



DIAGNOSIS RELATED GROUPS: LEADING THE DEBATE

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Brussels

DRGs System

Clinician Perspective:

The point of view of a French
clinician



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Aix en Provence - France

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- **What is the situation in France ?**

Different types of Hospital :

- **Public Hospital**
- **Non profit Hospital**
- **For profit Clinics**

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THE CASE MIX IN PUBLIC AND PRIVATE HOSPITAL

In France the share of the « for profit » hospitals (i.e. clinics) is important

Their source of financing is the same as public hospitals (« *Assurance maladie* »)

They can choose their activities

They do not have constraints of public service (they can refuse some patients and pathologies)

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WHICH KIND OF ACTIVITIES ?

COMPARED ACTIVITY: PUBLIC / FOR PROFIT

Dispersal of Case mix:

Private for profit clinics need only about sixty French DRG (GHM) to realize 80 % of their activity.

General Hospital need at least 124 GHM to realize 80 % of their activity

At least 200 GHM for the University regional hospitals

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COMPARED ACTIVITY PUBLIC / FOR PROFIT

The sector ex OQN (for profit) realize 55 % of the surgery (essentially scheduled) more than 75 % of the ambulatory surgery

The sector ex DGF (public and non profit) realize 80 % of the medicine 66 % of the obstetrics, and more than 90 % of the emergency admission

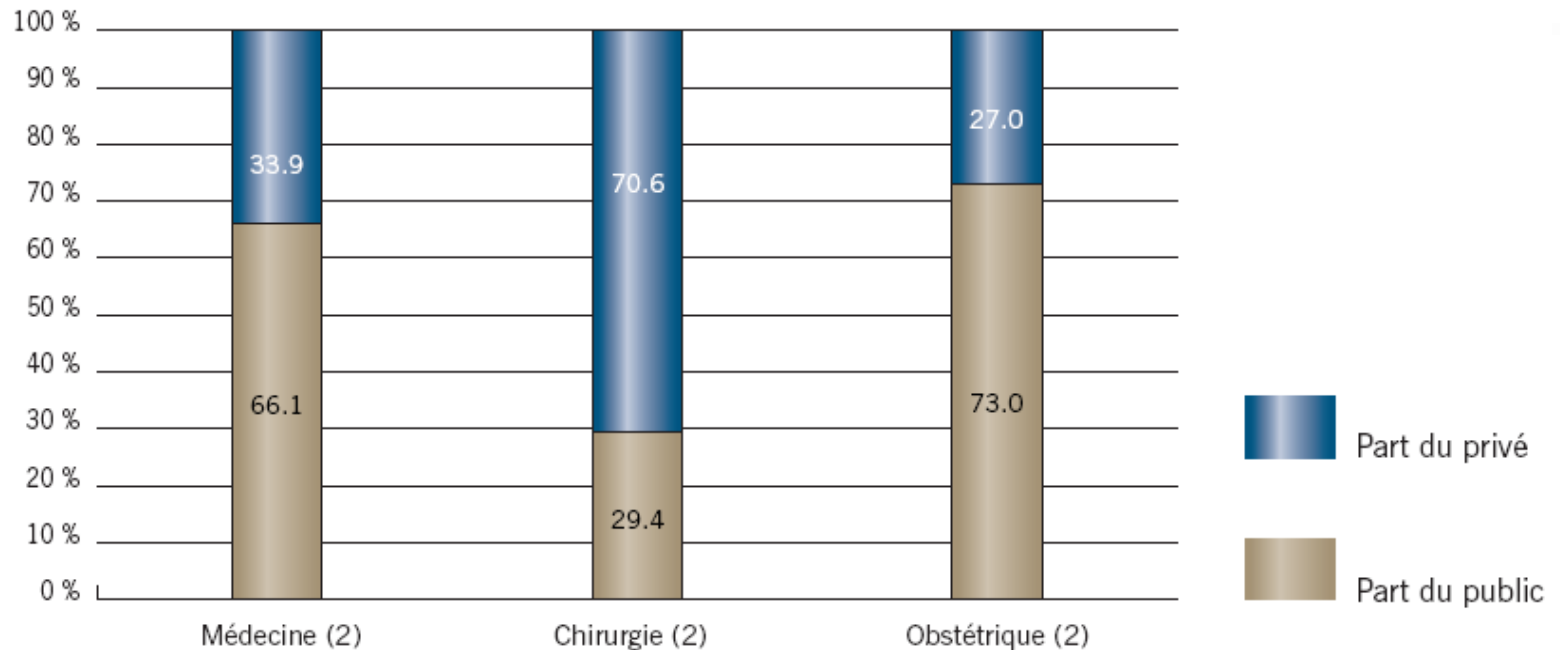
But, the least heavy 50 GHM (tonsillectomy, dental extractions, ligatures of veins, liberation of the carpal channel ...) are taken care in 70 % of cases by the commercial private sector

