

On being more dynamic in DRG refinement

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Hindle's analysis of past and present initiatives with regard to casemix classification review is perceptive (Hindle 2001). The issues he raises are important.

It is clear that Australia has been innovative and led the world recently in casemix development and application. That is why other countries are using the Australian system. Involvement by federal and state governments, administrators and clinicians has led to a system broadly accepted as a lexicon for acute hospital admission classification and a means of payment. This has been a major achievement and all concerned should be congratulated.

It is also clear that the system needs to be dynamic. This is the point that Hindle is making: that incremental change will not be able to lead to major improvement, but only marginal improvement. That is exactly what has been seen with submissions for the refinement of AR-DRG version 5. Only small numbers of proposals for changes were received, and no major changes were suggested.

The issues he raises for attention are crucial. The Australian Casemix Clinical Committee recommended strongly that direct estimates of cost were to be used when assessing resource use homogeneity in version 5. This has been taken on board as a substantial, but not the only, resource index to be used because of ongoing issues about costing data quality and reliability. Length of stay will also be taken into account. The move toward the use of costing data is seen by all concerned as important and necessary given the lack of acceptance of length of stay as a surrogate for cost. This needs to, and will be, extended.

Principal diagnosis remains a flaw in my opinion. It had been discussed and dismissed as too difficult an issue during the development of version 4, given that all data used to analyse improvements in performance of the classification were based on current usage of the term. It would require investment in a study using both forms of principal diagnosis - reason for admission and reason for resource consumption - to be collected together and costing assigned accordingly to enable the system to change. Such an undertaking is likely to take a major effort requiring system-wide co-operation and significant funding. It is healthy to raise it here as a priority for the future.

The descriptions of severity and complexity also remain a cause for concern for clinicians. Despite better descriptions by use of PCCL scores, further refinement is feasible. For example, better use could be made of data on multiple procedures, and of information on "up-transfers" (ie, to a higher care institution or setting) versus "down-transfers" (to a lower care institution or setting) - making sense but requiring systematic work for appropriate definition and agreement.

This becomes especially important with the potential for use of quality of care "report cards", so that outcome and other quality of care reports might be meaningfully adjusted for casemix complexity and severity to facilitate acceptance and interpretation. See Bolsin (2001) for further discussion of this matter.

Lastly, the issue of measurement of quality of care needs to be considered. Despite a world wide sea change in the approach of health care to issues of safety and quality, systematic means of measuring and benchmarking clinical performance are lacking.

In my opinion, bureaucracies are unlikely to welcome the idea of establishing entirely new administrative processes and measurement systems to monitor clinical performance. Marginal increases through refinement

and use of current administrative data sets are more likely to be accepted, funded and used than establishing complete new systems and bureaucracies.

This is an area in which major advances could be made in AR-DRGs that would not only make a difference to the business of health care, but might also make a difference to the people who use health care. After all, isn't that what it is all about?

References

Bolsin S 2001, 'League tables and professionalism: on quality in health care', *Australian Health Review* vol 24 no 3.

Hindle D 2001, 'The Australian DRG classification: are we ready for structural changes?', *Australian Health Review*, vol 24 no 3.