



Social Security Reform Co-operation Project
中国 - 欧盟社会保障合作项目

DRG Implications for Accounting Systems

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Financial Objectives of DRG Reform



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- To ensure transparency and fairness the distribution of funding in a publicly funded system – *‘Creating a level playing field’*
- To promote efficiency through
 - Risk Sharing between insurers and providers
 - Innovation in treatment and medical pathway design
- To promote cost and quality considerations in the funding of treatment and hospitals
- To introduce greater certainty in activity based financial planning

Financial Requirements for operating DRG system



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- In the medium term all hospital services are covered by case payment tariffs
 - *Otherwise costs will be allocated to fee for service activities*
- Financial Accounting standards must be consistent and preferably in line with international standards
 - *Financial Accounting defines the scope and the basis for recognising costs and incomes*
- Management Accounting must be consistent and use best practice
 - *Management Accounting allocates the total amount of costs to service directorates and DRG product lines and generates data for tariffs and budget plans*

Financial Accounting Requirements of DRG System



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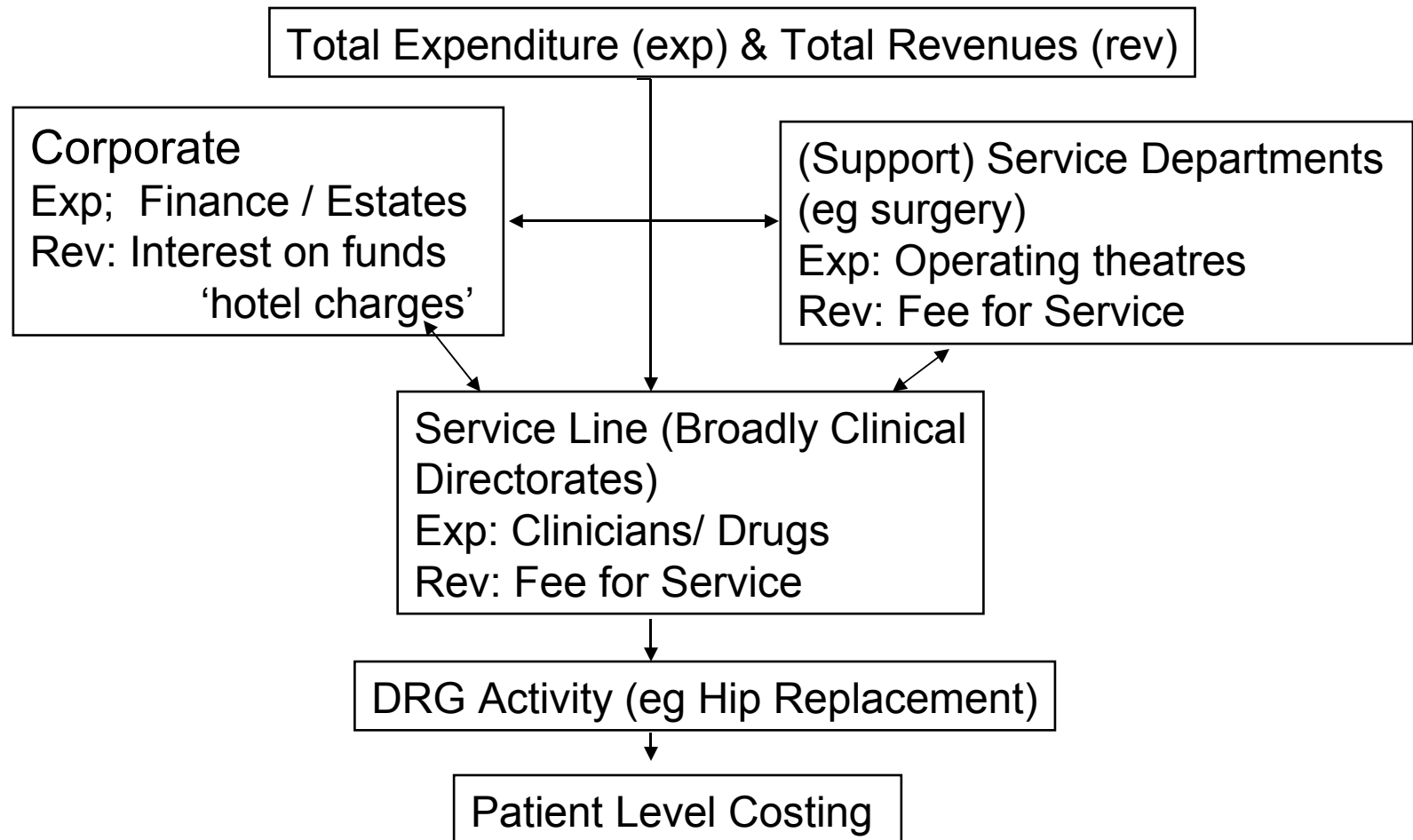
- Current state of Hospital Financial Accounting
 - It's a secret !! (no published accounts, limited external audit)
- Current MOH Financial Accounting Regulations (1999)
 - Based on Government rather than commercial standards
 - Cash based and no balance sheet
- International Hospital Accounting Standards
 - Accrual based
 - Full recognition of capital asset values, depreciation and financing charges
 - Recognition of assets and costs financed by non-exchange revenue (grants and donations)

- Current State of Hospital Management Accounting Systems
 - It is also a secret (!) but likely to be large variations
 - Most likely model is a contribution based system based on service departments generating surplus above marginal cost to fund large unallocated overheads
- DRG System implies full allocation of costs
 - Sophisticated cost attribution system involving multi level allocation of corporate overhead (eg finance and estates), support services (theatres/ pathology) to main service directorates and then to DRG activity
 - All costs covered including those financed by direct charges to the patient (deductibles and co-payments)
 - Need for consistency in treatment and use of standard costing approaches and bases

Overview of Cost and Revenue Allocation Tree



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Difficulties Encountered in Cost Allocation



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- Developing cost-allocation hierarchy (between different depts / levels) to solve cost allocation loops
- Definition of Service-lines for first stage cost allocation – *not necessarily same as Clinical Directorates*
- Absence of activity information to allocate support service costs (eg theatre operating time, pathology workload)
- Definition of cost allocation bases
- Allocation of non-tariff revenue



From Cost Allocation to Tariff Calculation

- Importance of Actual Cost Data
 - Consistency of recognition and allocation
- Benchmarking high performers versus average reference costs
- Single tariff versus tariff dis-aggregation
 - For predictability and accountability single point payment involving all medical costs is best
 - Hotel costs could be identified as a separate element within the tariff for co-payment and comparison purposes
 - Only for the most complicated high value cases, additional length of stay add-on could be considered
- International benchmarking
 - Comparability of DRG
 - Comparability of scope and cost allocation



Before DRG Reimbursement is addressed, the first step is....

- Need to change the culture and nature of accountability
 - More collaboration less un-regulated competition
 - Change of Governance Arrangements – new hospital boards with changed accountability
 - More transparency on public hospital finances
 - First Step → Publication of hospital accounts audited by private firms working under authority of China National Audit Office
 - Second Step → Introduction of enterprise accounting standards as amended for hospitals within 3 years for all category A hospitals