The heaviest 50 GHM (transplantations, grave multiple traumatism, cardio-thoracic interventions, pointed leukemia, etc.) are taken care in 71 % cases by the public hospital.

CASE MIX IN FRANCE

THE CASE MIX IN PUBLIC AND PRIVATE HOSPITALS

Parts de marché 2003 France entière (1) : détail MCO (en nombre) - Hospitalisation < 48 h (hors séances)



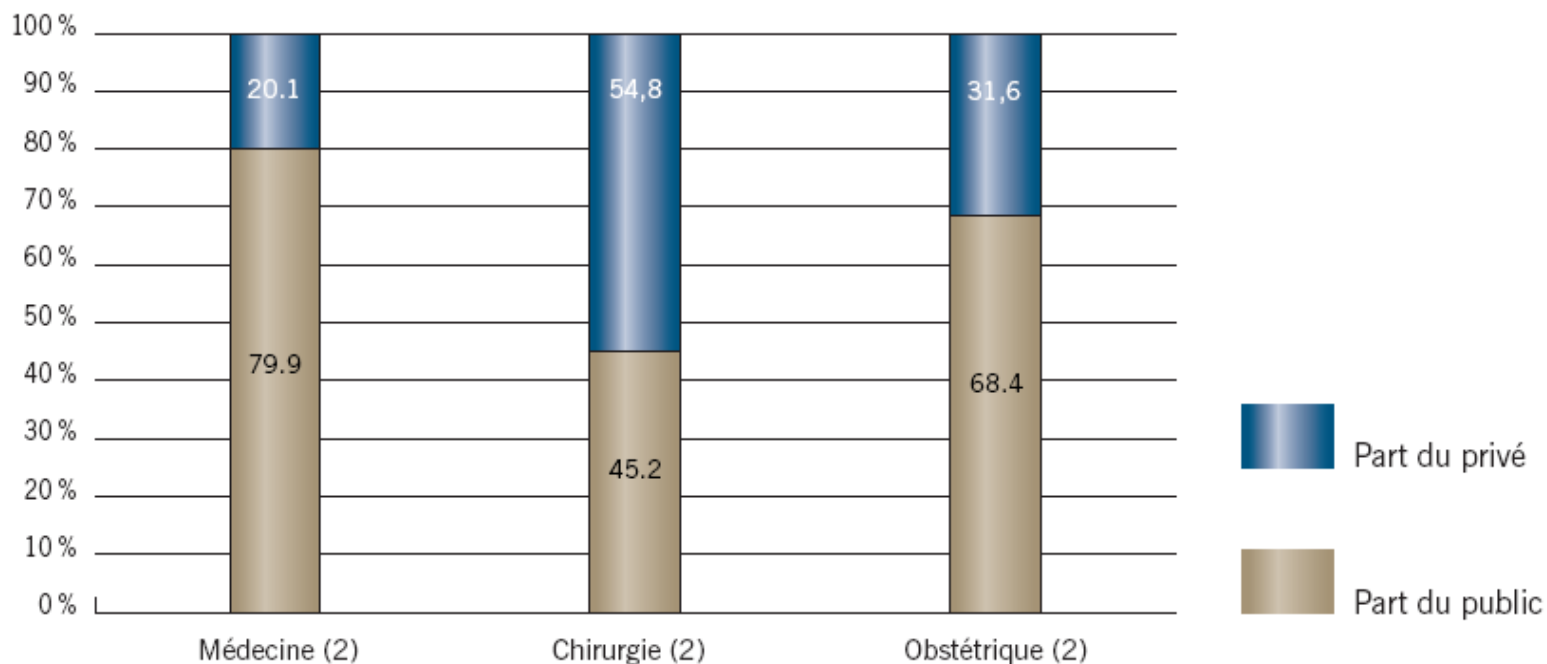
(1) En dehors de la Guyane, de St Pierre et Miquelon et des TOM. (2) Au sens du PMSI.

