HealthManagement
Promoting Management and Leadership

Framework For Managing Customisation Of Care

Healthcare organisations are increasingly in need of systems and approaches that will enable them to be more responsive to the needs and wishes of their clients. Customised service is generally perceived not only as better quality but also as more attractive, thus allowing a premium to be charged. Two recent trends, namely, patient-centred care (PCC) and personalised medicine, are first steps in the customisation of care.

PCC shifts the focus away from the disease to the patient. Personalised medicine, which relies heavily on genetics, promises significant improvements in the quality of healthcare through the development of tailored and targeted drugs. It is important to understand how these two trends can be related to customisation in healthcare delivery and, because customisation often entails extra costs, to define new business models.

If the notion of customisation of patient management in a clinical and economically practical way is relatively new to the healthcare sector, it is at the core of what is known as mass customisation in industry. This article aims to propose a framework for adapting the principles of mass customisation to achieve the greatest amount of customised care at the lowest cost in health care.

Methods

The proposed framework was grounded in a two-part literature search and review carried out by two of the authors (EM, MW). The first part identified key factors in a variety of services sectors that might prove relevant to customisation of services in healthcare through a search on Web of Science, EBSCO and CAIRN databases using the following combinations of key words: "mass customisation" AND "service". The authors searched PubMed (1992-2012) using the keywords "personalised medicine", "care customisation", and "patient-centred care" either alone or in two combinations: personalised medicine AND care customisation, patient-centred care AND care customisation. The review sought to establish an explicit link between the factors needed for implementation of mass customisation (Part 1) and the initiatives already implemented in healthcare (Part 2). When regular trends in certain factors appeared, (eg, use of IT), the reviewers discontinued analysis of articles on that factor.

A total of 740 items were selected in Part 1 and 560 in Part 2 the literature review. Bibliographies of selected articles were hand-searched to retrieve all cited articles relevant to the study. The final selection included 94 articles and books, which were all read in full.

Results

From the literature review, the authors identified six factors that could be related to the three steps (design, service delivered and assessment) making up their framework for the implementation of customisation in the care process. One factor was related to the design step (F1 = categorisation, ie, the better segmentation of patients in order to adapt service to patient pro?le), three factors were related to the technological and human factors involved in the service delivered (F2 = IT use, F3 = developing service skills and F4 = patient self-management) and two factors were related to assessment, i.e., whether the service provided met patients' needs and was financially sustainable (F5 = patients' experiences and F6 = economic impact).

Although the six key factors are distinct, they are interrelated components of the proposed integrative framework. In this integrative view, it is important to point out that the capability of patients and relatives to participate in self-management depends on two-way IT use. Actions that are taken by patients call for a response (information and coordination) from healthcare managers. On the other hand, managers request information from patients in order to identify their needs and provide a specific service. Factors related to work organisation, IT and service skills depend on the way patients are categorised. Finally, the level of care customisation that can be attained is secondary to financial criteria (business model), which governs the viability of any attempt at care customisation.

Conclusion And Discussion

This article has presented a framework to map aspects of customisation relevant to the development and implementation of enhanced care delivery processes. The framework, which integrates six key factors, was developed by considering initiatives already existing in the healthcare sector and by translating knowledge from other service sectors to healthcare.

The new framework's effective implementation depends on the socio-economic context of its implementation. In the current socio-economic context, both personalised medicine and PCC have been able to find a raison d'être, and care customisation is simply a logical and natural extension of these two concepts. The aim of personalised medicine (ie, treatments tailored to individual patients) could be extended to include not just therapeutic clinical appropriateness, but also organisational, social and psychological appropriateness. Care customisation could then profit from the professional support already accorded to personalised medicine. PCC, meanwhile, would be a strategy for rendering the concepts

of care customisation operationally.

For future research, the framework will need to be expanded and supported by empirical evidence. Ideally, the framework would motivate researchers to develop new theories and projects in healthcare management.

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