

Diagnostic Related Groups (DRG): Going Global?

You can't manage what you don't measure. This is a common theme among U.S. and European healthcare payers when deciding to adopt DRG systems to capture direct and indirect costs associated with medical procedures and post-procedure recovery. They hope these systems will facilitate better management and a positive means to control healthcare costs.

Some fear the very act of measuring may negatively affect care delivery, technology assessment, and access to care. DRG implementation, however, facilitates the adoption of comprehensive medico-economic studies that support better decision-making by all healthcare value purchasers.

How will DRG adoption impact the purchase of medical technology? Will the act of measurement create more equitable access to healthcare services? This edition lays the foundation for addressing these issues.

MARKET OVERVIEW:

Paying For Med-Tech In The U.S.

Healthcare expenditures are projected to increase at least 6% annually through 2005 with 1.5%-2.2% linked to the introduction of new medical technologies.

Most U.S. health consumers look to their health insurance to cover the latest medical technologies.

- 250 million Americans or 86% of the population, are covered by private or government health insurance.
- Of the \$1.3 billion spent in 2000, 39.5% came from private health insurance, 43.2% through public programs, and 17.3% was paid out-of-pocket.

Four U.S. health insurers cover 70%+ of the 180 million non-senior Americans enrolled in private health plans:

- The 42 Blue Cross/Blue Shield licensees cover 47% of those enrolled.
- The next three largest insurers, United Health, Aetna, and CIGNA cover 26% of health plan members.

Every year, CMS and private insurers evaluate, for coverage, many new medical technologies. Most insurers utilize Technology Assessment Committees (TAC) that mediate technology adoption decisions, using either dedicated in-house staff, or outsourcing to specialized technology assessment vendors.

Evidence-based practice centers have emerged to serve both government and private payers, including: BCBS-TEC, ECRI, Duke University, Johns Hopkins, and Stanford. Guidelines for these studies include:

- A positive health impact supported by clinical outcomes.
- Quality and integrity of presented medical evidence.
- Comparison of results with existing technologies.
- Demonstration of future access and availability.
- Performance metrics such as quality of life, functional status, cost burden, cost offsets, effects on productivity.

In today's environment, cost-effectiveness, or what CMS calls "value added", has become a primary consideration. Sound technology assessment includes evaluating an array of costs and outcomes that potentially impact resource allocation and purchasing decisions.

As a consequence healthcare decision makers are being challenged to integrate clinical and financial considerations when evaluating any new medical technology.

Sources: Healthcare Executive (Sept. 2002); Project Hope Report: The Impact of Medical Technology on Future Health Care Costs (2001).

CASE STUDY:

Opportunity Analysis

- **The Company:** World leader in telecommunications, operating in Europe.
- **The Challenge:** Identify European opportunities, key segments and potential partners to grow healthcare market revenues for the healthcare business unit.
- **Our Solution:** Conduct interviews and focus groups with hospital directors and healthcare facility executives to identify and develop a prioritized list of opportunities. Define the marketing-mix for the most promising opportunities. Use competitive intelligence to identify key business partners for each segment.
- **The Impact:** The client developed a successful business plan from the strategic recommendations and market data. In addition, the client entered into strategic discussions with top management of identified potential partners.



The MarkeTech Group

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Dr. Gerard Duru, Professor, Univ. of Lyon, France; President, International Society for Systems Sciences in Healthcare, and Applied Pharmaco-Economics Association

Q: In the US, the healthcare system continues its transformation towards implementing diagnostic related groups (DRG). What is the situation in Europe?

A: "European Healthcare" does not yet exist, but Europeans are truly searching for one. There is clearly a desire 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-state remains independent. There thus exist as many healthcare systems as member-states and the different reimbursement systems will continue to co-exist. However, we can define a trend throughout Europe for evaluating healthcare costs: the use of DRG type codes in France (GHM) and in Scandinavia (NORDDRG-O).

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

A: 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, for example, are relatively hostile towards this type of system. I am convinced that payment by medical procedure will continue to endure. Countries such as Italy and Germany operate the most advanced DRG-type healthcare systems.