Sources : Base nationale PMSI 2003 DHOS.

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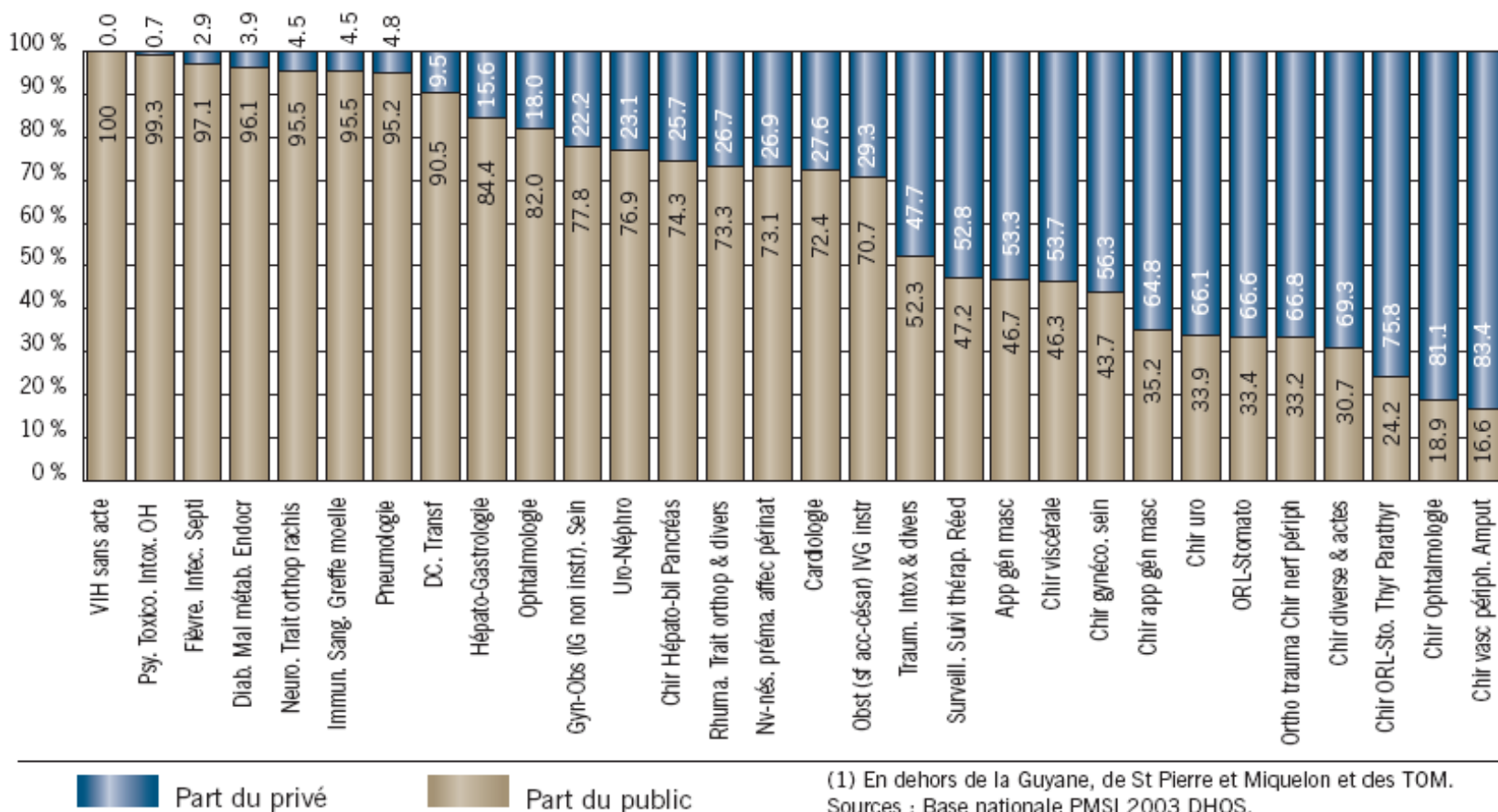


