National Costing Study- A Step Forward for Croatia

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While the question is not central to the issue, many countries embarking on hospital funding reform appear to start by asking - which DRG variant is most likely to improve hospital efficiency, contain costs and increase a data reporting transparency.

The question that is not being asked however, is whether the country is prepared to do what it takes to be effective in its implementing a DRG based hospital payment system. Is the country prepared to follow up with a costing program that would feed the construction of price-weights to accurately measure hospital activity and pay hospitals fairly?

In 2007 Croatia was one of these countries - after having selected AR DRG ver 5.2 acute hospitals started reporting their activity. Price-weights were developed by building on Australian relativities and no-cost studies were undertaken.

During the 10 year period Croatia made progress with its classifications. It developed DRG classes such as those that related to donor preparation and multi-organ and tissue explants, and also expand ACHI introducing additional chapters for laboratory services and more detailed list of imaging services.

It made no concerted effort however, to ascertain whether its DRG price relativities reflected true costs of production. Responding to complaints from hospitals about prices, Croatian Health Insurance Fund (CHIF) made a series of ad-hoc decisions that involved the manipulation of the Base Rate and the payment system. This has resulted in a system of relative weights that has been demonstrated to overpay some DRG groups and underpay others. An example of one anomaly is the price weight of W01Z which while using comparatively more resources, is 50% lower than A06Z.

Croatia made a significant effort to develop its health information systems which are now sending DRG invoices accompanied by discharge summaries to the CHIF immediately after the patient is being discharged. Except DRG related data, invoices contain a priced itemized list of medical materials and drugs used for the episode of care, which could be used for patient level costing.

Average length of stay is still high and the number of admissions per capita has not changed .

In terms of funding, the share of the health fund budget allocated to hospitals remained the same. One could argue therefore, that the hospital cost have been contained, although hospital reported significant deficits and the average time in which hospitals pay suppliers exceed twelve months.

Disappointingly, instead of addressing issues such as costing, there are certain indications that, the process is going in reverse direction by asking same question from the beginning of this summary – “Which DRG version to procure next?”.

If indeed the idea is to make progress, one of the next steps should be to conduct a national costing study to find out how much acute inpatient activity actually costs. It would be a wake-up call for the system and may form a pathway for the continuation of hospital system reform, including the review of the benefits package and development of national hospital master plan including the health information backbone design.