Diagnosis Related Groups

History
Diagnosis Related Groups (DRGs) were developed in the late 1960s by American researchers in response to the rising cost of health care. DRGs provide a finance and patient classification system using diagnosis, type of treatment, age and other related factors as the screening criteria. Hospitals are paid a predetermined amount of money for treating patients from a given DRG, regardless of the actual cost of care provided.

With widespread increases in health care spending around the world, DRGs have been introduced in several countries as a cost containment strategy. Reports indicate that 19 members of the Organization for Economic Cooperation and Development (OECD) have adopted some form of DRG-based price controls for hospital reimbursement. These systems are also designed for planning, budgeting, management and tracking care provided.

International Applications of DRGs
Most countries applying a DRG system have adapted the original American model to meet country-specific needs. Because the funding of health care systems varies significantly between countries, uniformly implementing a specific payment schema would be impossible. Even across state funded health care systems (where the primary aim of a DRG-based financing scheme is to improve production control) DRG-based financing implementation varies.

The Nordic countries have similar publicly funded health care structures. In Finland, the goal of DRG payments is to reduce the economic disparities between geographic regions, while in Norway, the goal is to decrease waiting lists and increase productivity. In Finland, unlike Norway and Sweden, patient choice between hospitals is restricted and competition between hospitals does not exist. As Norwegian hospital revenues (DRG funded) are directly related to admissions, there is a financial incentive for hospitals to decrease waiting lists and increase productivity or patient flow. Australia has applied only certain elements of the America developed DRG system. DRG payments in Australia generally finance inpatient hospital admissions, including intensive care units, while outpatient visits are not covered.
Advantages of a DRG-based system:

- DRGs allow for better transparency of hospital system management and financing.  
- DRGs allow paying agencies to better control the amount of money they spend in reimbursing hospitals.
- DRGs help paying agencies predict well into the future what the financial payouts to hospitals will be.

Potential Drawbacks of a DRG payment based system:

- DRGs have led to a reduction in the length of patient stay (LOS). While reduction in hospital LOS may have many benefits, most research suggests that patients are discharged “quicker and sicker” adding extra burden on an often inadequately resourced home-care infrastructure.
- A recent issue of concern is DRG up-coding. Up-coding is when a patient diagnosis is coded as more severe or acute than is actually the case. Providers up-code in order to receive a higher reimbursement for services. This practice distorts health statistics and abuses the financing system. In the face of imposed budgetary restrictions, providers may be tempted to miscode. Measures are being developed in various countries to curb this phenomenon by creating reward systems to motivate medically correct coding. German researchers found, however, that documentation is often insufficient to assign a DRG code.
- DRG-type systems are illness and acuity focused (rewarding for treatment of an illness), often neglecting disease prevention and health promotion.
- As nursing services are billed as a flat rate, being lumped into the ‘room rate’ of a hospital stay, problems arise in determining the cost of nursing interventions and establishing the link to patient outcomes.
- DRG payments do not distinguish between low and high dependency cases although hospital costs are greater in situations of high dependency. DRGs create a financial incentive for hospitals to avoid high-dependency patients thus threatening equity in access to health services.
- It has been noted that it is problematic to apply a DRG system to psychiatric patients or the chronically ill. Yet, globally, the numbers of people seeking health care for these conditions are increasing. As of 2001, 450 million people worldwide suffer from a mental or behavioural disorder. Annually, 11 million people are diagnosed with cancer; 5 million become permanently disabled following a stroke, and 177 million people currently live with diabetes.
Implications for Nurses

Nursing costs have been difficult to quantify and the profession itself has yet to reach a consensus on how to accomplish this task. The accuracy and validity of DRG payments, however, relies on nursing cost data. Increasingly, the literature is calling on nurses to develop a vocabulary to better articulate nursing work, thus facilitating its assessment. The ICN’s International Classification for Nursing Practice (ICNP) provides a standardised nursing language and is increasingly applied in care plans, recording and financial reporting.

DRG systems’ neglect of health promotion and disease prevention is of serious concern. Currently, nursing services are crudely approximated since much of nursing care falls in these two areas. Nurses will continue to be undervalued and underrepresented if absent in the health financing structures and processes.

DRGs introduce powerful incentives to shorten patients’ length of stay in hospitals. Adequate community and home care must be provided as well as effective referral systems, all highly dependent on qualified nurses.

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References

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