Q: What are the resulting implications in terms of: medical performance control/assessment systems; technology adoption; managing healthcare facilities?

A: The keys are evaluation and quality. Medical economics has seen a strong resurgence as a valued tool to guide and manage health systems. Nevertheless, in France, universal healthcare insurance provides little medico-economic data. Only manufacturers produce this kind of data on a large scale, often as a marketing tool. 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. In addition, the healthcare industry is finally addressing "demand" from patients whereas until now we have focused primarily on the "offer," or the quality of care. Consequently, cost/efficacy studies will play an informative role for both the patient and physician populations. In addition, physicians have started to understand the importance of 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.

Q: What is the ideal solution?

A: We can come up with wonderful theories but the greatest obstacles are the divergent interests of the stakeholders (patients, citizens, providers, payers, political decision makers), and trying to find a solution that satisfies these conflicting needs. 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. DRG type systems are indispensable to this end. 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. Overall, developed countries represent 88% of worldwide healthcare expenditures.

For a profile of Dr. Duru please visit: <http://lass.univ-lyon1.fr/pagperso.php3?idp=9>

Long version of this interview: www.themarketechgroup.com/news/minute/tmtg-min10-duru.pdf

ON THE HORIZON: Future DRG Systems in Europe

HIGHLIGHTS

- Although Italy and the Scandinavian countries have the most advanced DRG systems, all European Union (EU) member countries implemented DRG-type tools in the 1990s. Although often associated with the implementation of new information technologies, in most countries DRG policies primarily manage budgeting for healthcare facilities.
- Health systems within the EU face similar challenges such as aging populations and increases in spending. The planned expansion of the EU from 15 to 24 countries in 2004 will drive the creation of a cost-effective, EU-wide healthcare delivery system to ensure equitable care throughout the community.
- Due to the increasing reduction of coverage by state health insurance, voluntary or private insurance within EU member states will soon play a more important role.
- Patients will soon have a greater financial stake in healthcare coverage (e.g., the new co-payment policy in Germany).

AT STAKE!

- Tailoring DRGs to each country's specific requirements while making EU comparisons meaningful.
- Fair budgeting for healthcare facilities which takes into account patient mix.
- Guaranteeing the same quality of care throughout each member country in spite of varying per capita healthcare spending.
- Finding a consensus between payers, care providers and patients.

SO WHAT?

- The DRG system will be the basis for evaluating quality of care. DRGs will evolve with advancements in healthcare.
- Technology innovation will now be evaluated from both a clinical and medico-economic points of view.
- The individual development of each national health care system will require technology vendors to maintain country specific sales strategies.

Sources: The MarkeTech Group - EU Practice 2003

THE ASSOCIATE CORNER: Hospital Funding Reforms in France

Since the mid 1990s, healthcare cost-containment has ranked high on the agenda in France. The dramatic rise in healthcare expenditures has fostered a growing interest in reorganizing the system. Following the implementation of a "medical activity information system" (PMSI) based on a DRG (Diagnostic-Related-Groups) equivalent, the French government is experimenting with new funding reforms in 60 hospitals. These reforms aim to enhance consistency and financial accountability by introducing a common DRG-type hospital payment system for the public and private sectors.

Since 1985, public and private non-profit hospitals have received funds based upon level of medical activity, while private for-profit hospitals are financed based on a fixed rate. This system has two major drawbacks: lack of financial resources for the most active public sector hospitals; and, reduced cooperation between public and private sectors.

The new payment scheme includes such reforms as a per-case payment system for short-term care (e.g. surgery, obstetrics); resource allocation measured on an activity/hospital stay basis; classification of hospital stays; dual national cost scales (private/public). All French hospitals will use this system by 2004. These reforms are expected to strengthen the link between budget and level of medical activity, and to enhance equity in resource allocation. Positive long-term outcomes have yet to be proved in countries using DRG-type hospital payment systems.

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For more information, please visit: www.themarketechgroup.com/news/main.htm