

## DRG Adoption and Implementation In Europe

Interview with Dr. Gerard Duru

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Interviewer: Jerome Damien, TMTG

JD: In the US, the system continues its transformation from fee-for-service (FFS) towards diagnostic related groups (DRG). In spite of a recent lull, managed care market penetration remains high. What is the situation in Europe?

GD: I think all discussions should start with the understanding that "European Healthcare" does not yet exist, and that Europeans and the European Union (EU) are truly searching for a path at this level. There is clearly a desire to standardize, or at least to create a system where individuals from one member country can effectively receive care in another. We are still far off, however, from a European-wide healthcare system since each member is a sovereign country and remains independent with regards to choosing the best healthcare system for its population.

However, the pressure continues to grow, especially after the decision to admit 10 new countries into the EU. These countries have a much lower economic level (standard of living) than current EU members, with very simple and very different healthcare systems that date from their socialist bloc origins. The potential influx of patients coming from these countries is a considerable worry for the governmental healthcare institutions in more developed states such as France, Italy or Germany.

There thus exists as many healthcare systems as member countries and a co-existence will continue to survive in the near future between the different reimbursement systems: payment by medical act as in France for ambulatory medicine, or a system almost entirely managed by the state as in the UK with all of the associated consequences (private and public healthcare functioning at different levels).

However, it is possible to define a trend throughout Europe with regards to evaluating healthcare costs: the use of DRG type codes such as GHM codes (for the PMSI in France) or the NORDDRG-O codes in Scandinavia.

JD: Can these trends be applied to all healthcare providers, or is there a dichotomy between ambulatory medicine (payment by medical act) and inpatient/hospital care (reimbursement by pathology)?

GD: There exists: one, a dichotomy between ambulatory medicine and inpatient/hospital/public medicine as in France, and two, a certain heterogeneity regarding the use of DRGs by healthcare providers. To use the French example, the PMSI is relatively well implemented in most healthcare provider facilities (hospitals and clinics). It does take on a somewhat different flavor in public and private facilities, is emerging in psychiatric facilities and is just starting to see a presence in ambulatory medicine.

JD: What stage has the system reached? What are the preliminary outcomes (if any exist yet)?

GD: A huge gap definitely exists between political motivation and the reality of the situation. There is certainly political willingness to head towards a global payment system like capitation but French physicians are relatively hostile towards this type of system. I am convinced that payment by medical act will continue to endure.

JD: Which countries are leading this effort?

GD: Italy is relatively advanced in this area since it was faced with, a few years ago, serious problems due to poor organization within its healthcare system. The government decided to treat these problems by reevaluating the system and decentralizing healthcare, with the understanding that a patient in Naples may receive lower quality treatment than the equivalent patient living in Milan.

Overall, I find that the most recent German initiatives, enacted only few weeks ago at the most, look very promising. There is a consensus among stakeholders that has led to redefining unity in healthcare: "who supports (or is behind) whom?" For example, costs incurred from a work stoppage are now covered only by contributions from employees.

"For what are we unified?" Dental prostheses, eye care, in-vitro fertilization and medical transportation (ambulance) are all financed through social security.

JD: Will we see this applied to Europe as a whole?

GD: Not in the near future.

JD: What are the resulting implications? In terms of medical performance control/assessment systems?

GD: The key words are evaluation and quality. Everything else simply represents tools used to accomplish this objective.

JD: What are the resulting implications? In terms of the digitization of medicine.

GD: Digitization is inevitable. Everything fits with widespread adoption of information technology, such as rules and regulations that require an increasing ability to trace events, and patients who no longer hesitate to sue their physician. The key point is knowing when to use data. Of course, physicians and the medical governing bodies have yet to come to a consensus on this issue.

JD: What are the resulting implications? In terms of technology adoption. Let us take the example of the non-invasive treatment of aortic aneurysms in the U.S. the provider facility earns revenues from fees related to the pathology as well as other auxiliary services. Is the only way for a new technology to enter the market through proving the cost effectiveness of the treatment and to disregard the post-hospitalization medico-economic benefits?

GD: Medical economics, a discipline thought dead, has seen a strong resurrection due to its value as a tool to guide and manage health systems. Nevertheless, this assertion may seem a slight paradox when considering that at present in France, universal healthcare insurance provides very little medico-economic data. Only manufacturers produce this kind of data on a large scale, reserving it only for the appropriate governing body. This data eventually becomes an integral element of the marketing effort.

