

## **CASEMIX VIEWS**

To promote a good understanding regarding the concept of casemix and its effective use, the SMA organised two Casemix Seminars in November 1999.

### **Casemix: Bane or Boon?**

The first seminar held on 6 Nov 99, sponsored by Parkway Group Healthcare, dealt with the question of Casemix, "Bane or Boon?"

Prof Don Hindle was invited to give a keynote address on the subject. Prof Hindle has spent several years working in the health sector in North America, Europe, New Zealand and in Australia. He was consulted in projects relating to residential aged care, casemix funding of hospitals, utilisation review, clinical pathways, outcome measurement, and product costing.

Prof Hindle's answer was that casemix is a tool to classify production efforts of the healthcare delivery system for purposes of costing, payment and healthcare planning. Casemix classifications like DRGs are seen to provide a better basis for understanding the care funded by healthcare funders and corporate healthcare purchases.

In contrast, many care providers are skeptical about casemix funding. They are worried about increased interference by funders and purchasers. Prof Hindle observed that many clinicians believe that casemix classifications like DRGs are crude and clinically illogical in parts. He commented that Singapore doctors are not as negative as the Australian counterparts in this respect to casemix.

In his opinion, the use of casemix provides all parties with the opportunity to continue the same battles they have always been fighting. For example, health funders have always wanted to simplify and generalise whereas clinicians have always wanted more complexity in describing their work. It is not a new idea – clinicians have always categorised their patients. Rather, it is a very old idea which can and should be better used.

The main problem with casemix, according to Prof Hindle, is that care providers have failed to use casemix to defend their interests in health outcomes.

Prof Hindle reiterated that casemix funding is a good idea: it provides the opportunity for payers and care providers to work together to promote value for money – to make sure that the scarce health resources are used to ensure the most health possible.

Casemix can be used for more purposes other than cost containment. Casemix is useful in helping care providers to improve resource management and hence to increase value of the health dollar. Therefore, clinicians have to take the lead in applying casemix ideas to manage their work.

### **Singapore Casemix**

Dr Jason Cheah, Assistant General Manager, Casemix Management, Parkway Group Healthcare also spoke in the seminar to acquaint our doctors on the development of casemix in Singapore. Casemix is a tool to help us manage our healthcare resources effectively and in so doing, keep healthcare affordable. It is a means of allocating resources that takes into account the broad spectrum of disease conditions, their varying degrees of severity and significant patient variables such as age and gender.

To oversee the implementation of casemix in Singapore, the Ministry has formed the Casemix Taskforce comprising of Ministry officials, senior clinicians and hospital administrators. The Casemix Project Office (CPO) coordinates all casemix related activities in MOH and the public sector hospitals and provides secretariat support to the Taskforce. Both clinicians and administrators are working closely in various committees to address issues such as finance, information management and quality of care.

To ensure the validity of the AN-DRG System in the Singapore context, the MOH has established the Clinical Classification Committee (CCC) comprising of senior clinicians of various specialties. These specialties will continue to monitor the data as they are collated over the next few years.

Casemix began at two pilot sites, Changi General Hospital and National Heart Centre in May 1998. This was extended to the other restructured hospitals and Alexandra Hospital in October 1998. Casemix would be used at the end of 1999 as a financing mechanism to determine the amount of subsidies to be given to the public hospitals for acute inpatient care and day surgery on a per DRG basis.

In 3 to 5 years, casemix will be introduced to the private sector. Casemix will be used in controlling the level of medisave charge limits (i.e. how much a patient can be charged should he decide to use his Medisave funds to pay for his hospital bills) and balance billing.

### **Surviving Casemix**

The second seminar held on 27 Nov 99 dealt with the practical application of casemix and its effects on the doctors' practice.

#### **What can you do?**

Dr Gregg Herring, Managing Director, Herring Health & Management Services Pte Ltd and former Executive Director of the Australian Private Hospitals Association spoke on the past, present and future of casemix funding, in the context of the Australia experience. His advice to doctors in Singapore is to (1) anticipate, participate and educate themselves on what casemix is about; (2) ensure that the DRG classification system reflects their practice; (3) work with hospitals to develop sensible length of stay, clinical pathways and ancillary expenditures. He concluded that "DRGs just classify patients; it is for what and how you use them that counts".