(1) En dehors de la Guyane, de St Pierre et Miquelon et des TOM. (2) Au sens du PMSI.
Sources : Base nationale PMSI 2003 DHOS.

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Parts de marché en 2003 France entière (1) : détail par Groupe d'Activité (en nombre) - Hospitalisation < 48 h (hors séances)

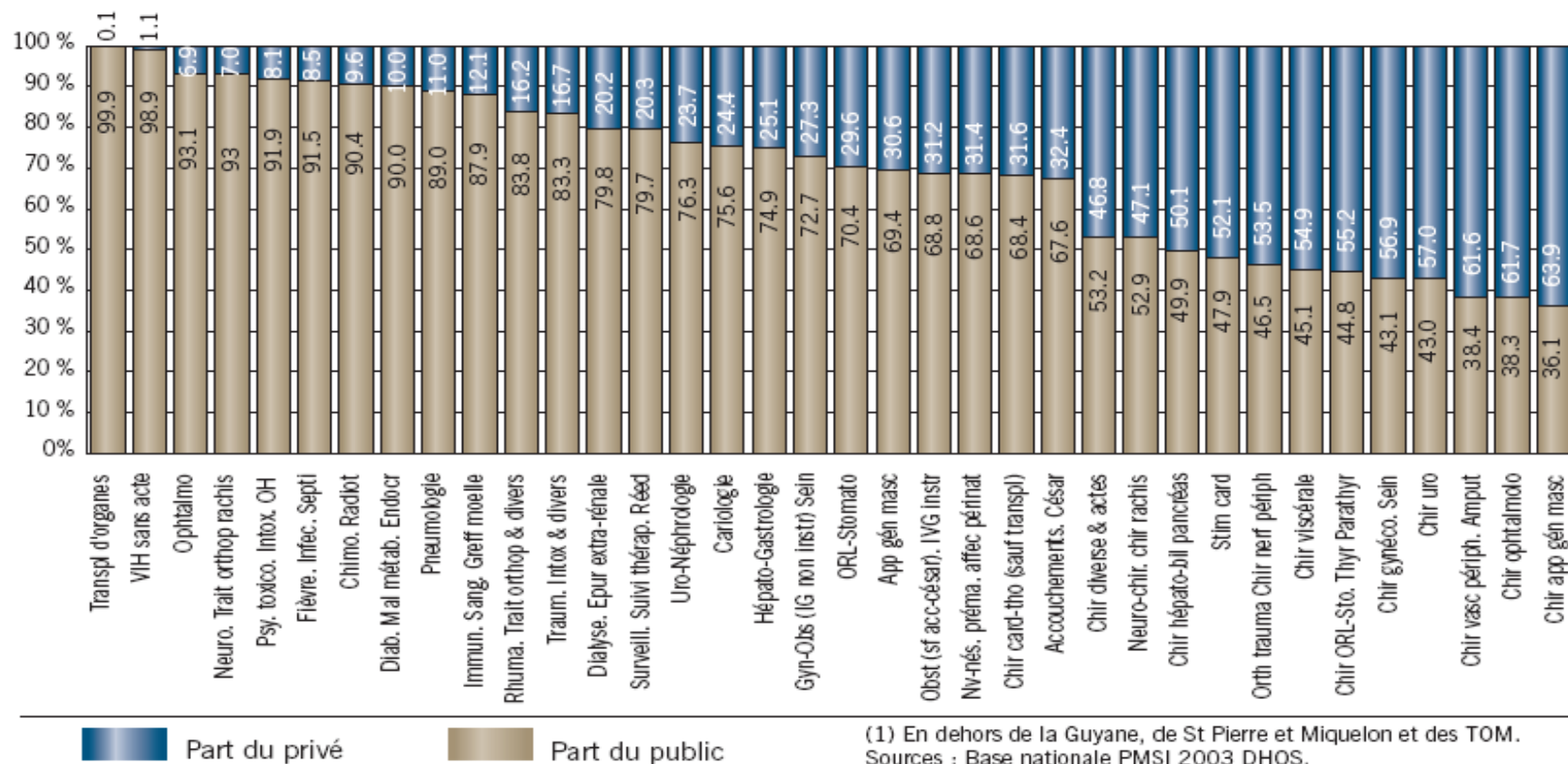


(1) En dehors de la Guyane, de St Pierre et Miquelon et des TOM.
Sources : Base nationale PMSI 2003 DHOS.

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Cancer - Parts de marché 2003 France entière en hospitalisation
secteur MCO (en nombre)

MCO : «au sens du PMSI»

	France entière (2)		
	Nbre séjours ou séances		
	Public + ParaPublic	Privé	Part du Public
Hospitalisation > 48h	688,651	264,543	72.2%
Hospitalisation < 48h	479,303	223,759	68.2%
Séances (1)	2,419,997	740,717	76.6%
Total	3,587,951	1,229,019	74.5%

(1) En 2003, la radiothérapie est essentiellement réalisée en soins externes dans le secteur privé.

(2) En dehors de la Guyane, de St Pierre et Miquelon et des TOM.

Sources : Base nationale PMSI 2003 DHOS

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The French DRG were developed since 1984 from the 4th release of the Fetter DRG with a lot of modifications.

Since this date a lot of release were developed to increase the medical and economic descriptions.

Before « T2A » (i.e. : prospective payment with GHM) :

The different releases of GHM classifications (until V 9 release) were built only on public hospitals data base

So, we did not know exactly the contents of GHM in for profit clinics.

French DRG are used for prospective payment since 2004 for public hospital and 2005 for » for profit » clinics

In the « T2A Model » they have a lot of adaptation for outliers, critical care, expensive medications like chemotherapy

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What about the quality of French DRG/GHM V 10 release (800 Groups):

The PVE (Explained variance of costs) is:

- 20.1 % for the public sector (i.e. ex DG)

- 30 % for the for profit sector (i.e. ex OQN),
(for respectively 559 and 557 groups (DRG/ GHM V 10 Release).
(the big difference between both PVE is explained partially by the more important scheduled surgical activity of "for profit" clinics.

