BMC Health Services Research

MEETING ABSTRACT Open Access

Urgencies and DRGs

W Fischer

From 26th Patient Classification Systems International (PCSI) Working Conference
Munich, Germany. 15-18 September 2010

Introduction

Flat rates based on Diagnosis Related Groups (DRGs) are being introduced in a growing number of countries to remunerate acute inpatient treatment. In doing so, it will have to be decided – among other things – whether inpatient emergency services should be remunerated separately from the DRG flat rates or as part of them. Without separate remuneration, there may be a perception, or fear, that wrong economic incentives with regard to emergency services could develop. To be able to decide about a separate remuneration of emergency readiness and/or emergency treatment, one must know how to categorize services, what the costs of emergencies are, and how the remuneration can be deduced from them.

Methods

By means of internet searches, the author describes different solutions of emergency patient classification systems and emergency flat rates in France, the United Kingdom, and New South Wales (Australia). Additionally, he shows various approaches towards regulations in Switzerland, Germany, the United States, Canada, and Victoria (Australia). Out of the information collected (reference year 2008), he draws up suggestions with a view to deciding whether any increased emergency costs would justify separate remuneration, and how this could be set up.

Results

In France, an annual flat rate based on the size of the emergency ward/department is paid to remunerate emergency readiness. (The size of the emergency ward is calculated on the basis of the budgeted number of emergency attendances.) Emergency admissions (emergencies with subsequent inpatient admission) are paid through GHS flat rates (GHS = "Groupes homogènes de séjours" = French DRG flat rates). Outpatient emergency attendances are paid at a flat rate of € 25.

In the United Kingdom, different HRG flat rates are defined for elective and non-elective cases (HRGs = Healthcare Resource Groups = British DRGs). In this way, 10% of the total remuneration volume is redistributed. (Non-elective cases encompass not only emergencies but also births, newborns, and transfers.) Additionally, there is a three-tier emergency tariff to remunerate for inpatient and outpatient emergency attendances. It is defined by means of approximately 10 emergency HRGs.

80% of the emergency tariff is paid on the basis of the planned emergency attendances in order to cover emergency readiness. This is done regardless of the actual number of emergency attendances ("80/20 rule"). These emergency flat rates are paid for emergency admissions in addition to the non-elective HRG flat rate. 50% of the latter are paid on the basis of the planned number of emergency admissions, and 50% as per actual admissions ("differential tariff").

In New South Wales (Australia), emergency services are categorized into seven levels according to their roles and staffing. 80% of emergency costs (for inpatient and outpatient cases) are paid by a budget for emergency readiness. To this end, the planned cases are weighted by means of the emergency patient classification system UDG ("Urgency and Disposition Groups") which defines 11 patient categories.

Three base rates are used according to hospital type. (The three hospital types are "general referral hospitals" or "large metropolitan districts"; "children's"; and "small metro districts" or "rural base".) The remaining 20% of emergency costs are paid by UDG-weighted emergency flat rates. For emergency admissions, an ARDRG flat rate is paid additionally.

In Switzerland, acute inpatient treatment will be remunerated from 2012 onward by the SwissDRG-System, an adapted GDRG-System. Following a law

ZIM, Wolfertswil, Switzerland

introduced at the end of 2007, the new flat rates must not contain public welfare services. Hence, emergency readiness has to be calculated and remunerated separately from DRG flat rates, independently of the number of cases.

In Germany, there is no separate remuneration for emergency admissions. In principle, hospitals are ordered to participate in emergency services. Hospitals which do not participate have to expect a deduction of € 50 per case.

Conclusions

The main suggestions put forward in this paper, which were deduced from several others, are the following:

(1) Emergency readiness should be defined and remunerated by performance contracts. A bonus system could promote the attainment of certain emergency targets.

(2) To be able to assess the costs of emergency treatment, all DRGs should be split as per the criterion "with/without emergency attendance".

The concept of "emergency attendance" must therefore be defined. A medical definition would be: "Emergency attendances are attendances of patients who are required to be treated within X (e.g., 12 hours)." If cost differences arise, these can be taken into account by applying separate DRG weights for DRGs "with emergency attendance" and DRGs "without emergency attendance".

Published: 6 October 2010

Reference

1. Fischer W: **Notfallvergütung im Krankenhaus.** *Patientenklassifikationssysteme und Notfallpauschalen bei DRG-basierter Vergütung von stationären Behandlungen* 2009, 180, ZIM, Wolfertswil.

doi:10.1186/1472-6963-10-S2-A12
Cite this article as: Fischer: Urgencies and DRGs. *BMC Health Services Research* 2010 **10**(Suppl 2):A12.