Editorial

Diagnosis Related Groups: Evading Social Responsibility?

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In *Legal and Ethical Implications of Health Care Reimbursement by Diagnosis Related Groups,* published in this issue, Professor Marshall Kapp provides a helpful analysis of legal issues of concern to those who fear that health care financing reforms may ignore genuine health care needs. The author notes: "These issues arise chiefly because the DRG scheme focuses on control of resource consumption, rather than on assurance of quality or access, and thrusts responsibility for balancing those three elements on the individuals and facilities that provide health care services." I take this statement as an invitation to explore areas which lie outside the scope of his article, in particular, the role of physicians in weighing the social costs of care.

The DRG system represents a social mechanism for rationing supposedly scarce resources. It does so by converting health care professionals and hospitals from providers of care into agents for rationing health services. Whether or not medical malpractice standards can curtail potential injury to patients, the fundamental question is whether the system itself is just.

The assertion that today's physician must weigh the social costs and benefits of medical interventions as well as the benefits and costs to the individual begs the question. Who is responsible for ensuring an efficient distribution of resources? If society faces a critical shortage of resources to care for its ill and injured, must not society provide a remedy? The distribution of health care is not an individual or even a collective professional responsibility but a societal one. As such, it must be guided by principles of justice developed on a societal level.[1] If society insists that health professionals act as rationing agents, it recasts the social obligation as the individual responsibility of a physician or hospital.[2]

There are practical reasons that individual providers are not in a position to develop criteria for rationing care. It is not possible for individual providers to have adequate knowledge of all the social, economic, and technologic factors that affect the distribution of health care. Even with perfect knowledge, providers do not have the power to effect change on the large scale necessary to achieve a fair distribution of care. The expertise and experience required to care for individual patients do not necessarily accommodate that needed to distribute resources among all people. Nor should clinicians be burdened with that task. Even though they are sensitive to ethical problems in caring for their own patients, their decisions, often made privately and in the absence of explicit, universally applicable criteria, cannot provide a coherent, consistent set of principles for caring for the population as a whole. But even if the limitations on clinical capabilities could be overcome, there remains the basic question of whether individual providers should have the responsibility to ensure that resources are distributed efficiently and fairly.

Individual physicians, other health care providers, and such institutions as hospitals operate within a health care system structured, albeit loosely, by society. The fact that we find ourselves groping for a less costly system indicates that the structure has proved inadequate to distribute appropriate care at tolerable levels of expense.[3] Tinkering with the behavior of those who provide the direct care seems unlikely to force the systemic changes needed to solve distributional problems.

Asking physicians to force cost-effectiveness into the system by their individual decisions (on treatment, admission, discharge, etc.) is akin to asking parents to change the public school curriculum by refusing to help their children with their homework. Providers operate at the micro level of the health care system. What is needed are criteria for allocating resources at the macro level of the whole nation.

Do DRGs provide appropriate criteria for a fair and efficient distribution of health care? Without relying on any single theory, one can confidently say that distributive justice requires attention to the kinds of care that should be available and to their equitable distribution, that is, to the fairness of access to care.[4] The scarcity of resources merely poses a constraint on the means that society has at its disposal to satisfy its distributional obligations. DRGs address only one economic aspect of the distributional question. They offer incentives for restricting the scope of hospital services offered to patients in order to reduce costs. Even assuming that DRGs will eventually be applied to other than Medicare patients, it is too much to expect that by themselves DRGs can remedy such structural problems as the urban-rural maldistribution of physicians and hospital facilities, the unavailability of services for those without health insurance or private funds, and the direction of medical education and scientific research. Reliance upon such a limited mechanism to force providers to restructure

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the panoply of health care services is both misguided and unfair.

One might compare this approach with that of other countries. Under the British National Health Service, for example, Great Britain has established limits on resource availability. Individual practitioners are obliged to make choices within the overall constraints, but are not responsible for making the National Health Service economically sound. National policy has simply limited, *a priori*, the extent of care available. Of course, it is not easy to acknowledge that not all patients can undergo dialysis. Facing a social limit upon a service, the physician cannot provide that service to all patients who might conceivably benefit from it. It is distressing to see, as Aaron and Schwartz have noted, that British physicians often rationalize social rationing as medical judgment by incorporating socially imposed limitations into their medical criteria—for example, when assessing a patient's suitability for dialysis.[5] In assessing the relative needs of patients for the service, the physician may have to revise his or her medical criteria of suitability. However, the physician need not weigh the social costs of providing the service to any particular patient. Society has already circumscribed the range of choice, and the physician is free to act within that range in the best interests of the patient. Both physician and patient are assured that they may seek the best available care. The patient need not fear that the physician is cost-cutting at his expense. This is not to suggest that the British system is a suitable model for the United States. Nevertheless, the British system may be more honest than our own because the nation accepts responsibility for the necessary rationing and does not place practitioners in the untenable position of balancing patient welfare with social costs.

Professor Kapp suggests that the informed consent process of physician-patient communication may alleviate the discomfort surrounding DRGs and enable patients to make intelligent decisions in light of the cost and resource implications of treatment alternatives. There are several problems with this suggestion. First, it appears to assume that all patients are capable of making personal treatment decisions that are consistent with social and economic objectives, an assumption that seems unwarranted. Second, it assumes that patients who wish to receive services beyond those financed under DRGs will be able to pay for them. This will certainly not be true for a large segment of the population. For those for whom it is true, the generation of costs of additional treatment seems counterproductive to the motivating purpose of DRGs—to limit overall costs. Third, the DRG system provides little, if any, financial incentive to physicians to spend additional time in discussion with their patients. The result is that patients may have virtually no opportunity to learn of the economic considerations that influence their physicians' judgments. Finally, the use of informed consent to convert medical decision making into economic decision making seems wholly misplaced, a variation of blaming the victim. Patients have the right to consider the costs of their care, but the burden of solving the economic crisis of the health care system cannot be placed upon their shoulders alone, just as it should not be placed on the shoulders of their physicians.

DRGs may be an important step forward in devising financial systems to limit health care expenditures. But if DRGs are expected to transform the entire health care system into one that is both economical and fair, they are doomed to failure. No one would argue that providers should not strive to avoid unnecessary and wasteful procedures. However, their individual decisions at the micro level of allocation cannot solve the cost crisis in health care, much less the distributional problems. To the extent that DRGs force the individual provider to make an economic decision at the micro-allocation level, they are likely to be both unfair and ineffective. What is needed is responsible direction at the level of macro-allocation.

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