The DRGs—A Procrustean Solution

Introduction

For a ten-day stay the hospital room charges were $15 — in 1913! A five-day stay following an appendectomy in 1935 was $45. In 1985, that "same" room for five days would cost about $2500. Medical and surgical bills have shown similar large increases. A straightforward, uncomplicated appendectomy in 1935 cost around $75; today, in 1985, that "same" operation would be billed at about $600. To cover these costs, at least in part, the premiums for hospital and medical insurance have also skyrocketed. General Motors, for example, spent $400 million for medical benefits in 1984, which amounted to $5700 per active worker, or about $550 per automobile manufactured by General Motors (See E. H. Morreim, Hastings Center Report, June, 1985).

Federal expenditures, through Medicare, have grown so enormously that, unless a substantial reduction be made, by 1995 the deficit could rise to $300 billion. Clearly, something had to be done to reduce health care costs substantially. The Federal Government has taken a major step in this direction when Congress enacted Title VI of the Social Security Amendments of 1983, which included a prospective payment system (PPS) as the mode of reimbursement to hospitals for Medicare patients. The heart of the PPS is the Diagnosis Related Groups (DRGs).

The essence of the DRG principle is that patients are classed into one of 468 categories by virtue of their principal diagnosis, the medical condition which ultimately caused their hospitalization. For each of these categories there is a predetermined length of stay (LOS) and dollar reimbursement. The hospital receives that specified amount even though the patient, in fact, may have been discharged a day, or days, earlier or later than the standard LOS. In the former case, the hospital is the "winner" and retains the "over payment", while in the latter, the hospital is the "loser" and has to absorb the extra costs. Carefully to be noted is that the actual expenditures incurred by a particular patient has nothing to do with the reimbursement received. This system is designed to promote more efficiency in hospital management both by rewarding it and by punishing inefficiency.

The stated intention of this system is to contain health care costs while providing high quality care for the patient. Advocates of the PPS and its DRGs are convinced that the system will stimulate healthy competition (and cooperation!) among hospitals. It is foreseen that some hospitals will either close, merge, or be bought up by more efficient hospital groups. But critics remain skeptical.

Dollars and Quality Care

Concern about the impact of the DRGs on the quality of care which Medicare patients will receive led to a survey being taken of some 450 hospital administrators. Of these, 8% felt that the quality of care would actually improve, 38% believed that there would be no change, whereas about 54% opined that the quality would drop. What the final outcome actually will be remains to be seen. (See, Modern Health Care, Nov. 15, 1984).

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The system began the third year of its three year phase-in on October 1, 1985. During this transition period, the reimbursement rate was determined in part by the historical experience of the particular hospital and in part by the regional and national figures. This procedure was an attempt to cushion the potential negative financial impact on the hospitals. Starting with the fourth year (October, 1986), the reimbursement will be based on a single national rate for each DRG.

Although the DRGs' rules provide for some reimbursable extra days of hospitalization or extra costs, these provisions are not adequate. These include the notion of "outliers" — day outliers and cost outliers. If the patient's hospital length of stay exceeds a certain threshold point or the cost exceeds a certain amount, the system provides for extra reimbursement, but one which is deemed hardly sufficient. For example, an actual patient classified in DRG 170 is allowed 14.6 days stay. If he stays beyond that cutoff period there is no reimbursement for the extra days until day 35. Beyond that time the patient is a "day outlier" and the hospital will be reimbursed a small percentage of the basic rate. In this particular case, the reimbursement for the first 14 days was about $13,000. For day 15 to 34, the hospital received nothing, while for the patient's hospital stay from day 35 to 102 (time of discharge) the hospital received about $5,000 yielding a total of about $18,000. The service actually given to that patient was valued at approximately $73,000. That meant that the hospital had to pick up, as a loss, the difference — $55,000.

Inequities and Potential Injustices

With this mode of reimbursement, hospitals are experiencing a significant loss of income. At Yale-New Haven hospital, for example, studies have calculated that it could lose, on the average, $798 for each Medicare patient it treats (See, Dolenc and Dougherty, Hastings Center Report, June, 1985, p. 21). For many hospitals Medicare payments represent about 40% of their total revenues. Since previous reimbursement was open-ended, that is, based on reasonable costs actually incurred, the hospital could absorb the cost of providing care to the indigent as part of the overall operating expenses of the hospital. In effect the 3rd party payers (e.g., Medicare, insurance companies) were picking up the tab. Now, this manner of "paying for the poor" is almost entirely eliminated.

Thus, the potential harm which can result from the DRGs, as now constituted, includes the following:

1. It will become increasingly difficult for the hospitals to provide care for the indigent.
2. Medicare patients will be less attractive, especially the chronically ill.
3. The system has built-in an incentive to avoid the admission of the most severely ill patients.
4. Quality of care will drop, as patients will be discharged as quickly as possible.
5. The carrying on of research and the development of new technology are discouraged.
6. The physician will be under pressure to treat the patient with the economic health of the hospital in mind rather than having foremost the well-being of the patient.
7. Hospitals will tend to seek shelter in the arms of systems or for-profit-making chains which would remove local control and make the profit motive dominant.
8. Hospitals will tend to reduce or eliminate those services which do not contribute either to shortening the patient's stay or to reducing his treatment and care requirements.

Reflections

Our culture, in its worship of the body beautiful and body healthy, has raised health care to a new peak of concern. Of course, it is also true that as human beings (and Christians) we have a moral obligation to maintain our life and our health.

But to what extent? Technology has provided us the means to restore health and even postpone death for weeks, months, years. What effort are we obliged to expend in order to maintain optimum health? One must not forget that health of body (and of mind) is subordinated to the higher values of the spiritual life. The former two are to serve the latter. If in striving to maintain life and health we jeopardize or injure our spiritual life, then we have an inversion of values. The measure of the State's obligation to provide health care is a function of our own obligation to do so. Certainly, the State is not obliged to maintain our life and health at a higher level than our own obligation. But it is obliged to help individuals and families discharge their health responsibilities when they cannot. Hence, Medicare, or something similar, is necessary to assist the elderly and others to maintain adequate health as the Bishops' Pastoral on Health and Health Care urges (November 19, 1981, United States Catholic Conference).

While the DRGs have noble objectives — to contain health care costs and to maintain high quality care for Medicare beneficiaries—the DRGs as presently constituted appear to have unfortunate side effects, such as those discussed above. The Government needs to listen to the critics and institute appropriate corrective measures.

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