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Meeting abstract

The role of diagnosis related groups (DRGs) in healthcare system convergence

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Introduction

Healthcare systems in the early 1970s, the so called 'golden age' of the welfare state, came much closer to what we characterize as distinct *ideal types*: the Private Insurance System, the Social Insurance System and the National Health Service (NHS). During the past decades, as a consequence of problem pressure caused, for example, by globalization and demographic change, healthcare systems have grown more alike and become 'hybrid' over time. This can be interpreted as a form of healthcare system convergence.

One possible explanation for this convergence is that systems have learned from one another. In our contribution, we show that DRGs (1) provide a convincing example for policy learning and the diffusion of ideas in healthcare systems and (2) corroborate our argument regarding system convergence and hybridization. Taking the United States, England, and Germany as examples, we show that these most distinct cases of healthcare systems have implemented DRGs, yet with very different objectives and consequences.

Methods

The proposed contribution is placed in the field of comparative research on healthcare systems. In our case selection, we follow the *typology* of healthcare systems by selecting a 'most distinct case'-design. The US represents a Private Insurance System, while the English NHS is a state-led healthcare system of the Beveridge type. Germany, finally, with the oldest Social Insurance System in the world, stands for the Bismarckian type of healthcare system. We examine these cases by collecting qualitative data from three in-depth case studies.

Results

DRGs were first developed in the US private insurance system at a time when healthcare cost was continuously rising. The public Medicare program implemented DRGs in 1983 to stop price inflation in medical care. Hierarchical control was thereby exerted over formerly autonomously acting service providers. In the private, market-based healthcare system of the US, DRGs therefore brought more hierarchical control over service providers.

In 1992, the British NHS adopted an analogous version of DRGs, referred to as Health Resource Groups (HRGs). Here we witness how HRGs changed from a pure accounting mechanism, and a tool to monitor clinical performance, to a far more expansive instrument for solving institutional deficiencies such as waiting lists. Finally, HRGs brought a performance component into the provider remuneration method, thereby serving as a vehicle for competition. Thus, we see that while the private, competition-based healthcare system implements DRGs to bringing more hierarchy into the healthcare system, the state-led NHS system in Britain introduces HRGs to pave the way for market principles.

The German social insurance system was the last in our sample to introduce DRGs. Although observations for Germany can only be tentative, we observe that, initially, DRGs were implemented here for promoting competition between hospitals. We expect that competitive forces will have a major effect in shaping the hospital - provider landscape, thereby undermining the planning capacities of the regional state authorities. Potentially, these developments will provoke more hierarchical state regulation in the form of (minimum) quality standards, and the definition of a minimum set of services that hospitals will be obliged to offer.

DRGs in Germany, therefore, must be seen against the backdrop of a more general trend of decreasing the social insurance elements of corporatist self-regulation in favour of competition as a coordination mechanism 'in its own right', and of more hierarchical state regulation.

Conclusion

In our examination of the implementation of DRGs in the U.S. Private Insurance System, the English NHS, and the German Social Health Insurance system, we show that DRGs are a flexible instrument to be implemented against the backdrop of specific healthcare policy objectives. We find that these three systems employ DRGs in very different ways, i.e., according to their functional requirements and in line with their policy objectives. The integration of non-system specific components through DRGs contributes to the hybridization of healthcare systems and therefore to convergence.