Foreword 1

This book has global application; it will find an eager audience among policy leaders, technicians, hospitals, and physicians. In Organisation for Economic Co-operation and Development (OECD) countries, in which DRGs have been implemented since the 1980s, there is still little or no comparison three decades later across countries, in terms of key building blocks, and whether or how variations in design make a difference. How many categories are enough, and when are there too many? When do DRGs begin to look like a fee-for-service model? Which cost-accounting system works best? Almost all DRG experts are conversant in one or two, or perhaps a small number of systems, without any in-depth knowledge of the larger number of countries in the European Union (EU) which have implemented some form of DRGs.

As with other mechanisms and policies in the health sector, the book sheds light and presents evidence on the importance of history and context. As far as DRGs are concerned, the book suggests, there is no "one size fits all" situation. At least not yet. While a uniform approach across Europe may emerge at some point, it is clear that the experience of countries to date is defined by EU Member States taking different approaches in terms of clinical categories, patient classification systems, costing and allocation, quality, and their readiness to respond to the somewhat euphemistically termed "unintended consequences" that seem to emerge in every implementation process. The diagnostic across countries is both interesting and useful, and will be enlightening to students in any country looking for ways to improve the casemix system, either under design or already fully implemented. The variation in the short term takes the

form of an opportunity to provide a menu of options for solving technical issues within each of the building blocks.

Still, it is remarkable that, from a broader vantage point, there is a path of convergence in payment models for hospitals across Europe, with some mix of DRGs and global budgets. Within the bigger picture, guidance is also given, not only on what to do about individual building blocks, but also in terms of the need to constantly "mind" or monitor and update the system in place. A former United States Medicare administrator in the late 1980s, Dr. William Roper, once argued that a system of DRGs would collapse under its own complicated and technocratic weight, to be replaced by a simpler and more powerful capitation model for the full benefits package. That day has not yet arrived, although the book competently offers a glimpse of the future, which shows a system that includes outpatient stays and the emergence of payment for entire episodes of care, as is the case in the Netherlands.

Yet, this book will be appreciated beyond the EU and other OECD countries. As a peripatetic World Bank health economist working in middle- and low-income countries since the 1990s, upon arriving in a country and visiting the leadership, a clear pattern of priorities emerges from the first meeting with a Minister of Health. The discussion typically starts with a series of questions about how to mobilize more funds for services in the health sector. This is often an ambiguous and meandering discussion, which highlights the need to assess fiscal space, and raises some questions (from me back to the Minister) regarding sectoral efficiency and performance. Resource allocation, not new money, quickly becomes front and centre. Like the Europeans and North Americans of the 1970s and 1980s, the Minister agrees that the system needs to restructure incentives to improve performance, while simultaneously facing a landscape of changing demographics, changing disease profiles, and increasing citizen dissatisfaction regarding responsiveness. Almost without exception, the Minister then pronounces that the sector needs DRGs for hospitals, and in quick succession wants to know in how many weeks might "we" (together) implement the system in the country. Such a scenario has often played out in the countries of the former USSR in the 1990s, in the Middle East in the first decade of this century, and in South and East Asia in the last few years. My colleagues report that examples of this type of discussion are increasing in number in Latin America and (most recently) Africa; for example, in Ghana, Kenya, and South Africa.

Starting with the hospital sector in non-OECD countries makes sense. That is where the money is. The share of expenditure for inpatient acute care is typically more than 50 per cent of all spending. In China, it is 58 per cent, in Brazil over 60 per cent and in the countries of the former USSR it was often above 70 per cent. Most countries face significant challenges with both technical and allocative efficiency. Some effort to move from line-item budgets and/or fee-for-service payment holds the promise of addressing multiple objectives related to improved sectoral performance.

At the same time, the move to some form of DRGs is not risk free. Non-OECD countries have often bought a software grouper from Australia, the United States or the Nordic countries. More recently, they have begun to download from the United States Medicare web site an open-source DRG grouper, with 350

categories and 3 levels of severity. "We can start right away" is often the remark heard from the Minister's staff. However, the European country experience is that this model takes time to implement well – typically 5–10 years, and it took even longer in the United States. This book is an insightful and helpful guide on the multiplicity of paths that need to be followed – at times in parallel, at times in concert – while at the same time providing options for finding the fastest and most direct path to implementation.

