DRGs and the development of service delivery strategies

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I read Hindle's paper on structural change in the DRG classification with interest, and support many of the views contained in that paper (Hindle 2001). I would preface these comments with a disclaimer that they are my personal views and not that necessarily of the Department of Human Services, South Australia.

Having used DRGs extensively over the past decade for research, trend analysis and funding purposes, it is apparent to me that we have come a long way since the early inception of the DRG work by Fetter and the Commonwealth need to be acknowledged for the leadership and support they have provided in this process. However it is also apparent that we can make more significant improvements given what we have learned to date.

I am interested in structural changes of DRGs for at least three purposes: funding, clinical understanding, and strategic development of service delivery.

In terms of funding, the current DRG structure does not reflect resource allocation particularly well. Cost data has improved considerably and we can now use the results of this work to inform the classification system as well as to develop cost weights. Reviews of cost data have shown that there are significant numbers of DRGs that are not resource-homogeneous. The ongoing debate over the last few years relating to use of the same-day flag reflects both the confusion and lack of progress on these issues.

While it is recognised that DRGs were not designed for funding purposes, it is a fact of life that a number of states and territories have gone down this path. Under these circumstances there is an increasing probability that funding models include disincentives to improving clinical practice. More importantly, it will continue to separate the understanding and impact of clinical practice on resource consumption. For example, that the DRG system does not explain severity well is highlighted by the fact that South Australia has had to calculate an index of within-DRG "unexplained" severity in order to improve the equity of funding.

The problem with funding strategies is compounded, as is indicated in Hindle's paper, by the need to pick a single diagnosis and/or single procedure code as the principal code in order to assign a DRG. In most circumstances, clusters of diagnoses are likely to be more realistic and better able to reflect clinical practice, particularly in the case of older and/or chronically ill patients.

In terms of clinical understanding, the need to use single diagnosis and single procedure codes (without any links to quality and outcomes of care or necessarily a view to a more holistic treatment protocol) will limit our ability to understand changes in clinical practice and patient/clinician expectations. The use of clinical protocols, which reflect best practice and have embedded in them desired outcomes, needs to be supported as an appropriate strategic development, particularly where they are designed to foster the continuum of care. However, this is not to say that clinical protocols will be valid or appropriate in all circumstances

Hospitals and clinicians are investing more energy in terms of understanding the resourcing decisions, making use of more detailed morbidity data and improved clinical costing systems. However, there is not the corresponding effort at the State or national health authority level to explore significant redevelopment of the DRG system to help better understand, from an administrator's and funder's perspective, the decisions and outcome requirements at the clinician level.

Any redevelopment work should be focused on making better use of the data and the relationship between the provision and application of resources. It is difficult to use funding models prospectively to support clinical practice changes and drive improvements in health care delivery, other than in a crude way, given the limitations of the current DRG system. Apart from some minor strategic decision based on known obvious factors, we are trapped into using historical data and slowly redefining historical patterns of care.

There is an increasing interest in providing holistic care which leads to the need to more carefully assess the resource decisions between prevention, acute care, post-acute care, having regard to the burden of diseases and change of population profile. There is a need to make strategic decisions in terms of resource allocation, and these are being undertaken at the margin and incrementally given the lack of information to make more bold moves. Increasingly, this calls for the further development of the DRG system and a better integration with other classification systems, even well before broader resource allocation decisions can be made.

Reference

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