

Using Australian DRGs in New Zealand: collaboration for progress

MICHAEL RAINS

Michael Rains is Senior Analyst, Decision Support and Contracts with Capital and Coast District Health Board, New Zealand.

During the course of writing this commentary, I invited opinions from several other people who have been working with DRGs over the last two or three years in New Zealand. Although the sample was hardly representative, there was a relatively high degree of consistency of views.

One matter on which we were agreed is that, with respect to areas of potential improvement in Australian DRGs, Hindle (2001) agrees with us! Most of the ideas that he presents have been the subject of informal discussions among interested parties across the Tasman. Hindle does not claim otherwise, but adds to our understanding by presenting the ideas in a clear and relatively comprehensive way. In short, his is a very good review that raises several important issues.

With respect to weaknesses in the existing classification, New Zealand has direct experience of many of the circumstances described by the author. We have also suffered in similar ways with regard to process: we are continually working in compressed timeframes which are not conducive to more significant developments. One simple example of the adverse effects of time pressures that has come to my notice of late is the continuation from AN-DRG version 3.1 to AR-DRG 4.1 of the grouping anomaly for bilateral hips. The fix for version 4.1 made by Victoria for 2000-01 is described at www.dhs.vic.gov.au/ahs/hdss/vicdrg4s.pdf. This continues a known problem from the earlier version.

New Zealand has tended to 'piggy-back' Australian developments, and few significant local changes have been made thus far. We have mostly used the State of Victoria's adjustments to AN- and AR-DRGs (which are minor in terms of classification structure) together with Victorian cost weights (with some adaptations to suit our particular circumstances). Most of the Victorian adjustments have their equivalents in other Australian states and territories, and it follows that we share a common and serious interest in the development of the Australian DRG classification and all that it entails.

We perhaps differ from Australia in terms of the depth and breadth of knowledge about the DRG classification and ways that it can be applied to resource allocation and analysis. To put it bluntly, there is a lack of broad-based institutional knowledge in the general casemix area, despite good pockets of expertise in sub-areas such as coding and costing.

It is therefore not surprising that we are eager to establish more significant and ongoing collaborative ventures than have been possible thus far. In particular, it would be useful to us to grow our knowledge by being involved with Australia and other users of AR-DRGs along the lines suggested by Hindle. It seems to me that it will be much easier to develop an understanding of the issues and the opportunities by being involved in the design and not only in the application of DRGs.

If we are to make the required improvements, we must be able to establish an ongoing source of expert advice, and especially that which comes from the clinically knowledgeable. This is especially important at present. Current trends in New Zealand's health sector accent quality and effectiveness of service provision, for which the clinical background to the DRG classification and related systems needs to be as expert as possible.

We see the involvement of expert clinical and other practitioners as essential for the evolution of a quality product. The Australian Casemix Clinical Committee (ACCC) has been an excellent model, and it has been

good that New Zealand has been invited to have representatives on the Committee since 1996. The apparent demise of the Committee in recent times is a little disturbing. However, I understand it will soon reappear in a slightly modified form. If so, New Zealand would wish to again be involved.

We think the patient clinical complexity level (PCCL) measure is important, and Australia's designers are to be congratulated for its development. However, I think its potential has not yet been fully realised within the classification itself.

New Zealand has used AN-DRG version 3.1 and CCL values in work related to premium adjustments for tertiary services. In this work indices were constructed that reflect patient severity and could be used either to determine a premium or to allocate a given funding pool. This work will probably be updated using PCCL. Given the possibilities for continued use of PCCL in this way, we are particularly keen to see this system developed further for robust measure of complications and comorbidities. Hindle's suggestion that we might incorporate some continuous variables could be part of this.

Examples of current thinking in New Zealand about possible refinements come from a recent national study of fracture of neck of femur. Participating orthopaedic surgeons were of the view that the PCCL scoring system might be improved in several ways. One concerns the apparent undercounting of the effects of other neurological disorders that could have a significant impact on the outcome of a hip replacement. Other suggestions were that there is too little difference in the impact of PCCL scores between medical and surgical DRGs, that the effects of chronic conditions on surgery are underrepresented, and that the impact of anaesthetics in elderly patients with chronic conditions should be taken into account in the calculation of PCCL.

The surgeons were particularly interested in the possibility of separating the impact of complications from comorbidities. The current arrangements are one of the aspects of structure that Hindle notes have remained unchanged since the late 1970s. It might have been reasonable at that time to claim ignorance with regard to the difference between complications that were avoidable and those that were not, and even between a complication and a comorbidity, but there are no excuses in 2001. Another interesting idea suggested by the surgeons was that the classification should be sensitive to whether a complication occurred before or after surgery.

Finally, let me underline the point about collaboration. We need a basis for valid comparison within and between countries, and the growth in the number of countries using Australian DRGs presents an opportunity that should not be missed. The quality of the tools used for developing benchmarks or comparisons is important to ensure the results have acceptable meaning to clinicians and managers alike. One way to ensure the potential is fully realised is to establish long-term collaboration on DRG refinement. New Zealand would be an enthusiastic participant in such a venture.

Reference

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