A few years ago, the World Bank published a manual to help countries design, build and implement new payment systems. The chapter on casemix was certainly the centerpiece of the book. The book was written because countries wanted to know not only "what" to do, but also "how" to do it. That book drew on a very small number of countries in Central Asia, but most OECD and non-OECD countries aspire to have a health sector similar to those found in Europe today. Countries such as Germany, the United Kingdom, the Netherlands, Denmark and Sweden have in place models that are often held up as examples, if not actually emulated. Estonia has become the prime example of what can be done well, from a rather dismal start point, and within a short space of time. This list and mix of advanced and yet relatively similar European countries identified in the book become an optimal platform from which to really assess the impact and potential of DRGs in terms of transparency, efficiency, quality, and so on. The book shows that, while there are predictable patterns of impact, such as reduced length of stay, changes in numbers of beds, admissions and occupancy, there are also significant variations across the EU. And while most of the world sees Europe as relatively homogeneous, the book also shows that organization, financing and delivery models continue to vary from country to country. Finally, the country case studies are quite rich in detailing the political, economic and technocratic approaches used in these individual countries, and (again) provide a strong message to learn from others, but perhaps also to develop unique and innovative solutions that reflect history and the special issues in any single country. The key message of good design is mingled well with certain "preconditions" of success relating to political support, the necessary legal framework, autonomy in the delivery system, good information systems, and proactive quality assurance systems.

Enjoy, learn, compare, and be careful at the design and implementation stages. The World Bank is a founding partner in the European Observatory on Health Systems and Policies, and Bank experts will greatly appreciate this work. With some Observatory books and publications, the experts contribute, but in every case we also learn. We learn along with our many client countries, most of which aspire to a system like those found in Europe today.

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Foreword 2

As a starting point, I think it is a good idea to use a private example to present a book dealing with issues common to, and important for, all European countries.

Since the 1990s, Bulgaria has moved from the socialist model of centrally planned health care to a single-payer health insurance system. The payment of hospitals, formerly based on annual line-item budgets, gradually began to be based on reported activities, known as "clinical pathways". Each of these pathways is defined for a set of similar diagnoses and has a fixed price. Prices were negotiated between the insurer and professional physicians' organizations. This was just the opposite of what had taken place for 40 years – after centrally planned budgets, prices and wages, the country set out optimistically, with the hope of a free market in hospital care! A few years later, however, it became clear that the agreed prices of clinical pathways were influenced by medical lobbyists and had no direct connection to the costs actually incurred in hospitals – neither in respect of the ratios between the different diagnoses and conditions, nor in terms of the varying degrees of severity within a diagnosis. This was due to the fact that the clinical pathways were based on the main diagnosis and procedure, but neglected the severity of the patient's condition and concomitant diseases. Thus, the more pathways a hospital reported, the more money it received, and the milder the cases that were treated, the more "cost-effective" (that is, profitable) the hospital was. As a result, within ten years hospitalizations in the country increased by 68 per cent and the statistics reported a "growth" in diagnoses, mainly for the well-paid clinical pathways. Part of this increase was also due to newly opened private hospitals specializing precisely in these well-paid areas. Paradoxically (or

actually, not surprisingly), despite the increase in financial resources, citizens' dissatisfaction with the health care system also increased.

Given the rapidly increasing hospitalizations and associated costs, global budgets at hospital level were introduced, while the accounting continued to be carried out through clinical pathways. Immediately, questions emerged: how can we determine a fair global budget? How can we encourage those performing well and limit those that are inefficient? How can we ensure transparency? How can we ensure access and quality, without stimulating excessive consumption? The system of clinical pathways was not able to provide adequate answers to these questions, so Bulgaria began to look for alternatives, and intends to introduce a DRG-based payment system, following the example of many other countries in Europe. However, to reveal and compare the strengths, weaknesses, opportunities and threats of European DRG-systems, as well as their design – which is clearly different across countries due to their intended use – is a big challenge for countries such as Bulgaria that want to introduce DRG-based payments which are based on reliable data reflecting patient needs and actual costs, and which incentivize the provision of appropriate, high-quality and efficient care.

Therefore, this book – with Part One focusing on the main issues relating to DRGs, as well as Part Two presenting structured DRG system comparisons across twelve European countries – imparts extremely interesting information for countries which are about to introduce DRGs to finance hospitals. It will certainly be useful, not only for me, but for all others engaged with this issue. It is essential reading for people who ask questions, share problems, offer solutions and disseminate best practices.

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