	Public	For profit
Surgical Stays (type (GHM ' C ')	27.8	37.2
Medical Stays	16.1	20.0

(PVE in GHM V10 by sector and type of GHM %)

ATIH service Classifications and medical information Mars 2007 - simulation V11

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« T2A Model » :

Part of prospective payment

- There is a Small part of global budget for the Missions of General Interest (MIG); but this part is very low for General Hospital (7%) compared to the part of GHM payment (in my opinion it is one of the smallest part in European Countries)

- There is a more important part of global budget for university hospital, for teaching, research and innovations (MERRI)

- In my opinion, actually the part of prospective payment is too important; we are not able to identified such part and such variability with our tools.

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« T2A Model » :

Modalities of Prospective payment :

- There are two different modalities of “T2A”:
- Only a prospective payment in public hospital
- A prospective payment in “for profit” clinics but with fee per procedure for the Doctors.

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« T2A Model » :

Prices list :

Actually two different prices list (Public and for profit)

But, goal of one prices list in 2012

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Various points (classification, ENC (cost weight study), ...) are problematic:

Perimeter of the measured activity (hospital stay and all around the hospital stay)

Variability of patient characteristics badly or not taken into account in the classification:

- severity
 - social factors
 - emergency hospitalization
 - age
- ENC (Cost weight study):
- Nursing intensity

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Characteristics patients badly or not taken into account :

- **Severity**
- **social Factors**
- **Emergency Hospitalization (versus scheduled hospitalization)**
- **Age**

The distribution of these characteristics are not the same :

- **between the different hospitals**
- **and between the different sectors (Public, Non profit, For profit)**

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Emergency or not ?