#### **What is the Singapore doctor's role?**

The next speaker, Prof Tan Ser Kiat who has been involved in the development of casemix in Singapore, shared his perceptions. Prof Tan stressed

that the main role of the healthcare professionals remain unchanged. Casemix is based on best practice. The involvement as professionals can make casemix work for the benefit of all Singaporeans so that quality healthcare can remain accessible and affordable.

Is casemix a method of cutting the health budget? Not so, according to Prof Tan. Casemix is a tool to ensure that distribution of resources and funds is equitable and based on meaningful data. The bottom line is quality and it is not meant to reduce funding or to restrict good practice.

### What not to do

Dr Robyn Mason, the Executive Director of Australia Medical Association, Victoria shared 10 lessons on "The Victoria Experience of Casemix : What Not to Do". Her messages are :

Lesson 1 : Ensure that the introduction of Casemix funding is not used to disguise a reduction in total hospital funding.

Lesson 2 : Ensure that before the new funding arrangements are introduced, there is valid, reliable and easily collected baseline data for:

O costs  
O patient throughput  
O quality of care

Lesson 3 : Casemix funding is not suitable for small hospitals of less than 15 beds. Alternative or adjusted arrangements should be developed for these hospitals.

Lesson 4 : Small hospitals do not have access to the same infrastructure as large hospitals to manage the introduction of new systems. Education and technical support from large institutions needs to be available to smaller centers.

Lesson 5 : As DRG reimbursement is based on average costs, it often inaccurately measures the complexity and cost of patient care, even after numerous refinements. Consequently, tertiary teaching hospitals may be disadvantaged.

Lesson 6 : Remuneration of doctors according to generated Casemix revenue may be convenient for hospital management, as it ties doctor payments to hospital income, but it is totally illogical and inappropriate.

Lesson 7 : With the passage of time, bureaucracy will develop a liking for DRGs which will be misinterpreted for validity and so the use of DRGs will be inappropriately extended to measure quality of care and to further impinge on clinical autonomy.

Lesson 8 : New funding systems may not have implicit nor explicit financial incentives which undermine access to care for a particular group of patients, for example, elective surgery patients at the expense of emergency patients or those with chronic illness.

Lesson 9 : It is essential for the future of medical education and the evolution of the health care system that clinical research, education of junior medical staff, purchase of equipment are adequately and explicitly funded.

Lesson 10 : An integrated funding arrangement, that funds the whole episode of care, is desirable. Cooperative arrangements between hospitals and community care providers benefit hospitals and their patients.

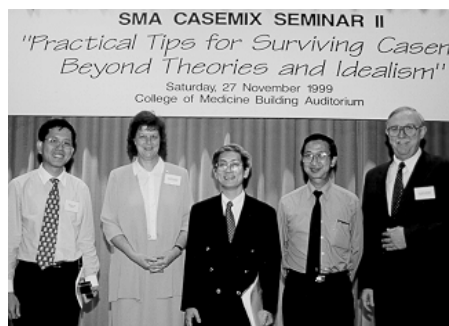
Casemix in Victoria has its benefits as well as a number of perceived shortcomings. For example, the reduction of standard of care through cost cutting is possible but it does not necessarily have to be so. The Victoria experience of introducing casemix was at the time of great budget cuts in healthcare. The rush for the implementation of casemix may explain the drop in standard of care that has been observed.

### Conclusion

The take home message for casemix is DRGs just classify patients. It is for what and how doctors use them that count. Casemix can be used positively to manage our healthcare resources and delivery system to be of high quality and yet affordable. What needs to be done is to set the weigh tags correctly and to apply the reimbursement fairly.



Prof Don Hindle.



(L-R) Dr Paul Chui, Dr Robyn Mason, A/Prof Goh, Prof Tan Ser Kiat, Dr Greg Herring.