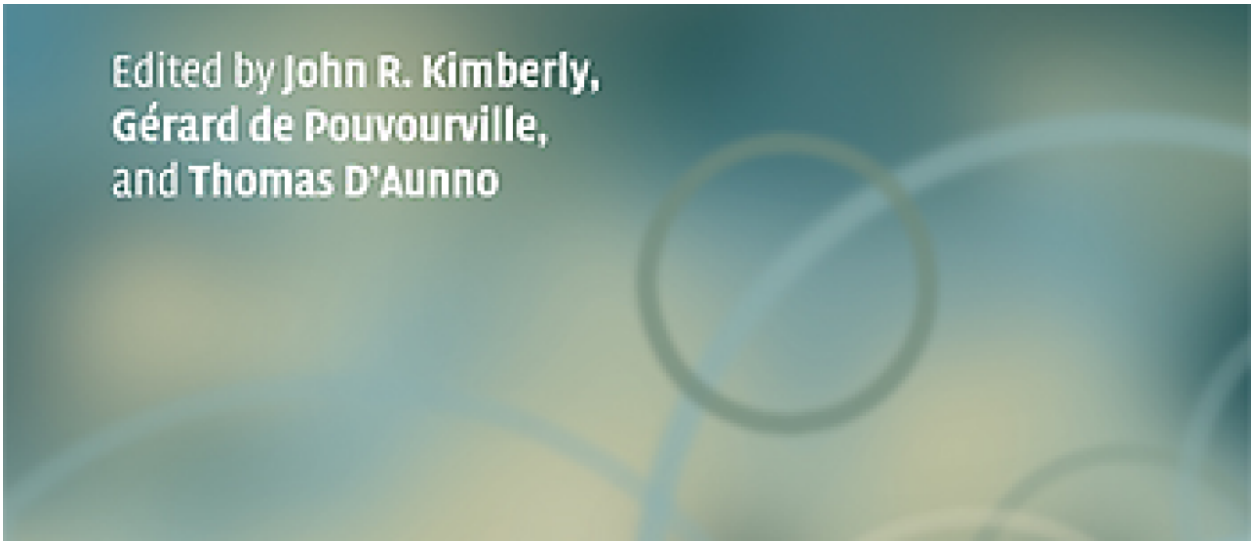
Exploring the migration of patient classification systems worldwide



By Robert Goldsmith

It has been called the most significant innovation in US medical financing since the Second World War. Introduced in 1983, the Diagnosis-Related Groups (DRGs) system for classifying patients gave healthcare providers and payers a tool to manage patient care and slow the rising cost of health care. Since then, DRGs, or patient classification systems (PCSs) as they are known outside the US, have caught the attention of health care policymakers around the world.

This migration of PCSs from the US to other countries is explored in *The Globalization of Managerial Innovation in Health Care*, a new book co-edited by INSEAD professor **Thomas D'Aunno**.

“What we're trying to understand is how countries are using these systems, why they are using them, and what is the pattern of adoption and use," says D'Aunno. “We want to understand how they develop, how they affect power among the managers, the physicians, and the governments and insurance companies that pay for services. And we want to understand the conditions under which the system migrates around the world.”

In many countries healthcare is the largest single industry. Spending tops 15 per cent of gross national product in the US, and in other developed countries it averages 10 per cent. Yet until the DRG patient classification system was introduced in the US, there was no way for those who paid the cost of healthcare (such as Medicare in the US) to know how their money was being managed. DRG gave Medicare, for example, a way of comparing the outputs of one hospital with those of another. Medicare uses this data as a basis for paying hospitals in a standardised fashion for the products they produce.

“This is an important managerial technology,” says D’Aunno, who adds that the study offers a specific example of the broader issue of how management practices in general migrate from country to country.

“There are actually very few empirical studies that examine the diffusion of management practices around the world and how they vary,” he says, “and so we wanted to try to make a contribution in understanding globalisation by taking one management practice in one very important industry and understand how it travels around the world.”