I sincerely believe that the supplementary insurance plans (mutuelles) in France will substantially improve their risk management capabilities (as will universal healthcare insurance) due to the high likelihood that they will face increased coverage responsibilities. Part of these responsibilities will be covered by an expected increase in premiums. This, however, will not suffice, especially with increased competition from other private insurers. Due to this, the supplementary insurance plans will be forced to conduct medico-economic studies for new technologies. Private insurance has also started to provide full coverage for certain services.

JD: Regarding the management of healthcare facilities?

GD: It is clear that healthcare providers can no longer escape evaluating and analyzing their "cost of production," and that all new technologies will be evaluated for both their clinical and economic value. DRGs should, consequently, take into account new technologies.

JD: Regarding medical practices?

GD: I believe that this necessary healthcare cost management initiative will have two major impacts.

One, the general practitioner's role will evolve to that of a specialist in general medicine. The role of gatekeeper will most likely be passed on to highly qualified and highly experienced nurses.

Two, is the general realization by physicians of the usefulness in evaluating medical performance/outcomes. However, the European mindset will most likely resist centralized outcomes evaluation. Instead, I believe groups of physicians will self-audit themselves based using outcomes databases

established from anonymous data. These data-warehouses will make it easier to establish standard outcome and performance criteria. Subsequently each individual physician will be able to compare his own outcomes data to this standard. I am absolutely convinced that competition between physicians, foreseeable regarding quality of services rendered, will push them to do everything in their power to stay "above the standard."

JD: How will patient responsibility evolve?

GD: This is the future challenge and will be intensified by the aging population. This challenge will certainly be expensive. For example, it costs 830 Euros per year on average for drug coverage for someone over the age of 65, 250 Euros per year for drug coverage for those under the age of 65, and we will need to fight hard against waste (50% of purchased drugs will not be used) and find an alternative method for coverage (patients appear just as reassured to see the bottle of pills as they are by the effectiveness of the drug).

Returning to Germany's example, the German government will soon implement a co-pay system (10 Euros per consult). This represents a revolution for those accustomed to leaving the doctor's office without paying one penny.

The healthcare industry is finally addressing "demand" from patients whereas until now we have focused primarily on the "offer," or the quality of care, when analyzing healthcare. Consequently, cost/efficacy studies will play an informative role for both the patient and physician populations.

JD: What is the objective?

GD: Here we touch on a very sensitive point when trying to determine the boundaries between unity and individual liberties. This is a real choice society must make, and the current trend leans towards a more liberal position. This is particularly true for diseases linked to "risk behavior" such as smoking: should we take an "all for one" position and cover someone who smokes four packs per day and gets cancer? There is a famous case in the U.K. of an individual whose second bout with lung cancer was not covered because s/he had failed to quit smoking.

JD: What is the ideal solution?

GD: I should ask you the question "Is there an ideal solution?" We can come up with wonderful theories but the greatest obstacle to their implementation is us: our individual representations of the facts, and how these facts relate to our own interests. The interests of the stakeholders within the healthcare system (patients, citizens, providers, payers, political decision makers) are often not in sync. This translates to trying to find a solution that satisfies a multitude of conflicting necessities. In general no solution exists that optimizes each group's requirements at the same time; in this case, satisfying each point of view (and accompanying requirements) of the stakeholders in the healthcare system. For an ideal solution to exist, we would need to impose its implementation, as in a dictatorship. Otherwise only a consensus works. I believe that an ideal solution does not exist, however, we must do what is possible to come to a general consensus. Not an easy task to accomplish of course.

A necessary condition to reaching a consensus is to implement an effective, reliable and transparent information system. DRGs (or the equivalent systems) are indispensable to this end. I would recommend revising DRGs every five years, since medical knowledge, medical technology and the entire healthcare system are constantly evolving. We must also not hesitate to grow the number of mathematical models for classification, each based upon an outside metric in order to identify the one that will allow us to take into account the two following criteria (again multi-centric): medical criteria, physicians must identify a group of patients/diseases of which the homogeneity has meaning from a medical point of view; and economic criteria, within each of these groups the dispersion of costs must be as low as possible. It is crucial that we define the allotment rules of patient to a group. Recent developments in data mining and in knowledge discovery databases will prove extremely valuable in order to succeed.

I would conclude by saying that the increase in healthcare spending is not as negative as some might lead us to believe. Healthcare spending is an excellent indication of a country's economic health. If this were not the case, Africa would not represent only 0.4% of world healthcare expenditures whereas the OECD represents 88%.



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