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CONFERENCE ABSTRACT

Integrated categories for integrated care - the importance of patient centred categories

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Categorisation systems such as DRGs and ICD are fundamental to contemporary health services planning (what gets done where), funding (price and budgeting), operational management (performance metrics) and governance (which interests are recognised). A well implemented system makes a large difference: for example Activity Based Funding (ABF) has revolutionised the acute hospital sector, and driven major improvements in efficiency, management and governance

All formal categorisation systems, by the very fact of distinguishing classes, create boundaries. When such systems are used normatively (for example, for budgeting) then those boundaries affect the behaviours of participants, whether clinician, system manager, funder or consumer. The result is that the inherent biases of such a system can become institutionalised, and boundaries risk becoming a border to defend, rather than an obstacle to be removed

By their nature, integrated health care systems need to be patient centred (i.e. “follow” patients/ consumers across multiple platforms), extended across time (cover multiple phases) and interdisciplinary (drawing on a range of professions and organisations). This creates interesting issues with respect to the design and development of categorisation systems, which must also be patient centred, stable across time and be meaningful in multiple settings. Such a system can lessen conceptual and practical boundaries between the systems required for integrated care. It is also an opportunity to ensure integrated systems are genuinely patient centred

Existing categorisation systems such as ICD, DRGs and the ICF have developed for different reasons, and embody distinctive views of health, disease, care and “patienthood”. For example, the ICD/DRG approach – which embodies a “medical” logic – is largely silent on the variables that need to be considered in funding, providing and evaluating the ongoing care. Many of these variables are already at play within the acute episode, but are unrecognised by coding and classification systems (e.g. disability, social context and self-efficacy).

A multidimensional approach: Progress has been made conceptually on recognising the multidimensionality and continuity of care, a prominent example being the multi-axial framework within WHO International Classification of Functioning, Disability and Health (ICF) which, amongst other elements, recognises the patient’s capacity and incapacity to function as variables, while also recognising the significance of medically defined conditions.

We propose that the time has now come for a pragmatic approach that adds patient centred “dimensions” to existing classifications. By way of example, we consider the implications for

integrated care classification, starting from an ICD/ DRG perspective. By adding a dimension that references ongoing, stable patient attributes germane to service integration, we show that – at least in principle – it is possible to develop stable, meaningful patient centred categories that extend across time and space, thus supporting patient-centred integration

By forging those linkages, the broader care integration project can stay centred on maximising patient benefit, rather than being distracted by institutional boundaries. Integrated care needs integrated classification systems.

Keywords: classification; ICF; categories; integrated care systems