G.Nisand and al Strasbourg

	répartition	effectif	somme €	moyenne €
Préadmissions	28,6 %	16 736	70 740 118	4 227
Urgences	30,5 %	17 866	123 100 143	6 890
Autres	41,0 %	23 999	125 036 452	5 210

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The new GHM Release :

GHM V11 with four levels of severity (> 2 300 Groups)

An improvement of the PVE (Explained variance of costs):

6.8 % in the public sector (ex DG)(33% of increase)

4,7 % in the For profit sector (ex OQN) (16 % of increase).

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The new GHM Release:

V11 with four levels of severity (it is better to talk about complexity (> 2 300 Groups)) :

Why such an evolution?

If the goals are to describe all the variability between patients on medical aspects, social aspects ..., hospital, clinics...

Different kinds of mission

⇒ The evolution of the number of group will be exponential

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PRICING SYSTEM :

There is a National cost weight study (ENC) since 1993, but it is only used to built a relative scale between the GHM

The National annual prices are established on the basis of:

The available national budget

This relative scale

Political decisions

Price/Volume Regulation : one of the most important problems

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Impact for Clinicians:



Codification

Planning

Practice : decreased length of stay

Quality ? Results ? Mortality ?

...

It is difficult to conclude on these different points, because the analysis is complex and the data are often not available

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Consequences: personal point of view

Waiting list : No waiting list before

**Except in some specialities and for some doctors,
the situation has not changed**

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Consequences : personal point of view

Accessibility :

The for profit clinics did not have any constraints and could refuse any patient if they wanted

They have chosen and choose their pathologies

Actually , the situation is the same

For the moment the publics hospitals accepts (they have to do that) all the patients , but in each hospital, in each department, there is a temptation to increase profitable activity

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Consequences : personal point of view

Volume of activity

**There is an increase of the volume of stay
(for three year the government has been including
systematically an « ex ante » increase of 1.7 % of
the volume of stay in the calculation of national
prices)**

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Consequences : personal point of view

Codification of activity

There is an increase of the quality in codification of the activity

(but this increase of quality

(actually not really a « DRG' Creep) is included in the calculation of national prices)

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Consequences : Personal point of view :

Economic situation of hospital :

Analysis show that 20 to 25 % of GHM prices are under the cost (stroke, intensive care...)

The financial situation of a large part of hospitals is bad: there are overdrawn

What about the future ?

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« One of the major problems associated with introducing DRG weighted funding for acute-care hospitals in Australia has been the inadequacy of the cost weights used in some States. This stems firstly from a lack of reliable patient cost data from a sufficiently broad spectrum of hospitals to modify the DRG classification, and secondly from clinicians' inadequate understanding of how cost weights are developed. The latter has insulated hospital administrations and funding agencies from demands for improved costing systems. Most complaints by clinicians about DRG classification or funding deficiencies would be resolved if there were better patient costing systems in hospitals. Better costing systems would also be invaluable to clinician managers.

Clinicians should be insisting that their hospitals do better in this area. «

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**Inadequate data modeling causes
Medicare misallocation of billions**

2007 Scot M. Silverstein, MD

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Personal point of view

Length of stay: it seems to decrease

Re-hospitalization: no conclusion for the moment

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CONCLUSION (I) :

We wanted a prospective payment versus a global budget

But actually a lot of modalities are bad

The risk of selection of patients exists

EVOLUTION OF CLASSIFICATIONS IS ESSENTIAL TO DECREASE VARIABILITY INTRA GHM AND INTER HOSPITALS

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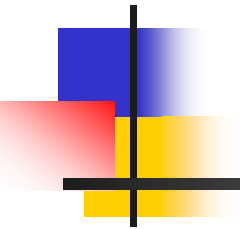
CONCLUSION (II)

Do not forget that patient Classification system (PCS) are not perfect and cannot explain all the variability . They are not tools for quality (it is the same thing for the economic models)

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THE END....

Thanks for listening