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# Managing customization in health care: A framework derived from the services sector literature

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ABSTRACT

Organizations that provide health services are increasingly in need of systems and approaches that will enable them to be more responsive to the needs and wishes of their clients. Two recent trends, namely, patient-centered care (PCC) and personalized medicine, are first steps in the customization of care. PCC shifts the focus away from the disease to the patient. Personalized medicine, which relies heavily on genetics, promises significant improvements in the quality of healthcare through the development of tailored and targeted drugs. We need to understand how these two trends can be related to customization in healthcare delivery and, because customization often entails extra costs, to define new business models. This article analyze how customization of the care process can be developed and managed in healthcare. Drawing on relevant literature from various services sectors, we have developed a framework for the implementation of customization by the hospital managers and caregivers involved in care pathways.
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## 1. Introduction

This article addresses key issues relative to care customization in healthcare delivery and proposes a pragmatic framework to study and guide its management.

From the patient's point of view, care customization has always been an important aspect of quality in healthcare. Every patient wants to feel that he/she is getting the care that is tailored to his/her particular needs [1,2]. As the traditional notion of the "doctor-patient relationship" implies, customization is at the core of the conception of care for health professionals. As in other sectors, a customized service is perceived not only as better quality but also as more attractive, thus allowing a premium to be charged.

Two relatively new concepts, *patient-centered care* (PCC) (organizing patient management to meet the needs of the individual patient) and *personalized medicine* (tailoring therapy to the patient's biological characteristics and in particular to their genetic profile have the potential to enhance customization of care substantially) have each generated a great deal of interest and investment and have developed independently. We see significant potential for them to be integrated and introduced into day-to-day patient management, yet we know of no attempts, either conceptually or practically to do so. There is a need to understand both how they might be integrated and whether the underlying economics make it feasible.

If the notion of customization of patient management in a clinical and economically practical way is relatively

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new to the healthcare sector, it is at the core of what is known as mass customization in industry. Mass customization in industry has been defined by Davis as "*the production of personalized or custom-tailored goods to meet consumers' diverse and changing needs at near mass production prices*" [3]. The principle of mass customization cannot, however, be transferred directly to healthcare but must be adapted to the complexity of care delivery systems. Our aim in this paper is to propose a framework for adapting the principles of mass customization to achieve the greatest amount of customized care at the lowest cost in health care.

## 2. Patient management as a production process

Three different sets of actors play a role in healthcare delivery and patient management: caregivers working in healthcare organizations or care pathways, managers who are in a position to implement organizational changes in care processes (the quality manager, the head of the medical performance analysis department, or some other senior executive, depending upon the division of duties within the organization) and, finally, the policy-makers (government ministries or agencies) who can influence priorities and needed resources. In short, the policy-makers decide on the changes to be made at the macro-level, the managers decide how these changes will be carried out at the meso-level, and the caregivers decide who will do what and when (work organization) at the micro-level. Coordination among these three roles is an ongoing challenge, and for this reason, a common framework for care customization that will align these stakeholders in their efforts to deliver individualized care within an acceptable time and cost frame is needed.

The context within which patient management takes place can, in general, be described as follows: ever ***faster delivery*** of appropriate care because of ever tighter budgets; a wider choice of advanced medical technologies available for patient care, necessitating ***greater coordination*** among staff; more interventions within an ambulatory care setting, while ***eliminating hospital-to-hospital transfers***; an increasing ***emphasis on patients and their relatives*** as beneficiaries of a service; an expectation that better informed ***patients*** with greater freedom of expression ***can help co-design and co-produce the care process*** and will thus encourage patient self-management [4]. In short, the context is complex and customization of a process where time is crucial, the steps making up the process are highly diverse, interaction with patients and relatives is high and that occurs on a large scale (more than a thousand processes a day in some healthcare organizations), represents a huge challenge in management. It is the challenge of managing the uniqueness of each patient on a large scale in order to achieve higher patient clinical outcomes and service better tailored to meet patient needs under tighter budgets.

## 3. Toward customization: personalized medicine and patient centered care

Customization is not totally absent from healthcare, but its link with the intervention it qualifies is often not explicit. An example of this is the customization in handover training in order to ensure continuity of care [5] and use of information technology (IT) to share information and improve interactivity. Nonetheless, there is no global integrative approach to customization in healthcare in these initiatives. Personalized medicine and patient-centered care are also steps toward customization, but each one has its limitations and they are not linked managerially.

Personalized medicine is a focal point of current clinical and translational research. The rapies tailored to increasingly narrow patient segments on the basis of the patients' genetic characteristics have been developed, and improved treatments for diseases such as breast cancer and hepatitis C [6] have already been put into practice. The new knowledge acquired by the use of novel pharmacogenomics techniques is expected to induce major quality improvements with regard to personal health planning, early diagnosis, prescribing the right drug for the right patient, and predicting treatment side effects.

The linkage between personalized medicine and better health has so far been biologically driven, as the emphasis has been on actions designed to reveal the appropriateness of a given treatment in biological terms [7]. Interventions based on the socio-economic status rather than biological characteristics of patients have been less critical to improving health and are more geared toward ensuring social equity. However, quality of care is determined not only by the treatment but also the organization of the clinical pathway within which treatment is delivered [8]. Personalized medicine – which relates to treatment strategies- and care customization – which relates to the overall care process – complement each other [9]. Care customization translates personalized medicine into clinical practice by redesigning care delivery processes from the early decision-making stage (disease management and choice of treatment) right through to patient follow-up and counseling.

There is also an evident link between Patient-Centered Care (PCC) and care customization. In 1988, the Picker/Commonwealth Program for Patient-Centered Care (now the Picker Institute) coined the term Patient-Centered Care to call attention to the need for clinicians, staff, and healthcare systems to shift the focus away from diseases and back to the patient and family [10]. The Institute of Medicine (IOM) defined PCC as "care that is respectful of and responsive to individual patient preferences, needs, and values" and that ensures that "patient values guide all clinical decisions" [11]. Its wide-ranging definition lists the attributes of the design of a service from a patient's point of view: respect for the patient's ideals; coordinated and integrated care; clear, high-quality information and education for the patient and family; physical comfort; emotional support and alleviation of fear and anxiety; involvement of family members and friends, as appropriate; continuity including care-site transitions and access to care [12].

Furthermore, PCC would benefit from a more integrated and coordinated process of care such as greater care customization but first there needs to be a better understanding of the experience of illness and of how to address patients' needs within complex and fragmented healthcare delivery systems [13,12]. There are two important differences between PCC and care customization.

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