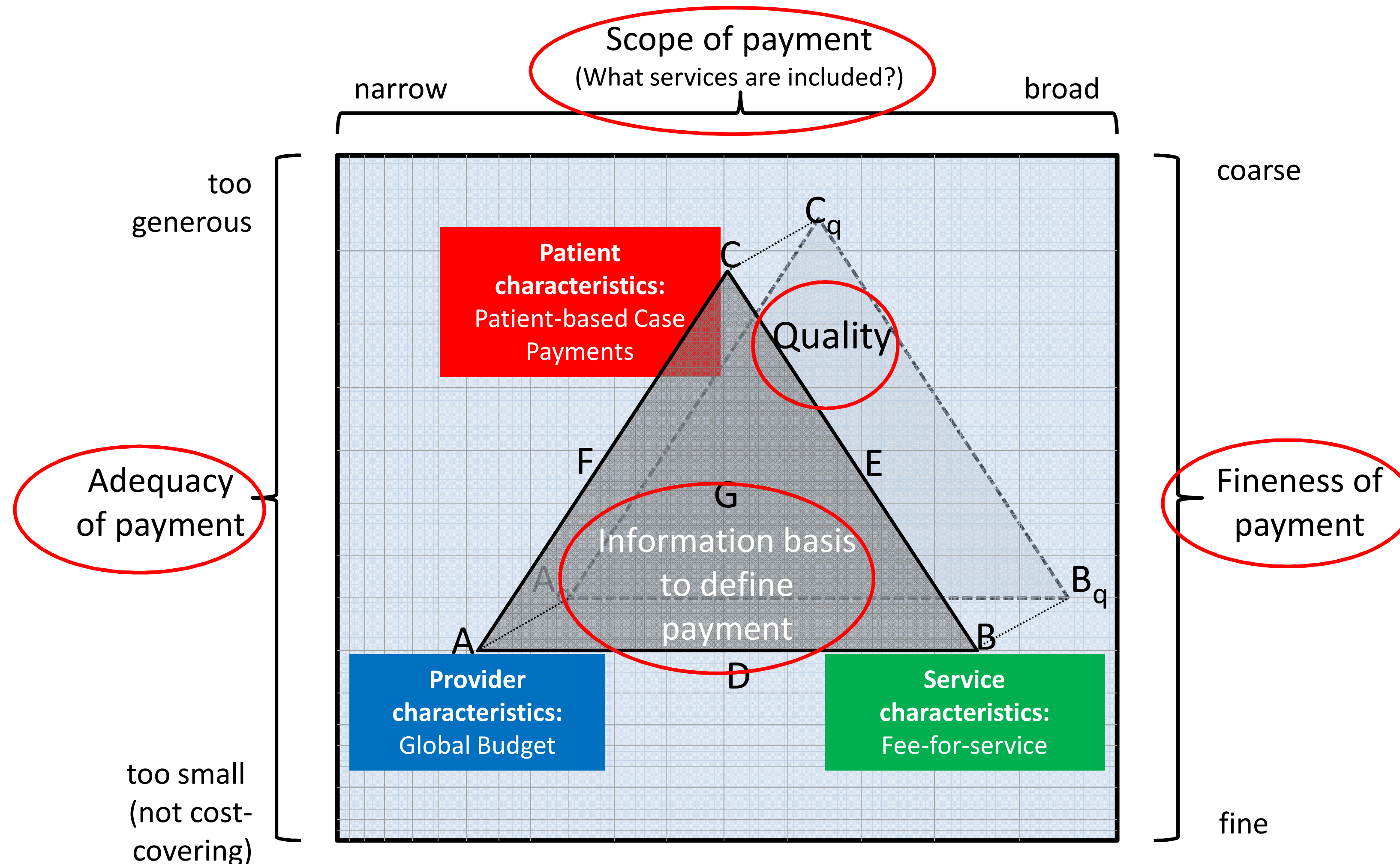
Basic characteristics of DRG-based hospital payment systems

	England	France	Germany	Netherlands	Sweden	US (IPPS)
Patient classification system	Healthcare Resource Group (HRG)	Groupe Homogène des Malades (GHM)	German DRG (G-DRG)	Diagnose Behandeling Combinaties (DBC)	NordDRG	Medicare severity DRG (MS-DRG)[a]
Year introduced	2003	1996	2003	2005	1995	1983
Prior payment system	Global budget (with activity adjustment)	Global budget (with activity adjustment)	Global budget (with activity adjustment)	Global budget (with activity adjustment)	Global budget (with activity adjustment)	Fee-for-service
Frequency of revisions	Annual	Annual	Annual	Irregular	Biennial	Annual
Applied to	All hospitals treating NHS in- and outpatients	All hospitals, in- and outpatients	All hospitals, in- and outpatients	All hospitals, in- and outpatients	Depending on county, in- and outpatients	All hospitals treating Medicare patients (some exceptions)

Analysing hospital payment



Design Options To Improve Hospital Payment Systems I

Framework dimension	Design options to improve hospital payment (theory)	Examples from Europe
Information basis	Diversify the information basis: to provide a balanced set of incentives	England and Germany: stronger procedure orientation of DRG systems than in the US; add-on payments to reduce skimping incentives of DRG-based payments. Germany, Netherlands, and Sweden: provider-level budgets or volume ceilings to balance incentives for expansion of activity
Scope of payment	Combine a broad scope of payment with add-on payments: to make providers responsible for all costs of care, including after discharge, and to encourage delivery of priority services	All countries (except Sweden): broad time scope: DRG payment includes readmissions within 30 days (or 42 days in the Netherlands) All countries: broad scope: physician salaries are included in DRG-based payments All countries: narrow scope: add-on payments for certain high-cost priority services on top of DRG-based payments

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Framework dimension	Design options to improve hospital payment (theory)	Examples from Europe
Adequacy of payment	Improve payment adequacy, so hospitals are adequately reimbursed for services they provide Pay hospitals on the basis of what it costs to deliver efficient and high-quality care, to reflect care in line with clinical guidelines	Ger, Nl and Swe: standardized bottom-up cost data collection in (a sample of) hospitals for reliable cost-weight calculation All countries (except Eng): two-year time lag between data collection and payment (instead of three years as in US). England: best-practice tariffs: encourage efficiency and quality by setting payments in line with clinical guidelines (may be above or below average costs)
Fineness of payment	Improve the fineness of payment categories to enable better adjustment for severity of illness	All countries : finer payment systems than the US Germany: possibly better severity adjustment through calculation of Patient Cumulative Complexity Level (PCCL)
Quality	Link payment to quality to ensure value: when quality of care is measured, payments can be adjusted accordingly	England: CQUIN payment framework links 2.5% of hospitals' contracts to achievement of a set of locally agreed quality measures England: best-practice tariffs: higher payments if providers adhere to quality standards

Thank you very much for your time and attention!

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