Case Mix Adjusted Implementation in Romania – Pilot, Running and Developing – Can We Do All Right at the Same Time?

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About:

- Introduction and health system background
- Early Case Mix efforts/experiences
- Pilot, national roll out, full scale implementation, development (the “cycle”):
  - Data collection, grouping and analysis
  - Reimbursement
  - Other essential issues
- Conclusions

Introduction and health system background

- 23,000,000 inhabitants, 42 counties
- Capital – Bucharest, 2,500,000 inhabitants
- Social Health Insurance System (1997)

- **4.5% of GDP for health (2003) – 150 USD per capita (including informal payments)**
- **65% hospitals, 12% subsidized drugs, 10% primary care, 7% ambulatory care, 3% emergency services, 1.5% dentistry**

Introduction and health system background

Early Case Mix efforts/experiences (I)

- **1995-1997 USAID, 3M**
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- Mainly about descriptive statistics, including average length of stay (ALOS) by DRG, coefficient of variation, relative weights, and budgets done at the consultant level
- Minor local involvement

Early Case Mix efforts/experiences (II)

- **1999-2001 Pilot Project, University Hospital Cluj, USAID, DHHS, NIHRD**
- Main results: developing and testing methodologies related to costing, coding, quality of care , hospital management, implementing information systems
- Major involvement of local expertise and decision makers

Data collection, grouping and analysis

- **Pilot:** 23 hospitals, MBDS, Dx and Px coded, software developed, central project data base; cost data collection at NHIH level, aggregated dep. level, different imported groupers
- **National roll out:** as pilot BUT central institutional database for ALL hospitals
- **Full scale implementation**: mainly same as national roll out
- **Development:** adapted coding of Px, Ro grouper and RWs, patient level cost data collection, quality monitoring

Reimbursement

- **Pilot:** 23 hospitals,100% case mix reimbursement methodology, 15% prospective and 85%retrospective contracting, public tariffs
- **National roll out:** same as pilot, BUT for 185 hospitals (larger than rural hospitals)
- **Full scale implementation:** all acute care inpatients, increasing the prospective %
- **Development:** adjusters (i.e. outliers), going to 100% prospective (national weighted tariff), creating incentives to change behavior at hospital and central level

Other essential issues (I)

- **Pilot:**
- Institutional involvement of local stakeholders
- Pilot functioning based reflected in legislative changes
- Basic technical parallel with basic implementation activities
- Extensive training
- **National roll out:**
- Parallel SMOOTH phased out from project stage
- Central Institution for technical activities coordination established
- Explicit operational funding
- Pilot financing

Other essential issues (II)

- **Full scale implementation:**
- NO external financing of operational technical or strategic activities
- Institutional financing of current activities
- Communication and involvement of ALL actors well coordinated
- **Development:**
- External donors attracted
- Long term strategies and short term plans legislated
- Extended group of (at least) basic technical people
- REFINEMENT of technical, operational and strategic options

Conclusions (I)

- **More like questions…:**
- Good balance of technical with strategic?
- Good balance of Hospitals involved?
- Romanian adaptations (procedures codes, grouping system, relative weights…etc)?
- National tariffs?
- Training of the people?

Conclusions (II)

- **…versus some answers…:**
- Phased approach, legislated and with doable targets
- Involving and educating the local partners
- Focus on local needs and situation, balancing it with the available international expertise and funding
- Not reinventing the wheel but, why not, creating the car of the future!

…and some symbols!

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