The book, whose other co-editors are **John Kimberly** of Wharton and **Gerard de Pouvourville** of ESSEC, builds on an earlier study by Professor Kimberly. Supported by the INSEAD-Wharton Alliance, it explores the adoption of PCSs across 15 countries and analyses their similarities and differences. It starts with introduction of DRGs in the US in 1983 and ends with the introduction of a PCS programme in Germany in 2005. Currently 32 countries worldwide use a PCS.

Before PCSs were introduced, payers - such as Medicare or the UK’s public healthcare system, the NHS, had no way of knowing what hospitals were doing or what the true costs were of what they were doing. With a PCS, payers have a tool to do this. They know what kinds of conditions patients are being admitted for, how many patients a hospital treats for each condition, and the average cost of treatment for each condition. The payer then uses this average to determine how much it will reimburse for each condition.

“So the use of a DRG as an accounting tool is very important in the government's battle to control costs because now they have some empirical foundation,” D’Aunno says. “Basically it puts data in the hands of the payers.”

D’Aunno says the migration of PCSs is accelerating because of the continued rise in healthcare costs and because healthcare reform is high on many political agendas. PCS systems also travel well because they are adaptable to a variety of national priorities and policies. The study allows policymakers who are thinking of introducing a PCS in their country to compare themselves with other similar countries.

“Basically the book helps you learn from the mistakes or successes of your peers so you don't repeat them,” he says. “For example, Switzerland has had a hell of a time adopting this, so policymakers can see what Switzerland did wrong and how can they learn from it. On the other hand, Japan and Portugal went very quickly. They can see what these countries did right and how they can copy that.”

While there are many factors in favour of the migration of PCSs, there are also factors opposed to it. Countries with decentralised national systems, for instance, will have more difficulty in adopting them. Germany for example, which despite being highly organised and developed technologically, spent many years reconciling its 18 different regions and payment systems before it successfully introduced a PCS in 2005.

France and Britain, which share many similarities including national healthcare systems, have had widely differing experiences implementing their PCSs, according to D’Aunno. The British system for healthcare payments is very centralised with the National Health Service paying for 95 per cent of all healthcare in the UK. As a result, implementing a PCS in the UK was comparatively easy. But France, which has a reputation for being highly centralised, is having a more difficult time because a lot of elective surgery in France is done in the private sector. Many employers in France offer private healthcare insurance to their employees to complement national insurance.

“Both governments are fairly centralised, and France famously so, but the payment system is more fragmented in France than in Britain, so we saw quicker adoption in the UK than in France,” D’Aunno says. “These comparisons provide very interesting patterns in adoption.”

Moreover, PCSs are controversial, says D’Aunno. Hospital managers like them because it gives them a tool to use in negotiations with payers. On the other hand, it puts doctors under the gun. The same hospital manager can use the data to influence doctors to treat patients more economically.

“Physicians tend to be viewed as the loser,” says D’Aunno. “They generally try to resist efforts to manage their practice, they feel like they are the ones who know what is best for the patient and if it needs extra cost, they feel they should be entitled to practise that way.“

Also, since hospitals are paid a fixed amount for each diagnosis, they have an incentive to discharge patients quicker than is prudent and pocket the difference. Another problem is known as “DRG creep” where the hospital adds another category so they can get an extra payment. Grandma comes in for a hip replacement and suddenly she also has pneumonia. One patient, two payments.

And not all DRGs are created equal. Some conditions are more profitable than others. This has resulted in specialty hospitals that only treat highly profitable illnesses such as cardiac, Orthopaedic or cataract surgery.

Nevertheless, says D’Aunno, because of the growing concern about the rising cost of healthcare, the adoption of patient categorisation systems is certain to increase with more and bigger countries getting on board and using these systems extensively for payment. He concludes: “This is an important tool for all the major stakeholders to use in their battles about balancing the bottom line with the quality of care.”

The Globalization of Managerial Innovation in Health Care is co-edited by ***Thomas D'Aunno****, former Novartis Chaired Professor of Health Care Management at INSEAD, who is currently Professor of Health Care Policy and Management at Columbia University Mailman School of Public Health. The book’s other co-editors are* ***John Kimberly****, Professor of Management at the Wharton School, and* ***Gerard de Pouvourville*** *of the Centre National de la Recherche Scientifique (CNRS) in Paris and Professor of Health Care Management at ESSEC.*

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