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Introducing Diagnosis-Related Groups in Kazakhstan: Evolution, achievements, and challenges

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ABSTRACT

In 2012, Kazakhstan introduced Diagnosis-Related Groups (DRGs), as part of a package of reforms which sought to contain costs and to improve efficiency and transparency in the health system; but the main challenge was to design and implement a DRG system in just one year.

In 2011–2012, Kazakhstan developed its own DRG system. Initially 180 DRGs were defined to group inpatient cases but this number was subsequently expanded to more than 400. Because of time limits, the cost weights had to be derived in the absence of existing standard hospital cost accounting systems, and a national patient data transfer system also needed developing. Most importantly, huge efforts were needed to develop a regulatory framework and build up DRG capabilities at a national level.

The implementation of DRGs was facilitated by strong political will for their introduction as part of a coherent package of health reforms, and consolidated efforts to build capacity. DRGs are now the key payment mechanism for hospitals. However the reforms are not fully institutionalized: the DRG structure is continuously being refined in a context of data limitations, and the revision of cost weights is most affected by insufficient data and the lack of standardized reporting mechanisms. Capacity around DRG coding is also still being developed.

Countries planning to introduce DRG systems should be aware of the challenges in moving too quickly to implement DRGs as the main hospital reimbursement mechanism.
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1. Introduction

Kazakhstan is an upper-middle income country in Central Asia which spent 4.3% of GDP on health in 2013, 53% of which was from public sources [1]. When Kazakhstan gained independence from the Soviet Union in 1991 it inherited an overcapacity in inpatient care with 1091 acute care hospital beds per 100,000 population in 1990. Under the Soviet system there was a strong incentive for the continuous expansion of staff and bed numbers as financing mechanisms were input-based. Since independence, hospital capacity has more than halved (444 acute care hospital beds per 100,000 population in 2013), but it remains well above the EU average (356 per 100,000 in 2013) [1]. The average length of stay is very long (9.4 days in acute care hospitals in 2013) compared with the EU average (6.3 in 2013) which potentially explains why the bed occupancy rate is so high (86.8% in 2013, 76.6% in the EU in 2012)

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Table 1
Summary of achievements and challenges in the introduction of DRGs in Kazakhstan.

Achievements	Challenges
• Strong political will for implementation as part of a coherent package of reforms • Development of new DRG system in the absence of standard cost accounting system in hospitals • Development of a patient data transfer system • Technical and managerial capacity building at the national level to support implementation of DRGs • Implemented as key payment mechanism for inpatient services nationwide	• Resistance to data sharing at the institutional level • Basic clinical coding with gaps in the coding of secondary diagnoses, co-morbidities, complications and procedures • Highly specialized hospitals skewing reimbursement system in their favour • Current service price based system not sufficiently accurate estimate of service costs • Use of DRGs for purchasing only a certain proportion of inpatient services reduced impact on efficiency

despite the relatively low throughput of patients (14.7 acute hospital discharges per 100 in 2013, 16.2 in the EU) [1].

Reforms since independence have sought to move to output-based financing mechanisms, but cost containment and ensuring adequate financing for the hospital sector have proved difficult. The current restructuring process is wide-ranging as it encompasses wholesale reform of health financing mechanisms and provider payment mechanisms to improve efficiency and equity, alongside reforms to the health care delivery system to strengthen primary and inpatient care [2]. In the hospital sector two aspects of the reform programme which have had the greatest impact are the introduction of DRGs for purchasing services and the autonomization of providers. Most hospitals remain state-owned, but over the past 20 years they have been granted greater managerial autonomy, having previously been the responsibility of their respective level of government. After the radical decentralization of purchasing to the local level in 1999, there has been a gradual consolidation and defragmentation of resource pooling with regional health departments purchasing all services from 2005 to 2009. Since 2010, the purchasing of hospital services has been centralized in a single agency under the Ministry of Health (the Medical Service Purchasing Committee) [2].

The introduction of a national DRG system for the reimbursement of hospitals in Kazakhstan in 2012 is an interesting example of DRG implementation, because despite facing many challenges, the new system was planned and implemented in less than a year rather than a more gradual approach over a transition period, and employed a Kazakh DRG classification and cost-weight system, rather than adapting an existing international DRG system (Table 1).

The government of Kazakhstan decided to adopt DRGs as a key instrument for improving financial transparency. Grouping large numbers of similar patients enables managerial analysis and improved efficiency by incentivising hospitals through financial mechanisms to improve performance [3,4]. In addition, a DRG system was regarded as an important vehicle for transforming inpatient care towards a more market-driven system and as a more equitable mechanism for public resource allocation across the country to address geographical disparities. This paper adds to the growing literature in the field examining the practicalities of implementing DRGs and how the challenges can be approached or mitigated [5,6].

2. Background

Kazakhstan first implemented a form of DRGs under a decentralized regional financing model in 2005 but then abandoned it in 2009 for an alternative nationally financed case-based system. In common with similar reforms in some other post-Soviet countries, this case-based funding system resulted in a major upward pressure on the budget [7]. The initial DRG system in place before this failed to elicit the expected improvements in hospital performance because there was a conflict between the incentives created by this system and the planning system which was still based on input norms as the main determinant of funding allocations. Due to rigid financing rules and procedures, purchasers were not able to purchase selectively according to performance results and hospital managers were not able to reallocate and use resources in more cost efficient ways [2].

The case-based funding reform in 2009 involved the development of Medical Economic Tariffs (METs) which used normative clinical protocols, resource unit prices and standardized volumes for cases to reimburse hospitals. The MET system placed an excessive burden on the health budget, due to significant transaction costs caused by overwhelming volumes of hospital claims, together with the unintended over-treatment of patients and up-coding to higher MET rates, which are common features in the initial development of case-based payment systems [8,9]. The health budget was spent after 9–10 months and the Ministry of Health was obliged to approach the Ministry of Finance for additional funding.

With the new DRG system, immediate exclusive coverage of the same services and scope as the METs was deemed politically necessary as any restriction would be perceived as a step backwards. However, the existing patient classification system based on the METs was not compatible with DRG systems used internationally, so Kazakhstan decided to develop its own DRG groups. It was felt that adapting and adjusting an existing system would take longer than self-developing one and that the MET system was generating sufficient data to enable them to do it, and this is not unusual in the Central-East European context [10].

The urgent need to replace the MET system resulted in an extremely ambitious timescale for DRG implementation; the policy decision to move to a national DRG system covering most inpatient hospital services was made in 2011 and the national DRG system has been in place since January 2012. Countries tend to move gradually from a DRG patient classification system to a full hospital reimbursement system over a multi-year transition period [11]; but circumstances in Kazakhstan meant that DRGs had to be

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