The development of patient groupings for more effective management of health care

A comment

JACOB HOFDIJK *

After reading Sanderson's and Mountney's paper for the first time I had mixed feelings. I shared the need expressed by the authors for new groupings, but I doubted the arguments put forward for the health benefit approach. I spent a long time trying to reconcile these views.

The need for the development of condition groupings is a logical consequence of the widespread use of the diagnosis-related group (DRG) concept and the increased quality of the data collected. The concept was developed in the late 1970s, with attempts to improve the management of health care resources. Utilization review in the USA led some hospital managers to think it possible to apply management techniques from the business world to health care. One of the first questions was 'What is your product?'. The answer was silence, as this concept was largely undefined in health care. The other important question was whether information describing the process or output was available.

The Yale researchers Bob Fetter and John Thompson consequently defined 2 production functions to describe the production process of a hospital: one to describe the output 'produced' by the physician and one for the intermediary products produced by the ancillary service departments. This approach was first applied to in-patients, as these data were collected on a routine basis in US hospitals. The UHDDS (the uniform hospital discharge data set) was used to generate a medically relevant set of patient management categories, focusing on the clinical resources. Based on the same data set other grouping methods were developed, like the disease staging and patient management categories, focusing on the clinical condition and clinical care process. These were not used for funding and, thus, less widely used.

The introduction of the DRG concept has changed health care management enormously. Health care suddenly had a 'product' and maybe it could be run as a business. Objective information became an important factor in the management process, although the basic data were still rather poor and incomplete. When more and better data became available the DRG grouping was refined, which led to a better clinical acceptance of the concept. Health care, however, is delivered by many health care providers in many different settings, each contributing their specific products. The simplest model of health care introduced by the authors distinguishes a link between the conditions of patients and the resulting actions. Having introduced 3 matrices for diagnostic actions, treatment and follow-up actions, the authors confuse me by choosing to focus on the single condition/treatment matrix. This simplifies the health care provision system too much. The authors state the need to obtain a better view of the relationships between the patient's condition and the care provided. With this improved insight, the purchasing and planning of services for the population can be based on the actual needs of the population. This approach however needs the still missing data on the health conditions of the population. The emerging electronic patient record might if it 'follows the patient, in twenty years lead to a basis for the grouping of the conditions of the population'.

I agree with the authors about the impact of the electronic patient record for improving the information base. The episode of care approach, which links all actions of care to the 'treatment' of a patient might be the best model. However, we need international standards to be able to apply these concepts internationally. A vital issue, though, will be to find the incentive for clinicians to use the electronic patient record in daily practice. It is essential to give the clinicians the incentive to use electronic record systems. These systems should offer a high payout. The potential for groupings to support the management process of health care delivery is growing, particularly as the process-related data collection is improving. One needs always to remember the Hornbrook paradigm, which links the management objective to the grouping methodology. So no one grouping method is a panacea for health care management, but health care management needs a wide range of tools. For quality management another grouping method is needed than for health care funding or internal budgeting.

My main argument is that health care management benefits from grouping. The proposed initiative of the authors to develop new grouping systems should be supported as it can contribute to a better understanding of the process of care by clinicians, managers and purchasers. The goal is still a long way off, but patients can benefit from researchers sharing experiences on an international level.

REFERENCES